

# M&E in the Rwanda Health sector Mission report

22/11-27/11/2008

Liesbeth Inberg & Nathalie Holvoet

**BOS-PRSP**  
**Institute for Development Policy and Management**  
**Universiteit Antwerpen**  
**Lange Sint Annastraat 7**  
**2000 Antwerpen**  
[www.ua.ac.be/iob/dev/bos](http://www.ua.ac.be/iob/dev/bos)

## 1. Introduction

Belgium is the lead donor in the health sector in Rwanda where last year (October 2007) a SWAp was introduced. The Belgian Embassy in Kigali and DGOS asked BOS to provide support for the improvement of the monitoring and evaluation (M&E) mechanism in place for the Joint Health Sector Support (JHSS) program.

In order to make a first assessment of the M&E mechanism, Liesbeth Inberg of BOS participated in the Joint Health Sector Review (JHSR) which took place on 24<sup>th</sup>, 25<sup>th</sup> and 26<sup>th</sup> November 2008. The objectives of the mission were

- To participate in the JHSR and to appraise and analyze the JHSR from an M&E perspective.
- To identify the needs for future assistance in M&E in the health sector to the Belgian Embassy and/ or the M&E taskforce of MoH.

This mission report consists of four sections: the first section provides some background information on Rwanda; the second session gives information on M&E in the new aid modalities and on M&E in Rwanda at both the central and health sector level; the third section describes and appraises the JHSR of 2008 and the last section presents possibilities for future assistance.

## 2. Background information

This section provides some general information, information on the health sector and information on donors active in Rwanda.

### 2.1 General

Rwanda is a low-income country with a GDP/capita of 1,206 in 2005. With a Human Development Index (HDI) of 0.452 it is ranked among the countries with a low human development (161 out of 177 countries). The Gender Development index (GDI) is slightly lower with a value of 0.450 (rank 140/157). Table 2.1 gives an overview of the scores on the sub-indicators of the HDI and GDI.

Table 2.1 scores on the sub-indicators of the HDI and GDI.

	Female	Male	Total
--	--------	------	-------

Estimated GDP per capita (PPP USD), 2005	1,031	1,392	1,206
Life expectancy at birth 2005	46.7	43.6	45.2
Adult literacy rate 1995-2005	59.8	71.4	64.9
Combined gross enrolment ration for primary, secondary and tertiary education (%) 2005	51	51	50.9

Source: UNDP 2007/2008 report

### *Policy*

Vision 2020, developed in 2000, describes the long term vision of Rwanda and presents a framework for the development of Rwanda; it forms the basis for the elaboration of national and sector plans for the medium term. The objective of Vision 2020 is the transformation of Rwanda into a middle-income country by the year 2020. Vision 2020 consists of 6 pillars: good governance and a capable state; human resource development and knowledge based economy; private sector-led economy; infrastructure development; productive and market oriented agriculture; and regional and international economic integration. Cross-cutting areas are: gender equality; protection of environment and sustainable natural resource management; and science and technology, including ICT.

The medium-term framework is described in the second Poverty Reduction Strategy Paper (PRSP) of Rwanda, the Economic Development and Poverty Reduction Strategy 2008-2012 (EDPRS). The EDPRS consists of three flagships: ‘sustainable growth for jobs and export’, ‘Vision 2020 Umurenge – poverty reduction in rural areas’ and ‘governance’. The objectives formulated for health are: ‘to maximise preventative health measures and build the capacity to have high quality and accessible health care services for the entire population in order to reduce malnutrition, infant and child mortality, and fertility, as well as control communicable diseases’ (Republic of Rwanda, 2007: xii).

## **2.2 Health**

The external evaluation of the Health Sector Strategic Plan (HSSP) 2005-2009 highlights impressive improvements of some of the impact health indicators between 2005 and 2007. For example the Infant Mortality Rate (/1000 live births) declined from 86 to 62 (target 61), the Under Five Mortality Rate (/1000 live births) declined from 152 to 103 (target 110) and Total Fertility Rate (%) declined from 6.1% to 5.5% (External Evaluation Team, 2008).

