MID TERM REVIEW OF THE RWANDA

THIRD HEALTH SECTOR STRATEGIC PLAN

(HSSP III, JULY 2012 – JUNE 2018)

External Evaluation Team

03rd August – 31st August 2015

Final Report

Kigali, 27 October 2015

FOREWORD

In order to achieve its mission and objectives as defined in the Health Sector policy, the Ministry of Health conducted the Mid-Term Review of HSSP III in August 2015 to measure progress and achievements within the past three years (2012-2015).

The objective of the Mid–term review was to assess the overall progress made in the implementation of HSSP III, identify challenges, lessons learnt, and formulate recommendations to accelerate the implementation aimed at achieving the desired impact.

The third Health Sector Strategic Plan (HSSP III: 2012-2018) is being implemented within the framework of achieving government objectives in regards to the Sustainable Development Goals and poverty reduction as defined in the EDPRS II (2012-2018) and vision 2020.

HSSP III is inspired and guided by vision 2020 that will make Rwanda a Lower Middle Income Country by the year 2020. It will continue and expand the work undertaken as part of EDPRS II, in the delivery of health services.

The DHS 2015 and HSSP III (2012-2018) Mid-term review showed very important improvements in terms of geographical access to health services, a tremendous decrease in child mortality, and there was also a substantial improvement on maternal health indicators. HIV prevention and treatment services were availed countrywide, and Rwanda is making remarkable progress towards eliminating mother to child HIV transmission.

We strongly believe that at the end of HSSP III, the health sector will be able to provide comprehensive and integrated care at all levels of service delivery in a client friendly way. The HSSP III Mid-term review report will be used to update HSSP-III (July 2015- June 2018) with the participation of all stakeholders.

Dr. Agnes BINAGWAHO
Minister of Health

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ABBREVIATIONS AND ACRONYMS

AABB	American Association of Blood Banks
AfSBT	African Society of Blood Transfusion
AIDS / SIDA	Acquired Immuno-Deficiency Syndrome
ANC	Ante Natal Care
ART	Anti-Retroviral Treatment
BCC	Behavioural Communication and Change
BEmOC	Basic Emergency Obstetric Care
BECS	Blood Establishment Computerized System
BTC / CTB	Belgian Technical Cooperation / Coopération Technique Belge
CAMERWA	Central Drug Purchasing Agency in Rwanda (ED)
CBEHPP	Community-Based Environmental Health Promotion Program
CBHI	Community Based Health Insurance schemes (= Mutuelles)
CBHP	Community-Based Health Program
CBNP	Community-Based Nutrition Program
CCM	Country Coordination Mechanism
CDC	Centre for Disease Control
CDPF	Capacity Development Pooled Fund
CEmOC	Comprehensive Emergency Obstetric Care
CHC	Community Health Clubs
CHU	Centre Hospitalo-Universitaire
CHUB	Butare University Hospital (teaching hospital)
CHUK	Kigali University Hospital (teaching hospital)
CHW	Community Health Worker
C-IMCI	Community Integrated Management of Child Illnesses
COGE	Health Centre Management Committee (Commite de Gestion)
COHSASA	Council for Health Service Accreditation of Southern Africa
COPD	Chronic Obstructive Pulmonary Disease
COSA	Health Committee (Committee Sanitaire)
CPD	Continuous Professional Development
CQI	Continuous Quality Improvement
CPR	Contraceptive Prevalence Rate
CSO	Civil Society Organization
DA	District Assembly
DG	Director General
DH	District Hospital
DHS+	Demographic and Health Survey (+ = with HIV testing, done in 2005)
DHMT	District Health Management Team
DHU	District Health Unit
DOTS	Directly Observed Treatment Scheme / Short Course
DP	Development Partners
DPG	Development Partner Group
DPR	Disaster Preparedness and Response
DPT	Diphtheria, Pertussis and Tetanus
DQA	Data Quality Assessment
DSST	District System Strengthening Tool
EAC	East African Community

ED	Essential Drugs
EDPRS	Economic Development and Poverty Reduction Strategy
EDSR	Enquête Démographique et de Santé au Rwanda (=DHS)
EHCP	Essential Heath Care Package
EHTWG	Environmental Health Technical Working Group
EIDSR	Electronic Integrated Disease Surveillance and Response
EID	Epidemic and Disaster Prevention, Management and Response
EMR	Electronic Medical Records
EMRS	Electronic Medical Record Systems
EPI	Expanded / Enlarged Program for Immunisation
ESR	Epidemic Surveillance and Response
EU	European Union
FAMCO	Family and Community Health Physicians
FANC	Focused Antenatal Care
FARG	Genocide Survivors Support and Assistance Fund
FBO	Faith Based Organisation
FED	Fonds Européen de Développement
FP	Family Planning
GAVI	Global Alliance for Vaccines and Immunisation
GBV	Gender Based Violence
GDP	Gross Domestic Product
GFATM	Global Fund for AIDS, TB and Malaria (=GF)
GMP	Good Manufacturing Practice
GP	General Practitioner
GOR	Government of Rwanda
GSMM	General Senior Management Meeting
HBV	Hepatitis B Virus
HC	Health Centre (= CS)
HCV	Hepatitis C Virus
HF	Health Facilities (including DH and HCs / HPs)
HF	Health Financing
HH	House Hold
HIS	Health Information System
HIV / VIH	Human Immuno-Deficiency Virus
HMIS	Health Management Information System
HP	Health Post (= Dispensary)
HR	Human Resources
HRG	High Risk Groups
HRH	Human Resources for Health
HRTT	Health Resources Tracking Tool
HSP	Health Sector Policy
HSS	Health Systems Strengthening
HSSP	Health Sector Strategic Plan
HSWG	Health Sector Working Group
HW	Health Worker
ICCM	Integrated Community Case Management
ICT	Information Communication Technology
I-DHS	Interim (or mini) Demographic and Health Survey (2007)
IDSP	Integrated Disease Surveillance and Response

IFMIS	Integrated Financial Management Information System
IHP+	International Health Partnership plus
IMCI	Integrated Management of Child Illnesses (=PECIME)
IMR	Infant Mortality Rate (/ 1000 live births)
IPC	Infection Prevention and Control
IPT	Intermittent Presumptive / Prevention Treatment (for Malaria in Pregnant Women)
IRS	Indoor Residual Spraying
ISMM	Internal Senior Management Meeting
ISO	International Organization for Standardization
ISPG	Gitwe Institute of Higher Education
ISS	Integrated Supportive Supervision
IT	Information Technology
ITN	Insecticide / Impregnated Treated Bed Nets
JADF	Joint Action Development Forum
JANS	Joint assessment of National Strategies
JFA	Joint Financing Agreement
JHSR	Joint Health Sector Review
JPC	Joint Permanent Commission
KFH	King Feisal Hospital
KHI	Kigali Health Institute
KIR	Key Indicator Results
LB	Live Births
LLITN	Long Lasting Impregnated Treated Bed Nets
LMIS	Logistical Management Information System
LNR	National Referral Laboratory (Laboratoire National de Référence)
LABOPHAR	Pharmaceutical Laboratory
MARP	Most at Risk Populations
MCH	Maternal and Child Health
MDG	Millenium Development Goals
MDR	Multiple Drug Resistance (TB)
M&E	Monitoring and Evaluation
MH	Mental Health
MIFOTRA	Ministry of Public Service, Skills Development and Labour
MIGEPROFE	Ministry of Gender and Women Promotion
MIJESPOC	Ministry of Youth, Sport and Culture
MINAFRA	Ministry of Infrastructure
MINALOC	Ministry of Local Administration, Community development and Social Affairs
MINECOFIN	Ministry of Finance and Economic Planning
MINEDUC	Ministry of Education, Science, Technology ad Research
MOH / MINISANTE	Ministry of Health
MINISTERE	Ministry of Land, Resettlement and Environment
MIS	Management Information System
MMR	Maternal Mortality Ratio (/100,000 births)
MMI	Military Medical Insurance
MOU	Memorandum of Understanding
MPPD	Medical Production and Procurement Division
MSH	Management Sciences for Health
MSM	Men having Sex with Men
MTEF	Medium Term Expenditure Framework
MTR	Mid Term Review

NA	Not Available
NBTS	National Blood Transfusion Services
NCBT	National Centre for Blood Transfusion
NCD	Non-Communicable Disease
NCDA	Neo Natal and Child Death Audits
NFNP	National Food and Nutrition Policy
NGO	Non-Governmental Organisation
NHA	National Health Accounts
NIDA	National Identification Agency
NISR	National Institute for Statistics and Research
NLTCP	National Leprosy an TB Control Program (= PNILT)
NMR	Neonatal Mortality Rate
NN	Neo-Natal
NRL	National Referal Laboratory (Laboratoire National de Référence)
NSP	National Strategic Plan
NS	Not Stated
NTD	Neglected Tropical Diseases
OAG	Office of the Auditor General
PAC	Post Abortion Care
PBF / PBC	Performance Based Financing / Performance Based Contracting
PEPFAR	President's Emergency Plan for AIDS Relief
PEFA	Public Expenditure and Financial Accountability
PFM	Public Financial Management
PH	Public Health
PHC	Primary Health Care
PIH	Partners in Health
PLWHA	People Living With HIV and AIDS (see PVVIH)
PMTCT	Prevention of Mother-to-Child Transmission (of HIV)
PNBC	Programme Nutritionnel à Base Communautaire (= C-Nutrition)
PNC	Post Natal Care
PNLS	Programme National de Lutte Contre le SIDA
PPP	Public Private Partnership
PS / PS	Permanent Secretary / Private Sector
PW	Pregnant Women
QA	Quality Assurance
QC	Quality Control
QMS	Quality management System
RAMA	Rwanda's Medical Insurance Agency (formally employed in public sector)
RBC	Rwanda Biomedical Centre
RDB	Rwanda Development Bank
RDHS	Rwanda Demographic and Health Survey (= DHS)
RDT	Rapid Diagnostic Tests (for Malaria)
RDU	Rational Drug Use
RED	Reach Every District (EPI Strategy)
RH	Reproductive Health
RHCC	Rwanda Health Communication Center
RICH	Rwanda Interface Council for Health
R-SPA	Rwanda Service Provision Assessment Study (2007)
RSSB	Rwanda Social Security Board

RWF	Rwanda Franc
SAMU	Service d'Aide Médicale d'Urgence
SC	Steering Committee
SCH	Schistosomiasis
SDC	Swiss Development Cooperation
SDG	Sustainable Development Goal
SGBV	Sexual and Gender Based Violence
SMS	Short Message System
SP	Sulfadoxine-Pyrimethamine
SPIU	Single Project Implementation Unit
SPR	Slide Positivity Rate
STG	Standard Treatment Guidelines
STH	Soil Transmitted Helminths
SWAp	Sector Wide Approach
TA	Technical Assistance
TB	Tuberculosis
TFR	Total Fertility Rate
TOR	Terms Of Reference
TOT	Training of Trainers
TSR	Treatment Success Rate
TWG	Technical Working Group
UFMR	Under Five Mortality Rate (/1000 live births)
UNFPA	United Nations Fund for Family and Population
UNICEF	United Nations Children Fund
UPHLS	Umbrella of Persons with Disabilities fighting HIV & AIDS
UR	University of Rwanda
USAID	United States Agency for International Development
USD	US Dollars
USG	United States Government
WB	World Bank
WHO / OMS	World Health Organisation
WHO/PES	WHO Pesticide Evaluation Scheme

Conversion Rates (August 2015):

1 USD = 725 RWF (or 100 RWF = 0.137 USD) (in 2011: 1 USD = 595 RWF)

1 Euro = 785 RWF (or 100 RWF = 0.127 Euro) (in 2011 1 Euro = 845 RWF)

SECTOR PERFORMANCE INDICATORS HSSP (2000 – 2015-2018)

Table 1. Key HSSP Performance Indicator trends against HSSP Targets (Aug 2015)

INDICATORS	Baseline VISION 2020	HSSP I 2005	MTR Aug 2011	MTR Aug 2015	TARGET Mid 2015	TARGET June 2018
Source of Information*	**2000**	**DHS 2005**	**DHS 2010 HMIS 2011**	**DHS HMIS 2015**	**MDG 2015****	**HSSP III**
IMPACT INDICATORS						
Population (NISR)	7.7	8.6	10.5	11.2	11.3	11.5
Life Expectancy (NISR)	49		55	65.7	58	68
Infant Mortality Rate / 1,000 (DHS 2014-15)	107	86	50	32	28	22
Under-5 Mortality Rate / 1,000 (DHS 2014-15)		152	76	50	30	42
Maternal Mortality Ratio / 100,000 (same)	1,070	750	476	210	287	220
Total Fertility Rate (TFR), DHS 2014-15	6.5	6.1	4.6	4.2	4.5	3.4
HIV Prevalence Rate among PW 15–49 yrs	1.3	1.0	3.0	1 (RBC)	3.0	3.0
OUTCOME / OUTPUT INDICATORS						
Prev of Underweight (Wt/Age) among children 6–59 months	30	18	11	9	8	4
Prevalence of Stunting (Ht/Age) among children 6–59 months		51	44	38	24.5	18
Prevalence of Wasting (Ht/Wt)		5	3	2	2	2
% Births Attended in Health Facilities		39	69	91	78	90
% PW Receiving 4 ANC Visits		13	35	44	50	65
% Children <1 yr. immunized for measles		75	95	99	97	97
# Districts with One-Stop Center (GBV)			4	17	19	42
% Contraceptive Utilization Rate			31	41.5	36	40
% Modern CPR among married women 15-49	NA	17	45	47.5	62	72
% HF with VCT / PMTCT Services			94	96	96	96
% Malaria Prevalence Women / Children		NA	0.7 / 1.4	NA	<1 / 1.2	<1 / 1
% HHs with at Least One LLIN		18	82	81	85	>85
% TB Treatment		58	87.6	90	89	90

INDICATORS	Baseline VISION 2020	HSSP I 2005	MTR Aug 2011	MTR Aug 2015	TARGET Mid 2015	TARGET June 2018
Source of Information*	**2000**	**DHS 2005**	**DHS 2010 HMIS 2011**	**DHS HMIS 2015**	**MDG 2015****	**HSSP III**
Success Rate / DOTS						
% TB/HIV Patients Receiving ART			67	90	85	90
Diarrhea prevalence among the under-five (% U5 with diarrhea in last 2 weeks before survey)			13	12	11	9
INPUT INDICATORS						
% GOR Budget Allocated to Health***		8.2	11	14	12	15
Per Capita Total Annual Health Expend (USD)		NA	$ 39.10	$ NA	$ 42.00	$ 45.00
% Population Covered by CBHI		12	91	76.3%	91	91
Doctor / population ratio	1 / 75,000	1 / 50,000	1 / 16,001	1 /10.055	1 / 13,748	1 / 11,993
Nurse / population ratio	1 / 6,250	1 / 3,900	1 / 1,291	1 / 1.142	1 / 1,291	1 / 1,000
Midw / population ratio	NA	NA	1 / 66,749	1 / 4.037	1 / 45,000	1 / 25,000

* Note**:** For Impact indicators the recent DHS (2014-15) has been used. HMIS figures have been used for outcome and output indicators in the various sections of the document. Other figures come from annual reports of various MOH departments / units.

** The HSSP III document (page 4) gives as MDG target for 2015 a value of 30/1000LB, while DHS 2014/15 gives a result value of 50/1000LB, hence the conclusion in the text that this MDG has not been achieved.

*** The method of calculating this figure is based on the NHA methodology and is explained in the body of the report; it allows comparison between the various years.

1. EXECUTIVE SUMMARY

Background

The VISION 2020 sets three ambitious goals for Rwanda: 1) Become a middle-income country having halved the percentage of people living in poverty; 2) Raise life expectancy to 55 years; and 3) Reduce its aid dependency level. The EDPRS II (2013-2018) translates the VISION 2020 into operational strategies for the country, while the Health Sector Strategic Plan (2012-2018), being fully aligned to the EDPRS II, provides the health sector with a framework to guide the strategies, objectives, priorities, guidelines and plans to achieve its stated goals.

In Jan 2015 the MOH revised its Health Sector Policy, with overall aim to ensure universal accessibility to both geographical and financial terms for equitable and affordable quality health services for all Rwandans. This policy sets out four Policy Directions: (i) improve demand, access and quality of essential health services; (ii) strengthen policies, resources and management mechanism of health support systems; (iii) strengthen policies, resources and management mechanism of health service delivery systems; (iv) strengthen health sector governance, including M&E and reporting mechanisms.

As planned in HSSP III, a Mid-Term Review (MTR) was scheduled for early 2015. The overall purpose of this review is to assess the progress made in the implementation of HSSP III; and, determine whether the health sector is achieving set objectives. The Mid Term Review is part of on-going health sector monitoring and evaluation.

Methodology

A team of four international consultants had been recruited by the MOH to conduct this MTR in-country between 3rd to 22nd August 2015, supported by facilitators from MOH and WHO.
In the first week of the assignment, the Inception Report was discussed and endorsed by the MTR Steering Committee (chaired by the PS and co-chaired by USAID). It contained details on the methodology of the work, a draft roadmap, the Table of Contents (ToC) of the MTR report and the tools / questionnaires to be used during the interviews with all stakeholders at all levels.
The team continued to work on the basis of a Terms of Reference (Annex 1) and interviewed / discussed with the heads of many programs, key informants and members of Technical Working Groups (TWG), Units and sub-units of the MOH, other Ministries and other Stakeholders (see the program in Annex 2 and the list of people interviewed in Annex 3).
The team consulted National and International documentation (Annex 4), but was told to limit itself to national sources of information to what had been 'validated' by MOH

In the second week, the team conducted visits to all four provinces of the country where the various actors and stakeholders in seven administrative districts (including DA, DH, DHMT, District Pharmacy and Health Centres) and three National Referral Hospitals were interviewed (Annex 2, week 2). Districts were selected by MOH, based on their good / poor performance in the social sector scoring of Imihigo. During the visits efforts were made to interview as much as possible a wide range of actors and resource persons.

In the last week of the assignment, a few more interviews took place. The team then presented a power point of its main findings on all four components of HSSP III to the core team, highlighting key achievements, challenges and the main recommendations. Their comments and suggestions were included in the next version of the PPT that was presented during a meeting, chaired by DG/Planning and in the presence of many of the DPs. A final debriefing meeting was held on the last day of the assignment chaired by the PS, Dr. Solange Hakiba. Unfortunately, the intended Consultative Workshop, mentioned in the TOR and the Inception Report, did not take place.

MTR Team composition
The MTR team consisted of international consultants and national counterparts:

Table 2. MTR Team Members, August 2015.

NAME CONSULTANT	AREAS OF EXPERTISE	NATIONAL RESOURCE PERSONS
Jarl Chabot	Public Health Specialist	Mrs Aline Niyonkuru (MOH) Mr Alypio Nyandwi (MOH)
Abebe Alebachew	Health Economist / Finance Specialist	Mrs Diane Muhongerwa (WHO) Dr Albert Tuyishime (RBC)
Prosper Tumusiime	Health Systems Specialist (WHO-AFRO)	Mrs Mecthilde Kamukunzi (MOH)
Kwadwo Mensah	Human Resource Specialist	Mrs Stella M. Tuyisenge (WHO)

Limitations of the MTR
Conducting a full sector review during a three weeks in-country mission is a challenge bound to face limitations. Among the few limitations encountered during this exercise, we would like to mention (i) the short time available to meet some TWGs, Divisions and Units, limiting our understanding of challenges and plans for the future of certain programs and (ii) the fact that we could not consult some recent documents that are still awaiting validation by the MOH.

MAJOR FINDINGS OF THE MTR TEAM

The main conclusion of the 2015 MTR team is the observation that the Rwanda health sector has achieved all MDG targets thanks to bold and decisive leadership and strong implementation of its strategies and policies, but that the sector is now at a cross-roads, as it is facing the challenge to sustain the current level of service provision, while responding to (i) the significant reduction in external financing and (ii) the increase in secondary/tertiary care facilities/equipment together with the move towards the training of many specialist care providers.

The Ministry of Health has already rightly started to respond to these challenges by formulating various sustainability plans and initiated several efficiency enhancing measures. Next to these important initiatives, the MTR team suggests to (i) undertake a comprehensive study into the various cost items in the coming years for Primary, Secondary and Tertiary care; (ii) strengthen the inclusion of development partners and other stakeholders (Private sector, CSOs) in the policy dialogue on sustainable health care financing and cost-effectiveness measures. Finally, the team suggests to (iii) introduce the concept of 'gatekeepers' within the current levels of primary care, being staff at Health Centre level needed to avoid the indiscriminate use of the higher (and more costly) levels of care, seen in so many countries in the region.

Below is the summary of the major findings of the MTR team.
A. First we respond to the questions mentioned in the TOR of this MTR, related to the Effectiveness, the Relevance, Efficiency and Sustainability of the HSSP III. We summarize our observations, as they will also be addressed in the various sections in the body of the report.
B. Subsequently, we present the summary of our findings for each of the four components and sub-components of the HSSP III, looking at the various achievements, the challenges and the recommendations for each of them.

A. Summary of findings for each of the specific objectives of the TOR

EFFECTIVENESS

Strengths: HSSP III was effective in delivering the set targets in terms of outputs, outcomes and impacts as documented in the recent DHS results and various sector performance reports.
Challenges: The ultimate results of HSSP III achieving the 2018 targets will depend on the harmonious inter-relationships between all the five components. The tendency observed by this MTR indicates that the impressive expansion of secondary care could well affect negatively the primary care achievements of the past.
Recommendations: Ensure strengthening and sustainability of the CHW network, as it is the basis for any future improvement in the public health performance of the country. Revise HSSP III targets in view of its achievements and upcoming SDG commitments

RELEVANCE

Strengths: HSSP III priorities and strategies by and large remain relevant for the remaining period of the plan. With the emerging international commitments (SDGs) and challenges associated with the declining external resources, the relevance of some of the strategies in each of the components need to be reviewed and sharpened.
Challenges: Some of the strategies in the HSSP III are not congruent with the emerging context.
Recommendations: Each component needs to review the relevance of each of its strategies and interventions in view of constrained resourcing, status of the achievement of HSSP III targets and international commitments.

EFFICIENCY

Strengths: Rwanda is stepping up its efforts to enhance efficiency through rationalization of expenditures by each of the programs; health facilities focusing mainly on rationalization of human resources deployment as well as strengthening decentralization.

Challenges: The scopes with which the sector can enhance allocative, technical and operational efficiencies in each of the program areas have not yet been well explored.
Recommendations: In terms of allocative efficiency, there is a need to continue prioritizing PHC, balancing it with the higher referral systems; continue investing in subsidizing essential services and prioritize human resource development on skills that benefit the majority of the people. The sector can also enhance operational efficiencies through exploring the use of PBF as main payment mechanism; investing more on rational use of medicines, maintenance systems and rationalization of management of the different programs.

SUSTAINABILITY
Strengths: Rwanda has achieved most of its MDG targets and need to ensure that the gains made so far are sustained in an environment of declining external resources. Challenges of sustainability are recognized and strategies for domestic financing have been charted out, as part of new health financing sustainability plan (introduction of sin taxes and levies, private sector engagement, self-financing strategies for health facilities and enhancing risk polling and purchasing arrangements).
Challenges: the move towards self-financing and higher tariffs is likely to have a negative impact on affordability and might negatively affect the gains made so far, such as those in Family Planning. Programs are trying to come up with sustainability strategies that might fragment and reduce the effectiveness of the approach to be used.
Recommendations: Implement the Health Sustainable Financing Policy and approve the draft Health Care Financing Strategy. Fast track the implementation of the domestic financing strategies in general, and the innovative financing schemes in particular. The revision of essential package's list and its thorough costing should drive the sustainability agenda. There is a need to ensure that tariff revisions are based on stratified service costing exercise and to balance the need to ensure financial sustainability with affordability and sustaining the gains made so far. The MOH should work towards developing and implementing a sector wide sustainability strategy supported by proactive and adequate policy dialogue with MINECOFIN and DPs.

QUALITY
Strengths:: There are clear policies and strategic guidance on quality assurance and accreditation at primary and secondary levels of care, including capacity building.
Challenges: There is absence of an independent accreditation agency and inadequate budget and capacity for the institutionalization of quality assurance. Given the high service coverage achieved, quality at primary and secondary levels becomes the more critical issue to address.
Recommendations: Expedite establishment of the Accreditation Agency and institutionalize quality assurance at all levels with adequate budgets and capacity**.**

B. Summary of findings for each of the four components of HSSP III.

Component 1: PROGRAMS

Achievements

Table 1 provides an overview of the major trends between 2000–2010 with the baseline, the HSSP III targets for 2015 and 2018 and the results of the impact, outcome and output indicators of the HSSP III in 2014-2015.
In Maternal Health, Table 1 shows how Rwanda has achieved the MDG target for the Maternal Mortality Ratio not only ahead of MDG but also well before the HSSP III target year 2018. According to the recent DHS (2014-15), the MMR currently is 210 per 100.000 Live Births, while the target for 2015 was 287 and for 2018 was 220 per 100,000 Live Births.
For the IMR and U5MR Rwanda almost achieved the MDG targets. It is quite certain it will achieve its 2018 HSSP targets (see Table 1 above).
The Gender Based Violence (GBV) program is expanding access to more than half of the districts, serving between 20-30 victims per month!

Mental Health has expanded its services to the whole country, increasing substantially the number of psychiatrists and mental health nurses, thus providing MH nationwide and integrate its services among the various services at HC and DH levels
Prevalence of Stunting (Ht/Age) has been brought down from 51 in 2005 to 38 in 2015.
The other programs under MCH (EPI, and others) are consistently doing very well.

In Communicable Diseases and NCDs, the HIV program shows stable prevalence (3%) and a reduction in new HIV cases. The program is completely integrated in the general health services, while the detection of new TB cases is still increasing with the recent High Risk Detection approach. NCD programs have also been established in most health facilities and screening for a few diseases (Hypertension, Diabetes) has started.

Challenges
The two main challenges in Maternal and Child Health are (i) the high Neonatal Mortality Rate (NMR, being 20/1000 LB) that impacts on the IMR (being 32/1000 LB) and therefore could be a cause for not fully achieving the IMR MDG target; and (ii) the slowing down of the Contraceptive Prevalence Rate among married women 15-49 yrs (CPR = 47.5% compared with the target 62%) together with a substantial increase in the unmet need for FP services and commodities (from 12% to 19%). Reasons for this are not very clear at the moment, but various options are object of further reflection.

In Communicable Diseases (CDC) and Non-Communicable Diseases (NCD), the main challenge is the continuous increase of Malaria that is affecting large parts of the country (mainly the south and east) and in fact the whole of the east and southern African region. Main contributing factors of the malaria increase in Rwanda have been analyzed (LLITN less effective, global warming, influx from adjacent countries). The GoR has set a plan to address these contribution factors.

Recommendations
In Maternal and Child Health the team recommends to expand and continue the creation of NN corners in HCs and DH and standardize quality of newborn care, while at the same time improving the quality of intra-partum and postpartum obstetric care.
In FP and ASRH, the FP strategy need to be revised and modern promotional activities for the various age groups (youth in particular) should be developed.

In Communicable Diseases and NCDs, after a thorough analysis of contributing factors to the increase of Malaria, the Malaria Control Program has adopted a comprehensive plan to bring the epidemic down, However there is need to continue to investigate other contributing factors related to malaria increase in the country and the region. It will need an emergency action plan where all elements of the strategy will come together to become effective.

Component 2: HEALTH SUPPORT SYSTEMS

Planning and Financing (5.1 and 5.6)
Achievements:
Planning: Sub-sectors, districts and facilities have strategic plans that are well aligned to HSSP III priorities and strategic directions. There is a culture of developing, implementing and monitoring annual actions plans at all levels of the health system. The decentralization process has helped for establishment and function of DHMTs and DHUs, which helped districts to engage central Ministries about their priorities. There is a monitoring system supported by a well-functioning electronic health information system.

Finance: The major targets for increasing government allocation to health to 13% is met; maintaining coverage of CBHI at 91% is not achieved as coverage rate is about 76%. Figures on the increasing per capita health expenditure for health to $ 43 are not available at the moment. The overall financing of HSSP III over the last three years is not known, as off-budget resources

are not known in the last two years (HRTT latest report is only for 2012/13). With the declining external financing, there is also an understanding of the challenges of sustainable financing at all levels. The Health Sustainable Financing Policy endorsed in 2015 outlined the overall direction, while the draft Health Care Financing Strategy spelt out the mechanics of resource mobilization strategies, including innovative domestic sources. The government continues to be committed to see the CBHI scheme working, as can be evidenced by the decision (i) to continue financing the premiums for the very poor; (ii) to finance the debts of CBHI schemes from facilities until June 2015; and (iii) to shift the management of CBHI from MOH to RSSB to enhance its effectiveness and sustainability. The decentralization process contributed to enhancing efficiency of resource use.

Challenges

Planning: Resource mapping is often carried out and evolved into HRTT. The planning process currently is not informed by a resource mapping process that feeds into the budgeting process. The Health Resource Tracking Tool (HRTT) could serve this very purpose but its timing of data collection, analysis and reporting is not aligned with GORs budgeting and review calendar. The service delivery action plans is more driven by the district hospital; and DHU's role in the planning process is limited and its capacity for planning and monitoring needs further strengthening. There is also a need by development partners to provide resource information for the upcoming plans to ensure that it is captured in the planning and budgeting process at all levels.

Finance: Rwanda is currently experiencing a decline in external resources, which is a major challenge not only to respond to the new health sector priorities, but also to maintain the gains made so far. The extent to which the fiscal space of the government will cover the deficit is unknown. Health facilities are now increasingly taking over the employment of human resources using their internally generated revenue that used to be paid through external support. This may have a negative effect on the scope and quality of services provided. In addition the cost implications of the move towards more secondary and tertiary care have not been assessed, despite the recommendation by the JANS team in June 2012 (p. 7) to *"develop a costed strategic section for enhancing quality of tertiary care"*.

About 23.6% of Rwandese people in the informal sector are yet to be reached through CBHI. The mandatory law of CBHI enrolment is not enforced and many choose to opt out of the scheme. The scheme has significant financial deficit in covering the reimbursement costs to providers. The actual tariffs paid to providers are reported to not yet fully cover the cost of service provision (the unpaid cost range from 15% to 239% of the total cost).. The inclusion of the expanding health posts, paid as per HC tariffs, is likely to bring additional financial burden to the already stretched scheme. The underlying cause of this financial situation of the CBHI is its inability to collect adequate funding from its members that matches the costs for service utilization of its members.

Recommendations

Planning: Making better use of the Health Resource Tracking Tool can strengthen the planning and budgeting process further. This include aligning its annual timing of data collection to MINECOFIN's planning and budgeting calendar and enforcing its adherence and timeliness by all partners; enhance its use as driver or information source for prioritization discussions, accountability on resource utilization during joint reviews and annual planning/ budgeting process. This calls for planning, financing and information from TWG to develop a clear calendar that should provide adequate notice for DPs to provide meaningful contribution. There is a need to continue trying to work and come out with technical solutions around the differences in budget calendars. There is also a need to fast track the process of undertaking the next NHA.

In order to have a clear understanding of the availability and gaps of funding for HSSP III, it is prudent to limit the analysis of the government allocation to the health sector to only those budget lines that are used to finance the HSSP III activities. MOH should finalize the health financing strategic plan and start implementing the major strategic activities immediately. The sector would benefit a lot from a comprehensive look of sustainability of financing rather than developing

program based and fragmented sustainability plans. The planned MOH sector wide sustainability study needs to be fast-tracked. In this regard, the following activities should be given priority to generate evidence to inform decisions and actions on the sustainability of the health sector; (i) revising the package of services: differentiate services to be provided free of charge, on cost sharing or full cost recovery basis; (ii) cost the reclassified service package and estimate associated charges necessary for the sector to finance; (iii) undertake a fiscal space analysis to know the scope with which resources can be mobilized from the treasury; and (iv) assess the feasibility of introducing the innovative approaches. It is also important to relook at the strategies and mechanisms to foster and encourage private sector involvement.

Component 2: HEALTH SUPPORT SYSTEMS

Human Resources (5.2) & Knowledge Management and Research (5.9)

Achievements

The 2015 targets in the HRH field have been achieved in terms of numbers of Doctors, Nurses, Midwifes and Laboratory Technicians. In addition, key staff of MOH, RBC and in many hospitals completed Masters Degrees programs, following a strong and consistent capacity building drive that has also contributed to bonding of these professionals for a period of five years.

This increase in numbers of health staff has been made possible through an increment of institutional capacity for enrollments, retention strategies and teaching institutions. In 2012 there was just one medical school, in 2015 there are 2 medical schools and by 2018 five medical schools are expected to be in operation.

In Postgraduate training, MOH has set a target to produce over 550 medical specialists between 2012 till 2018 (7 years), most of them are currently still in training. They are expected to strengthen the whole referral system by increasing access and by providing good quality health care at the district level and above.

Challenges

In spite of the expansion in the provision of clinicians, there is still a shortage of specialized health professionals. Moreover, the specialization drive to produce these 550 clinical specialists within the country (and limited specialist training outside Rwanda) will draw candidates from the General Practitioner (GP) pool and thus deplete the GP numbers. While the drive to train specialist within Rwanda is highly welcomed, a consequence could be a shortage of GPs at the primary / district levels and below (Health Centres).

Another consequence to be considered is the operational costs that is linked to the provision of specialised care. Specialists are expensive to train and their services are also expensive, as they often employ sophisticated equipment in their investigations. It seems that the budgetary implications of such specialist training, employment, infrastructure and purchase / maintenance of sophisticated equipment has not yet been fully estimated, despite a recommendation by the JANS team in June 2012 (p. 7): *"the proposed investment in tertiary care and its implications in terms of recurrent cost and for the funding of other priorities, for example primary health care, need to be assessed. This requires development of a costed tertiary care strategy".*

Recommendations

The MTR team takes note of the decision by the Honorable Minister of Health that the post-graduate training of Family and Community Health Physicians (FAMCO) is not a current priority of the MOH. This can be justified taking the need for more specialised services into account, given the expected changes in the disease burden from Infectious to Non-Communicable Diseases. However, the timeframe with which these changes will occur is not really known.

Therefore, the MTR team suggests:

1. To initiate a detailed costing study that will provide financial information on the medium- and long-term consequences for the health budget (both investment and recurrent costs) in the provision of primary, secondary and tertiary care. The study should include the full package of care (including HR requirements) for each of the relevant levels.

2. To inventorise the available strategies and scenarios that will balance the costs for these three levels of care in the coming 10-20 years and thus allow for a rational decision on the future HRH and other investment priorities.

5.9. Knowledge Management and Research

Achievements

Achievement include the development of the National Health Research Agenda and collaboration between the MOH teaching and research institutions. In addition to the objectives and the guiding principles of the National Research Agenda (2014-2018), its priority areas have been usefully classified into nine thematic areas around: Disease Prevention and Control, NCDs, Maternal health, Health Promotion, Community health, EIDSR, HSS, Clinical Research and multi-sectoral research. As a consequence there is an increase of peer review publications in Health sector.
Another achievement is the improvement of regulation and review mechanisms by putting in place institutional review boards and programs based research collaboration.
All research is authorized by the MOH to avoid duplication and to ensure that it is a priority area.

Challenges

The main challenges are reduced funding for research and limited research capacity.
The research agenda is not fully promoted across the sector.

Recommendations

A lot of effort should continue into building staff capacity and interest in research, because there is a large amount of data generated by HMIS which can provide data for operational research. This can be done with limited additional funding and results would inform a lot of important decision making and thus should be encouraged.

Component 2: HEALTH SUPPORT SYSTEMS

Medical Products (5.3) till Quality Assurance (5.7)

Achievements

Storage capacity for health commodities has been increased at MPPD and at the district pharmacies. With 80% coverage of electronic LMIS, stocks are better monitored resulting in reduction of stock-outs to only 1% and 2% for district pharmacies and hospitals, respectively. The quality control laboratory has been constructed, drug therapeutics committees are functional in all hospitals. NBTS has achieved level 2 recognition with the African Society of Blood Transfusion (AFSBT), it has introduced new technologies, including apheresis and the number of voluntary donors have reached 61,700 this year (increase of 9%). Five satellite laboratories have been constructed and equipped in addition to the National Reference Laboratory (NRL). They have attained ISO 15189 rating of 4 stars and 5 stars, respectively, while over 33 district laboratories have been enrolled in the accreditation assessment. Since July 2013, 49 clinical laboratories and NRL have participated on international external quality assurance program quarterly. Six hospitals have been constructed and 5 hospitals upgraded to provincial and referral hospitals and 33 sectors have benefited from newly constructed health centres.

Challenges:

The Regulatory authority is yet to be set up and MPPD has not yet attained autonomy status. Apart from Ringer Lactate and oral morphine (in Huye), the local production of health commodities has not yet started. The District Pharmacies suffer from un-clarity of professional career perspectives.
NBTS will experience cuts in external financing, starting in 2016, while laboratories face challenges of limited infrastructure, inadequate human resource capacity for emerging technology, high dependency on programs for reagents and research that is still externally driven. Maintenance units for infrastructure and equipment are not adequate.

There is no independent quality assurance and accreditation body and quality assurance requires more effort for its institutionalization.

Recommendations

1. Continue to advocate for set up of a Medical Products Regulatory Agency, pursue the legal status of MPPD and explore local production of health commodities.
2. Develop an efficiency and sustainability plan for NBTS.
3. Enhance infrastructure for NRL (space, equipment, maintenance, reagents and trained HR).
4. Finalize hospital upgrades and construct and equip maintenance workshops.
5. Expedite establishment of the Quality and Accreditation Agency and provide adequate budgets and capacity to institutionalize quality assurance at sub-national level.
6. Establish a clear legal status for district pharmacies as they are currently operated under ministerial instructions.

Component 3: HEALTH SERVICE DELIVERY (6.1 - 6.4)

Achievements

Accreditation standards were developed and disseminated to the 42 hospitals, technical committees on Quality and Standards were set and 4 out of 5 hospitals have achieved level 1 accreditation. The coordination structures for health services at district level are established and functional. Decentralization has increased involvement and ownership of health services by the district administration. The community health program is well established with 3 CHWs per village and supervision from district and health centre levels. In 2014, four district hospitals have been upgraded to the level of Provincial Hospital and 3 more were upgraded to the level of Referral Hospitals (RH). Deployment of specialist doctors and mobilizing resources for specialised equipment has been initiated for the hospitals being upgraded. The SAMU services have been strengthened, ground ambulances increased from 97 in 2007 to 225 in 2014 and maintenance plans and schedules for ambulances exist.

Challenges

There is a turnover of 5 – 10% per year of CHWs, particularly for urban areas. With the decline in external resources, there is a risk of a decline in effectiveness of the community health program . In addition, the introduction of PPP at the level of Health Posts (HPs) might induce changes in the CHW program, as HPs might compete with the services from the CHW. A few districts may not be able to perform their responsibilities, because of varying capacities in leadership, planning, budgeting and management of the district authorities. Hospitals that have been upgraded to referral hospital level do not yet have authorization to charge for their specialized services at referral level. NRHs face limitations in number and quality of specialized staff, equipment and training or education materials. Some SAMU services remain unpaid due to some clients not being insured. Finally, there is no definite plan or mechanism for sustainable replacement of ambulances.

Recommendations

1. Strengthen the CHW program through improved coordination and supervision of CHWs and improve the management of cooperatives. Explore possible mechanisms to ensure the sustainability of the CHW program and undertake an evaluation and / or sustainability assessment of the Community Health Program.
2. Put in place a mechanism to enhance consultation and collaboration between financing partners and district local governments during the planning and budgeting process.
3. Explore mechanisms for the referral hospitals to be self-sustaining and improve the capacity for medical equipment, their repair and maintenance
4. Explore full cost recovery to sustain SAMU services as well as ensure replacement of ambulances and provide, for the interim, a guarantee fund for the uninsured while pursuing enforcing universal health insurance.

Component 4: GOVERNANCE (7.1 - 7.3)

Achievements

There is strong leadership of government in delivering results and managing different actors in the health sector. The coordination mechanisms at sector and sub sector levels are functioning. The DHU is now operational in all districts, capacity to develop action plans and monitor performance is improving, but need further strengthening at DHU level. The district SWAp guideline was revised and is implemented at district levels, which has strengthened coordination at district levels. Regular review of the performance of the health sector through quarterly JADF is taking place through MINECOFIN. The CSOs are formally represented and work often on an ad-hoc basis with the sector coordinating structures, including the CCM. Plans of development partners are fully aligned to government priorities and plans.

Challenges

Rwanda Health Care Federation that coordinates the private sector is relatively new and is not yet fully involved in the sector coordination mechanism and policy dialogue forums. The dependence of CSOs on HIV/AIDS funding and its reduction has negatively affected their functioning and their structures may not be sustained. The depth and scope of policy dialogue with DPs seem to have lost its force compared to the past. This is further affected by over delegation of policy dialogue issues from the HSWG to the technical working groups (TWGs) . Communication and harmonization among development partners is also reported to be inadequate. Progress is limited in bringing more off-budget into on-budget.

There is still mis-alignment of fiscal year by some development partners that hindered predictability during the budgeting process.

Recommendations

There is need to strengthen the quality and intensity of policy dialogue among ALL the sector stakeholders. Rwanda private sector health care Federation and the upcoming CSO Umbrella organization needs to be part of HSWG and TWGs. The forward and backward reviews would benefit from the active participation of CSOs and private sector in the process. Government and partners may consider supporting CSOs to diversify their source of funding and their sustainable functioning. Given that health facilities are moving towards self-financing, it is important to continue advocating for them to become budget entities and in the meantime fast track the efforts to develop and implement a PFM software at facility levels that can feed into IFMIS at district levels and below.

2. INTRODUCTION

2.1. Background and Objectives of the 2015 MTR

After a long and detailed preparatory process, the Rwanda Ministry of Health (MOH) started implementing the Health Sector Strategic Plan III (HSSP III) in July 2012. This document provides a strategic framework to guide health sector priorities, strategies and implementation arrangements at all levels. As planned in HSSP III, a Mid-Term Review (MTR) was scheduled for mid 2015. It is part of on-going health sector monitoring and evaluation process.

T**he overall objective** of this MTR is to assess the progress made in the implementation of HSSP III and determine whether the health sector is on track to achieve its set objectives and targets. The review exercise also intends to explore emerging opportunities and challenges in the sector and beyond; and provide recommendations to further strengthen the health service delivery and systems at all levels of the health system.

Specific Objectives of the MTR:

1. Effectiveness: To assess the extent to which targets set in the HSSP III are being met across all the key components (Programs; Health Support Systems; Health Service Delivery; and, Governance).
2. Relevance: To assess whether identified HSSP III priorities are still aligned to National and Global goals and respond to the emerging needs.
3. Efficiency: To assess whether resources allocated to the implementation of HSSP III were available and used efficiently.
4. Sustainability: To assess if achieved results will be sustained by the health sector.
5. Recommendations: To identify challenges, and lessons learnt; and formulate recommendations to improve the overall implementation of HSSP III (short and long-term).

2.2. Methodology

The MTR process used a mix of approaches to arrive at the conclusions and recommendations of this report as provided by the terms of reference (Annex 1) and beyond, including the following:

Preparatory meetings were held with different hierarchies of the MTR Steering Committee (SC) to agree on the inception report that outlines the timeline, the sampling of the field visits, the interviews and also the tools to be used during the MTR process. It also helped to get consensus on the major deliverables of the MTR team. The MTR team worked under the direct supervision of the Directorate General of Planning, Health Financing and Information Systems.

Desk Review. The team reviewed national and international documentation that helped inform the findings of MTR. Through the Planning Directorate, the MOH Website and various TWGs, the MOH availed relevant information to the MTR team. The team was advised not to consult documentation that had not yet been validated. Thus the most important sources of information and data were the annual reports by MOH, the DHS and various reports from the DPs (JANS report).

Road Map and Consultative Workshop. In consultation with the core team, a Road Map was elaborated and adopted by the Steering Committee. At the end of the assignment, a PowerPoint presentation was discussed with the Core Team to share the main findings of the report. Their comments and suggestions were included in the next version of the power point that was presented during a meeting, chaired by DG/Planning and in the presence of many of the DPs. A final debriefing meeting was held on the last day of the assignment chaired by the PS, Dr. Solange Hakiba. However, for various reasons, the intended Consultative Workshop, mentioned in the TOR and the Inception Report, did not take place.

Key Informant Interviews (KIIs): The team undertook KIIs at national, provincial, district and facility levels to get qualitative information on their achievements, challenges and suggestions for the future. Questionnaires and Tools for the various interviews had been prepared and to the extent possible were shared with the relevant persons in advance. MOH provided meeting rooms within its premises and facilitated all the appointments at the national level and the selection of the provinces and districts visited. Most interviews were held with the MOH staff, but other GOR Agencies (MINECOFIN, RSSB) and other stakeholders (DPs, Professional Councils, Civil Society and Private Sector and Districts) were also consulted (see Work Program in Annex 2 and Persons met in Annex 3).

The Field Visit (Map in Annex 5) of four days was undertaken by two teams, together visiting all the four provinces and 7 Districts, interviewing the relevant administrative authorities (2 Mayors, 3 vice Mayors, 3 District Executive Secretaries, 1 Finance Director, 6 DHMTs, 4 District Pharmacies, 4 CBHI Coordinators and 1 CHW supervisor) and the health authorities at the various levels (43 National Referral Hospitals, 1 new Referral Hospital, 2 Provincial Hospitals, 4 District Hospitals, 4 Health Centres and 1 Health Post). Districts were selected by the MOH, based on their good / poor performance in the social sector scoring of Imihigo.

The MTR was conducted by a team of four international and eight national team members from the MOH and partners with their respective areas of expertise.

Table 3. Names of International consultants of the MTR with resource persons

NAME CONSULTANT	AREAS OF EXPERTISE	SPECIFIC RESPONSIBILITY OF THE CONSULTANTS	NATIONAL RESOURCE PERSONS
Jarl Chabot	Public Health Specialist	MCH, Disease Prevention & Control, Health Promotion. HIS Management, M&E, HSSP Implementation	Mrs Aline Niyonkuru (M&E report specialist) Mr Alypio Nyandwi (M&E report specialist)
Abebe Alebachew	Health Economist / Finance Specialist	Planning, Budget Monitoring. Health Financing, Costing and Financial Gaps Governance	Mrs Diane Muhongerwa (WHO, Health Economist) Dr Albert Tuyishime (RBC)
Prosper Tumusiime	Health Systems Specialist	Medical Products, Diagnostic Services and Infrastructure, QA Standards & Accreditation. Service Delivery (CBH, District, Provincial + National Hospitals, Pre-Hospital)	Mrs Mecthilde Kamukunzi (System analysis specialist)
Kwadwo Mensah	Human Resource Specialist	HRH, Knowledge Management + Research. Cross-cutting issues (Gender, Capacity Building, Regional Integration)	Mrs Stella M. Tuyisenge (WHO, Systems Specialist)

2.3. Limitations

Conducting a full sector review during a three weeks in-country mission is a challenge bound to face limitations. Among the few limitations encountered during this exercise, we would like to mention (i) the short time available to meet some TWGs, Divisions and Units, limiting our understanding of challenges and plans for the future of certain programs and (ii) the fact that we could not consult some recent documents still awaiting validation by the MOH.

2.4. Acknowledgements

The MTR team would like to express its gratitude to the Honourable Minister of Health, Dr Agnès Binagwaho and senior management of the MOH for meeting with the MTR team and giving

guidance on where to focus the MTR: efficiency, sustainability and quality. The MTR team would also like to express its sincere gratitude to all members of the Core Team, the Steering Committee, headed by the DG Planning, Finance and M&E. The SC and the various TWG members showed active interest and commitment to guide and inform this MTR through the elaboration of the TOR, the selection and provision of the national team members, review and approval of the inception report, arranging for the individual interviews and meetings. We want to thank them all for their time and valuable ideas and comments during our discussions. Special thanks are due to Mrs Aline Niyonkuru, Mr Alypio Nyandwi, Mrs Mecthilde Kamukunzi and Mr Albert Tuyishime for the intensive and demanding work to organise the many meetings, the field visits and the final Core Group meeting.

Our sincere thanks are also due to Mrs Diane Muhongerwa and Mrs Stella Matutina Tuyisenge for organising the complex logistics and participating on behalf of WHO in all the discussions and filed visits during these three weeks.

Finally, Dr Olushayo Olu, WHO representative in Rwanda and Dr Martin Ovberedjo are kindly thanked for their practical support and advice during all stages of this assignment.

3. HSSP COMPONENT 1. PROGRAMS

Summary findings and figures

Table 4. Component 1: PROGRAM related indicators

			VALUES		
PROGRAMS	**MAIN OUTPUTS**	**INDICATORS**	**Baseline 2010**	**Results 2015**	**Targets 2018**
MCH IMCI EPI FP Nutrition GBV ASRH&R	• Access / quality MCH services improved • Infant and <5 mortality reduced • % Fully vaccinated maintained • Access / quality to FP services improved • All forms of malnutrition reduced • GBV cases are reported and managed • Quality / access to ASRH improved • SRH status of adolescents improved	% Births attended in HF	69	91	90
		% PW with 4 ANC visits	35	44	65
		% Vaccinated measles <1yr Fully Vaccinated < 1 yr	95 90	99 93	97 95
		Contraceptive Prevalence Rate (%)	45	47.5	72
		% Underweight / Stunting	11 / 44	9 / 38	4 / 18
		# DH One-Stop Center	4 (DSS)	17	42 (DSST)
		% Teenage pregnancy (<20)	4.7	5.5	3.3
HIV/AIDS	• Access / quality of HIV / AIDS services improved	% HIV Prev. in PW / ANC	1.5 (TRACnet)	1	0.6 (TRACnet)
		% HF with VCT / PMTCT	94 (TRACnet)	96	96 (TRACnet)
Malaria	• Access / quality of Malaria services improved	Malaria Prevalence women / children <5 yr	0.7 / 1.4	NA	<1 / 1
		% HH with 1 LLIN or more	82	81	>85 (DHS/HMIS)
Tuberculosis	• Access / quality of Tuberculosis services improved	TB Treat Success rate SS+	87.6	90	90 (TB Annual Report)
		TB/HIV patients receive ART	67	90	90
Mental Health	• Mental health integrated in all HC/DH	% HC with MH services	16	85	100
Neglected Tropical Diseases	• Integrate NTD is general services	% Children of 1–15 yrs de-wormed	83	102	90
Noncommunicable Diseases	• Access / quality to NCD services improved	4 baseline studies	0	NA	1 / yr
		# of HF providing NCD services according to national norms	0	97	500

Integrated Disease Surv+R	• Effective and efficient IDSR / DP&R	% HF implement IDSR	12	92	100
Health Promotion	• Access / quality of health promotion services improved	Diarrhea prevalence among <5 children	13	12%	9
		% Community Health Clubs with enhanced capacity	14	40	70 (RHCC Annual Report)
Environmental health	• Environmental health awareness raised	% Food establishments with satisfactory hygiene standards	0	MOH not resp	90 (Inspection reports)
		% HF with effective waste management systems	55	76	>90 (DSST)

Note: Access and Quality indicators are lumped together in this Table.
Sources for the tables below are DHS figures and (annual) reports from the various Departments and Units, checked and verified by their Unit Heads.

3.1. Maternal and Child Health (MCH)

3.1.1. Maternal and Neonatal Health

Table 5. Baseline and targets for Maternal and Neonatal Health

EXPECTED OUTPUTS / OUTCOMES	BASELINE 2011	TARGETS 2015	FINDINGS 2015	TARGETS 2018
% Births attended in HF (= DH + HC)	69	78	91	90
% PW receiving 4 ANC standard visits	35	50	44	65
% Deliveries with 1 PN visit within 48 hrs	37	50	42	65
% CHW – ASM providing maternal and newborn health package	20	100	100	100
% DH with functional C-EMONC	80	100	85	100
% HC with functional B-EMONC	80	95	85	100

Note 1: Indicator 4 is to be replaced (no additional value) and information on B-EmOC and C-EmOC awaits the results of a recent needs assessment.

Achievements

The Maternal Mortality Ratio (MMR) in 2015 is 210 per 100,000 Live Births ahead of the target in 2015 which is 287, thus achieving a result even beyond the target of 2018 being 220. This enormous achievement is mainly due to (i) the sensitization of PW to deliver at health facility; (ii) attend prenatal consultations stimulated by local leaders, CHWs and health providers. (iii) improvements in the referral system, notably the expansion of B-EmOC and C-EmOC capacity and (iv) the work of Ambulances to bring the women in need timely to the DH or PH.
Delivery of PW in a HF is quite high at 91% which largely contributes to reduced MMR. In most HF, the partogram is available but there are no data on their specific use.

The Community Health Network has defined its intervention package, consisting of FP (ST methods, condom and injectables), IMCI, TB and Nutrition. It is felt that this package is currently the maximum that can be asked of the 3 CHW in each village. Unless their numbers, selection and/or capacity and training is expanded, new interventions (NCD, Implanon) should not be added to their tasks.

Challenges

ANC (4 visits) is still low (44%) despite the presence and the dedication of the third CHW to this purpose. It was expected to be higher, but compared with other African countries still quite commendable. MOH is waiting for the results of EmONC need assessment currently underway to confirm these figures.
71% of all maternal death occurs in hospitals, pointing to possible high institutional mortality and or to possible delays in the timely arrival at the hospital (45%), A specific study into the possible causes of the high NMR seems timely and necessary at this moment.
In 2013 the most frequent cause of death in HF were neonatal illness, counting for 33,3% of all mortality in HF. No information is provided on Maternal Death Audits on 2014-15.
Cultural beliefs traditional practices (use of herbs) around child birth are still strong. This could have a negative impact on the health of the women and the delivery of their babies.

Table 6. Recommendations for Maternal and Neonatal Health

Summary Actions to be undertaken	Medium-term HSSP III Transition July 2015 – June 2018	Long term HSSP III Beyond June 2018
Action 1	Study the effectiveness of facility related MCH causes of death (see suggestions in	* Peri-operative mortality rate: • Obstetric and gynecological admissions related

	the next box) Continue work on maternal death reviews	to abortion / PAC • Study Institutional maternal mortality ratio
Action 2	Revise and update your indicators and targets for 2018. Include the 2015 WHO core indicators for the Quality and safety of Maternal Health	Consider the introduction of upgrading courses for some of the CHW (selection criteria to be defined), but take the introduction of HP into account
Action 3	*I*nvolve men in pregnancy and referrals during the HSSP III and beyond	Collaborate with the efforts to develop a full Vital Registration System

3.1.2. Child health

Table 7. Child health

EXPECTED OUTPUTS/ OUTCOMES	BASELINE 2011	TARGETS 2015	FINDINGS 2015	TARGETS 2018
Per capita < 5 visits seeking treatment for ARI + malaria + diarrhea in HC / C-IMCI (ICCM)	0.6 / 0.2	0.72 / 0.35	0.95 / 0.2	0.8 / 0.5
Average # of < 5 children seen by CHW / month	1.1	3.5	1.26	5

Note: This last indicator has been replaced with sick children < 5 yrs, hence a much lower figure.

Achievements

Infant Mortality Rate (IMR) currently stands on 32, being close the MDG target of 28/ 1000 LB in 2015 and 22/1000 LB in 2018.

Under five Mortality Rate (U5MR) stands at 50/1000 LB, still away from the MDG target for 2015 (30) and for 2018 (42) (HSSP III, pg 4). (It is possible that the HSSP III document on pg 4 has a typing error, but the question of the team on this issue has not received a clear reply).

While these achievements are all quite positive, they also raise questions why the IMR target for 2015 has not been reached, while the MMR target has been achieved. One of the possible reasons is the NMR that contributes substantially to the IMR and U5MR (contributing 35% to overall U5M and 64% to IMR). However, other reasons might also play their part (Malaria epidemic, referral system, BEmOC, or high teenage pregnancies), thus indicating the need for a thorough analysis of the available evidence to propose measures to bring these figures down.

There is information on Neo Natal and Child Death Audits (NCDA) (asphyxia). Most DH now have well equipped NN Units (resuscitation equipment, Oxygen, Kangaroo methods), but training of staff in NN Care is still behind and needs to be prioritized, as Neonatal Mortality Rate (NMR) is high (20 per 1.000 LB).