### *Health Policy and Health Sector Strategic Plan*

The Health Policy of 2004 is based on Vision 2020, the first PRSP and the decentralization policy. The Health Policy has seven policy objectives:

1. To improve the availability of human resources;
2. To improve the availability of quality drugs, vaccines and consumables;
3. To expand geographical accessibility to health services;
4. To improve the financial accessibility to health services;
5. To improve the quality and demand for services in the control of disease;
6. To strengthen national referral hospitals and research and treatment institutions;
7. To reinforce institutional capacity.

Because important programs had been initiated and many targets had already been reached or were foreseen to be reached in 2008, HSSP II has been developed one year before it was actually envisaged. HSSP II is expected to be approved before the end of 2008. The format of the HSSP II is based on the sector strategic plan outline, presented in the 'National Planning and Budgeting and MTEF guidelines'. In the development of the HSSP II, the findings and recommendations from both an internal and an external evaluation of HSSP I were taken into account. The HSSP II is in line with the Vision 2020, the EDPRS, the Good Governance and Decentralisation Policy, the Health Policy, the MDGs and the Africa Health Strategy.

The goal of HSSP II is: 'to continually improve the health of the people of Rwanda, through coordinated interventions by all stakeholders at all levels, thereby enhancing the general well-being of the population and contributing to the reduction of poverty' (Ministry of Health, 2008: 25).

The HSSP II has three components for service delivery, i.e. 'family planning, maternal and child health, reproductive health and nutrition', 'health promotion and prevention of disease' and 'curative and rehabilitative services'. For support services the HSSP II identified eight components, almost completely corresponding with the seven components of HSSP I:

- Planning and M&E
- Health Financing
- Human Resources for Health (including basic and in-service Training)
- Infrastructure, Equipment and Transport
- Commodities Supply and Logistics (including Pharmaceuticals)
- Quality Assurance
- Research
- Institutional Strengthening (including Governance)

The HSSP II will be implemented through national Joint Annual Work Plans (JAWP) which are developed yearly by the MoH and all partners.

#### *Health financing*

9.1% of the total GoR budget is intended to be allocated towards health, not yet reaching the target of 15%. The public budget execution rate in the health sector is 96%, which points at a high absorption capacity (Ministry of Health, 2008: 17).

The PER Health 2006-2007 identified four major funding sources for the health sector of Rwanda: government revenues (including revenues generated from taxation, loans, grants, donations and donor contributions through budget support), donor funds (on-budget and off-budget), internally generated funds by health facilities (user fees) and health insurance pooled funds from household expenditures (Ministry of Health, 2008: 22).

In 2006 the MoH decided to expand a successful pilot for programme-based financing (PBF) nationally. For this end, the ministry created a special unit, Cellule d'Appui à l'Approche Contractuelle (CAAC). According to the HSSP II, the first successes of the PBF programs are already visible.

HSSP II indicates four problems in health financing. Firstly, a major share of the health budget is used for vertical programs instead of targeting the entire health system. Secondly, a huge amount of the funds provided by NGOs and Development Partners are not included in the budget and household expenditures are often not properly estimated. Thirdly, the nominal public expenditure level in the health sector is lower than expected (11.4%, target is 15%). Finally, an important part of the health expenditure is funded by external sources, thus endangering sustainability.

### 2.3 Donors

Total Official Development Assistance (ODA) to Rwanda was USD 602.7 million in 2006, which is around 25.6% of GDP of 2006. 26% of ODA was channelled through budget support, provided by the African Development Bank, European Commission, Sweden, United Kingdom and the World Bank. In 2007, Belgium, EFA-FTI, Germany and the Netherlands joined these budget support donors (Ministry of Finance and Economic Planning and Development Partners, 2007).

In order to enhance the coordination, harmonization and alignment of aid in Rwanda, the Government of Rwanda and the Development Partners (DPs) have elaborated a Rwanda Aid Effectiveness Report since 2005, which documents key achievement in all joint activities of the past year and highlights forthcoming developments. In 2006, Rwanda's Aid Policy was formulated which increased advancements in aid harmonization and alignment (Ministry of Finance and Economic Planning and Development Partners, 2007).

Between 2005 and 2007 donors made some progress on most of the indicators of the Paris Declaration, as demonstrated in table 2.2. When looking specifically at Belgium, it is remarkable that the scores on some of the indicators are lower in 2007 than in 2005. Especially worrisome are the declines in the use of country PFM systems and procurement systems and in the predictability of aid. However, in view of the fact that Belgium has provided sector) budget support since this year, these scores will probably improve again in the next survey.

Table 2.2 summary table of survey on monitoring the Paris Declaration

	Indicators	2005	2007	2010 Target
3	Aid flows are aligned on national priorities Belgium	49% 84%	51% 77%	85%
4	Strengthen capacity by co-ordinated support Belgium	58% 0%	84% 0%	50%
5a	Use of country PFM systems Belgium	39% 52%	42% 15%	59%
5b	Use of country procurement systems Belgium	46% 75%	43% 66%	64%
6	Strengthen capacity by avoiding Parallel PIUs Belgium	48 0	41 18	16
7	Aid is more predictable Belgium	66% 79%	67% 52%	83%
8	Aid is untied	82%	95%	More than 82%

9	Use of common arrangements or procedures Belgium	42% 0%	38% 10%	66%
10a	Joint missions Belgium	9% 0%	21% 50%	40%
10b	Joint country analytic work Belgium	36% 100%	42% 100%	66%

Source: OECD/DAC, 2008 survey on monitoring the Paris declaration, Rwanda country chapter

The health sector receives 12% of ODA, from 16 DPs<sup>1</sup> (Ministry of Finance and Economic Planning and Development Partners, 2007). In 2007 a Memorandum of Understanding (MoU), signed by the major DPs, officially launched the Sector Wide Approach (SWAp) in the health sector. The aim of the MoU is ‘to improve the efficiency, effectiveness and impact of the health sector policy and health sector strategic plan by increasing transparency on all sides; improving the predictability and allocation of financing and better coordinating the multiple inputs and activities which serve sector objectives’ (Ministry of Health, 2007, 2).

The Belgian Government, German Cooperation and DFID signed an agreement with the MoH to provide sector budget support (SBS). These three DPs and the Swiss Development Cooperation also made financial commitments to install a pooled fund for technical assistance.

### 3. Monitoring and Evaluation (M&E)

This section provides some background on M&E within the new aid modalities. It includes information on M&E at the central level and in particular at the health sector level in Rwanda.

#### 3.1 M&E within the new aid modalities

Within the reform agenda set for donors and recipients (Paris Declaration 2005, Accra Agenda for Action 2008) one of the crucial reform areas relates to M&E. From recipients it is expected that they “endeavour to establish results-oriented reporting and assessment frameworks that monitor progress against key dimensions of the national and sector development strategies and that these frameworks should track a manageable number of indicators for which data are cost-effectively available’(indicator 11)(OECD/DAC, 2005: 8). On the other hand, donors should “work with partner countries to rely, as far as possible, on partner countries’ results-oriented reporting and monitoring frameworks’ and that they “harmonise their monitoring and reporting requirements, and, until they can rely more extensively on partner countries’ statistical, monitoring and evaluation systems, [work] with partner countries to the maximum extent possible on joint formats for periodic reporting’ (OECD/DAC, 2005: 8). Despite these commitments, progress in the implementation of the reforms is slow. The 2008 survey on the Paris Declaration demonstrates that only three (Mozambique, Tanzania and Uganda) out of 54 countries surveyed had result-oriented frameworks that were deemed adequate (OECD/DAC, 2008a:58-59).

<sup>1</sup> Belgium, Germany, Italy, Luxembourg, Switzerland, United Kingdom, United States, European Commission, Global Fund, World Bank, UNAIDS, UNFPA, UNHCR, UNICEF, WFP and WHO.