Challenges

Post Natal Care (PNC) coverage (within 3 days) is too low. This is probably due to under documentation especially for the first visit as all newborns and mothers have to be seen by a health provider before being discharged. The indicator does not seem to follow the internationally accepted definition of PNC visit within the first 48 hours after birth. Guidelines on the time of first visit for the CHW and staff appear not always clear.

The referral system (Rapid SMS, Ambulance) possibly is activated too late only when the first symptoms of Fetal Distress (heartbeat) have appeared. Action should then be taken immediately

The indicators presented for Child Health appear insufficient to allow any serious monitoring of improvements in child health. They need to be revised and include amongst others the number of home deliveries and the use of PNC services.

Table 8. Recommendations for Child Health

Summary Actions to be undertaken	Medium-term HSSP III Transition July 2015 – June 2018	Long term HSSP III Beyond June 2018
Action 1	Strengthen interventions on the factors that determine the high NMR, both at community and facility levels	Sharpen the indications for timely referral during delivery at home.
Action 2	Revise / Update the guidelines for the first visit after delivery by CHW and staff	Continue training CHW to use the Rapid SMS when signs of fetal distress appear
Action 3	Expand and strengthen the PNC Program (Rapid SMS, Information, training in NN Care)	Update the IMNCI indicators to allow proper monitoring of the program (link with SDG)

3.1.3. Sexual and Gender-Based Violence (SGBV)

Table 9. Outputs SGBV

EXPECTED OUTPUTS/ OUTCOMES	BASELINE 2011	TARGETS 2015	FINDINGS 2015	TARGETS 2018
# DH with One-Stop Center (GBV)	4	19	17	42

Achievements

- Over the last three years, 13 new One Stop Centres have been established and equipped bringing their total number to 17 districts. They are fully equipped and staff is permanently available coming from health providers, police and a lawyer.
- On average 30 clients visit the each Centre every month, showing the high need for these services.
- Various Ministries are involved ((MIGEPROF, Justice, Police, MINALOG, Health)) and funds for social re-integration of GBV victims have been made available. A National Steering Committee composed of different stakeholders has been formed to coordinate GBV.

Challenges

- Need to scale up to all 30 districts and 37 district hospitals.
- Provide adequate equipment, staff etc.
- Many victims do not seek help early and frequently destroy the evidence of violence before seeking help because of lack of understanding of the help available.
- Health Centres sometimes refer the clients to the Centre without proper first aid treatment
- The work on Adolescent and Sexual Reproductive Health & Rights should be brought together with SGBV.

Table 10. Recommendations for SGBV

Summary Actions to be undertaken	Medium-term HSSP III Transition July 2015 – June 2018	Long term HSSP III Beyond June 2018
Action 1	Continue the building and setting up of One-Stop Centres in the rest of the District Hospitals, equip and staff them to offer help to victims of SGBV.	Intensify awareness creation on SGBV using mass media on the help available to victims of SGBV in the communities, targeting especially the youth and community leaders.
Action 2	Develop manuals and guidelines on a package of activities, including emotional rehabilitation, to educate the health care workers, police and other multi-sectoral staff on their different roles. Develop their competence in handling victims.	Currently the focus of SGBV is to provide services for victims. Public education and campaigns to reduce the incidence of SGBV including more severe punishment for offenders is to be expanded nationwide
Action 3	In District Hospitals without One-Stop Centres, educate health workers specifically assigned to SGBV duties on the first aid care of victims and what to do for them before sending them to the Centres including the need to preserve evidence and how to make the patient physically and psychologically comfortable.	Support inclusion of knowledge on SGBV in the curriculum of junior schools and in the activities of social organisations like youth clubs, churches, mosques and other SGBV vulnerable groups so that adolescents are better prepared to avoid SGBV and in the event of SGBV know what to do.

3.1.4. Expanded Program on Immunisation (EPI)
(Vaccine Preventable Diseases)

Table 11. Findings in Immunisation

EXPECTED OUTPUTS/ OUTCOMES	BASELINE 2011	TARGETS 2015	FINDINGS 2015	TARGETS 2018
% Children immunized measles <1 yr	95	97	99	97
% Districts >80% DTP-HepB-Hib3 coverage	100	100	97	100
Drop-out rate for Pentavalent 3 (%)	1	1	1.4	1
% Districts conducting quarterly surveillance	93	95	96.6	95

Achievements
EPI Coverage for DPT 3 and Measles is very high, while 93% of children < 1 year are fully immunised in 2014.
Rwanda is free for polio, neonatal tetanus has been eliminated and the country is on track.
Next year, a new vaccine will be added to the currently used vaccines. Rwanda has introduced new vaccine in its routine immunization program; rotavirus vaccine and rubella vaccine thus totaling twelve vaccines in vaccination program.
Cold chain equipment is available in 42 DH and No Vaccine stock-outs have been recorded.
Funding by GAVI will be sufficient to purchase the various vaccines till the end of HSSP III in 2018. The Government is co-financing all new vaccines and purchasing 100% of traditional vaccines'.
Research on rotavirus vaccine impact and effectiveness is ongoing.

Challenges
Sustainability to cover the cost of new vaccines after GAVI support

Table 12. Recommendations for Immunisation

Summary Actions to be undertaken	Medium-term HSSP III Transition July 2015 – June 2018	Long term HSSP III Beyond June 2018
Action 1	Start now looking for funding beyond 2018	Ensure funding for all vaccines beyond 2018

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

Table 13. Adolescent and Sexual RH & Rights

EXPECTED OUTPUTS / OUTCOMES	BASELINE 2012	TARGETS 2015	FINDINGS 2015	TARGETS 2018
% HCs offering the minimum package of youth-friendly adolescent services	8%	50%	60%	95%
% Teenage pregnancies (<15-19 yrs)	4.7%	4.1%	5.5%	3.3%

Achievements

In May 2012 the MOH-MCH unit produced an ASRH&R Policy that guide the interventions in this field. An ASRH&R Package has been defined for youth friendly SRH services.

The policy defines a set of four interventions + research and Capacity Building, but no ASRH specific indicators are mentioned in the Strategy.

In the districts more than half now provide some level of ASRH services (Centre in DH or Corner in HC), all staff is trained, but equipment is often still missing

Challenges

Limited number of health facilities that provide the full range of ASRH services.

Rights-based approach is formally adopted but is not operationalised

% Teenage pregnancies has increased from 4.7% in 2012 to 5.5% in 2015, 1% higher than the 2015 target and even higher than 3.3% 2018 target.

Special and focused FP services for the youth are too few and of insufficient quality. Innovative messages for the younger age-groups need to developed.

Table 14. Recommendations for ASRH&R

Actions to be undertaken	Medium-term HSSP III Transition July 2015 – June 2018
Action 1	There are good reasons to evaluate the ASRH&R strategy from 2012 and draft a new strategy to address this increase in teenage pregnancies (obviously in collaboration with the FP unit of the MCH Department)
Action 2	The ASRH interventions at district and HC levels need to be strengthened and become more output oriented.
Action 3	Strengthen partnership between the Health and Education sectors regarding comprehensive sexuality education and access to FP services for young people.
Action 4	Relevant output indicators have to be proposed for the remaining years of HSSP III

3.1.6. Family Planning (FP)

Table 15. Findings in Family Planning

EXPECTED OUTPUTS / OUTCOMES	BASELINE 2011	TARGETS 2015	FINDINGS 2015	TARGETS 2018
Contraceptive utilization rate for modern methods women 15–49 yrs	31%	36%	44%	40%
Contraceptive prevalence among married women 15–49 years (CPR)	45%	62%	47.5%	72%
Unmet need for FP	18.9%	12%	19%	6%

Achievements

In Dec 2012 GOR-MOH produced its Family Planning Policy, defined a minimum FP package and its ambitious goal (70% CPR by 2016) to be achieved through an intensive collaboration between public and private sectors and several demand and supply side interventions.
Results are mixed: Women in Rwanda have on average 4.2 children during their reproductive life and 53% of women use contraception, regardless of the method.
HCs and higher facilities have been equipped with vasectomy sets and Implanon
There is good coordination in the procurement of commodities
Private sector facilities are included in the training and supplies (after MoU)

Challenges

The reasons for the slowdown in the CPR and the high unmet need are not well-known and require further analysis for deeper understanding:

- There are still various misconceptions (rumors and stigma) in the community around FP
- Staff turnover is quite high, especially for nurses
- MOH recently decided to charge rural and urban users of FP services. The effect on the use of these services is not well known and needs to be documented.
- The Catholic Church is still opposing the use of contraceptives and controls a substantial number of health facilities (estimated at 20%), but they offer services in Health Posts.
- Special FP services for the youth (ASRH) are few. Innovative and specific messages are to be developed to reach the various age groups that make use of FP services
- The contribution of the private sector in most of the districts is very limited

Expedite the implementation of the FP Strategy from 2012 and include innovative messages that can reach the younger age-groups. As part of such a revision of the FP Strategy it is advised to focus in particular on the Long Term FP (LTFP) methods, as these contribute much more to the reduction of the CPR. In the meantime, study urgently the reasons for the lowering CPR in relation to the high unmet need for FP services.

Table 16. Recommendations for Family Planning

Summary Actions to be undertaken	Medium-term HSSP III Transition July 2015 – June 2018	Long term HSSP III Beyond June 2018
Action 1	Study at short notice the reasons for the slowing down of the use of FP services and the high unmet need in FP.	Consider training some CHW of A2 level Nurses in the HPs in the use of Implanon
Action 2	Include new and innovative messages and BCC for the various age groups, targeting girls and boys separately and social stigma and parents / teacher's role in sexual education.	Ensure funding for FP commodities after 2018. Consider to convene a FP workshop with all stakeholders to accelerate FP uptake and ensure financial sustainability in procurement of FP commodities
Action 3	Revise FP Targets and include % FP needs satisfied as part of the next DHS	Focus your implementation strategy on those target groups that prefer LTFP methods

3.1.7. Nutrition

Table 17. Findings in Nutrition

EXPECTED OUTPUTS / OUTCOMES	BASELINE 2011	TARGETS 2015	FINDINGS 2015	TARGETS 2018
% children <5 yrs screened in CBNP	70	82	71	88
% children in nutrition rehabilitation program / total children mal-nourished	70	82	86	88
% Moderate Anemia in Children 6-59 months / Women Reproductive Age	3 / 14	NA / NA	3 /15	2 / 12

Note: Indicator changed to include severely malnourished

Achievements

In Jan 2014, MINALOC, MOH and the Min of Agriculture produced the National Food and Nutrition Policy (NFNP), specifying seven Strategic Directions, such as to prevent stunting, reduce anemia (children and women) and improve food & nutrition in schools. In 2012 District Plans to eliminate malnutrition have been adopted in every district.

Prevalence of Stunting (Ht/Age) brought down from 51 in 2005 to 38 in 2015. Similarly, Underweight (Wt for Age) reduced from 18 to 9 and Wasting (Wt for Ht) reduced from 5 to 2.

Strong and sustained ownership for the CBNP by Government (Mayors signs performance contract) and there is one comprehensive plan for all sectors

The CBNP is firmly present in all villages with all CHW trained in Maternal, Infant and Young Children nutrition education

Vit A for children 6-59 months and Iron (for PW during ANC) are distributed systematically.

National Nutrition mapping is underway and will visualize who is doing what, where in what district in order to reduce overlap of the activities, Increase possible collaboration and know the gaps existing.

Challenges

Multi-sector coordination among five social cluster Ministries (Health being the lead) is not always easy. There is no common budget and no joint reporting on the food and nutrition indictors from the districts.

Food fortification is underway but needs to be improved,

There seem insufficient Human Resource for nutrition program within the social cluster ministries

Table 18. Recommendations for Nutrition

Summary Actions to be undertaken	Medium-term HSSP III Transition July 2015 – June 2018	Long term HSSP III Beyond June 2018
Action 1	Strengthen home and food fortification (Wheat and maize flour fortification)	Ensure funding to reduce stunting and anemia beyond 2018
Action 2	Introduce routine monitoring of stunting at community level	
Action 3	Integration of de-worming and Vitamin A supplementation in routine service provision in the communities	
Action 4	Document success stories and lessons learned from multi-sectoral nutrition interventions	

3.2. Disease Prevention and Control

3.2.1. HIV and AIDS

Table 19. Findings in HIV & AIDS

EXPECTED OUTPUTS / OUTCOMES	BASELINE 2011	TARGETS 2015	FINDINGS 2015	TARGETS 2018
HIV Prevalence	3	NA	3	NA
HIV Prevalence among PW in ANC	1.5	1	1	0.6
% HF with VCT / PMTCT services	94	96	96	96
% HF offering ART and HIV-HBV co-infection treatment	83	90	96	95
% Patients in need ART + receive it	90	94	79.5	96

*Targets for 2015 and 2018 have revised with the implementation of the 2013 guidelines.
The 2018 target should be changed from 96 to 87.5 (HIV NSP target)
** Findings have been calculated based on the updated treatment criteria (2013 guidelines)

Achievements

- HIV prevalence in the adult population has remained stable since 2005 at 3% (RDHS 2005, 2015 and RAI-HIS 2013). HIV prevalence remains higher among women than among men.
- Using combination prevention strategies, the incidence of new HIV infections is now at 0.27% in the general population and M2C transmission stabilized below 2% for the past 3 years.
- The geographic coverage of HIV prevention interventions and HIV treatment has also increased up to more than 95% of all health facilities to allow the accessibility of HIV comprehensive services to the Rwandan population.
- Currently there are some 153,147 (80% of those in need) HIV+ cases on treatment (up from 89,319 in 2010), partly due to the higher cut-off point of the CD4 count of 500 (before 350);
- The full package of drugs and OI (including nutrition support) is available at HC level and distributed to PLWHA on monthly basis..

Challenges

- There is an expected decrease in funding of up to 40% or more.
- As the program matures, drug resistance may occur among people on treatment.
- The prevention of HIV among key population (FSW) is still a challenge. Recent studies have shown that prevalence is still higher in this group than in the general population.

Table 20. Recommendations for HIV and AIDS

Summary Actions to be undertaken	Medium-term HSSP III Transition July 2015 – June 2018	Long term HSSP III Beyond June 2018
Action 1	Increase treatment coverage to reach all people infected by HIV by Implementing Test and Treatment approach.	Retain patient on life-long treatment and achieve treatment success to reduce HIV related morbidity and mortality
Action 2	Focus on prevention and treatment of key and priority populations such as FSW, pregnant women, adolescents, couples etc -	Continue implement evidence based interventions to prevent new infections.
Action 3	Develop and implement a sustainability plan for the HIV program.	Identify new funding opportunities to support HIV
Action 4	Reinforce quality of care, retention and surveillance	Maintain quality of care

3.2.2. Malaria

The objective of the Malaria Control Program (MCP) is to enter the malaria pre-elimination phase in 2018. However, over the last 2-3 years, the SPR has gone up to 34%. A thorough analysis carried out by the Mal & OPDD-RBC with partners has found the main contributing factors which include: increase of health utilization and reporting by private health facilities (135 private clinics and some 200 additional public HF which include new health post, climatic anomalies (abundant rainfall , increase of temperature related to climate change), substandard LLINs with low insecticide content and efficacy and increase in insecticide resistance, and (v) high malaria burden in districts (counting almost 80% of all malaria cases) located at the borders of neighboring countries. In addition LLIN durability has shown that LLINs efficacy last less than 1.8-2 years and hence need to be replaced before the required 3-5 years as per the WHO/PES.

Table 21. Findings in Malaria

EXPECTED OUTPUTS / OUTCOMES	BASELINE 2011	TARGETS 2015	FINDINGS 2015	TARGETS 2018
Malaria prevalence women / <5 children (%)	0.7 / 1.4	<1 / 1.2	NA	<1 / 1.0
Malaria incidence / 1,000	26 / 1,000	20 / 1,000	184/ 1,000	15 / 1,000
Slide Positivity Rate (SPR) (%)	15	8	37	<5
Malaria proportional morbidity (%)	4	3	16.6	3
% HH with at least 1 LLIN ownership	82	85	81	>85
% children <5 yrs sleeping with LLIN (in households with ITN)	70	80	80	82

Achievements

1. BCC: Most recently in the RMIS 2013, nearly all women (95%) are aware that mosquito bites 'cause' malaria and two in three women (66%) know that sleeping under a mosquito net protects against malaria. Nearly all women reported that malaria treatment can be received from the public sector. The most commonly cited source of information about malaria was the radio (79%), followed by CHWs (46%).
2. Diagnostic and treatment: In 2010, Rwanda had achieved one of the highest rates of parasitological diagnosis in Africa, with an estimated 94% of suspected malaria cases being parasitologically diagnosed through microscopy or RDTs in 2010 as compared to 56% in 2009. In 2014, 99% of all suspected malaria cases were tested before treatment.

iCCM is delivered by approximately 30,000 CHWs based at the village level which greatly increases health care access and utilization. As a result 96% of children < 5 years with malaria were tested and treated with ACTs within 24 hours in 2014 while only 62% were treated within 24 hours in 2008.

3. Vector control. The mainstay of vector control in Rwanda is universal coverage with LLINs targeting the entire population in the country. The 2015 DHS shows 82% of households owning at least one LLIN. Respectively, 80% and 88% of children < 5 years slept under a mosquito net the night before the survey. Overall, 74% of pregnant women aged 15-49 slept under a mosquito net the night before the survey. The latest IRS campaign using carbamates was conducted in 2014-2015 and resulted in the coverage of 99% of targeted structures.

Given Rwanda's success with LLINs, the MoH has prioritized mitigating pyrethroid resistance with IRS in order to conserve the efficacy of the bed nets. The Mal & OPDD will continue to monitor insecticide resistance and possibly adopt other insecticide classes for IRS if needed.

4. M&E. The Mal & OPDD is routinely monitoring epidemiological data and malaria control interventions efficacy through surveillance using HMIS-SIS-Com, program report and data. Data are used to prioritise malaria control interventions in high malaria burden districts.

As a response to malaria upsurge, the Malaria Control Program has opted to prioritize malaria control interventions in high burden districts and to introduce innovative strategies such as an adult malaria Home-Based Management of Malaria by CHW for the moment in three high malaria burden districts (test phase) to be expanded to other high burden districts later.
Other interventions will be: (i) Introduction of long half-life anti-malarial drugs (DHA+PQ) and use of Primaquine to kill the mature Plasmodium Gametocytes; (ii) Distribute and replace LLINs with effective Insecticide and potentially use of synergist (PBO) in order to address insecticide resistance; (iii) intensify and increase the Indoor Residual Spraying (IRS) in high malaria endemic areas with use of efficacious insecticide following monitoring of insecticide resistance; and (iv) continue monitoring of malaria control interventions and investigate other factors contributing to malaria increase in Rwanda and the region.

Challenges
The main challenge is the substantial increase in SPR to 37%, up from 15%, in 2010 due to many factors, such as (i) including increase of insecticide resistance, (ii) climatic anomalies (iii) within a context of external funding decline with increase of Malaria in southern and eastern Africa region. (iv) Another challenge is the high costly insecticide used (due to insecticide resistance) for IRS which impacted the reduction of structures usually sprayed with pyrethroids which are four folds cheaper.
There is a need for a sustainability plan and a malaria multi-sectoral strategy, that is costed to address this serious challenge to the program and the affected districts as well as a regional malaria strategy to curb malaria in high burden districts located at the border of neighboring countries.

Table 22. Recommendations for Malaria

Actions to be undertaken	Medium-term HSSP III Transition July 2015 – June 2018
Action 1	Develop a costed malaria sustainability plan to reduce the SPR back to below 20 per 1000
Action 2	Search for additional resources to order a sufficient number of impregnated Bed Nets (efficacious in the context of increase pyrethroid resistance) and blanket IRS in additional high malaria burden districts
Action 3	Mobilize extra funds to implement new and innovative strategies and interventions
Action 4	Strengthen the role of CHWs in malaria BCC

3.2.3. Neglected Tropical Diseases (NTD)

The Neglected Tropical Diseases in Rwanda mainly refer to the Soil Transmitted Helminths (STH) and Schistosomiasis (SCH) of the intestines.

Table 23. Findings for NTD

EXPECTED OUTPUTS / OUTCOMES	BASELINE 2011	TARGETS 2015	FINDINGS 2015	TARGETS 2018
% Children of 1–15 yr de-wormed	83	86	102	90

Achievements

- The massive drugs administration for prevention and control of STH and SCH has been successful as the complete target population has been reached (102%). However, in terms of reducing moderate anemia in women or children, no improvements have been recorded over the last 5 years.
- Reporting on Anemia and Schistosomiasis has now been integrated in HMIS.
- Prevalence of Schistosomiasis is estimated at 1.9%, being the country average, but with some high prevalence pockets in various lake areas
- Other NTD like Trachoma, Filariasis do not pose a serious Public Health problem

Challenges

- The various strategies to control the NTD (mentioned in the HSSP III, pg 41) have not been systematically addressed during the interview. It is unclear to what extent they have been (effectively) implemented. Other issues coming up during the meeting:
- There is no funding for the NTD program other than one donor whose funding is expected to finish by end February 2016.
- De-worming of children from 1 to 15 years has been always integrated within the Maternal and Child health week. It will be challenging to organize de-worming campaigns alone if no MCH week is taking place, due to limited funds. Only de-worming medicines are mobilized and granted but distribution cost are not covered.
- Effective prevention and control of NTDs require others interventions by other sectors to address key determinants such as lack of potable water, inadequate sanitation, poor personal hygiene, and poor drainage.

Table 24. Recommendations for NTD

Actions to be undertaken	Medium-term HSSP III Transition July 2015 – June 2018
Action 1	Actively search for funding sources to be able to continue and expand the anti Helminths and Schistosomiasis interventions

3.2.4. Tuberculosis (TB)

Table 25. Findings in Tuberculosis

EXPECTED OUTPUTS/ OUTCOMES	BASELINE 2011	TARGETS 2015	FINDINGS 2015	TARGETS 2018
TB treatment success rate (SS+) (annual)	87.6	89	90	90
TB Prevalence / 100.000			85	
% Laboratories with QA	78	88	NA	90
% TB/HIV patients receiving ART by the end of TB treatment	67	85	90	90

Note Data on % Laboratories with QA will be available with the Annual report 14-15 release.

Achievements

- The focus on High Risks Groups (HRG) that might get TB has now been decided and has started for (i) Prisoners, (ii) HIV+ patients (about to start), (iii) contact tracing of TB patients, and children < 15 years (to be included in IMCI) and adults > 55 years (will initiate later).
- Collaboration with HIV is very good (supervision, M&E, TWG) under the RBC umbrella, this will allow efficiency gains in the future.
- New diagnostic tools are introduced, such as mobile X-Ray machines and GenXpert, together allowing for more active case-detection.

Challenges

- TB detection in children remains a serious challenge.
- Financial issues are similar as in HIV and Malaria, but the Unit has not yet made preparations for serious cost reductions. This is now a high priority, as no sustainability plan has been prepared up till now.
- Staff (15 funded by MOH and 10 with funds from GF) reductions are likely at the end of 2017.

Table 26. Recommendations for Tuberculosis

Actions to be undertaken	Medium-term HSSP III Transition July 2015 – June 2018
Action 1	Prepare a cost reduction plan for the NTCP with important efficiency measures to be taken in the coming months and years
Action 2	Plan this together with HIV and be part of the RBC sustainability Plan.

3.2.5. Epidemic Surveillance and Response (ESR)

The main objective of the ESR program is to prevent and control epidemic diseases and other public health emergencies in Rwanda through the implementation of an effective and efficient national Integrated Disease Surveillance and Response (IDSR).system. IDSR reports on 23 diseases, 19 of which require immediate reporting if they occur. The other four should be reported on a weekly basis.

Table 27. Findings in ESR

EXPECTED OUTPUTS / OUTCOMES	BASELINE 2012	TARGETS 2015	FINDINGS 2015	TARGETS 2018
% Public HF implementing IDSR	12	50	100	100
% Licensed private HF implementing IDSR	0	100	73	100
% Districts with epidemic preparedness and response plans	0	30%	30%	100%

Achievements

- Roll-out to HF (all public health facilities and 70,9% of licensed private health facilities) the Electronic Integrated Diseases Surveillance and Response (IDSR), replacing the previous paper-based system with an IT system, integrated with the HMIS.
- Indicators of IDSR show 90% completeness of reporting by HF and timeliness (within 24 hrs or weekly, being 80-85%). The program analyses these reports every Monday of the week.
- An intensive competency based field epidemiology training program managed to train 28 field epidemiologists, 26 of 28 trainees that have completed the required competencies, while 24 were awarded a master degree. A third cohort of 14 trainees are currently undergoing training. From 2012 to June 2015, Seventy nine outbreaks were properly investigated and managed.

Challenges

- High turnover of staff and inadequate capacity of supporting surveillance at HC / DH levels.
- There is limited Laboratory capacity at peripheral level (DH and satellite laboratories) to perform some of the laboratory. analysis that is required for detection and control of outbreaks and other public health threats. Eg: bacteriology capacity and food laboratory (Molecular, toxicology, etc).
- The multi-sectoral nature of the division vis à vis the emergency and response to outbreaks

Table 28. Recommendations for ESR

Actions to be undertaken	Medium-term HSSP III Transition July 2015 – June 2018
Action 1	Strengthen lab capacity for surveillance of food and water borne diseases. Coordinate this with the Hygiene Department.
Action 2	Strengthen multi-sectoral coordination in preparations for expected epidemics
Action 3	Initiate expansion EDSR from HC level to HP and Community levels
Action 4	Develop retention plans to reduce the high turnover of staff.
Action 5	Introduce new indicators to monitor EDSR (see suggestions below)

Note: Indicators suggested to be included in the remaining three years of HSSP are:

- % of DHs with trained and functional rapid response team
- % of CHWs trained on IDSR
- % of outbreaks with laboratory confirmation
- % of outbreaks reponded to in a timely manner and properly managed.

3.2.6. Mental Health

Table 29. Findings in Mental Health (MH)

EXPECTED OUTPUTS / OUTCOMES	BASELINE 2012	TARGETS 2015	FINDINGS 2015	TARGETS 2018
Proportion of HCs providing integrated MH care	16%	100%	85%	100%
% CHWs trained and providing community-based care in mental health	0	50%	80%	100%
% Implementation of National Strategy against drug abuse in prevention and treatment of MH	0%	20%	60%	80%

Note: See also the findings of the Ndera Neuro-psychiatric hospital (6.3).

Achievements

- A National Mental Health Policy 1995 was revised by the MH program, It mentions 10 interventions, each with its objectives and strategies.
- There is qualified staff: RH with psychiatrists and DH with MH Nurses. There are 8 psychiatrists. In 2018 there will be 15 up from zero psychiatrists in 2000. For drug abuse management, one staff was trained at Master level in Addiction Psychiatric studies.
- In 2013 a specialisation in psychiatry was launched at UR to train psychiatrists in Rwanda
- The MH Nurses visit the HCs for supervision of difficult cases and prescription of specific drugs. Integration of MH in the various HF (DH and HC) is a reality. To increase the quality of mental health services, the Mentoring and Enhanced Supervision at Health Centers (MESH) model was successfully tested in Burera District. There is a plan to scale this up to other districts and eventually to the entire country.
- In the villages 15.000 CHW have been trained to recognize mental health suffering. Each village has a CHW trained in mental health from 2014 when Rwanda was commemorating 20th anniversary of Genocide against Tutsi. The number of mental consultations has gone up, indicating reduced stigma and recognition of the psychological problems.
- Other achievements include establishment of a referral Rehabilitation Center for drug and alcohol addiction in and creation of specialization in psychiatry within UR.