### 3.2 M&E in Rwanda: the central level

The last update of the Comprehensive Development Framework (CDF) report (World Bank, 2007), on which indicator 11 of the Paris Declaration is based, shows that the overall score for the establishment of a result-oriented M&E framework for Rwanda is A<sup>2</sup>. It points at the fact that progress is being made, although not yet enough, yet the basis exists for more substantive progress. The indicator is composed of three sub-components, i.e. 'stakeholder access to information', 'quality of information' and 'coordinated country-level M&E'. The first sub-component is assessed with a D, meaning that significant actions have been taken already, although further action is needed. The other two sub-components have obtained a score A. It is an improvement compared with the CDF progress report of 2005 when all three criteria were assessed with an A. The report furthermore highlights the following good practice of Rwanda: 'Rwanda has used existing sector strategies to inform its medium-term strategy. This has facilitated linking the strategy to the budget; on the basis of the sector strategies, line ministries prepare sectoral MTEFs that form the basis for the MTEFF.' (World Bank, 2007: 9)

Vision 2020 does not pay specific attention to M&E. However, 47 key indicators are formulated for monitoring of which ten relate to health<sup>3</sup>. On the other hand, the EDPRS devotes a whole chapter to the monitoring and evaluation of the EDPRS. The chapter presents a preliminary framework with four indicator matrices with the purpose 'to allow the construction of simple causal chains linking public expenditure in the budget to desired EDPRS output and outcomes' (2007:142). In order to have a manageable framework, sectors are supposed to report only on a few key indicators to the national level. Within each sector more detailed indicators are provided and discussed during annual Joint Sector Reviews. The four indicator matrixes are: A matrix with strategic outcome indicators (no more than twenty) which will be used to evaluate the strategy at the end of the EDPRS period, a matrix with intermediate indicators (no more than thirty) which are more or less directly linked to the actions of the government, the summary policy matrix (no more than thirty) which should serve as the triggers for the release of budget support funds and the second generation matrix for which adequate data are not yet available. There are six health related strategic outcome indicators<sup>4</sup> and five health related intermediate indicators<sup>5</sup>.

---

<sup>2</sup> For the score of the status of implementation of the Comprehensive Development Framework the LEADS method has been used. There are five scores: L Little action (due to a wide variety of circumstances, including political developments, capacity constraints and unforeseen events, action has remained at a virtual standstill), E Elements exist (There is some basis for making progress, either through what already exists, or definite plans), A Action taken (Progress is being made, although not yet enough, and the basis exists for even more substantive progress), D Largely developed (Significant action taken already, although further action is needed) and S Sustainable (There are no warning signs of possible deterioration, and there is widespread expectation that the progress achieved is sustainable)

<sup>3</sup> Women fertility rate, infant mortality rate, maternal mortality rate, child malnutrition, HIV/AIDS prevalence rate, malaria-related mortality, doctors per 100,000 inhabitants, population in a good hygienic condition, nurses per 100,000 inhabitants and laboratory technicians per 100,000 inhabitants.

<sup>4</sup> The health related strategic indicators are: Infant mortality rate, Incidence of stunting (height for age) (%), Maternal Mortality Rate, Total fertility rate, Malaria prevalence (% of adults in Eastern province), HIV incidence (% of adults aged 15-24)

<sup>5</sup> The health related intermediate indicators are: % of women aged 15-49 years using modern contraceptive techniques (DHS, HMIS), % of women giving birth in health centres (no data source), % of population living within 5 kms of a functioning health centre (HMIS, annual), Number of insecticide treated bed nets distributed annually (Population Service I (PSI), MINISANTE), % of population covered by health insurance (HMIS, MOH and private insurance bodies)

The Joint Staff Advisory Note (JSAN) of 2008 reports the following on the monitoring framework of the EDPRS: ‘The indicators are generally considered to be appropriate, given the assessment of poverty and institutional capacity. However, the link between the outcome indicators and the policy matrix needs to be made more explicit. Also, given the differences in regional poverty rates (where the Eastern region has contributed most to poverty reduction and the South the least), IMF/WB staff would recommend that the monitoring framework also present indicators by regions to monitor the effectiveness of interventions.’

To monitor progress in the context of general budget support, a Common Performance Assessment Framework (CPAF) was developed, which overlaps almost completely with the monitoring framework of the EDPRS (government of Rwanda, 2008: 10).

#### *National Institute of Statistics of Rwanda*

The National Institute of Statistics of Rwanda (NISR) is the overall coordinating agency of the National Statistical System. Among other things, the NISR works with other ministries and local development units in the development of statistical indicators, design of surveys or enhancement of statistical systems. The NISR works together with the MoH on official statistics for the health sector. The NISR is in the process of elaborating a plan for the first National Development Strategies on Statistics (NSDS) which should be implemented in 2009. The aim of the NSDS is to view concerns, priorities and strategies holistically in order to promote harmony, consistency, rationalized and well coordinated statistical data collection activities (<http://statistics.gov.rw>).

### **3.3 M&E at the health sector level**

This paragraph presents a short overview of elements of the M&E system in the health sector, by looking at policy, methodology, organization, capacity and participation of actors outside government<sup>6</sup>. It is not the intention to give a complete and detailed analysis of the M&E system.

#### **3.3.1 Policy**

The health sector in Rwanda does not have a specific policy for M&E. However, references to M&E are made in several documents.

The Health Sector Policy (2005) mentions that the government shall put in place mechanism to supervise, monitor and evaluate the implementation of the Health Sector Policy with a focus on specified input and process indicators (human and financial resources, utilization of services etc); evaluation will be conducted both internally and externally in collaboration with the Ministry of Health’s partners. Finally, it is stated that the Health Management Information System (HMIS) will be reinforced to better inform decision-making in the health sector (Government of Rwanda, 2005a: 14).

---

<sup>6</sup> These headings (plus ‘quality’) are used by Holvoet and Renard (2006) in their assessment of M&E systems of several African countries. Although their focus was on the central level, the framework is also applicable to the sector level.

Three components of HSSP II relate to M&E: ‘planning and M&E’, ‘research’ and ‘institutional strengthening and governance’. The strategic objectives for these three components are respectively: ‘to develop, update, monitor and evaluate evidence-based policies and plans’, ‘to promote and inculcate a culture of research’ and ‘to ensure that health interventions are responsive to people’s needs, managed efficiently and transparently, and that all actors are participating in planning and evaluation in a well coordinated manner’ (Ministry of Health, 2008: 26).

Moreover, one chapter of the HSSP II is devoted to M&E with paragraphs on a mechanism for M&E, Joint Sector Review, presentation of the key performance indicators, evaluation and communication on progress. It is stated that ‘a monitoring, review and evaluation framework is an integral part of the HSSP as it provides the basis for measuring progress in relation to targets both during and after implementation. It addresses the need for accountability and ensures that decision makers have the information at their disposal to reflect on and analyze performance so that they build lessons into future plans. As stakeholders increasingly use these health sector performance indicators to measure the returns of their investment, the requirement to put robust monitoring, review and evaluation mechanisms in place becomes all the more pressing’ (Ministry of Health, 2008: 35).

#### *Joint Sector Reviews*

The EDPRS includes one paragraph on JSRs in the chapter on M&E (7.2.4). The paragraph describes that the first PRSP initiated the process of annual JSRs, which should supply information for the PRSP Annual Progress Report. According to the EDPRS “the scope and depth of the Joint Sector Reviews has generally increased during the implementation of the PRSP, culminating in a highly participatory and very extensive self-evaluation by each sector in 2006’ (Republic of Rwanda, 2007: 153).

Rwanda intends to link the JSR more explicitly with the annual budget process, by focusing on the consideration of budget execution information, creating in this way the foundation for performance budgeting. Besides, in order to foster mutual accountability in the relationship with donors, the JSR should also pay attention to the role and impact of external aid (Republic of Rwanda, 2007).