Challenges

- There are few external resources for mental health
- There exists now a legal framework for MH related interventions, awaiting validation
- Stigma towards mentally ill patients still exists (also among nurses and other staff in the HF)
- Quantity of staff needs to be increased and Quality of mental care improved.
- Psychologists are hardly involved in the mental care, this should be expanded.
- Integration of mental health package at community level requires election of a new CHW at village level for NCDs and Mental Health
- Abuse (mainly alcohol and various drugs) among youth is a serious problem, addressed through different programs such as:
  - Integration of unit of drug prevention and control in MH Division/RBC which main mission is to organise sensitisation and treatment of drug abuse consequences and addictions
  - A law governing narcotic drugs and psychotropic substances in Rwanda
  - Huye Rehabilitation Centre for drug and alcohol addictions that is already functional

Table 30. Recommendations for Mental Health

Actions to be undertaken	Medium-term HSSP III Transition July 2015 – June 2018
Action 1	Operationalize the Centre for Drug Abuse in Huye
Action 2	Adapt curriculum program for schools; Develop guidelines for youth on drug use prevention.
Action 3	Continue training of mental health nurses and expand the information to CHW

3.2.7. Non-Communicable Diseases (NCDs)

Table 31. Findings in Non-Communicable Diseases

EXPECTED OUTPUTS / OUTCOMES	BASELINE 2012	TARGETS 2015	FINDINGS 2015	TARGETS 2018
# HF with capacity to provide NCD services according to national norms	0	45	97	500
# Staff from public and private health facilities trained on NCDs	0	1,284 / 360	NA	2,442 / 660
# CHWs trained and implementing NCDs	0	10,000	NA	40,000

Achievements

- In March 2015 MOH produced a NCD Policy, setting out its guiding principles, policy objectives and key priorities. A Strategic Plan was developed with defined package of care by level of HF.
- The Unit developed clinical guidelines for 6 clusters namely Hypertension, Heart failure, Diabetes, Renal failure; Chronic Obstructive Pulmonary Disease (COPD) and Asthma, Cancer Diseases, including injury and disabilities with relevant treatment protocols
- The Rwanda Step study was conducted, providing reference to some NCDs prevalence and their risk factors. The main proposed interventions are public awareness raising, early screening (annually), and availability of necessary drugs (a list of NCDs essential drugs has been developed and the level of utilization defined).
- A Law governing the use of tobacco in Rwanda has been established
- A training manual for health care providers on trauma management was elaborated. There is one GP per DH, working in emergency services, 70% of them have been trained.
- A compilation of data on road traffic accidents is done weekly; prevention strategies are proposed
- A draft national operational plan for eye care was developed and quantification of eye medicines and consumables has been made. A vision center was established in a pilot phase of project meant to establish vision centers in district hospitals.
- A program for cervical cancer screening has been initiated.
- Palliative Care for chronic patients with advanced age, HIV-AIDS patients, late cancers or neurological diseases (hemiplegic, paraplegic cases) has been initiated under the NCD program. Its effectiveness and costs still needs to be studied.

Challenges

- Increase of NCDs as development and life expectancy grow, undermining health gains and imposing financial and economic costs on Government and households
- Community and health workers awareness in relation with NCDs risk factors and early detection need to be strengthened to avoid late medical consultations and delayed diagnoses
- Financial constraints to meet NCDs budget, as the budget allocated to NCDs is very low.
- Insufficient NCDs diagnostic capacities for detection of cancer and cardiac diseases
- Lack of specialized NCDs services: radiotherapy, chemotherapy and palliative care
- Some NCDs interventions are expensive: cardiac surgery, radiotherapy, chemotherapy.

Table 32. Recommendations for Non-Communicable Diseases

Actions to be undertaken	Medium-term HSSP III Transition July 2015 – June 2018
Action 1	Introduce and expand E-Health for advice and consultation for District doctors
Action 2	Expand NCD information to CHW. Consider establishment of CH Technician
Action 3	Promote adoption of relevant laws
Action 4	Revise and update the NCD indicators (link with SDG indicators)

3.2.8. Disabilities

Table 33. Findings Disabilities

No Table with Indicators provided in HSSP III

Achievements

- There is a National Council for People with Disabilities (under MINALOC) that started in 2011. Collaboration with the NCD program in the MOH already exists but still needs to be formalized and intensified (see 4.2.8).
- A (baseline) study on the prevalence of the various disabilities has been done, but the results are not yet available.
- Laws related to protection of disabled persons, modalities of facilitating persons with disabilities access medical care,… have been developed.
- There are 8 workshops producing prosthesis and orthotics in public hospitals.

Challenges

- While MOH has been advocating for a legal framework to support people with disabilities, there is not yet policy to prevent or provide support (wheel chairs, other specialised equipment).
- There are no indicators mentioned in the HSSP III,
- However, MOH is responsible for the long-term care of patients that need Palliative care. The NCD program is expected to address this issue in its next annual plan.

Table 34. Recommendations for Disabilities

Actions to be undertaken	Medium-term HSSP III Transition July 2015 – June 2018
Action 1	A Rehabilitation Centre will be opened in Eastern Province
Action 2	Formalize the collaboration between the Council and the NCD Unit
Action 3	Propose jointly specific Indicators and outputs for Palliative care and Care for disabled persons

3.3. Health Promotion and Environmental health

3.3.1. Health Promotion

Table 35. Findings in Health Promotion

EXPECTED OUTPUTS/ OUTCOMES	BASELINE 2011	TARGETS 2015	FINDINGS 2015	TARGETS 2018
Diarrhea prevalence for U5 children <5	13%	11%	12%	9%

Achievements

- A national Health Promotion Policy and Strategy has been developed and is being implemented since 2014.
- The Rwanda Health Communication Center with partners is in the process of disseminating the policy and strategy at decentralized levels for ownership and a training workshop has been organized for enhancing capacity of health promotion officers at district level.

Challenges

- No dedicated health promotion officers at decentralized levels

Table 36. Recommendations for Health Promotion

Actions to be undertaken	Medium-term HSSP III Transition July 2015 – June 2018
Action 1	Strengthen capacity of health promotion officers at decentralized levels Strengthen the capacity hygiene inspection teams and health promotion officers at decentralized level.
Action 2	Revise the indicators for Health Promotion to show its broad set of interventions Demonstrate the effect of behavior change communication activities

3.3.2. Environmental Health and Medical Waste Management

The Environmental Health is a vast area, including Hygiene and Sanitation Promotion, Health Care Waste Management and Hospital hygiene, Food Safety and water Quality; Climate Change, Occupational Health and Safety, Disaster Management etc. However, there are only 2 staff in this department. grossly insufficient to undertake this large variety of interventions.

Table 37. Findings in Environmental Health

EXPECTED OUTPUTS/ OUTCOMES	BASELINE 2011	TARGETS 2015	FINDINGS 2015	TARGETS 2018
% Food establishments with satisfactory hygiene standards	0	40	32% No responsib	90
% HF with effective waste management systems	55	83	76	>90
% CHC with enhanced health promotion / BCC	14%	50%	40%	70%

Note: First indicator is no longer the responsibility of the MOH. MOH is to put in place policy, guidelines, SOPs and others tools for Monitoring of Food Safety and Hygiene. It is the responsibility of District Hygiene Inspection committees to enforce the implementation of standards in food establishments.

Achievements

- Food safety Policy developed and validated by technical team, Still to be validated by EH-TWG and approved by higher authorities.
- The District Hygiene Inspection committees were established in all Districts.
- The Hygiene inspection tools developed, validated and distributed to the all Districts
- Capacity building at decentralized level (Director of Health and Environmental Health officer at District levels) were trained on hygiene inspection techniques..
- The Ministerial guidelines and SOPs on Health Care Waste Management's were developed and validated by EHTWG, SMM and GSMM still to be signed by Hon. Minister of Health and distributed to the DHs for use in the Waste management activities.
- Almost 38/47 (80%) of DHs have modern incinerators and just 9 (20%) don't have or use Demonfort Burners..There are also multipurpose / separated waste pits at each hospital for remaining waste that does not need to be burned.
- The Community-Based Environmental Health Promotion Program, uses the Community Health Club (CHC) methodology that brings together between 50-100 heads of Households to be taught once a week for 2 hours the essentials of Hygiene (a total of 20 lessons during a period of 6 months with a Certificate at the end on the basis of a training kit with visual designs on good and bad practices). Facilitators come from HC staff and are trained by District supervisors (after a TOT course). After each dialogue session/lessons, practical work is undertaken, like building latrines, protect water sources or building washing facilities.
- There are CBEHPP/CHC training manuals, road map, vital tool kits and membership cards for these Community Health Clubs.

Challenges

- Insufficient budget to scale-up the Community Health Clubs (CHC) activities.

Table 38. Recommendations for Environmental Health

Actions to be undertaken	Medium-term HSSP III Transition July 2015 – June 2018
Action 1	Increase the number of CHC
Action 2	Develop a sustainability plan for Environmental health unit to scale up functionality of CHCs
Action 3	Reinforce the capacity of Hygiene inspection teams in collaboration with the DAdmin.
Action 4	Revise the indicators for Environmental Health to show its broad set of interventions

4. COMPONENT 2. HEALTH SUPPORT SYSTEMS

Summary Findings and Figures

Table 39. Component 2: HEALTH SUPPORT SYSTEMS indicators

			VALUES		
SUPPORT SYSTEMS	**MAIN OUTPUTS**	**INDICATORS**	**Baseline 2010**	**Results 2015**	**Targets 2018**
Planning & Budgeting	• Decentralized planning is the norm • Planning/budgeting tool harmonized	# Districts submit annual plans / budgets on time	NA	30	30
Human Resources for Health (HRH)*	• Quantity/quality of HRH respond to needs • Rational distribution based on norms • Performance of TI strengthened	Doctor / pop ratio	1 / 16,001	1 /10.055	1 / 11,993
		Nurse / pop ratio	1 / 1,291	1 / 1.142	1 / 1,000
		Midwife /pop ratio	1 / 66,749	1 / 4.037	1 / 25,000
		Lab tech/pop ratio	1 / 10,626	1 / 10,500	1 / 10,000
Medical products	• Generic drugs locally produced • Hosp. Drug Therapeutic Committees • HF with no stock outs	% Drugs locally produced	<2	0	>11
		% Hosp. Drug Therapeutic Committees	45	100	100
		% HF with NO stock-outs	55	98	98
		% prescriptions with antibiotics in DHs/HCs	≥65	NA	≤40
		% HF with online tracking system for all procuring entities (e-LMIS)	0	98%	100
		# Pharmacy regulatory legal instruments and establishments of regulatory institutions	18	32	45
		# District pharmacies with good storage conditions	0	14	30
Diagnostic Services (incl lab facilities)	• Nat Ref Lab in construction • Reported stock-outs of Lab / Rx tracer	% Construction finished	30	NA	100
		% of laboratories with at least 2 trained staff in good laboratory practices within the lab network	76	89	100
		# Labs in accreditation	10	33	All
Health	• Existing HF to universal	# Sectors without HC	20	7	0

Infrastructure	coverage • Develop maintenance systems		sectors	sectors	
		% DH with workshop for maintenance	3	NA	31
Health Financing (HF)	• GOR contribution to health • Performance PBF and CBHI	% GOR budget for Health	11	14%	15
		Per capita expenditure on health (USD)	$39.10	NA	$45.00
		CBHI coverage	91%	76%	91%
Quality Assurance & Accreditation	• Align quality indicators to performance	DH eligible for accreditation (>70%)	0	35	60
		# Provincial hospitals eligible for accreditation (> 70%)	0	5	7
		% HCs with functional QA team	0	100%	100%
		# HC eligible accreditation	0	NA	200 / 487
Information Management	• Roll out ICT infrastructure and various HIS • Develop e-Health Policy	% HF with functional IT	84	96%	100
		% HCs and DHs using Open EMR or other individual medical records system	8	62%	80
		% of registered private clinics and dispensaries reporting routinely to HMIS	5	75%	90
		# CHWs tracking PWs using Rapid SMS	8,183	14.658	14,837
		# A2 nurses that completed e-learning	0	264	1,750

* HRH data from MOH, HRIS database.

4.1. Planning, Budgeting and Monitoring

The main objectives of strengthening the planning, budgeting and monitoring in the health sector is to enable subsectors, districts and facilities develop, implement and monitor their five year strategic and annual plans in accordance and alignment with the HSSP III. The main strategies planned in HSSP III include strengthening planning and M&E capacities at all levels, harmonizing planning and monitoring processes and procedures, continue improving the data quality, use and dissemination, as well as undertaking performance and impact evaluations. The major targets set for the HSSP III and their achievements are presented in table 40.

Table 40. Findings in Planning, Budgeting and Monitoring

EXPECTED OUTPUTS / OUTCOMES HSSP III	BASELINE 2011	TARGETS 2015	FINDINGS 2015	TARGETS 2018
# Administrative Sectors without a HC	20	10	7	0
% HF with functional IT Infrastructure (internet Computer including modems	0.84%	95%	96%	100%
% of HC and DH using Open EMR or other individual medical record system	8%	50%	62%	80
% of private registered clinics and dispensaries reporting routinely to HMIS	5%	70%	75%	90
# Registered CHWs tracking PW using Rapid SMS	8.183	14.837	14.658	14,837

Achievements

As can be seen from table 40, most of the targets set in this system for 2015 are met. All sub-sector strategies (e.g. HIV/AIDS, TB, Malaria, etc.) are now aligned to HSSP III timelines and priorities. Over the last three years, a national guideline for policy and strategic development was developed and implemented by programs and districts. The health sector policy and M&E plans were revised. To ensure that cooperation partnership is fostered, the district SWAP guideline was also developed which has strengthened districts' joint decision making processes and structures.

Decentralized levels have developed their own District Health and District Hospitals Strategic Plans based on the guideline received from the national level. Facilities also take into account partners' expected contribution (not forward looking budget) and Internally Generated Revenue during action plan development. Different training and mentorship programs have been carried out to build the capacities of the decentralized level of planning, budgeting and strategic plan development and monitoring and evaluation. The training of district planners for using this integrated planning tool has been postponed to October/November 2015. Although the major decision-making on resource allocation remains with the National Ministries, the benefit of decentralization has been to allow the HF to have better access to decision makers that can either take actions themselves or follow up with other higher-level authorities. It also opened a room for dialogue between districts and sector ministries under the leadership of MINALOC.

There are also important achievements in strengthening health management information systems. The national health observatory warehouse is developed and will soon start to be used to communicate the sector results through it. Rwanda has made many gains during the past years in the area of Information management. These include achievements in the automation of systems that are operational at all levels of the health system (HMIS, SISCom, RapidSMS, LMIS). During 2013-2014 fiscal years, there are three key realizations under the Health Information Management:

- TRACnet, the HIV electronic-based system and the TB paper-based systems were migrated into HMIS, and were integrated in one national reporting system with purpose of harmonization and sustainability.
- The sector improved reporting compliance for the HMIS to nearly 100%.

- Planning, Monitoring, Evaluation and Coordination reinforced the data quality control through a standardized and regular data quality assessment (DQA) and integrated supportive supervision (ISS) methodology at all health facility levels.
- Most the HMIS tools have migrated to data warehouse. Electronic Medical Record (EMR) is now functional.

The HRTT has been revised and has become more flexible and comprehensive. It is largely aligned with the HSSP III priorities and intervention areas, as well as with the MTEF framework. The information generated in the 2012/13 HRTT report, if produced at the right time could have improved the budgeting process at all levels.

Challenges

The planning process looks incomplete at the lower levels due to inability of the DHU to come up with a comprehensive plan. There is also limited use of available data by district level decision makers. While facilities have their annual plans, districts do not have a health sector comprehensive district wide annual plan. Districts are consulted in the development of the MOH annual plans but the consultation and agreement on the priorities and targets are not detailed enough, as there is no district health plan that brings all the action plans of facilities and DHU together. The budgeting process is at best informed by the previous year expenditures and trends. The HRTT is only used as a reporting tool and not as a means to inform the planning and budgeting process during the forward and backward looking reviews. Its timing of data collection does not well fit to inform these processes. The engagement of DPs in the planning process is limited. The alignment of DPs and GoR planning processes are not yet effective. There is still a significant proportion development support that still uses off-budget mechanisms. Some development partners are unable to fund some areas of HSSP III like infrastructure.

Table 41. Recommendations for Planning, Budgeting and Monitoring

Actions to be undertaken	Medium-term HSSP III Transition July 2015 – June 2018
Action 1	• Align the HRTT timing of data collection to MINECOFIN's planning and budgeting calendar, using Rwandan fiscal year for all partners, with allowing adjustments to be made in the middle of the year. Consult with partners how to implement this process.
Action 2	• Enhance its use as driver or information source of prioritization discussions and accountability on resource utilization during joint reviews and annual planning and budgeting
Action 3	• Workout a practical strategy to work around the differences in budget calendars, which allows some adjustment in the course of implementation
Action 4	• Strengthen the role and capacity of DHU to develop a comprehensive district plan, that could help implement the new Imihigo guidelines and better use of information for planning and decision making

4.2. Human Resources for Health (HRH)

Table 42. Findings in HRH

EXPECTED OUTPUTS / OUTCOMES	BASELINE 2011	FINDINGS 2013 / 2014	TARGETS 2015	FINDINGS 2015*	TARGETS 2018
Doctor / population ratio**	1 / 16,001	1 / 10,739	1 / 13,748	1 / 10,055	1 / 11,993
Nurse / population ratio***	1 / 1,291	1 / 1,142	1 / 1,291	1 / 1,142	1 / 1,000
Midwife / population ratio***	1 / 66,749	1 / 4037	1 / 45,000	1 / 4,037	1 / 25,000
Lab tech / population ratio***	1 / 10,626	1 / 8,518	1 / 10,500	1 / 10,500	1 / 10,000
# of A2 nurses who completed E-Learning course to upgrade skills****	0	N/A	588	264/300	1488
% DH / DHU preparing staff census with iHRIS	0	80	100	100	100

Source: IHRIS 2015

*The information in this table refers to the situation with doctors as at August 2015, while for the other professionals, the figures refer to the situation at December 2014

.

The overall objective of Human Resources for Health (HRH) chapter under HSSP III is to ensure availability of an adequate, equitably distributed, quality, motivated, and productive workforce, responsive to the country's changing needs and demands. Three key objectives were defined:

- Increase quantity, scope, and quality of HRH to adequately respond to the country's needs;
- Expand and strengthen the capacity of teaching institutions (TI) to augment HRH production;
- Improve HRH management, ensure rational deployment, adequate and equitable distribution and retention of HR staff.

Achievements

- The Doctor / Population ratio targeted for 2015 was achieved in 2014 and was 130% of the expected target of 2015.
- Similarly the Nurse/population ratio targeted for 2015 was achieved already in 2014 and was 110% of the expected target of 2015..
- The Midwife/population ratio was achieved in 2014 and the percentage increase indicated was 1,200% of the expected value of 2015. However, this figure could well be a computation error, as it is inconsistent with the general statement that "the country is short of midwives" in the districts and at the National level.
- The Lab tech/population ratio also showed a similar trend where the targeted value in 2015 was achieved in 2014 at 120% of the expected value of 2015.
- Capacity Building of key staff at MOH and RBC; as well as Directors of District Hospitals, Hospital Administrators, Chief Nurses and HR Heads has been undertaken. This involved Masters Degrees and PhD courses. The upgrade also served as a retention strategy. There is no statistical information available on how capacity building and bonding have influenced health worker attrition. The Medical Personnel Specialist informed the team that only two doctors have absconded without completing their period of bonding.
- Mandatory CPD has been started for doctors since 2011 and a CPD policy for all health professionals was approved to start in 2014/2015 fiscal year.
- The Capacity Development Pooled Fund (CDPF) from MOH and DPs has been used to develop capacity in HR, including training of biomedical engineers and technicians and to support HRH programs (especially nursing and midwifery) which also involve recruitment of lecturers from other countries and buying of equipment for teaching hospitals to increase intake and scope of training in different medical specialties. Funds to support the continuation of these activities will be mobilised after 2015,

- Medical education is expanding fast and by 2018 five medical schools are expected to be in operation, namely (i) the University of Rwanda, College of Medicine and Health Sciences; (ii) ISPG (Southern Province), being currently in its 3rd year of operation; (iii) Adventist University of Central Africa has been requested by the Rwandan Government to start a Medical School and is due to commence in 2016; (iv) University of Global Health Equity has been granted accreditation and is due to commence a school of medicine in 2018 and (v) Kigali (Independent University) will start medicine program in 2018.
- Effective retention strategies have been implemented
    a) Doctors, midwives, nurses and other health professionals that continue to work in the public sector will be eligible for further career development opportunities.
    b) All staff sign retention contracts
    c) Performance based finance is another incentive to stay

  Detailed staffing norms have been prepared and are now due for revision

To mitigate the consequences of the current decline in external funding in HRH, MOH conducted a situational analysis that came up with three main suggestions:
- Reduce the reliance on external funding for HRH Financing to Sustainable Levels.
- Link HRH planning and health worker production to health care needs.
- Strengthen HR Management to support health worker productivity and retention.

The situational analysis led to the HRH sustainability plan with the following recommendations:
- Gradually increase GoR funding; Give health facilities authority to generate income with improved staff qualification and equipment; Establish the real cost of staff production.
- Introduce these interventions over a period of ten years.
- Develop policies and regulations that would allow government doctors to work in private practice, including taking specialists off government payroll.
- Track health professionals who do not return home after training abroad.

Challenges
- There is currently not enough staff and the desired skill mix of the available staff is not optimal; several categories are missing e.g. specialist doctors, midwives, among others.
- There is continuous staff turnover in health facilities
- The staffing norms are sometimes poorly understood, as the same norms are mentioned for different levels of facilities. In addition, norms are not always implemented, leading to dis-balanced staffing. Thus there are examples that a District hospital like Kibogora has more qualified staff than a Provincial hospital like Bushenge.
- The desired expansion of training to increase health worker output has put training institutions under pressure: (i) there is not enough faculty (though the HRH program in post graduate medical education has reduced the pressure considerably), (ii) the training infrastructure and equipment have been stretched to accommodate the increase in student numbers. As a result, most schools have not been able to achieve the desired increase in yearly intake of students in the various programs.
- The specialization drive to produce clinical specialists has implications for HRH at national level. If the medical specialization is a four year program, the latest entrants should be the 2014 graduates who would be able to finish by 2018. The HRH program started in 2012, and the College of Medicine and Health Sciences produced a total of 88 (2012), 130 (2013), 76 (2014), making a grand total of 294 doctors (see table 43 below). With the requirement to do one year internship, only 218 new doctors (2012 and 2013 graduates) qualify to begin postgraduate training. Thus the remaining 332 doctors will have to be drawn from the GP pool in the country. This will drain the GP pool in the districts and therefore affect the health services provided by GPs at the primary and district levels.

Table 43. Intake and Output of College of Medicine and Health Sciences

Program	Course duration	Intake 2011/2012	Output 2011/2012	Intake 2012/2013	Output 2012/2013	Intake 2013/2014	Output 2013/2014	Intake 2014/2015	Output 2014/2015
Bachelor of Med-Surgery	6 years	108	88	98	130	102	76	186	99

Table 44. Recommendations for HRH

Summary Actions	Medium-term HSSP III Transition July 2015 – June 2018
Action 1	Develop a clear HRH Development Plan for the coming 10-20 years, that is costed. Include the various professions to be trained for each level of care. This will ensure that PHC gains are not lost and costs are likely reduced. Involve DPs in such a study and look for DPs interested to replenish the CDPF. Address the JANS recommendation of June 2012 (p. 7).
Action 2	Harmonize staffing norms among HF and explain these norms to HR staff in district hospitals and health centres during monitoring and supervision visits. Accelerate training of staff on iHRIS and extend internet coverage to all health facilities.. Include attrition in the iHRIS tool. Investigate reason for the continued staff turnover in spite of existing retention strategies and implement feasible solutions. Address the shortage of midwives based on available gap analysis
Action 3	Consider pre-service training of interns and MDs and CPD for practicing health professionals in a comprehensive way to broaden their knowledge and skills on the needs of the various levels of care (from referral hospital to district hospital and health centre/ community outreach levels) Prepare good mentors / supervisors for the graduates that are sent from the referral hospitals to the DH, where different pathologies are seen and different skills are required.
Action 4	Organise teaching methodology skills for all trainers who have not learnt modern teaching skills
Action 5	To sustain the observed increases in health professional numbers, liaise with the Ministry of Education to strengthen secondary education, so that sufficient numbers of students qualify to pursue various health courses. Initiate programs to create awareness in the secondary schools on careers available in health to attract students (medicine, nursing, midwifery, lab technician and other health professional training). Mount similar programs in medical schools and among GPs to attract doctors into the less popular but essential specialty areas e.g. anesthesiology

4.3. Medical Products Management and Regulation

Table 45. Findings in Medical Products

EXPECTED OUTPUTS / OUTCOMES	BASELINE 2011	TARGETS 2015	FINDINGS 2015	TARGETS 2018
% HF with NO stock-outs of tracer drugs	55	95	98	98
% Generic drugs locally produced	<2	>6	0	>11
% Prescription of antibiotics in DH / HC	≥ 65	≤ 60	NA	≤ 40
% Hospitals with Drug Therapeutic Committees	45	90	NA	100
% HF with online tracking system for all procuring entities (LMIS)	0	80	98	100

Achievements

The pharmaceutical policy has been drafted; relevant laws have been reviewed and ministerial orders have been submitted for approval and the legal framework and policy for traditional practice are being developed.

Storage capacity has been increased by 1800 pallets, including cold storage and improved security at central level. Two stores have been built in the Economic Free trade Zone and a warehouse has been constructed at the Medical Production and Procurement Division (MPPD) increasing storage capacity by two-thirds, resulting in closure of 3 ware houses that were earlier on rented. Many district pharmacies have expanded storage space. MPPD distributes all medical products to the district pharmacies on a monthly basis, while all district pharmacies distribute medical products to health facilities also on a monthly basis with appropriate distribution trucks.

MPPD has a total of 69 staff at central level and staff at district pharmacy level range from 4 to 10. At health centre level, A2 nurses are trained to take care of the health centre pharmacies. BTC has been training professionals and instituted clinical protocols in different hospitals. In the context of regional integration, the EAC Medicines Regulatory Harmonization project has been supporting in the development of EAC guidelines, including; Good Manufacturing Practices (GMP), Quality management System (QMS), Medicine evaluation and registration (M E&R), Information management system (IMS) and other quality and regulatory systems and some of these have been domesticated and others in the processes of domestication in Rwanda.

Previously there were commodity stock outs, but measures have been put in place to increase availability of commodities. The district pharmacies have increased their stocks and assets and reduced stock-outs. Using locally generated funds they have expanded and rehabilitated district pharmacies. MOH holds quarterly meetings known as Monitoring, Training and Planning (MTP) with District Pharmacies to review issues pertaining to availability and distribution of medical supplies and strategies for better performance. In addition the use of electronic logistics management information systems has improved commodity stock management. The electronic LMIS has 80% coverage. Stock-outs are monitored monthly for 250 products; only 1% and 2% stock-out rates have been observed for district pharmacies and hospitals, respectively.

Quality control is undertaken using WHO approved laboratories where samples are sent for quality control; the National quality control laboratory has been constructed ,equipped and staffed and once fully operational, will be used for testing and analysis of samples and pharmaceutical products on the market.

Drug and Therapeutics Committees have been instituted in all public and faith-based hospitals and is functional. The pharmaco-vigilance system is in place. Specific clinical protocols have

been reviewed to promote medicines rational use and medicine selection is done based on the National List of Essential Medicines. The last edition of the List was approved in 2015.

Challenges
The Regulatory Authority is yet to be established and local production of medical products has not yet started; there have been negotiations with investors who want to invest in pharmaceutical products production, however, none are yet to commit to investment. Furthermore, there is a challenge of enforcement of laws and implementation of policies and strategic plans, including regulation of traditional medicine and medical devices. Rational use of medicines and other health technologies need to be monitored as well as their pricing.

MPPD does not have adequate capacity to provide for all the needs of the public sector. While at central level, the filling rate for the program products is over 98%, the filling rate remains at 61% (up from 50% in 2012/2013) for the non-program products. The factors for the stock-outs include slow responsiveness of the suppliers and long administrative processes. In addition, there is difficulty in matching the needs at district with that at central level, although to some extent the quarterly meetings and the use of LMIS linked to the central MPPD systems address this problem.

Every health centre pays for its supplies but many health centres are indebted to the district pharmacies. Whereas health centres visited tend to get the bulk of their essential drug supplies from the district pharmacies, MPDD covers less than half of the drug needs of the district, the rest being procured from the private suppliers. (Over 99% of supplies are from the district pharmacy in Ruhinda health centre and 40% of supplies from MPPD by Burera district pharmacy). At Butaro hospital, cancer drugs are bought by Partners in Health (PIH), distributed through the district pharmacy system and given free to patients.

Program products are managed and distributed by district pharmacies without getting any management fees (MPPD takes the entire 9% fee and does not compensate the district pharmacies). This may further complicate the financial situations of the district pharmacies as health centres and hospitals are in arrears, ranging from 193m RFW to 500m RFW during the 2014/15 financial year.. While district pharmacies have appropriate trucks for commodity distribution, the central level outsources public trucks. However, MPPD is in the process of procuring the appropriate trucks. On the other hand, the district pharmacies have only one truck and when broken or undergoing maintenance there is a transport shortage.

Some suppliers have provided sub-standard products (suppliers from Pakistan and Belgium. They have been black listed but with pending court cases (retracting products, payments).
Most staff of MPPD does not have formal training, they learn on the job while working. Lack of career growth for staff at district pharmacy is an issue that has been discussed but not resolved. In addition the electronic LMIS utilization has challenges of computer illiteracy among the staff at lower levels and irregular or no access to internet.

The Pharmaceuticals department expressed need to revisit the indicators as some indicators are no longer easy to be calculated due to data element structure .

Table 46. Recommendations for Medical Products

Actions to be undertaken	Medium-term HSSP III Transition July 2015 – June 2018	Long term HSSP III Beyond June 2018
Action 1	Improve the forecast and quantification of the pharmaceuticals and avoid expiries and stock-outs of products at all levels	Establish regulations for and explore local production of pharmaceuticals to maximize availability of products.
Action 2	Improve enforcement of laws, strengthen registration and post-market surveillance to promote quality assurance for health commodities and institute the accreditation	Continue to explore regional collaboration within context of EAC, including pharmaceutical training at a centre of excellence at University of Rwanda

	system for the quality control laboratory once operational	
Action 3	Continue to pursue the legal status of MPPD to establish an autonomous body.	Strengthen the pharmaceutical regulatory system through continued advocacy for the autonomous regulatory agency that oversees, among others, new pharmaceutical products, product registration, inspections, quality assurance and enforces the regulations, regulates traditional and complementary medicine practice and develops a pricing policy to regulate the private sector.
Action 4	Improve skills and number of human resources for the pharmaceutical sector	Review / update the pharmacy related indicators

4.3.1 National Centre for Blood Transfusion (NCBT)

Table 47. Progress of NCBT Indicators 1

EXPECTED OUTPUTS	BASELINE 2011	TARGET 2015	FINDINGS 2015	TARGET 2018
% Increase in No of regular blood donors	10%	32%	42%	75%
Safe blood administration to patients through:				
• Haemo-vigilance through creation of Hospital Transfusion Committees	NI	NI	NI	40%
• Hospital Supervision	NI	20%	21.7%	75%
• Mentorship of Hospitals	NI	16.6	16.6%	100%
• Hospital Satisfaction	NI	%85%	86.7%	90%

NI = New Indicator; **TTIs =** Transfusion Transmissible Infections

National Centre for Blood Transfusion (NCBT) ensures: (i) blood donor mobilization, recruitment and retention,(ii) Process blood (making plasma, packed Red Blood Cells, Platelets and Cryoprecipitate AHF (to be distributed to health facilities). NCBT consists of 5 centres, one in each province and the centre in Kigali. Each centre is headed by a doctor trained in Transfusion Medicine. NCBT has currently 138 staff, hoping to be fully staffed at the end of the year with 151 staff. Its two main activities are (i) blood donor mobilization, recruitment and retention (through 466 mobile blood collection centres and 11 vehicles) and (ii) the laboratory that processes blood (making plasma, packed red blood cells, platelets and cryoprecipitate anti-hemophilic factor to be distributed to 60 health facilities (Provincial/referral hospitals, district hospitals, private hospitals/clinics and 2 health centres)

Achievements

Staff capacity has been built, mentor system is in place and all program Nurses are upgraded to A1. The Quality Management System is based on American Association of Blood Banks (AABB) standards. The NCBT has achieved Level II Accreditation by the Africa Society for Blood Transfusion (AfSBT). All regional centres have a Blood Establishment Computerized System (BECS) in place and the system is centralized. New technologies including aphaeresis have been introduced. The number of voluntary donations increased by 9% to 61,771 this year from that of last year and all potential donors are tested for TTIs (Transfusion Transmissible Infections) which are HIV, HBV, HCV and Syphilis.

Challenges

Challenges encountered in blood transfusion services include expected enormous budget reductions: PEPFAR pays for 59% of all operations and will reduce its budget by more than 70% .

[1]. Indicators and data obtained from RBC / National Centre for Blood Transfusion

Similarly Global Fund pays for 35.5% of operations and will reduce the budget by up to 50% . These cuts are expected in the middle of 2016. Actions are being taken, such as (i) cost recovery through RSSB and other health insurance schemes, (ii) centralization of blood component production and (iii) selling plasma for fractionation of stable blood products. Furthermore, there are insufficient core equipment and computers needed for the various activities. In the HSSP III, no outcomes or outputs indicators were defined for blood transfusion. These have now been suggested at the top of the page.

Table 48. Recommendations for NCBT

Actions to be undertaken	**Medium-term HSSP III Transition July 2015 – June 2018**
Action 1	Develop a sustainability plan for the program
Action 2	Develop an efficiency plan for NCBT including the selling of blood products
Action 3	Strengthen capacity of blood transfusion services by availing core equipment

4.4. Diagnostic Services

Table 49. Findings Diagnostic Services

EXPECTED OUTPUTS / OUTCOMES	BASELINE 2011	TARGETS 2015	ACHIEVEMENT 2015	TARGETS 2018
% Labs with at least two trained staff in good lab practices	76	100	89	100
Number of A0 and A1 Lab Technicians in place in DH and HC	151	291	329 RHs: A0=22 A1=42 DHs: A0=92 A1=106 HCs: A0=22 A1=38	516
# Pharmacy legal instruments	18	30	32	
# District Pharmacies with good storage facilities & capacity		NM	14	

Achievements

Five satellite laboratories have been constructed and equipped in addition to the National Reference Laboratory (NRL). The human resources of these laboratories have been trained. Human resource standards have been set up and on average 8 out of 12 of the required human resources are present. Heads of Units at NRL have masters qualification, the minimum at referral hospital level is Bachelors qualification, at district hospital level, advanced diploma and at health centre level, certificate qualification. These laboratories have been internationally assessed with ISO 15189, with 4 star rating for the satellite laboratories and 5 star rating for the NRL. Rwanda has won trophies in the EAC Region for laboratory quality. Over 33 district laboratories have been enrolled in the assessment using CDC/WHO checklist in order to improve their standards.
With regard to laboratory supplies, NRL monitors stock and chain supply, ensuring timely supplies to districts. A laboratory information system (LIS) is in place to monitor lab commodities.

For quality assurance, proficiency panels are being used for laboratory staff and the performance is rated at 100%; external quality assurance for human resource is done, as well as validation of equipment. Samples are sent to NRL for quality control and also to accredited external laboratories. The NRL sets norms and standards for each level, including for human resources. Maintenance is sub-contracted and supported either by projects or by government domestic funding

Challenges

Major challenges revolve around inadequate human resource capacity for emerging technology, high dependency on programs for reagents and research that is still externally driven. For the cancer centre at Butaro Hospital, although biopsies could be done in other hospitals, it requires orientation of hospitals and enhanced referral systems for oncology. The space for the laboratory is not adequate. Currently both pathology and clinical laboratories are in one same place that should be separated.

Table 50. Recommendations for Diagnostic Services

Summary Actions to be undertaken	Medium-term HSSP III Transition July 2015 – June 2018	Long term HSSP III Beyond June 2018
Action 1	Improve the capacity of the laboratory network including molecular diagnosis for infectious diseases, human resources	Enhance infrastructure for NRL (equipment, maintenance, reagents and trained HR)

	training, appropriate equipment within the laboratory network and strengthening the laboratory information systems (LIS) with links to EMR for clinical laboratories	Strengthen laboratory equipment maintenance
Action 2	Strengthening quality management systems within the laboratory network for accreditation	Increase funding for research (clinical trials, operational research, etc.) and reagents
Action 3	Implement Laboratory equipment harmonization policy	Improve the data base of existing technologies including assessment / standardization
Action 4	Update the Diagnostic Services indicators and targets and their monitoring system	

4.5. Health Infrastructure Development

Table 51. Summary of Infrastructure

Indicator	Baseline	Findings 2015	Target 2015	Target 2018
% of adequate infrastructure in HFs based on norms and standards	8		27	50
% of DHs with effective maintenance workshop	<5		50	80

Achievements

Item	Number	Names
Hospitals Constructed	6	1.Remera Mbogo specialised HC 2.Upgrade Kibuye Hospital 3.Kinihira 4.Ruhango 5.Bushenge 6.Upgrade Kirehe
District Hospitals upgraded to provincial hospitals	4	1.Kinihira 2.Ruhango 3.Bushenge 4. Rwamagana
Health Sectors with newly constructed HCs	33	
New maintenance workshops constructed	0	
Biomedical engineers trained	2	
Biomedical technicians trained	51	

Five hospitals were constructed, equipped and provided with mortuaries and incinerators. New health centres have been built in 33 sectors and the number of sectors without health centres has now been reduced from 20 to 7. The remaining 7 are planned to be constructed in the coming year. Fifty-one technicians were trained at A1 level for improved infrastructure management. A new advanced degree training for biomedical technicians has just started at the Integrated Polytechnic Regional Centre (IPRC) with the support of the capacity development pooled fund (CDPF). Previously a similar but lower level training was sponsored by GE Foundation and Global Fund. A number of health facilities that were either built or rehabilitated were visited

A booklet of service packages prescribes dimensions for health facilities and list of standard equipment have been developed . Management of equipment is facilitated by use of software and breakdown time for medical equipment is monitored using checklists. Active maintenance is either provided by the specific maintenance unit or outsourced through maintenance contracts.

All district hospitals have strategic plans and plans for equipment since 2012, aligned to HSSP III; they develop annual operational plans. The norms and standards for hospitals are being worked on and are due for validation by December 2015.

Guidelines for receiving donations (getting rid of defective equipment and ambulances) have been drafted. The guidelines may benefit from an on-going in-depth study on donations regarding infrastructure, medical supplies and equipment. Results are expected in January 2016. Most facilities visited had maintenance plans and were supported by the biomedical technicians from the central level (Medical Technology and Infrastructure Division) and District hospital and the district maintenance teams.

Challenges

MOH has strived to achieve geographical equity but there are challenges, such as infrastructure for construction of new hospitals, rehabilitation / extension of old hospitals and staff not willing to work in remote areas.

The only cancer centre in the country, at Butaro hospital does not offer radiotherapy and have to refer the cases requiring radiotherapy to Mulago Hospital, Uganda at a rate of 20-30 patients per month.

Table 52. Recommendations for Health Infrastructure, maintenance and referrals

Summary Actions to be undertaken	Medium-term HSSP III Transition July 2015 – June 2018	Long term HSSP III Beyond June 2018
Action 1	Finalize the upgrading of hospitals to referral hospitals and their accreditation Construct two District hospitals (Nyabikenke and Byumba)	
Action 2	Assess existing health facilities and infrastructure against the norms and standards	Consider providing comprehensive radiotherapy services in-country
Action 3	Strengthen capacity for maintenance workshops	

4.6. Health Financing

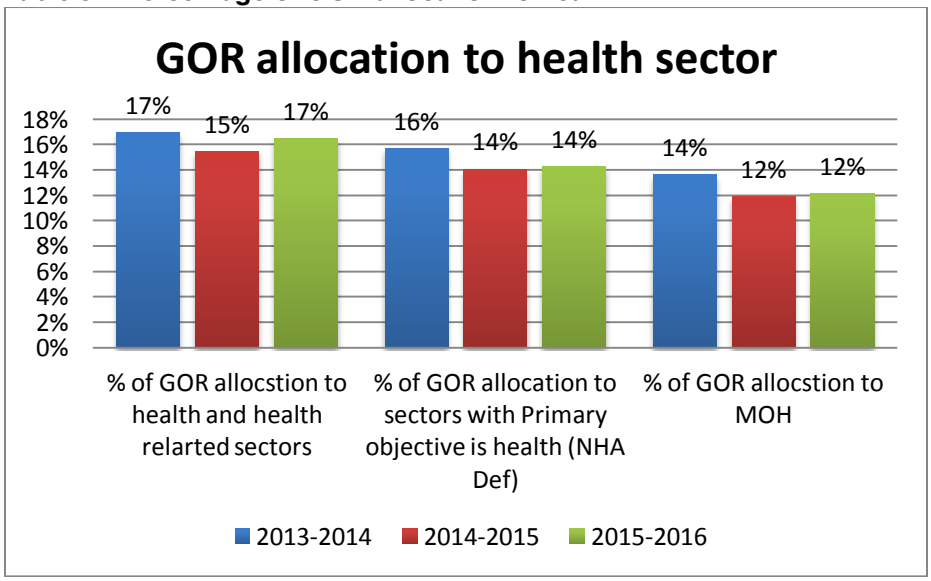
The major targets for financing by 2015 were to increase government allocation to health to 13%, per capita health expenditure on health to $ 43 and maintain coverage of CBHI at 91%.
The envisioned strategic directions set are increasing financial access and protection, enhancing efficiency in allocation and use of resources, increasing internal revenue generation, improving coordination and effectiveness of external assistance and sector participation.

Table 53. Findings Health Financing

EXPECTED OUTPUTS / OUTCOMES	BASELINE 2011	TARGETS 2015	FINDINGS 2015	TARGETS 2018
% GOR budget allocated to Health	11.5	13	14%	15
Per capita total annual expenditure on health (USD)	$ 39.10	$ 43.00	NA	$ 45.00
% Population covered by CBHI	91	91	76.3 %	91

Achievements
As can be seen from table 53 while the HSSP III MTR target for resource allocation is met, the CBHI coverage rate declined. There is no information about per capita total expenditure on health, since a NHA was not conducted in the last five years.
GOR has continued to invest in the health sector. Despite becoming a foundation sector under EDPRS II, the health sector continues to receive a satisfactory share of the national budget. The MTR target for GOR allocation is met, if all those interventions whose primary objectives is health are considered. It is important to note that there is no clear definition of the Abuja declaration and the practice varies from country to country. If health and its macro-economic determinants are considered, Rwanda has achieved more than the Abuja Declaration with 17% (see Annex 6 for details of these derivations and exclusion notes). But if health sector is defined as programs that are under HSSP III interventions, the % allocation to health is around 12 %.
The latest findings from HRTT estimated that the GOR's share of the total health budget of 2012/13 to be 23% while external financing was about 73%, the dominant share coming from the Global Fund and USG.

Table 54. Percentage of GOR allocation to health



(see definition of the three alternatives in annex 6)

The overall funding arrangement is not fully known, especially as there is no information on off-budget support by DPs and CSOs for 2013/14 and 2014/15. The data on table 55 shows a some funding gap, but this is mainly due to the lack of information on off-budget support, which accounted for about 40% of total funding in 2012/13.

Table 55. Projections and estimated allocation by source of funding (in USD)

YEARS	2012/13	2013/14	2014/15
Total HSSP Cost	582,600,000	590,500,000	607,300,000
Projected financing			
Government	237,304,653	148,874,683	156,203,898
DPs	97,499,984	91,066,700.70	88,472,207.80
Total	334,804,638	239,941,384	244,676,106
Allocations			
Government-MOH Data with Adjustment	242,290,917	238,513,791	251,987,827
Government RTT	116,342,714	111,128,638	123,902,548
Development Partners (HRTT)	331,716,430	341,643,532	340,764,122
DP (SPIU)	NA	127,165,646	143,839,206
Total Funding			
HRTT	538,873,863	514,014,611	532,865,399
(MOH/Government and RTT/DP)	574,007,347	580,157,323	592,751,949
(MOH/government and SPIU DP	242,290,917	365,679,437	395,827,033
% of allocation vs projection			
Government -MOH data	102%	160%	161%
Government -HRTT data	49%	75%	79%
DPs funds -SPIU		140%	163%
DPs fund-RTT	340%	375%	385%
Indicative Total Funding gap (%)	2012/13	2013/14	2014/15
RTT data	8%	13%	12%
(MOH/Government and RTT/DP)	1%	2%	2%
(MOH/government and SPIU DP		38%	35%

Source: information given to the MTR team by MOH, SPIU and the HRTT report. MINECOFIN shared this financing data through MOH.

Over the last three years, the Health Financing Policy was also revised and a new Health Financing Strategy, Rwanda's first health financing strategic plan, is awaiting validation. There is now also an understanding of the challenge of sustainable financing and an interest and policy direction towards diversifying domestic sources funding. The Health Financing Sustainability Policy outlined the overall direction, while the draft Healthcare Financing Strategic Plan spelled out the mechanics of resource mobilization strategies including innovative domestic sources (see

Box 1 below). The strength of the country system has motivated the Global Fund to use result-based funding mechanisms - channeled as a sector budget support - for the first time as a global pilot. The CBHI management has shifted to RSSB to ensure that there is more centralized and better financial management oversight, reduction of fragmentation of management and enhance efficiency and cost-effectiveness.

There is more emphasis given to the role of the private sectors as demonstrated not only by the establishment of the health posts as PPP, but also by the efforts being made to work with the private sector in tertiary care. An assessment on the engagement of private sector is also carried out. The Sustainable Financing Policy has policies and strategies crafted to engage and provide incentives for the private sector.

The decentralization process contributed in enhancing efficiency. Facilities have started to rationalize their human resources, when faced with the reduction in external assistance, although some of them struggle to provide similar quality services. There are efficiency gains in managing infrastructure projects close the place of construction. Facilities are now focused more than ever before on generating more IGR for self-financing. Efforts are also made to strengthen the financial management at facility levels.

BOX 1: Innovations in domestic financing

Innovative options will be developed for raising domestic resources to cover a larger part of health resources. Key initiatives that will be pursued include:

- Establishment of social markets for health products like mosquito nets;
- Development of a sustainability plan for HIV/AIDS and other programs;
- Cost recovery and cost saving plans for health products, including blood products;
- Monetizing accreditation of private health facilities;
- Establishment of new revenue generating projects across all levels of the health system including public hospitals to set up semi-private wings
- Promoting Public Private Community Partnership.
- Sin taxes of tobacco, alcohol, processed food, etc. and
- Levies on products like mobile phone, transport, etc.
- Encourage the private sector to invest is supply and demand of health services including medical tourism by creating an enabling environment: establish PPP framework providing incentives for designing proposals/cases to interest the private sector to invest in health and creating new opportunities for partnerships

Source: MOH, SHF policy, 2015

Enrollment of CBHI has recently started to pick-up, but achievements have been reversed over the last three years. However, they remain the highest coverage rate and best practice in Africa in terms of the informal sector coverage. The stratification of premiums is reported to have helped to increase the funding ability of the scheme. The government continues to be committed to see the scheme working as can be evidenced by (i) decision to pay for the payment of the premiums for the 23% of the population-the very poor; (ii) financing the debts of CBHI schemes from facilities until June 2015; and (iii) decision to shift the management of CBHI from MOH to RSSB to enhance its effectiveness.
The shift is expected to reduce the fragmentation of the pool (from 30 to 1), and use the experience and expertise of RSSB to enhance the financial management of the scheme. A study has been carried out about the deficit and financial capacity and, in two years, an actuarial study is planned to be carried out to know the real deficit and help chart out its sustainability. Based on its findings, FMOH could revisit the benefit package and MINECOFIN contribution rates.

PBF continued to be the means to encourage providers to focus on the outputs of the services they provide. Resources from government, GF and some other partners are using it as output-based payment systems to generate more value for money in the Rwandan health system. It is reported that the clinical side of PBF is working well, while this is not the case for the community side

Challenges

The challenges of health financing are well known and documented (see Box 2). Rwanda has started experiencing a decline in external resources: a reduction of PEPFAR and the Global Fund funding . The decline in external resources is a major challenge not only to respond to the new health sector priorities but also to maintain the gains made so far. Despite the fact that the government of Rwanda has shown its commitment to increase resources to the health sector over the last few years, and given that the health sector is a foundational rather than the priority sector, the fiscal space available may not be able to fully meet the declining external resources with the current composition of funding sources.

According to HRTT estimates, more than 55% of the health resources are still managed at the national level (lower levels benefit from it) although there was a slight increase for decentralized levels from 2011/12 to 2012/13 budgets. All the stakeholders' interviewed clearly stated that decentralization has improved the efficiency with which resources are utilized at the district level (HR, infrastructure) but has not made a significant contribution to increase funding to districts. There is also inequality among districts and programs in resource allocation. The geographic inequality in per capita allocation ranges from the highest going to Nyarugenge to the lowest in Nyanza district (HRTT report). Spending continues to favor HIV/AIDS while funding to non-communicable diseases remains low but increasing (HRTT report).

Health facilities are now increasingly taking over the employment of human resources from their internally generated revenue that was used to be paid through external support. On the whole, while hospitals have managed to retain these retrenched staff, many health centers were not able to absorb all and have rationalized their HR deployment. The government is fully aware that the current funding availability at the facility is being compromised and self-financing is being promoted, as one means to ensure sustainability. Until such an objective is achieved there might not be adequate resources enough to sustain

BOX 2: Challenges in health financing

The main challenges are summarized as follows:

- On resource mobilization and allocation
  - High dependency on external public financing (61%) with projected decline of resources
  - Gap of 33% of required financing for executing Health Sector Strategic Plan
  - Low contribution of private sector in health (1.7% of private GDP for health)
  - No clear mechanism for ensuring allocative efficiencies in use of resources
- Emerging problem of non-communicable diseases and their associated high costs of care
- ON CBHI and insurance issues:
  - Decline in CBHI membership level
  - Lack of capacity to effectively collect premiums and attain optimal recovery level
  - Inefficiencies in the health system and parallel systems (pools). Multiple pools reduce bureaucracy but increase administrative costs
  - High administrative costs for some agencies, especially social health insurance and CBHI, principally due to the verification process of health providers' bills.
  - Inadequate coordination mechanism among insurance agencies
- Internal Generated related and facility capacity issues:
  - Health facilities internal resources not regularly reported and accounting and reporting of expenditures in health facilities not adequately monitored
  - Staff capacity at sub-national level on PFM including gender responsive budgeting Limited research in health financing areas and weak cost benefit analysis of various interventions, especially when prevention interventions are prioritized (real costing of services). Weak linkages between purchasing mechanism (result-based financing), programs, and health systems functions.
  - Inadequate understanding and analysis of cost related to health service delivery at all levels (community, health posts, health centers, and district, provincial, and referral hospitals)
  - Lack of systematic way to review health financing performance indicators against targets and deadlines

Source: MOH, Draft Health financing strategy

current quality and emerging health conditions like NCDs. While the overall direction of the financing policy and strategy is commendable, there is a need to fast track some background works that will inform the decisions to overcome the challenges in health financing.

About of 23.6 % of Rwandese of the informal sector are yet to be reached through CBHI. There is no accurate information on who these 23.6% are and where and how to reach them. Although membership to insurance scheme is mandatory by law, enrolment into the CBHI continues to be voluntary, as there is no enforcement mechanism (positive or negative incentive) so far. However, according to some district interviews, those that are not covered are reported to include those with big families (unable to afford the entire family) and youth who feel they are healthy. There are very little set mechanisms to enforce enrollment. With the transition to RSSB, the mobilization of communities to increase enrollment will remain the function of the local authority and additional strategies need to be explored into on how to reach this unreached segment of the population. Members that are enrolment into CBHI through partial payment obtain the full benefit package and there is not mechanisms set to enforce payment of their full contribution.

Although government is taking responsibility, there is a significant financial deficit in covering the reimbursement costs to providers by CBHI. The fragmented management of collection of premiums and high management costs at district levels have contributed to this deficit. Some of these challenges are expected to be redressed by the transfer of CBHI to RSSB. The actual tariffs paid to providers are reported to not yet fully cover the cost of service provision. Management inefficiencies have been documented amongst health insurance schemes. For example, an analysis of administrative costs as a share of total expenditure showed significantly high ratios e.g. 23% for CBHI and estimated to be 42% for both social and community health insurance (NHA 2010). The major source of financing of IGR of health providers (health centers and hospitals) remains the CBHI, being about 80% of total revenue. All the facilities visited by the MTR team reported that CBHI owes them a huge sum of reimbursable funding, which reduced their ability to pay the district pharmacy. The inclusion of the expanding health posts, paid as per HC tariffs, is likely to bring additional financial burden to the already stretched CBHI scheme. The strengthening of risk equalization among district pools through RSSB management are likely to address some of the issues of timely payment ability of the schemes to providers. RSSB need to recognize that CBHI is not like formal or private insurances scheme and has unique features that need to be maintained in the near future. This calls for the RSSB to learn further and deeper about the functionality of CBHI and work out the strategies based on the principle of high political commitment and prudent management.

The underlying cause of this financial situation of the CBHI, in addition to inefficiencies, is related to the inability of the scheme to collect adequate funding from its members to cover the costs for their utilization. All the schemes visited clearly reported that the money collected isn't adequate to cover the cost of care. Tariffs paid to the facilities were set some time back and have not been adjusted for inflation or to cover the cost of care. The actual tariff paid by CBHI for instance is much lower than the cost of services provided: If we take lab and x-ray as examples:

Table 56. Comparison of current tariff CBHI and tariff based on real cost (RwF)

Category	Type of services	Current Tariff for CBHI	Estimated tariff based on cost	% of cost \ cost not paid up
Laboratory	GE	379	3187	741%
	Hemogram Complete	1500	5090	239%
	Groupe ABD Rhesus	506	1407	178%
	Bilirbine total	1097	1267	15%
X-ray	Hand (Fet B)	1170	2861	145%
	Foot (Fet B)	1170	3073	163%
	Histero-sapingographie	3150	8082	157%

	Echographie abdomen	2100	4375	108%

According to the draft study by the MOH, the tariffs are lower than the cost for each of these services, ranging from 15% to 741% (see table 56). This indicates the need for the revision of premium rates. Given that the current tariffs are more than the premium rates and much less that the cost of care, some KIIs expressed their view that revising it upwards could have a negative effect on enrolment rates. There is thus a need (i) for a careful analysis of the willingness and ability of the people from the informal sector to pay and (ii) for a thorough analysis of the costs of services to inform a pragmatic setting of tariffs and premium rates.

PBF's spending so far is skewed towards HIV/AIDS and is now facing reduced financing as a result of the international environment. The PBF at the community level hasn't been able to provide adequate incentives for retaining CHWs (15-20,000 per quarter). In some of the districts visited, the CHWs attrition rate is as high as 10%. The management of cooperatives still face some challenges and the CHWs do not fully owned it. It is therefore necessary to rethink about the whole model in terms of financing. These cooperatives have started employing their accountants to manage them better. But there is a need to work out strategies whereby these cooperatives stand on their own and sustain themselves.

The major strategic shift being considered in the health sector is enhancing efficiency gains and ensuring sustainability of financing. As clearly stated earlier, these strategies are well articulated in the new heath financing sustainability policy and the not yet validated strategic plan.
The major recommendation of the MTR team is that MOH should consider endorsing the strategic plan and start implementing the major strategic activities right away in a comprehensive manner rather than developing program based and fragmented sustainability plans.
In this regard, the following activities should be given priority to generate evidence to inform the sustainability of the health sector; (i) revising the package of services, as services to be provided free of charge, on cost sharing or full cost recovery basis; (ii) cost the reclassified service package and estimate associated charges necessary for the sector to finance; (iii) undertake the fiscal space assessment to know the scope with which resources can be mobilized from the treasury; (iv) assess the feasibility of introducing the innovative approaches.
These cost and funding aspects of the assessment will provide the necessary evidence to inform the sustainability agenda. Based on the findings of these, then MOH and MINICOFIN have to decide on the best options available. Table 57 summarizes some of the sustainability actions that need to be considered, all of which are stated in the draft health financing and sustainability strategic plan.

Table 57. Actions to be considered as part of a broader sustainability plan

	International Best practices	Some recommendations moving foreword
Enhancing mobilization of Resource	Deepen existing well performing resource mobilization strategies	Advocate for continued government resource allocation
	Introduce new promising ones (articulating the steps needed)	Fast track • The advocacy for the introduction of the sin-taxes and levies • In the long term with middle income country status, work towards financing through long term • Private sector engagement • Self financing of facilities with due consideration of affordability and maintaining the gains made so far
	Reduce dependency on poorly performing financing sources	Work towards reduction of OOPs to the minimum

	International Best practices	Some recommendations moving foreword
	Improving quality and predictability of existing sources in line with the Paris Aid Declaration,	Continue to work and engage partners
Risk pooling	Increase the size of risk pools and reducing fragmentation through cross-subsidies, mergers etc.	Scale of the innovative mobilization strategy (Tontine) Develop some enforcement mechanisms for CBHI enrolment In the long term advocate for one consolidated Insurance in RSSB
	Improve equity by ensuring major and most vulnerable population groups are covered	Carry out equity assessment of access and utilization of health care services to better determine services and populations associated with greater inequity Continue to invest on protecting the poor
	Deepen risk pool by ensuring that core services and most significant costs are covered	Review and adjust the CBHI benefit package at all levels
	Ensure risk pools are viable and sustainable	Revise premiums based on the ability to pay and cost of service studies
Purchasing	Changes to the benefits package or essential care package, to expand or rationalize it	Undertake periodic review of the essential health care package in view of gradually expanding the scope of care that can be provided at an affordable cost. Define a clear service charging strategy considering public health benefits and affordability (free services, cost sharing; and cost recovery)
	Develop more active purchasing functions (e.g. through better use of information on provider performance and costs	Continue enhancing the PBF and performance contracting model to deliver results Revise charges based on an analysis of cost of care
	Identify areas for improved economy (e.g. through negotiation reduced prices for pharmaceuticals or shifting tasks appropriately to mid-level staff	Continue regulating the health services charges for all types of facilities
	Changes to the benefits package or essential care package, to expand or rationalize it	Undertake periodic review of the essential health care package in view of gradually expanding the scope of care that can be provided at an affordable cost. Define a clear service charging strategy considering public health benefits and affordability (free services, cost sharing; and cost recovery)

The MTR did not carry out a detailed efficient analysis. But the sector can benefit a lot by closely looking at the current expenditures through an allocative, technical and operational efficiency lenses. From the observation in the field some examples of enhancing efficiency gains are suggested in table 58. The sector should consider undertaking such an analysis as part of the sustainability actions mentioned above.

Table 58. Examples of efficiency gains to be considered

Efficiency areas	Areas to look for gains	Some Recommendations From our field visits and observation
Allocative Efficiency	Allocating resources towards services that optimizes outcome	• Continue investing on PHC with balance to strengthen the referral system • Maintain gains made so far by ensuring public financing subsidization of essential services • Prioritize HR capacity building funds in skill areas that will benefit most people e.g. public health qualification • Consider prioritize programs that are yet to achieve their targets

Technical Efficiency	Using "inputs" mix more efficiently	Maximise utilization of infrastructure by ensuring availability of staff
Operational Efficiency	Systems and procedures	• Define a results based resource allocation formula for use at national and sub-national level • Consider PBF to be main payment mechanism in the long run • Invest on rational drug use • Enhance maintenance systems and capacity • Continue rationalising management cost (e.g. CBHI) • Enhance joint planning and integration of service delivery

Table 59. Overall Recommendations for Health Financing

Actions to be undertaken	Medium-term HSSP III Transition July 2015 – June 2018	Long term HSSP III Beyond June 2018
Action 1	• Undertake fiscal space analysis including the feasibility of innovative domestic financing • Get consensus with MINECOFIN on the feasible strategies and implement those that are found feasible	Continue advocating for increased domestic sources allocation, including from MINECOFIN
Action 2	• Determine the type of services that are going to be (i) not charged, (ii) charged on cost sharing and (iii) on full cost recovery basis • Undertake a costing exercise based on three above policy decisions and set the appropriate tariffs to be paid to the facilities	Further strengthen facility autonomy /self financing strategy
Action 3	• Continue to the move towards UHC by reaching the remaining 23.6% of that are not members of CBHI. • Review the benefit package of CBHI and undertake thorough costing exercise • Set affordable and equitable premiums commensurate enough to cover the cost of providers based on evidence based ability to pay analysis • Maintain the basic features of CBHI	Ensure sustainability of CBHI by improving its management and reducing fragmentation and ensuring cost containment.
Action 4	Ensure that the private sector is part of the heath sector planning, financing and information TWG Strengthen the PPP unit within MOH and RBC to engage the private sector and fast track the regulatory framework being worked out	Design incentives mechanism to promote the private sector engage in production and high level curative specialized hospitals Explore the feasibility and implement PBF as provider payment mechanisms for all sources of funding and all components of health systems.

4.7 Quality Assurance, Standards and Accreditation

Table 60. Findings in Quality Assurance HC, DH, PH and NRH

EXPECTED OUTPUTS / OUTCOMES HSSP III	BASELINE 2011	TARGETS 2015	FINDINGS 2015	TARGETS 2018
% HC with functional QA team	0	50		100
# HC eligible for accreditation	0	40 / 450	0	200 / 450
# HC accredited	0	0	0	150
# HC that linked accreditation – PBF	0	450	450	450

EXPECTED OUTPUTS / OUTCOMES HSSP III	BASELINE 2011	TARGETS 2015	FINDINGS 2015	TARGETS 2018
% DH with functional QA team	0	100		100
# DH eligible for accreditation	1	10 / 40		30 / 40
# PH eligible for accreditation	0	4	4	4
# DH accredited	0	5	0	15
# DH that linked accreditation – PBF	0	All DHs	All DHs	All DHs

EXPECTED OUTPUTS / OUTCOMES HSSP III	BASELINE 2011	TARGETS 2015	FINDINGS 2015	TARGETS 2018
% NRH with functional QA team	20	100		100
# NRH eligible for accreditation	1	5	3	5
# Nat Referral Hosp accredited	1	2	1	5
# NRH that linked accreditation–PBF	0	5		5

Achievements

The Health Services and Quality Assurance unit, established in 2014, aims to oversee quality assurance and accreditation in the health sector. The National Policy for Quality and Accreditation of Healthcare System in Rwanda (2015-2019) and the Health care Quality and Accreditation strategic plan (2015 – 2018) were developed. Hospital accreditation standards were developed and disseminated to the 42 hospitals. A technical committee on Quality and standards was set up at central level, including partners. At hospital level, there are accreditation steering committees while all health centres have quality assurance committees. Efforts have been made to empower committees at health facility level by encouraging designation of a focal person to coordinate quality and accreditation. For example at Ruhunda health centre in Rwamagana, a quality assurance team exists at the HC and meets every month to discuss the health indicators. The continuous quality improvement (CQI) plan is developed by the team and is dynamic.

Baseline assessment was carried out in 42 hospitals and performance is assessed every semester. PBF has been linked to accreditation, using accreditation standards to assess quality performance of hospitals. Under the Council for Health Service Accreditation of Southern Africa (COHSASA), King Faisal Hospital was re-certified for the second time in 2013 while CHUK is at 83% and CHUB at 65%. A consultation meeting and a stakeholder workshop were held to obtain consensus on establishment of the accreditation agency and its composition. It was agreed to

- Work on the terms of reference;
- Create an organization to take care of accreditation in the next 3 years, applying accreditation of Rwanda healthcare standards and the surveyor training program; and finally
- Create the accreditation agency according to international standards.

Five selected hospitals started the accreditation process including the new referral hospitals (Kibungo and Ruhengeri) and the provincial hospitals (Rwamagana, Bushenge and Ruhango). Of these, by October 2014, four had achieved level 1 accreditation. By October 2016 they will be assessed for level 2[2]. The 5 hospitals have a quality improvement program and a quality improvement committee. Patient satisfaction surveys have been conducted in the 5 hospitals. 37 more hospitals were enrolled in the accreditation program. Accreditation has focused on public sector facilities initially, but the private sector health facilities are being prepared to pursue the program by training their staff in quality improvement techniques. Standards have been shared with three private hospitals.

Regarding training and capacity development, 37 staff from different institutions and partners were trained by the Joint Commission International and certified as Rwandan Accreditation Surveyors to assess compliance to accreditation standards. Five hundred staff have been trained on quality, IPC and hospitals accreditation at hospital level and a further 58 facilitators (2 teams for Health Facilities and one for Central level) are undergoing training as quality improvement facilitators on quality and certification, for one year in-country course by the Rwanda Health Systems Strengthening Activity (RHSSA) consultant.

Challenges

Some challenges have been encountered and include

- There is no independent accreditation body; currently the coordination of the program is being done by the MOH accreditation steering committee and partners
- Progress in institutionalization of quality assurance is hindered by non-designation of staff to coordinate quality assurance in health facilities, absence of special budget for quality assurance, and limited capacity building.
- Accreditation challenges include factors beyond the primary control of the health facilities (e.g. infrastructure, human resources, etc.)
- Both new and old health facility infrastructure face design challenges in terms of patient safety and quality care standards. Issues of standardization and harmonization of procurement of medical equipment
- Insufficient technical expertise in specialized critical areas, such as emergency care services and hospital infection prevention control

Table 61. Recommendations for Quality Assurance

Actions to be undertaken	Medium-term HSSP III Transition July 2015 – June 2018
Action 1	Expedite establishment of the Healthcare Accreditation Organization to coordinate the system and all quality improvement initiatives.
Action 2	Institutionalize quality assurance at all health facility levels with adequate budgets and capacity
Action 3	Scale up the standard driven approach to continuous quality improvement at all levels of health facilities including private and very critical services.
Action 4	All new constructions and rehabilitation to prioritize standard design considerations in terms of patient safety and quality of care and link with accreditation standard
Action 5	Review and redefine quality assurance indicators and set realistic targets at various levels
Action 6	Include private HF into continuous quality improvement programs

[2]. There are 3 levels of accreditation:

1) Level 1 on policies, procedures, plans and structures (takes 2 years)
2) Level 2 on implementation of policies, procedures and plans (takes 2 years)
3) Level 3 for data (takes 3 years)

4.8. Health Information Management

The issues related to this section are presented and discussed under 8.1.

4.9. Knowledge Management and Research

Table 62. Findings in Knowledge Management & Research

EXPECTED OUTPUTS / OUTCOMES	BASELINE 2011	TARGETS 2015	FINDINGS 2015	TARGETS 2018
% MOH budget dedicated to research	0.4	1	0.18	2

Achievements

- All health related research has to be authorized by MOH in order to be able to collect data
- There is collaboration between MOH and the teaching institutions, as teaching institutions are represented in two TWGs – the MOH HR-TWG and the Knowledge & Management (KM-TWGs, while the Planning & HIS TWG is sometimes also present.
- There is a research proposal review committee at different levels who can approve research but before approving research, MOH requests the researcher to consult the department / division responsible for the topical area to ensure alignment of the priorities and the use of research findings. The National Ethical Committee has to approve all research.
- MOH is now working on a legal framework to give legal backing for clinical trials in clinical research.

Constraints / Challenges

- The target was for the MOH to allocate 1% of its funds to research by 2015 from a baseline of 0.4% in 2011 but funding for research has progressively reduced from 2011 and in 2015 the allocation to research is 0.18%.
- At the district level, research is not much undertaken because there is little funding for research as well as lack of technical capacity. Research that needs special materials and equipment can be difficult to organise due to limited resources.
- Most of the research that is taking place is for professional advancement (such as Masters Dissertations) or for donor funded research.

Table 63. Recommendations for Knowledge Mgmt and Research

Summary Actions	Medium-term HSSP III Transition July 2015 – June 2018	Long term HSSP III Beyond June 2018
Action 1	Intensify staff capacity building and interest in research at all levels. Identify priority areas in research and communicate to all levels to help staff focus on priorities in research proposals	As development partner funding reduces, MOH should increase its research funding towards the 2% recommended by WHO, especially to universities and research institutions
Action 2	Engage DP in priority research areas and ensure alignment of DP funded research to Rwanda's interests	Provide research infrastructure in all areas depending on specific requirements
Action 3	Pursue the development of legal framework for legislation on clinical trials	Include health research in priority areas in performance contracts of staff.

5. COMPONENT 3: HEALTH SERVICE DELIVERY

Summary Findings and Figures

Table 64. Component 3: HEALTH SERVICE DELIVERY

			VALUES			
HEALTH SERVICES	**MAIN OUTPUTS**	**INDICATORS**	**Baseline 2010**	**Targets 2015**	**Results 2015***	**Targets 2018**
Community-Based Health Care (CBHC)	• Increased number of skilled CHW • CHW cooperatives financially sustainable	% Functioning cooperatives & financially sustainable	30	80	50	100
		# of districts providing NCD/AIDS/Palliative care in the community	0	NA	NA	30
District Health Services (DHS): HP, HC and DH	• Planning coordination by DHMTs • % HF with electricity / water • Data private practitioners within HMIS	% Working DHMT in 30 districts	NA		100	100
		% HF with electricity / water	56 / 66		NA	95 / 98
		% Private clinics in HMIS	5		NA	70
Provincial, Referral and National Referral Hospitals (PH, RH & NRH)	• Capacity-building of hosp. managers • Accrued process on track • PH and RH provide supervision to DH	# Trained hosp. managers	15		NA	60
		# National referral hospitals accredited	1		1	5
		% DH supervised 4x/yr	NA		NA	100
Referral Systems	• # Proper referrals HCs to DH • % HF with referral guidelines in place	# ambulances/district	5		5	6
		% HF with effective ambulance maintenance plans	40		NA	100

5.1. Community-Based Health Program (CBHP)

Table 65. Findings in the CBH Program

EXPECTED OUTPUTS / OUTCOMES	BASELINE 2011	TARGETS 2015	FINDINGS 2015	TARGETS 2018
% CHW cooperatives functioning and financially sustainable	30%	80%	50%	100%
# of districts providing AIDS and NCD /Palliative care in the community	0	25	NA	30

Community health is guided by the National Community Health Policy and the National Community Health Strategic Plan 2013- 2018. Under this plan, the community health package includes community case management, mother and newborn health program, reproductive health, family planning, community-based nutrition program, environmental health and hygiene, behavioural change communication and the Rwandan community health information management system.

Achievements

The community health programs in the district are coordinated by the district supervisor. Each village (umudugudugu) has 3 CHWs (2 Binome and 1 for Maternal and Child Health). For the health centres in the district there is a person in charge of community health as well as person in charge of hygiene who all work with the CHWs. The CHW program covers various services: ANC, maternal newborn health services, family planning, post-natal follow-up, vital registration via rapid-SMS, community based nutrition, community case management, and BCC among others.

The CHWs offer community-based nutrition services. They hold a monthly session where they screen for malnutrition by weighing and measuring MUAC of children, providing supplementary micro-nutrients for all children between 6 months and 2 years of age, and referring those requiring further attention to the health centre. The CHWs provide the link between communities and health centres. They also do community case management where they provide management mainly for 5 conditions: malaria (following RDT diagnosis), pneumonia (treatment with amoxicillin), diarrhea (Zinc and ORS), malnutrition (micro-nutrient supplementation, referral to HC), and cough (honey and lemon). Home visits are made to each home at least on quarterly basis and behaviour change communication (BCC) is provided.

For maternal and child health (MCH), as soon as a woman is pregnant, she is followed up and reminded through entry into the systems via SMS for the ANC visits. The SMS is sent to the HC and this information is automatically relayed to the MOH server and available to the CHW supervisor at district level. At time of commencement of labour, the CHW sends a Ready Alert SMS to the health centre and an ambulance is dispatched to collect the pregnant woman. The same approach is used for any complications during pregnancy. The CHW follows up the mother after delivery to examine the baby (assessing temperature, weight and breathing), checks vaccinations and provides any other post-natal package elements. They also carry report the cause maternal and child deaths. The CHW provides family planning services to the community (using short term methods and the pill)

All CHW services are reported using the SMS and the performance of the CHWs is assessed using a set of PBF indicators. For the achieved indicators, the CHWs are given a bonus, 30% of which is reserved for the CHWs and 70% goes to the Cooperative to support income generating activities (IGAs). On average, 15,000 – 30,000 RFW per quarter is received as the 30% for the CHWs, although it could be higher depending on performance. In one instance in Musanze, a

CHW received 100,000 RFW in one quarter based on the number of referrals made to the health centre.

Capacity building of CHWs includes supervision by the district CHW supervisor and the health workers at the health centre as well as training. Any new intervention trains the CHWs in that field. New CHWs are trained at the HC for at least 5 days and there are opportunities for refresher courses.

Challenges
From the district interviews, there is a sense that the CHWs have a heavy workload where they are given additional work beyond their scope of work, especially by the local leaders and other health programs. It is reported that on average the CHW spends 3 hours per day on this work. However, it was emphasized that the 3 CHWs would in principal be sufficient to carry out the scope of work they are expected to provide.

From the field visits, it was indicated that there is a drop-out of the CHWs of around 5 - 10% per year. In one of the districts, during 2014, there were some villages that went without CHWs. One of the complaints was related to weak management of cooperatives where the executive of the cooperatives tends not to involve the other members in the decision and management of the affairs of the cooperatives. Fortunately, cooperatives are starting to be supported by accountants.

Some members of the community do not use the community health services optimally, especially the elite group in the urban areas and some women do not report to the CHWs when they get pregnant. Replacement of phones, torches and other materials used by the CHWs - after initial supply from MOH - are to be from the savings in the cooperatives. Sometimes this is a challenge.

With the introduction of public-private partnerships, Health Post are being opened, owned or run by private sector (nurses). It is not clear what relationship the CHWs will have with these new structures.

Table 66. Recommendations for the Community-Based Health Program

Actions to be undertaken	Medium-term HSSP III Transition July 2015 – June 2018	Long term HSSP III Beyond June 2018
Action 1	Strengthen the CHW program through additional persons to improve coordination of CHWs at district level and to provide the necessary follow-up, provision of adequate transport for supervision and improved management of cooperatives.	
Action 2	Explore modalities for appropriate linkages between Health Post extension and training of CHWs	

5.2. District Health Services and Management

Table 67. Findings in District Health Services

EXPECTED OUTPUTS / OUTCOMES	BASELINE 2011	TARGETS 2015	FINDINGS 2015	TARGETS 2018
% HF with electricity / water	56 / 66	80 / 80	NA	95/98
% Functional DHMT in all districts	NA	100	100	100
% DH eligible for accreditation (> 70%)	0	30	0	60
% HF using clinical protocols	0	80	NA	100

Achievements

DHMTs coordinate health services at decentralized level and are also responsible for supervision, resource allocation, ensuring compliance to regulations and policies. Hospitals have Boards of Directors and Health Centres have Health Committees with representation inclusive of the community. Coordination meetings at district level are held quarterly for all partners/stakeholders.

The country is implementing phase 3 decentralization and management of health facilities is under local administration. Health has become a mandate of districts under the revised decentralization law (Article 143). Decentralization has placed the districts at the core of coordination and planning and enhanced ownership and brought advantages of quicker decision making, due to proximity of supervisors at district level (all the technical supervisors who used to be at MOH are available at district level; issues for decision making do not have to be referred to MOH).

Priorities of the sector are in line with the EDPRS and Vision 2020; MINECOFIN shares the sector ceilings in response to the sector priorities and similar process is done at decentralized level; allocation of funds is then done according to priorities; MOH allocates funds to decentralized levels for activities to be carried out by decentralized levels; a challenge is the inadequate engagement between Development Partners and MOH in the planning and budgeting process.

With decentralization, districts have been re-enforced, planning is better, budgets are discussed and allocated to districts under leadership of MINECOFIN, and there is more ownership by districts where the Mayor is accountable. There are fora for joint planning and action including joint planning, Imihigo (jointly between MOH and districts), social cluster (different sectors consult), monitoring by the office of the Prime Minister for all agencies, ministries and districts, evaluation district by district by the President, Office of the Prime Minister and MINALOC.

The vice-mayor in charge of social affairs, chairs the DHMT. The roles, responsibilities and functions of the DHMT are available. The JADF is working well and has improved coordination of partners with quarterly coordination meetings as well as annual open days where partners report on activities done during the year. District health integrated planning tools have been drafted by the Ministry of Health and a guide to DHMT supervision of health centres is available. DHMTs are supported for implementation through accountability days, study visits (with involvement of partners). A host of work is on-going, including assessment of functionality of DHMTs and Boards of Directors, review and development of the legal framework and guidelines for DHMTs and assessment of relevance of M&E district offices in the districts.

The districts support health centres in establishing the plans and each month they hold a coordination meeting to evaluate health indicators (for quality and quantity) and provide feedback to the health centres. They report to MOH on health indicators. The district hospital M&E officers work with the District M&E Officers, where available, and the data managers at health centres to

generate and analyse these data during monitoring visits. Skilled professionals like accountants and use of appropriate financial management software like Quickbook have improved resource management.

Access to services has increased in districts with an extended number of health centres, health posts in areas without health centres as well as extending scope of health services, e.g. in HIV care and treatment where health facilities which were only able to test for HIV now offer ART. CHWs have additional tasks including treatment of malaria, pneumonia, diarrhea, GBV and SRH one stop centre where police, psychologist, mental and legal services are availed to victims and to provide mental health and counselling where needed.

Districts have an integrated plan and there is no single sector plan. The districts hold end of fiscal year consultations with Ministries and central agencies which communicate the budgets of funds available; where no such communication is available, plans are based on previous trends; during the consultation, needs are planned and resources advocated for (MOH provides HR and equipment); Planning sessions are organized with health centres to develop annual work plans and budgets with guidance from the districts in the context of DHSSP. In the planning process, the districts provide guidance on priorities based on national priorities, district and department plans and hospital strategic plans and all levels are involved. At the village level, the CHWs provide the village priorities which are summarised by the CHW supervisor and these are brought to the HCs where each department proposes its priorities. The HC management committee consolidates all plans and makes a summary for submission to the District Hospital. Joint sessions with health centres and hospitals and DHMT review the plans and health centres update them according to the comments from DHMT. The final plans are submitted to the District Executive for approval.

Sources of funds for the HC work plan include GoR budget for salaries and subsidies for ARV; Mutuelle, Consultation services, sale of medicines and donors (e.g. GF). All the medicines are bought by the health centre. PBF also helps with operational costs like transport costs and is paid quarterly. The health centre has two accounts, the current account and the pharmacy account. PBF also helps with operational costs like transport costs. During budgeting, consideration is made of the funds generated by health facilities, budget from partners and district internally generated revenue; the budgets from partners is received from memoranda of understanding while funds for staff salaries is communicated by MOH; during planning sessions, the districts work together with partners;

The overall coordination and oversight of health services in the district is done by the Health Committee (COSA) to which the Health Centre Management Committee (COGE) reports. The latter oversees the services provided in the health centre. COSA meets quarterly and constitutes the elected representative of each catchment area, one government representative, and the in-charge for health facility. The Health Centre Management Committee meets once a month. District leaders at all levels from village to district levels are sensitized on health issues and health performance indicators are included in the leaders' performance contracts.

There is greater capacity for generating local revenue with autonomy of the health facilities and this autonomy has contributed to easier and faster decision making without resorting to MOH.

Human resource capacity has improved at health service delivery level. All heads of health centres have upgraded to A1, there is a move to having skilled midwives in all health centres and hospitals although it is not yet fully achieved. All levels of staff have received complementary training including on-job training for HIV, TB, Malaria, essential newborn care, and life support training. Districts are now receiving specialists in hospitals, but priority is being given to those being upgraded to referral / provincial hospitals. In some districts, in-charges of health facilities have been trained in management, accountability, human resource management and monitoring and evaluation. In addition the health facilities are supervised monthly by the hospital and district health teams through integrated supportive supervision. Training is arranged where necessary.

Progress has been made in improving health indicators. For example, in Burera district, the CPR improved from 45% (DHS 2010) to 64% (survey 2013) while at Rusumo health centre, CPR increased from 17% to 52% and FANC was at 0% in 2012 and increased to current 33% while adherence to ART has been enhanced using the CHWs to accompany the patients while they are reminded of taking their medicine. At Kirehe hospital, neonatal deaths have been reduced from previous 37% to current 19% following quality improvement and community sensitization and mobilization by CHWs.

All district hospitals offer the district health package of services but one of the district hospitals visited, Butaro hospital, also provides cancer service package. It is the only cancer centre in the country and receives referral from CHUK, KFH and CHUB and from countries in the region. The hospital provides diagnostic and therapeutic services, including biopsies and chemotherapy.

Hospitals have introduced electronic information systems including LMIS, HRIS and EMRS (for HIV, NCDs and TB). Each quarter a coordination meeting is held and the data issue is permanently on the agenda as all health centres are represented. The district team in charge of M&E follows up and collaborates with the data managers at health centre level and the data are cleaned before dispatch. Every quarter the central level undertakes a data quality assessment comparing and cross-checking what districts are reporting.

The referral mechanism has been strengthened with a network of ambulances based at the district hospital and in some health centres.

Health facilities in the district are buying their medicines and commodities from locally generated revenue, resulting in reduced stock-outs. The LMIS is operational and makes it easy to track the medicines and commodities.

Challenges

Some districts may not be able to perform their responsibilities because of varying capacities in leadership, planning, budgeting and management, requiring continuous capacity building. However, functionality of the Districts, including DHMTs and how to assess it, needs to be well defined and agreed. Often, there are inadequate funds for implementation of the district plan. Communication between sector and districts has been an issue although now a legal framework has been developed. Although there are opportunities for the HCs to meet with partners and stakeholders through JADF and during planning and implementation of activities, there is room for improvement. In some health centres, there are limited opportunities. Furthermore, there are still gaps in use of data for action and decision making as well as gaps in communication of information.

Funds required to run district health services are not known and the districts operate through a district integrated plan that covers some sector components but may not adequately cover all sector needs. Furthermore, fiscal decentralization is still a challenge, as up to 50% of expenditure for districts is through earmarked funds from central level. Funding of the health facility budget from the district local resources is inadequate as only about 5% of the district local resource budget goes to health services, which could be attributed to the perception by leaders that health sector is wealthy from different sources. The largest portion of earmarked sector transfers from central level to districts goes to salaries, the rest going to community PBF, disease prevention, construction and maintenance. PBF money to cooperatives has declined with reduced funding from partners (WB, GF).

Some districts like Burera experience shortage of health professionals in health centres and hospitals. In addition, it is difficult retaining health workers whose funding from partners ends. In most cases, the abrupt cessation of funding does not allow government time to plan a responsible take over; For example at Kirehe hospital, the funding for staff was reduced by 50% (GF was supporting 8 and now supports 4, those laid off were support staff).

Sustainability remains an issue where CBHI is not paying well and where collection of CBHI funds (some people are not paying) and funds collected are not adequate to cover the costs of services provided. Up to 12 – 16% of clients do not provide co-payments, especially those in category 3, and yet they are given treatment.

Table 68. Recommendations for District Health Services

Actions to be undertaken	Medium-term HSSP III Transition July 2015 – June 2018	Long term HSSP III Beyond June 2018
Action 1	Re-define the functionality of districts and DHMTs and strengthen the district and DHMT capacity to deliver.	Plan for and invest in ambulance replacement
Action 2	Engage the partners to ensure that support to districts should be withdrawn gradually to allow development of sustainability plans	
Action 3	Put in place a mechanism to enhance consultation and collaboration between financing partners and district local governments during planning	
Action 4	Improve quality of data through capacity training and regular data quality assessments and build decentralized capacities for data analysis and use.	

5.3. Provincial and (National) Referral Hospitals (PH, RH and NRH)

Table 69. Findings in performance of Provincial and National Referral Hospitals

EXPECTED OUTPUTS / OUTCOMES	BASELINE 2011	TARGETS 2015	FINDINGS 2015	TARGETS 2018
# National Reference hospitals accredited	1	4	1	5
# Provincial Hospitals eligible for or in the process of accreditation (>70%)	0	5	5 / 7	7

Achievements

Upgrading, through a gradual process, of district hospitals to provincial hospitals was approved in 2014 to improve service packages with specialized services. Three hospitals have been upgraded to referral hospitals (in 2014) making a total of 7 referral hospitals with exception of KFH which is in the private sector. Deployment of specialist doctors and mobilizing resources for specialised equipment have been initiated for the hospitals being upgraded. One of the three hospitals is undergoing physical infrastructure upgrade (5 year initiative) and another needs extension.

Referral hospitals and teaching hospitals supervise lower levels and organize quarterly outreach visits to attend to patients in referral or provincial hospitals, which reduces the waiting lists of patients, especially for specialized surgery, hence reducing costs incurred by patients. It also offers an opportunity to train doctors and nurses

Among the specialized services there is a (i) cancer centre annexed to a district hospital (Butaro) which serves the EAC region for diagnosis and treatment, (ii) eye care at Kabgayi faith-based hospital (PPH) in Southern Province, and (iii) mental health at Ndera Hospital in Kigali.

Four Provincial Hospitals (PH):

There are four district hospitals that are in the process to become Provincial Hospitals (based on the 2014 Cabinet Decision). They are gradually receiving more (specialized) staff, more advanced equipment, more financial resources and an expansion of their facilities to provide more (specialized) services. While the catchment areas remains the same, the number of district hospitals these provincial hospitals will supervise regularly (supportive supervision including quantity and quality issues) will increase. These hospitals will have a functional electronic medical records system (EMRS), which will also be implemented in all hospitals, that has shown to increase efficiency considerably, creating surplus income for use by the provincial hospital. Another efficiency measure has been the full integration of HIV-AIDS care in the overall provision of services by the provincial hospital. For the moment, the provincial hospitals still report to the Mayor of the district and copy their reports to MOH. Once their status as provincial hospitals has been formalized, it is not clear if the lines of reporting will change, allowing the provincial hospitals to report directly to the MOH.

Referral Hospitals (RH):

There are three Referral Hospitals being established: Kibuye, Kibungo and Ruhengeri.

Ruhengeri Hospital:

Ruhengeri hospital has been running as a DH but has been approved for upgrading to a referral hospital (May 2014). Following the Cabinet approval, 6 specialists have been appointed to the hospital in the fields of pediatrics, surgery, internal medicine, anesthesia, ophthalmology, gynecology and psychiatry. This was in addition to the existing specialist (1 gynecologist (Director of Hospital), 2 dentists) and the general practitioners. Ruhengeri hospital was the first hospital enrolled for accreditation to meet the accreditation requirements for level 1.

A new hospital design has been developed and implementation is soon to start and its funding has already been approved by MINECOFIN. It is planned that infrastructure of Ruhengeri hospital will be upgraded in phases. Some specialized equipment like for radiology has been installed. Ruhengeri hospital continues to provide both DH and RH services until another DH has been established. The DHs surrounding Ruhengeri Hospital in Northern and Western provinces refer their patients to Ruhengeri Hospital

The hospital has both a strategic plan and annual plan based on the national priorities, sector priorities and community needs in the context of the HSSP III and District Health Strategic Plan. The hospital plans to establish private wings in each department where specialists can do consultations after working hours using a specific tariff and in the plan for the new building, in-patient private wards are planned for.

The hospital has put in place mechanisms to improve management. It uses software (Sage Pastel) for financial management. The hospital carries out joint (team) supervision for on-job training where staff spends a week working with those at lower levels to train and mentor. Administrators at hospital have been trained at Masters' level

Progress has been made in various health indicators. Hospital Maternal deaths (reduced from 72 in 2012 to 52 in 2014), and newborn deaths reduced from 11% in 2012 to 5% in 2014. The oxygen plant has been installed and is in operation (GE ACCESS support) serving ICU, maternity, neonatology unit and operating theatres (contributing to decreased deaths)

National Referral Hospitals:
There are three public National Referral Hospitals (NRH): CHUK, CHUB and Ndera. King Faisal Hospital (KFH) is a private hospital that receives those patients that cannot be properly treated in the other two referral hospitals. It has been formally accredited by COHSASA (South Africa) and therefore is considered at the top of clinical care in the country. Its work has not been addressed in HSSP III, therefore, this report will not assess its performance, but will call for its inclusion in the subsequent period of the strategic plan. The accreditation process done by COHSASA (South Africa), started already in 2010. It is now advanced (CHUB 65% and CHUK 83%), but expected to take a few more years to reach the required 90%.

CHUK and CHUB, with a total of around 1000 beds, operate under one Board of Directors. In 2014 a MoU was signed that defined their links with the Ministry of Education for their teaching and research responsibilities and with MOH for the provision of care and their supervisory role of the DH. Their functions are the same: (i) Provide quality care, (ii) train and teach students of medicine, nursing, midwives & allied health sciences, (iii) conduct research. (iv) through the PH and the RH they also support the DH in their catchment areas. CHUK estimates that about 75% of all referrals come to CHUK from 29 districts. Funding comes through MOH from MINECOFIN, being about 51% while 48% comes from own revenues. The remaining 1% comes from external sources.

The College of Medicine and Health Sciences, using the two teaching hospitals, produce some 100 medical doctors per year (recently this number is increasing and are expected to train 500 specialists between 2013 and 2020 that will be employed in the RH and PH). Most specialties are available in the two hospitals with the exception of a including (neurosurgery) for which patients are referred to King Faisal Hospital or abroad. ..

Ndera Neuro-Psychiatric Hospital functions as a Faith-based, Government subsidised hospital, co-funded by the MOH (39%), the Charity itself (16%), Income generation (40%) and CDC (5%). The hospital works closely with the Mental Health Division of the MOH (see section 4.2.6) in the areas of Mental Health, Neurology and Drug addiction patients (20% social cases). The mission of Ndera is to provide care and training, undertake research and supervise the provincial and district hospitals as well as the health centres in all areas of their mandate. Ndera has 360 beds, 12 doctors, mental health nurses, 8 clinical psychiatrists and 9 social workers. Training in mental

health is done in collaboration with the various nurse training schools. Ndera has an open software system for its patient administration and billing systems. Ndera feels it needs additional funds to expand it activities towards community mental health and for training of its staff.

Challenges

Provincial Hospitals (PH)

The provincial hospitals have made limited progress in putting in place mechanisms for increased internal revenue.

Referral Hospitals (RH)

The hospitals face a number of challenges. There is a high turnover of health professionals to private sector calling for need to explore retention strategies. Partner support is being reduced, often without opportunity to prepare how best to manage the situation, and has resulted in gaps in human resource numbers and skill. Worse still the upgraded referral hospitals have not yet received authorization to charge for their services at referral hospital rate, rather their services are still billed at district hospital rate. The tariffs being used were set in 2012 and have not been revised and yet costs have increased. As for financial management, there is insufficient training of accountants beyond their basic degree.

Equipment maintenance is not optimal. There are many broken down equipment in need of repair amidst inadequate biomedical technicians and engineers. There is no specialised staff for maintenance for both old and new equipment and at the same time users are not well trained on how to use the equipment.

For all the National Referral Hospitals (NRH), challenges mentioned were: limitations in number and quality of specialized staff, equipment and training or education materials. In addition, there is no training for Pharmacists in the NRH, but in the School of Medicine. Some of the specialists have not received any specific training in teaching methodologies. Others could benefit from (district) Health Management (refresher) courses. All NRH intend to increase their income by increase of tariffs, introduction of EMRS and in general adopt a more business-like approach. The lengthy accreditation process by COHSASA is also felt as a challenge.

Table 70. Recommendations for Provincial and Referral Hospitals

Actions to be undertaken	Medium-term HSSP III Transition July 2015 – June 2018	Long term HSSP III Beyond June 2018
Action 1	Finalise the Accreditation process of the NRH and the RH before 2018	Finalise the accreditation process for the DH before and after 2018
Action 2	Continue the process towards efficiency gains and reduce dependence on GOR through improvements in Planning, Financial Management, cost recovery and EMS, without compromising financial accessibility	
Action 3	Explore options of training Family Health Specialists to offer the district hospital health care package, given the emerging financial challenges	
Action 4	Initiate TOT and courses in teaching methodology for all trainers in CHUB-CHUK	Establish a Unit specialised in Teaching Methodology and TOT for district level and above
Action 5	Strengthen courses in District Management for all DHMT members	
Action 6	Increase the capacity for medical equipment repair and maintenance	

5.4. Pre-Hospital Care Services and Referrals

Table 71. Findings in Pre-Hospital Care Services

EXPECTED OUTPUTS / OUTCOMES	BASELINE 2011	TARGETS 2015	FINDINGS 2015	TARGETS 2018
# Ground ambulances/district	5/DH catchment	5/DH catchment	5 / DH	6/DH catchment
% HF with effective ambulance maintenance plans	40%	80%	89%	100%
# Ambulance Boats in Lake Kivu	1	1	1	?

Achievements

The emergency medical service unit (SAMU) was created in 2007 with 2 levels of intervention: primary intervention from site to hospital and secondary intervention from lower health facility to higher health facility or vice versa. The SAMU policy draft was developed and incorporated into the quality health care policy. Ground ambulances increased from 97 in 2007 to 225 in 2014. The district hospital ambulances are managed and repaired by the district hospitals. Maintenance plans and schedules for ambulances exist and there are contracts with specific garages for repair and maintenance. SAMU has developed a database and data were entered retrospectively while new data are entered directly.

For pre-hospital ambulances, initially there were 4 sites that were reduced to 3 in the city of Kigali. 9 different sites have been created resulting in decreased response time from more than 18 minutes to 12 minutes on average. At Headquarters site, there are 2 ambulances available 24 hours a day. A toll free call centre (912) was established in 2009 operating 7/24 and initially most of the cases involved road traffic accidents. By 2012, ambulances started receiving calls beyond road traffic accidents.

SAMU started with 12 personnel and now has 62 at Headquarters. For capacity building, there are courses on basic lifesaving skills, medical dispatch and continuous professional development (in cardiac support, learning from case management at SAMU, etc.) and planned continuous professional development with the Department of Injury. In 2013, ambulance attendants were trained (2 nurses and 2 drivers for hospitals and 1 nurse and 1 driver for health centres) in a first aid course by the Rwanda Red Cross trainers.

SAMU has undertaken international interventions where Rwandese were involved in incidents and has strengthened collaboration with other sectors, particularly that of Defense. Multi-stakeholder collaboration is in place through the Steering Committee for Disaster Management and there is direct collaboration with the Rwanda Air force for air ambulance (standby team with helicopter to provide air ambulance when necessary) and the Rwanda Marines with boat ambulance (procured and stationed on Lake Kivu at Kibuye marines).

Regarding funding of SAMU, salaries of staff are paid by the GoR while SAMU services are paid either through health insurance payments, or out of pocket (for patients not insured). The tariff is set by MOH and is based on distance and consumables used.

Challenges

Not all charges are paid, as the payments are requested after delivering the service and some people are not able to pay, especially those not insured. There is need for further discussions and collaboration with the special guarantee fund for cases falling within its mandate. Currently, there is no definite plan or mechanism for sustainable replacement of ambulances. However, work has started to develop a full recovery system. Alternative options for ambulance replacements include putting aside some percentage (e.g. 5%) of the revenue collected in an ambulance account to

contribute towards ambulance replacement in addition to national budget contribution for new ambulance procurements. Tracking system, earlier established using SMS set a culture of discipline, has become expensive and is not working as well as before.

Table 72. Recommendations for Pre-Hospital Care Services

Actions to be undertaken	**Medium-term HSSP III Transition July 2015 – June 2018**
Action 1	Explore full cost recovery to sustain the services including replacement of ambulances.
Action 2	Strengthen collaboration with the guarantee fund for the uninsured
Action 3	pursue enforcing universal health insurance
Action 4	Explore an alternative tracking system that is affordable

6. COMPONENT 4. GOVERNANCE

Summary Findings and Figures

Table 73. Component 4: GOVERNANCE

			VALUES		
GOVERNANCE	**MAIN OUTPUTS**	**INDICATORS**	**Baseline 2010**	**Results 2015***	**Targets 2018**
4.1. Regulatory Framework and Decentralization	• DH decentralization process completed • Planning/budgeting/reporting in DHU done	% DHUs operational	0	100	96
		% Districts having health commission meetings	16	100	96
4.2A. Partnerships Arrangements, Coordination	• Collaboration with private sector formalized • All stakeholders participate in district planning	% Districts implement SWAp guidelines	0	100	96
		% Partners participate in district health planning	0	100	95
4.2B. SWAp, Aid Effectiveness	• Develop SWAp guidelines / Joint Financing Agreement (JFA) with MOH/DPs • DPs provide resource information in time • Mutual accountability strengthened	% On-budget funding as % of total DP funds	44	62	55
		% DP provide resource information	95	100	100
4. Accountability and PFM	• Streamline all PFM systems (central/district) • Financial monitoring and audits strengthened	% On-budget / Off-budget resources	44 / 56	Off budget resources not reported by DPs	60 / 40
		% HF trained in PFM fiduciary issues	0	100	100
		% DH clean audits	0	Not all DH have been audited	95

6.1 Regulatory Framework and Decentralisation

The main strategic interventions outlines in HSSP III on decentralization are to develop a health sector decentralization roadmap (Strategic Plan) in consultation of MINECOFIN, MINALOC and the Ministry of Public Service, Skills Development and Labor (MIFOTRA); update decentralization guidelines for effective implementation of devolved service delivery; clarify roles/responsibilities of the MOH and district administration / DHU and between DHU and the service providing units (DH, HC, pharmacies, and CBHI); develop a relevant and strong capacity-building program for all district managers (DHU, DHMT, and DH) in planning and financial management; and establish a health commission under the Joint Action Development Forum (JADF).
Two of the three targets were achieved up to the midterm of HSSP III (see table 74).

Table 74. Findings in Regulatory Framework and Decentralization

TOPIC	EXPECTED OUTPUTS / OUTCOMES	BASELINE 2011	TARGETS 2015	FINDINGS 2015	TARGETS 2018
4.1. Regulatory framework, decentralization and Intersectoral activities	% DHU operational (timely comprehensive district annual planning, budgeting, reporting)	0	84%	100 (but not compressive health plan)	96%
	% Districts having quarterly health commission meetings.	16%	84%	100	96%
	% GOR funds disbursed to districts (grants: national health budget plus district transfers)	31.4%	45%	17% (2014/15 budget)	60%

All performance data have been provided by MOH.

Achievements
The DHU is now operational in all districts under the Vice-Mayor. There is division of labour and role definition between the DHU and the district hospital in the management of health service delivery. As described in the planning section, planning guidelines have been revised and all the health facilities are developing plans. 42 District Hospitals developed their five years strategic plans; 30 Districts Administrations are provided with District Health and M&E plans; 28 District Health M&E officers were trained in M&E fundamentals; 87 members of Mutuelle boards, 90 members of Pharmacy Boards and 126 members hospital boards were oriented on decentralized health activities.
Therefore, capacity to develop action plans and monitor is improving, but needs further strengthening at DHU level. Districts developed already a comprehensive multi-sectoral plan, but should also develop a comprehensive integrated health sector annual plan, even though this is not a requirement yet. There is a regular review of the performance of the health sector through quarterly JADF.

Challenges
The earmarked health sector grants assigned to district as budget by central level is made in consultation with districts; it is not entirely left for districts as is the case in countries with devolution. The resources that are available at districts' discretion are largely from their own generated taxes, where they can allocate / reallocate them to emerging priorities aligned with their district development plans, but without consulting national ministries and MINECOFIN. This discretionary power however is limited, because of the low tax base at the district level. For example, in one district the MTR team visited, the discretionary funding available was about 5% of the total district budget, All other resources come as earmarked transfers after negotiations with sector ministries (like MOH) and MINECOFIN.

6.2 Sector Organisation and Management

The main strategic initiatives to strengthen sector partnership include actively building capacity of the NGO, CSO, FBO, and private sector to participate in the various coordination structures; invite the regulatory bodies and professional associations (doctors, nurses, etc.) to become part of these coordinating bodies; strengthening of HSWG in its coordination, guidance, and supervision of the work of the TWGs. At district level, the actions include strengthening Joint Action Development Forum for effective coordination and accountability purposes by bringing the private sector into the JADF, and strengthening the health commissions of the JADF. All the four main targets of sector coordination have been realized (Table 75).

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Table 75. Findings in Organization and Management

TOPIC	EXPECTED OUTPUTS / OUTCOMES	BASELINE 2011	TARGETS 2015	FINDINGS 2015*	TARGETS 2018
4.2A Partnerships and coordination (Management)	% DPs, private sector, civil society, professional bodies participate in HSWG meetings	70	86	NA	96
	% Stakeholders participating in district health planning	0	85	NA	95
4.2B SWAp, Aid Effectiveness (H&A)	% On-budget funds disbursed as % of total DP funds	44	50	62% (2013/14 budget)	55
	% DP providing resource information	95	100	NA	100

Note: While MOH provided figures of 100% for the three boxes labeled with NA, the figures of 100% cannot be sustained from the interviews the MTR team did during their stay in-country.

Achievements

There is strong leadership of government in delivering results and managing different actors in the health sector. The coordination mechanism at sector and sub-sector levels (Joint Sector reviews, health sector working group and technical working groups) are functioning (with different levels of effectiveness) to facilitate joint decision making on policies strategies, priorities and overcome implementation challenges). The TWGs have been rationalized and restructured to make them more effective. The structure is now different than summarised in HSSP III. .

The SWAp guidelines were developed, assisting districts to have joint decision making processes and structures. The JDAF is also working at the district levels, with its own office in the district headquarters. It fostered more ownership of the processes by JDAFs and mayors at district levels. The coordination arrangement with development partners at the national level is much easier now due to the implementation of division of labour among DPs. The CSOs are actively represented and working with the sector coordinating structures, including CCM, with the exception of reviews organized by MINECONFIN. There is also good relationships and networking among the CSO umbrellas.

According to the reports from SPIU and SWAP secretariat, all the plans of development partners are aligned to government priorities and plans; decisions are made jointly on prioritization through technical working groups. The process of registration, accepting proposals, and renewing licenses of CSOs assisted for enforcing the implementation of the SWAP guidelines. There is a systematic mechanism for deployment of the CSOs through a joint action by MOH and districts. There is also progress in working with other countries through a Joint Permanent Commission (JPC), which helped sharing best practices and obtaining some technical and other types of assistance (China, Nigeria and Egypt). Finally, there is an effort to promote the engagement of the private sector.

The establishment of the SPIU within the MOH has facilitated the move by many partners to use country systems in providing development support. The only DP that is not using country systems and operate mainly off budget with the exception of its funding through SPIU) at the moment is USG. However, some development partners use SPIU, but they also channel part of their resources through other channels. There are gaps to bring some UN programs to use country systems, but progress is made on how to make it happen. The establishment of the SPIU and its functioning has reduced the establishment of many PRs and project management units. This has reduced not only transaction costs but also management costs and has enhanced efficiency by reducing the time required to kick start new projects and by facilitating dialogue and identify financing gaps when new program/projects are designed.

Challenges

Although there is a recently established the Rwanda Health Care Federation that coordinates the private sector with its own secretariat, so far it is not part of the coordination mechanism and policy dialogue forums. RDB is currently coordinating private sector initiatives, but lacks adequate understanding of the unique features of the private sector in health and needs support from MOH. There is limited access to funding for private sector, as banks see health sector investment as highly risky. The development of a regulatory framework to enable private sector investment in pharmaceutical production is yet to be finalized.

The dependence on HIV/AIDS funding and its reduction has negatively affected the functioning of the CSO umbrellas and their district branches. There has been reduction of staff in all the umbrellas. The existing CSO structures may not be sustained and there is a need to look for an establishment of an overall umbrella that coordinates all CSOs.

HSSP III does not include disability mainstreaming; Given that 5% of the population is estimated to be disabled, future health sector strategies should consider this as one of the shifts.

According to the interviews with CSO and private sector coordinating structures, the only forum they are not invited to is the backward and forward-looking Joint Reviews organized by MINECOFIN.

Few partners remained in the health sector after the MOH requested DP's division of labour. As a result, the depth and scope of the policy dialogue does not seem as robust as in the past. It has become more process oriented and with less policy discussions. Often meetings are called late and are inadequately prepared. There seems over-delegation by HSWG on policy dialogue issues to the technical working groups, which further undermines the dialogue. This is happening when in fact strong policy dialogue is required due to a changing environment, characterized by (i) a reduction of external resources; (ii) a serious concern over the sustainability of the gains made; (iii) the increase in specialised care that might reduce the attention and resource allocation for PHC; (iv) the need to set new targets in line with the upcoming of SDGs and the realization of some of the HSSP III targets.

Communication and harmonization among development partners is also reported to be inadequate. Progress is limited in bringing more off-budget resources into on-budget, mainly due to the fact that USG still is unable to do so. There is a lot of transaction and administrative costs on vertical M&E processes when implementation is managed through the CSOs and international NGOs. There is still mis-alignment of fiscal years by some development partners that hinders predictability during the budgeting process. It is reported that there is also some divergence expenditure figures between what is reported by implementers at the ground level and reported by the implementing NGO at national level when off-budget finances are reported. The capacity of the CSO umbrellas to assess and lead the process may also require some in-depth assessment, as there is a huge funding decline which after their capacities and sustainability.

Table 76. Recommendations for Sector Organization and Management

Actions to be undertaken	Medium-term HSSP III Transition July 2015 – June 2018	Long term HSSP III Beyond June 2018
Action 1	• Enhance the quality and frequency of policy dialogue between MOH and partners by crafting regular strategic policy agendas • Include Rwanda private sector health care foundation in SWG and TWGs • Include CSOs and private sector in the backward and forward looking of joint sector reviews	• Develop a strong regulatory framework that governs the relationship of the private sector with the insurance industry • Ensure future sector and sub-sector strategies are mainstreamed on people living with disabilities.
Action 2	Support the restructuring of CSO umbrellas and diversification of their funding source	
Action 3	Fast track the finalization of the legal framework for the domestic production of pharmaceuticals and ensure the framework provides adequate incentives during the procurement process	

6.3 PFM, Funding modalities and accountability

The major interventions planned in PFM include the design of a roadmap for rolling out of PFM in health facilities (DHs and HCs); improve awareness and capacity on public financial management in the district; advocate that district hospitals become budget agencies or reporting entities; develop integrated PFM tools for the health sector (e.g., guidelines and manuals for districts, integrated and compatible information systems, etc.); and establishment of PEFA and other information on health payroll control and status of public procurement at the district level.

Table 77. Findings in PFM, Funding and Accountability

TOPIC	EXPECTED OUTPUTS / OUTCOMES	BASELINE 2011	TARGETS 2015	FINDINGS 2015	TARGETS 2018
4.3. Accoun-tability and PFM	% On-budget / off budget resources increased	44 / 56	53/47	62(%) 2012/13 RTT report	60/40
	% HF trained in PFM fiduciary issues	0	100	100	100
	% DH with clean (internal or external) audits	0	90	NA	95

Source: MOH

Achievements

Although Rwanda rolled out a computerized Integrated Financial Management and Information System (IFMIS) to all districts, service delivery units (or 'subsidiary entities' such as administrative sectors and cells, health facilities, schools) were not included in this initial phase. Visited health facilities by the MTR team are trying to use any mechanism for strengthening their financial management system in an isolated manner: employing accountants or training them and sourcing software from wherever they can get it. There are now plans to strengthen capacity building of PFM staff at sub-national levels- MINECONFIN is to conduct a pilot of an easy-to-use application for accounting and reporting in 10 health centers, which can feed into IFMIS at district level and does not require internet access. The MOH has issued financial procedures manuals and is figuring out software to be used by district hospitals. The HMIS has been designed to collect financial information at the DH / HC levels, but in fact, information is rarely submitted to HMIS, especially not by the HC and HP levels. Hospitals at all levels do produce financial reports and transmit them to the MoH and districts. Additionally, the information from Cooperatives on Community Health Workers (CHWs) is integrated in the health centre's HMIS. Unfortunately, overall performance in financial management is very low, due to low capacity in areas such as financial recording, evidence of expenses and compliance with procurement rules.

Challenges

There is no comprehensive report on financial management or budget execution in the health sector, including both GOR, the DPs and CSO spending. MOH was able to audit about 66% of DHs in 2013. In 2014, the OAG outsourced external audits (through a private firm) on 8 DHs. The process was financed by the PFM Basket Fund (to which EU, KfW and DfID contributed).

In general, oversight on financial reporting and accountancy needs further strengthening. This is critical since health facilities are receiving funds from various sources such as MINECOFIN, MoH, district budgets, development partners, as well as generating their own revenue stream.

Table 78. Recommendations for PFM, Funding and Accountability

	Medium-term HSSP III Transition	Long term HSSP III
Action 1	Continue the effort to develop and implement a PFM software at DH and HC levels that can feed into IFMIS at district level	Continue advocating for health facilities to become budget entities
Action 2	Train the accountants in the facilities to build their capacities	

7. MONITORING AND EVALUATION

7.1 Monitoring and Evaluation of HSSP III

Table 79. Finding in M&E of HSSP III

EXPECTED OUTPUTS / OUTCOMES	BASELINE 2011	TARGETS 2015	FINDINGS 2015	TARGETS 2018
% HF with functional IT infrastructure	84	95	96.6	100
# A2 Nurses who have completed E-Learning course to upgrade their skills	0	588	264/300	1.750
% HCs and District Hospitals using open Electronic Medical Records (EMR)	8	50	62	80
% Registered private clinics and dispensaries reporting routinely to HMIS	5	70	75	90
# Registered CHW tracking PW, using Rapid SMS	8.138	14.537	14.658	14.837
% HF receiving at least one formal feedback report from HMID each quarter	0	50	100	100

Achievements

The HMIS & M&E unit within the Planning and HIS Directorate has been able to initiate and implement an impressive number of interventions.

The most important ones will be highlighted below:

1. HMIS collects and covers all routine data of all the sector information on all the four components of the HSSP III; 96% of all HF have a functional IT infrastructure in place and 62% of HCs and DHs have started to use an open EMR.
2. The HMIS is fully web-based and accessible at HC level and above
3. The District Administration (DA) Office is more engaged in the national HMIS, as the DA Office now prepares quarterly reports interpreting trends of key district indicators, using the HMIS data that are reported to the national level quarterly.
4. All major information systems are supported by the HMIS team: HRIS, LMIS, Resource tracking, EMR, Rapid SMS and others
5. Many of the HMIS indicator calculations are within the accepted margin of - 5 and +5%, when triangulated with the data from the population-based DHS figures. This is a strong indication of the reliability of the data
6. MOH participates in the National Vital Registration System under the responsibility of the NISR, where NIDA (National Identification Agency) is a stakeholder. This will allow the MOH in a few years to report on annual maternal and child mortality figures.
7. A data warehouse Platform has been designed and is being put in place to share data more effectively. It will include key indicators from all major data sources used in the health sector (including routine and non-routine sources). Its performance cannot yet be assessed.
8. Data Quality Assessment and Verification systems are in place and guidelines are used during the six-monthly integrated supervision to check the available information at district and lower levels

The MTR team just concludes that these advances in HMIS have been at the basis for the many achievements in all the components of HSSP III (programs, systems, services and governance.

Challenges

1. Information use still needs to be improved at all levels. This is now a first priority.
2. Linking all these systems into the national data warehouse is not yet finished, as it needs more IT inputs and clarification of the national data sharing policy.
3. Various systems are facing operational problems. An example is iHRIS that has problems to keep the information about staff movements updated.
4. The current Health Data Sharing Policy doesn't include provisions to protect individual patient data.
5. E-Learning has been applied only for A2 Nurses, no other courses have yet been initiated
6. For various programs, existing indicators are achieved or are stable over the last years. In others new indicators have come up that are not yet part of the existing monitoring system.
7.The Sustainable Development Goals (SDG) will be signed next month also by Rwanda. It is not yet clear what changes this will bring for the current HMIS data collection system.
8. Recent restructuring of RBC and MOH Planning and M&E teams and staff reductions for ICT and data management positions at national and decentralized levels, present challenges for sustaining some of the Ministry's current platforms and plans to expand use of key information systems – especially EMR

Table 80. Recommendations for M&E of the HSSP III

Summary Actions to be undertaken	Medium-term HSSP III Transition July 2015 – June 2018
Action 1	Revise and update the existing HMIS indicators and targets in view of (i) targets achieved and (ii) upcoming SDG indicators and targets;
Action 2	Expand E-Learning to areas, where training of peripheral staff is required.
Action 3	Bring all HIS systems together in the data warehouse and develop a strategy to build capacity and encourage widespread use of HIS dashboards and analysis tools
Action 4	Ensure protection of individual EMR information

ANNEX 1. TOR for the MTR of the Rwanda HSSP III, July 2012 - June 2018

TERMS OF REFERENCE FOR CONSULTANCY TO CONDUCT MID-TERM REVIEW (MTR) OF THE RWANDA HEALTH SECTOR STRATEGIC PLAN III JULY 2012 – JUNE 2018

I. Background

In July 2012, Rwanda Ministry of Health adopted the Rwanda Health Sector Strategic Plan III (HSSP III). This document provides a framework to guide health sector priorities, implementation arrangements at all levels.

As planned in HSSP III, a Mid-Term Review was scheduled for early 2015. The overall purpose of this review is to assess the progress made in the implementation of HSSP III; and, determine whether the health sector is achieving set objectives. The Mid Term Review is part of on-going health sector monitoring and evaluation.

The review exercise will also explore emerging opportunities in the sector and beyond and propose required strategies to improve the health services at all levels of the health system.

To this end, the MoH is planning to hire consultants who will conduct the MTR. Under the leadership of the Ministry of Health, this exercise will engage stakeholders at central and decentralized levels, including Administrative Districts, health facilities, community representatives, Civil Society Organizations (CSOs), NGOs, Development Partners (DPs), academic and research groups; who are expected to guide further implementation of HSSP III. These Terms of Reference provide the scope of work, timeline and expected deliverables for consultants.

II. Overall objective:

The main objective of this consultancy is to support the MoH to conduct the MTR of HSSP III.

III. Specific Objectives of the consultancy

- To assess the extent to which targets set in the HSSP III are being met across all the key components (Programs; Health Support Systems; Health Service Delivery; and, Governance)/ (Effectiveness).
- To assess whether identified HSSP III priorities are still aligned to National and Global goals and respond to the emerging needs (Relevance).
- To assess whether the resources allocated to the implementation of HSSP III were available and used efficiently (efficiency)
- To assess if the achieved results will be sustained by the health sector. (Sustainability)
- To identify challenges, and lessons learnt; and formulate recommendations to improve the overall implementation of HSSP III.

IV. Methodology

The following steps are proposed for conducting the MTR:

- **Preparatory Meetings**: For refining the Terms of Reference, reviewing the timeline, agreeing on outputs and the dissemination plan
- **Desk Review:** The consultants will review the national and international documents to inform the MTR process
- **Data Collection and Analysis:** Develop, test, and adopt data collection tools for field work to collect data and conduct data analysis
- **Consultative Workshops:** Share preliminary findings, collect and integrate stakeholder input
- **Write Report:** Present final report

V. Required Consultants

The Review team of consultants will be composed of:

1. Public Health Specialist with longstanding experience in health systems planning and management (International)
2. Health Economist/Finance Specialist (International)
3. Human Resource Specialist with a deep understanding of Health Systems (International)
4. Medical Practitioner with experience in epidemiology (National)

The Public Health Specialist will act as Team Leader for the MTR, and be responsible for developing a thorough methodology; coordination of the review process; liaising with the MoH; and, stakeholders.

V.1. International consultants:

1. Public Health Specialist (Team Leader):

Required:

- Advanced University degree (Masters or PhD) in Health Systems Management, Public Administration, or Public Health.
- Extensive knowledge, experience in health systems strengthening, health policy and planning in developing countries.
- At least 10 years of experience in conducting evaluation/review studies in the health sector, particularly of health systems.
- Demonstrated track record of successful similar work in other settings.
- Fluency in English (working knowledge in French is an advantage).
- Good communication and diplomacy skills.
- Knowledge of and experience with the health sector in sub Saharan Africa
- Experience of managing teams
- Conversant with international organizations/institutions operational procedures

2. Health Economist/Finance Specialist

Required:

- Advanced University degree in Health Economics, Health Financing or related fields.
- At least 7 years of experience in conducting evaluation/review studies in the health sector, particularly health systems financing.
- Extensive knowledge, and experience in health financing in developing countries.
- Extensive experience in conducting evaluation/review studies in the health sector, with a focus on equity, social protection, and health financing issues.

- Demonstrated track record of successful similar work in other settings.
- Fluency in English (working knowledge in French is an advantage).
- Good communication skills and team work.

	Activity	Number of days	Key Deliverables

- Knowledge of and experience with the health sector in sub Saharan Africa
- Conversant with international organizations/institutions operational procedures

3. Human Resource Specialist with a deep understanding of Health Systems

Required:

- Advanced University degree in Human Resource Management with experience on Human Resource for Health (HRH).
- At least 7 years of experience in conducting evaluation/review studies in the health sector, particularly HRH.
- Extensive knowledge, and experience in Human Resource Planning, development, and Management.
- Extensive experience in conducting evaluation/review studies in the health sector, with a focus on Human Resource Planning, development, and Management.
- Demonstrated track record of successful similar work in other settings.
- Fluency in English (working knowledge in French is an advantage).
- Good communication skills and team work.
- Knowledge of and experience with the health sector in sub Saharan Africa
- Conversant with international organizations/institutions operational procedures

4. Epidemiologist/Public Health Expert (National Consultant)

Required:

- University degree in Medicine with advanced degree in epidemiology.
- Extensive knowledge, and experience in health diseases program, health systems policy and planning in Rwanda.
- At least 5 years of experience in conducting evaluation/review studies in the health sector, particularly of health systems.
- Strong background in M&E of health programmes.
- Demonstrated track record of successful similar work in other settings.
- Fluency in English, and Kinyarwanda (Knowledge of French is an added advantage).
- Good communication skills.
- Knowledge of and experience with the health sector in Rwanda

VI. Location

The work station for consultants will be based in MoH and travel to selected Districts.

VII. Timeframe

The MTR will be conducted during the month of August 2015. The consultancy is expected to start on 3rd August 2015 and end on 28th August 2015. The final report will be available in September 2015.

VIII. Supervision

The Lead consultant will work under the direct supervision of DG Planning, Health Financing and Information System/ MoH and the DG will be answerable to the MTR Steering Committee. The team of consultants will work under the lead consultant.

1	Technical consultation with MTR core team	1	Minutes of the meeting signed
2	Briefing by MoH top Leaders on MTR implementation and key deliverables	1	Minutes of the meeting
3	Meeting with Steering Committee to discuss the scope of work	1	Minutes of the meeting signed
4	Literature review and development of the inception report with data collection tools.	3	Inception report and data collection tools review approved
5	Facilitate a workshop bringing together the members of Steering Committee and the Technical core team to discuss the inception report of MTR of the HSSP III.	1	1. Write invitation letter. 2. Prepare presentation 3. Minutes of the meeting signed
6	Data collection at central and decentralized levels	10	Report on data collected approved by steering Technical Core Team.
7	Data analysis, draft report and presentation of preliminary results to the technical core team and the Steering Committee.	8	Data analysis report approved by the Steering Committee.
8	Facilitate a stakeholders' workshop for the presentation of the draft report to Stakeholders and incorporation of all inputs	3	1. Write invitation letter. 2. Prepare presentation 3. Minutes of the meeting signed
9	Validation workshop of the final report of the Mid-term Review of HSSP III (Steering Committee and Core team).	1	Final report signed by Hon. Minister.

Appendix: Expected deliverables

ANNEX 2. Roadmap for MTR / Program of Work (August 2015)

DAY	TIME	PEOPLE TO BE VISITED	RESPONSIBLE CONTACT
Monday 03rd August	07:00	DG Planning	
	08:30	ISMM	DG
	10:30	Team of M&E (MoH, RBC) and consultant to discuss the roadmap	Mrs Aline NIYONKURU
	14:00	Meet WHO Representative	Mrs Dianne
	15:00	Technical Core Team of MTR (MoH & Partners)	Mr. Christian KIBIBI
Tuesday 04th August	08:30	Steering Committee of MTR	Aline NIYONKURU
	10:00	MCH TWG (Team A)	Aline NIYONKURU
	10:00	Planning and Health Financing TWG (Team B)	Mrs. Mechtilde KAMUKUNZI
	14:00	Meet MoH Leaders (Ministers, PS, DGs)	Dr. Fidele NGABO
	15:30	HRH TWG (Team A+B)	Mr. Alypio NYANDWI
Wednesday 05th August	10:00	Health Financing, PFM, SPIU and CCM (Team A+B)	Dr. Albert TUYISHIME Dr. Pascal KAYOBOTSI Mr. Duka Innocent Dr. Daniel NGAMIJE
	14:00	NCDs , Mental Health, Health Promotion and Environmental Health (Team A)	Dr Albert TUYISHIME
	14:00	Commodities, Technology, Infrastructure, Maintenance, Quality, Lab Services , Specialized services (Team B)	Mr Joseph KABATENDE Mr. Eric Gaju Mr. Eduard KAMUHANGIRE Mr. Ivan MUTABAZI NDERA Hospital, BUTARO Hosp.
	16:30	MINECOFIN (Team A+B)	DG Development Planning
Thursday 06th August	07:30	Quality standard and accreditation (Team A)	DG Clinical Services
	08:00	MINECOFIN (Team A+B)	DG of National Budget
	10:30	TWG of infectious diseases (TB, Malaria, HIV) / (Team A)	Dr. Michel GASANA Dr. Corine KAREMA Dr.Sabin NSANZIMANA
	14:00	RSSB (Team B)	DG Planning
	14:00	Faculty of Medicines and School of Public Health (Team A)	Mr Alypio NYANDWI
	15:00	Partners Coordination (Team B)	Mr Michel GATETE and Mr.Lazaro NDAZARO
	15:00	Blood Transfusion /Team A	Mr. Swaibu KATARE
	16:00	CAMERWA &SAMU	Mr Eric UWITONZE

SECOND WEEK: FIELD VISIT		
10th August,2015		
Districts	**Facility**	**Team**
NYAMASHEKE	BUSHENGE DH	Team A
MUSANZE	RUHENGERI DH	Team B

11th August,2015			
RWAMAGANA		RWAMAGANA DH	Team B
KARONGI		KIBUYE DH	Team A
12th August,2015			
KIREHE		KIREHE DH	Team B
HUYE		CHUB	Team A
13th August,2015			
GISAGARA		GKOMA DH	Team A
BURERA		BUTARO DH	Team B
14th August,2015			
KIGALI		Epidemic Surveillance Response Division	Team A
KIGALI		CHUK	Team A
KIGALI		NDERA	Team A
THIRD WEEK			
Tuesday 18th	07:30	Private Sector / Team B	
	09:00	Professional Councils /Team A	
	10:30	Civil Society/Team A	
	14:00	DPG meeting	
Wednesday 19th	10:00	Present the MTR key findings to the team of M&E team	
	19:00	Team of M&E to provide comments to the consultants	
Thursday 20th	09:00	Team of Consultants to finalize and share the PPT with M&E team and DG of Planning.	
Friday 21th	08:00	MoH M&E team to share the PPT with the Technical core team.	
	11:00	Team of Consultants to update MoH Leaders on the MTR implementation and the way forward.	

ANNEX 3. List of people interviewed during the MTR of HSSP III.

NAMES	INSTITUTION / POSITION
MINISTRY OF HEALTH	
Dr. Agnès Binagwaho	Hon. Minister of Health
Dr. Patrick Ndimubanzi	Hon. Minister of State
Dr. Solange Hakiba	Permanent Secretary, MOH
Dr Parfait Uwaliraye	DG Planning & Health Financing and Information System
Dr Theophile Dushime	DG Clinical and Public Health Services
Mrs Aline Niyonkuru	Sector M&E and report Specialist
Mr.Alypio Nyandwi	Sector M&E and report Specialist
Mrs Mecthilde Kamukunzi	Health System Analysis Specialist
Dr Pascal Kayobotsi	Health Financing Specialist
Dr Vincent Rusanganwa	Medical Personnel Planning and Capacity Development Specialist
Michel Gatete	Health Sector Partners Coordination Officer
Mr Eduard KAMUHANGIRE	Director of Health Services and Quality Assurance
Mr.Joseph Kabatende	Pharmaceutical Establishment and Inspection Specialit
Glorieuse Uwizeye	MoH/HRH Nursing Advisor
Mrs. Alphonsine MUKAMUNANA	Environmental Health Specialist
Mr.Donatien Bajyanama	Health Facilities Specialist
Mr.Jose Eduard MUNYANGAJU	Medical Supply Chain Coordination Officer
Mr.Innocent Duka	Director of Finance
Mr. Hamad BARIGIRA	Director of Human Resource and Administration
Mr Eric Gaju	E-Health Specialist
Christian Kibibi	MOH/District Planning and M&E officer
David Kamanda	MOH/Health Insurance officer
Ismael Niringiyimana	MOH/Health Economist
Matungwa Michel	MOH/Clinical PBF officer
Andrew Muhire	MOH/ Sector M&E and report Lead Specialist
Gervais Baziga	MOH/ Planning Specialist
GISAGARA Alex	MOH/ EAC Seconded staff to Clinical Services
RBC	
James Kamanzi	Acting DG/RBC
Dr Daniel Ngamije	SPIU Coordinator
Dr Gasana Michel	Head of TB Division/RBC
Dr Nsanzimana Sabin	Head of HIV Division/RBC
Dr Aline Uwimana	RBC/ Malaria/Division
Ida Hakizinka	CCM/Coordinator
Dr Albert Tuyishime	Director of Planning
Sabine Umuhire	Planning Specialist
Mrs Cathy Mugeni	Director of Community Program Unit
Dr Sayinzoga Felix	Director of Child & Maternal Dealth Audith
Mr Alexis Mucumbitsi	Nutrition Officer
Mrs Coroline Mukankunsi	GBV officer
Dr. Biraro Gilbert	Acting Director of Planning/SPIU
Mr Ivan Mwikarago	Division Manager/National Reference Laboratory Division
Theogene Namahungu	RBC/MTI
Sankran.V. Narayanan	BTC staff seconded to RBC/MTI
KIGALI University Teaching Hospital	
Dr HATEGEKIMANA Theobald	Director General of the University Teaching Hospital in Kigali (CHUK)
Dr SENDEGEYA Augustin	Director General of the University Teaching Hospital in Butare

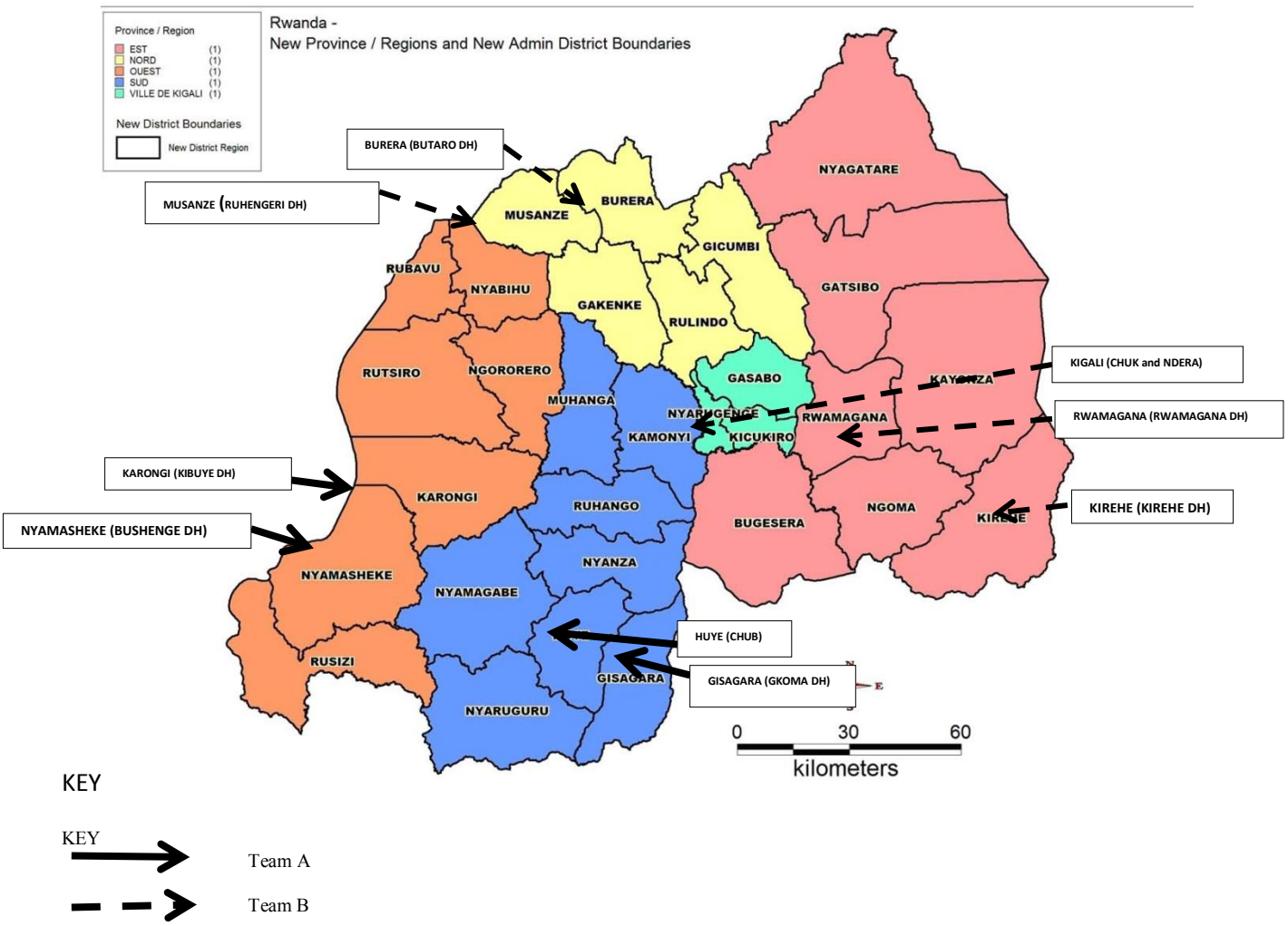
	(CHUB)
Prof. COTTON Philip	Principal of the College of Medicine and Health Sciences
MINISTRY OF FINANCE AND ECONOMIC PLANNING	
Mr Francois Sekamondo	Health Sector Focal person in the Planning Directorate
Mr.Godfrey Kabera	Director General of National Development Planning and Research
Mr. Caleb Rwamuganza	Director General of National Budget
Dr. Diane Ruranganwa	Medical Advisor/RSSB
Health Professionals Councils	
GASHEREBUKA Jean Damascene	Chair of Allied Health Professional Council
NDAHIRIWE Jean Baptiste	Registrar of Allied Health Professions Council
Julie KIMONYO	Registrar of the National Council of Nurses and Midwifry
CIVIL SOCIETY	
TUGIRIMANA Jean Berchmas	RRP+
SINGIRANKABO Ignace	Executive Secretary of RICH
BAHATI Innocent	Executive Secretary of ABASIRWA
KARANGWA Francois Xavier	UPHLS Coordinator
Northern Province / Musanze District	
Bagirishya Pierre Claver	Executive Secretary of Musanze District
Dr Ndekezi Deogratias	Director of Ruhengeli Hospital
Nyirafaranga Angelique	Community health Worker Supervisor
Jean Damascene Kamana	Community Based Health Insurance Coordinator
Muvunyi Athanase	Head of KARWASA Health Center
Northern Province /Burera District	
Clement Uwiragiye	Director of Health
Tegera Uwamungu JB	CBHI Mobilizer
Iradukunda Gregoire	Head of health Center
Uwamahoro Hyacinthe	Community Health Worker
BIZIMANA Jacques	District Monitoring and Evaluation officer
Dr HABIMANA Jean Francois Regis	Clinical Director of Butaro Hospital
MPANZIMANA Joseph	Director Of District Pharmacy
EASTERN PROVINCE /RWAMAGANA	
Yvonne Muhongayire	Vice Mayor of Social Affairs
Umuhoza M. Chantal	Director of Health
Nkuranga Jean Batiste	Director of Rwamagana Hospital
Jean Baptista Niyomugabo	Director of District Pharmacy
Jonas Ndayisaba	District Monitoring and Evaluation officer
Kaberuka Gerard	Head of Ruhunda Health Center
EASTERN PROVINCE /KIREHE	
MREKATETE Jacqueline	Vice Maire of Social Affairs
KAYIRANGA Jean Damascene	Director of Health
MBONYINSHUTI Francois	Director of District Pharmacy
MUNYESHURI Jean Claude	Director of CBHI
DrUWILINGIYEMUNGU, Jean Nepmscene	Director of Kirehe Hospital
DUKUZUMUREMYI RUKABU Narcisse	Head of Health Center
WESTERN PROVINCE/Nyamasheke District	
Dr Zubeli Muvunyi	Dr Zubeli Muvunyi
Nsabimana Damien	Director of Kibogora Hospital
Bankundiye Etienne	Position???
Mr Basabose Eustache	Position???
Mr Habiyambere Evode	Position???
WESTERN PROVINCE/Karongi District	

Director of Kirinda DH	Dr KANYARUKIKO Salithiel
Director of Mugonero DH	Dr Mfizi Jean
Director of Pharmacy	Mr. MURERAMANA Fidele
District Health M&E	Mr Ngabonziza Desire
Head of Kirambo Health Center	Mr TUYISENGE Samson
SOUTHERN PROVINCE	
Donathile Uwingabiye	Vice Maire/ Social Affairs
Dr Mashagiro	Director of Gakoma DH
Kalisa Benjamin	Director of Pharmacy
Development Partners	
Dr Olushayo OLU	WHO Representative
Jozef Maerien	UNFPA Representative
JESSE Joseph	USAID/HSS team Leader
Jan Borg	BTC/P.H. Expert
Taylor Charlotte	BTC /PFM Advisor
BANAMWANA Robert	UNFPA M&E Specialist
Atakilt Berhe	UNICEF
Dr GASHUMBA Diane	RFHP
KAYITANKORE Mugeni	EU delegation to Rwanda
OVBEREDJO Martins	WHO/HSS
TUYISHIME Stella Matutina	WHO
Muhongerwa Diane	WHO
Twahirwa Theoneste	SDC
Afrika Fulgence	Access Project
Mutwe Philipe	CDC
Kabalisa Max	JSI
Mary Burket	MSH/Home Office
Anne Martin Staple	MSH/Health Financing Lead
Pierre Dongier	MSH/ HSS Team Leader
Randy Wilson	MSH - M&E Team Leader
David Kamugundu	Rwanda Family Health Project

ANNEX 4. Documents Consulted

Author & Date	Title of the document
GOR/MINECOFIN, July 2000	Rwanda Vision 2020,
MOH, Aug 2011	Mid Term Review Report: Health is Improving! (90 pages)
GOR-MOH, Oct 2012	Third Health Sector Strategic Plan (HSSP, July 2012 - June 2018), final version
IHP+, June 2012	JANS Report (Joint Assessment of the Rwanda National Strategy)
MOH, 2014	MOH Structure, adopted
JANS team, June 2012	Joint Assessment of the Rwanda's Third Health Sector Strategic Plan
JANS TB, June 2014	JANS Final TB Report and PPT Presentation
JANS HIV/AIDS	
JANS Malaria	
MOH, 2011	Health Sector Situation Analysis (142 pages)
MOH/MCH, May 2012	Adolescent Sexual Reproductive Health and Rights Policy (41 pages)
MOH, Jan 2015	Health Sector Policy (41 pages)
MOH, March 2015	Health Financing Sustainability Policy (24 pages)
MOH, Oct 2014	National Human Resources for Health Policy (19 pages)
GOR, Jan 2014	National Food and Nutrition Policy (65 pages), Min Local Govt, MOH, Min Agriculture and Animal Resources
MOH, March 2015	Non Communicable Diseases Policy (16 pages)
MOH/MCH, Dec 2012	Family Planning Policy (36 pages)
MOH, Oct 2011	Joint Health Sector Review (JHSR 2010-2011), Backward looking (17 pages)
MOH, Oct 2012	Joint Health Sector Review (JHSR 2011-2012), Backward looking (3 pages)
MOH, Oct 2014	Joint Health Sector Review (JHSR 2013-2014), Backward looking (47 pages)
MOH, undated	Annual Report July 2011 - June 2012 (99 pages)
MOH, Nov 2013	Annual Report July 2012 - June 2013 (102 pages)
MOH, undated	Annual Report July 2013 - June 2014 (64 pages)
MOH, SitAn of various interventions, 2012	Maternal and Child Health, HIV/AIDS. Tuberculosis, Medical Product Management, Health Financing,
RDHS, 2014/15	Key Indicators Results (KIR, vs 31), (35 slides)
RDHS, June 2015	DHSS Key Findings (22 slides)
MOH, undated	M&E Plan for the HSSP III, 2014-2018 (60 pages)
GOR/MOH, July 2015	Rwanda's Performance against the MDGs, (31 slides)
MOH, undated	Performance Evaluation for Output Indicators (excel sheet for all interventions)
MOH, April 2012	Rwanda Health Resource Tracker Draft Output Report
MINECOFIN, Sept 2014	Budget Execution Report for Fiscal Year 2013/14 (30 pages)
MINECOFIN, Sept 2013	Budget Execution Report for Fiscal Year 2012/13 (31 pages)

ANNEX 5. Map of the various field visits



KEY

KEY

Team A

Team B

ANNEX 6. Rwanda Government contribution to the Health Sector 2013-2016

Budget Agency	DESCRIPTION	2013-2014	2014-2015	2015-2016
1.MINISANTE	Health sector budget	138,526,252,106	145,484,737,943	159,713,786,733
2. MINEDUC	College of Medicine and Health Sciences	4,396,874,890	3,608,535,729	3,162,388,899
3. MINADEF	Rwanda Military Hospital	1,125,051,798	5,176,371,128	3,931,634,728
4. MINADEF	Military Medical Insurance (MMI)	2,676,786,636	2,586,034,949	2,925,883,557
5 MINAGRI	One cup for milk per child	2,100,000,000	2,100,000,000	2,100,000,000
6. DISTRICTS	Nutrition	1,510,000,000	1,997,138,695	2,130,000,000
7. ALL BUDGET AGENCIES	Health Insurances (RAMA)	20,101,339,345	22,111,473,279	24,033,975,370
8. MINALOC	FARG (health assistance)	2,291,177,428	2,291,177,428	1,999,354,856
9. DISTRICTS	Support to vulnerable groups	1,700,574,799	1,700,574,799	1,700,574,799
10. DISTRICTS	Salaries for Director of Health	191,041,200	191,041,200	191,041,200
11. DISTRICTS	Mutuelle de santé	13,921,445,906	15,290,051,509	15,290,051,509
12. MININFRA	Development budget contribution (Water and sanitation)	8,911,056,516	13,616,027,966	28,584,304,791
	Total Health budget	**197,451,600,624**	**216,153,164,625**	**245,762,996,442**
	Total Gov't Domestic Budget	**1,165,596,376,531**	**1,398,691,919,277**	**1,488,015,793,285**
	%	**16.94%**	**15.45%**	**16.52%**

Note:
The data was given to the MTR team by MOH in consultation with MINECONFIN. Some of the figures are not similar with the budget proclamations.

In RWf	2013-2014	2014-2015	2015-2016
1. Health and socio-economic determinants	197,451,600,624	216,153,164,625	245,762,996,442
2. Primary objective is health (1+3+4+7+8+9?+10+11)	180,533,669,218	194,831,462,235	209,786,302,752
3. MOH and HSSP areas only ((1+10+11)	154,339,314,011	162,666,405,451	176,895,454,241.00
Health and socio-economic determinants (in %%)	0.17	0.15	0.17
Primary objective is health (in %%)	0.15	0.14	0.14
MOH and HSSP areas only (in %%)	0.13	0.12	0.12

Notes:
1. The definition of 'primary objective is health expenditure' (option 2) follows the international definition of NHA classification.
2. In many countries water and sanitation is considered a sector of its own and not included in health.
3. Nutrition is a multi sectoral response (agriculture, education and health) and in many countries it is only the health response that is considered as part of the health sector spending
4. The investment in producing human resource for health at the college level is part of the education assignment in many countries. Only on job training and specific cadres that are trained by MOH allocation are considered as part of health sector allocations.
5. Average annual exchange rate of 637, 668 and 688 RWF per one USD was used for conversion in the three years above.