The use of JSRs is more elaborated in the National Planning, Budgeting and MTEF guidelines (2008). According to the guidelines, JSRs should take place in February/March as a starting point for the preparation of the MTEF (stipulated in the Organic Budget Law). The JSR should analyze the achievements of the past year and recommend for the coming year. Besides, donors should share their financing intentions for the next budget year, plus the two subsequent years. In order to have a detailed discussion on the developments in the sector, the lead ministry should distribute a report on the implementation of the Annual Action Plan<sup>7</sup> and a concept of the Sector Performance Report<sup>8</sup> one week before the JSR. After the review the finalized Sector Performance Report should be presented to the Ministry of Finance and Economic Planning and the Prime Minister’s Office and used as input for the

---

<sup>7</sup> This report contains a detailed overview of how funds were spent and what direct outputs were achieved, in table form

<sup>8</sup> This report summarizes the key elements of the report on the implementation of the annual action plan, but complements this with information with an analysis of input, output, outcome, and impact indicators for the sector as a whole.



EDPRS Annual Progress Report. Furthermore, the Sector Performance Report forms the foundation for the Strategic Issues Paper, which provides background and justification for the budget of the sector Ministry.

The HSSP II on the JSR: “The main purpose of the joint sector review is to take stock of progress made in the sector, identify challenges and the reasons for them. A joint review will harmonize the annual reviews of development partners and thereby reduce the transactions costs of multiple external missions. The results obtained from the review would then be used to inform future strategies and plans and to reconcile plans with available budget by agreeing on most pressing priorities’ (Republic of Rwanda, 2008: 35).

The Memorandum of Understanding (MoU), signed in 2007, provides more detailed prescription for the JSR, a JSR will review:

- i. Progress in the previous year, based on a Ministry of Health report that will utilise the agreed monitoring framework and sources and will report the agreed performance indicators.
- ii. The budget execution reports for the previous year, including analysis of outputs achieved as well as resources expended.
- iii. Such additional reports and analysis as may have been commissioned by the cluster in order to inform the review. This will normally include a public expenditure review. It may include further independent analysis to help focus discussion at the review.
- iv. Resources likely to be available from domestic and donor sources in the coming year. Donors will provide indications of their future support for as many years as possible, including at least the MTEF period starting in the following January. This will help the review to assess the extent of any funding gaps.
- v. Policy and expenditure priorities to guide budget and MTEF preparation, including discussion of how identified financing gaps may be met from new commitments or re-allocations within the budget. This will include considerations of geographical balance and correspondence to the broad expenditure allocations identified in the EDPRS and the MTEF.

Furthermore a JSR will look forward by reviewing the budget and MTEF proposals for the coming year, setting priorities and approving the annual operational work plan and budget.

It is agreed in the MoU that the lead donor is responsible for the distribution of an annual report on donor performance with information on the disbursements by donors compared to previously advised commitments, future disbursements and compliance with the reporting requirements of the Government.

### **3.3.2 Methodology**

According to the new HSSP an overall M&E framework, describing what will be monitored and evaluated, how, how often, by whom and for what purpose is still lacking (Ministry of Health, 2008: 16). However, an agreed upon set of annual and periodic indicators has been developed in partnership with DPs, implementers and local governments, which will form the basis for the monitoring and control of HSSP-II at all levels of the health sector (Ministry of Health, 2008: 35).

To measure progress towards achieving the goal of the HSSP-II, 14 impact indicators are chosen, including all the health-related MDGs (see table below). Some of the targets are higher than the targets set in the EDPRS as the latter were already achieved (HIV and malaria prevalence and infant mortality rate) (Ministry of Health, 2008: 10).

Table 3.1 impact indicators and targets

	<b>IMPACT INDICATOR</b>	<b>TARGET</b>
1.	Infant mortality rate	50/1000
2.	Infant mortality rate in bottom wealth quintile	99/1000
3.	Incidence of stunting	27%
4.	Child malnutrition rate	18%
5.	Maternal mortality rate	600/100,000
6.	Total fertility rate	4.5
7.	Malaria prevalence among adults in the Eastern province	target to be set
8.	HIV incidence among 15-24 year olds	0.5%
9.	HIV prevalence in pregnant women	target to be set
10.	Vertical transmission rate of HIV from mother to child	target to be set
11.	Prevalence of WHO priority diseases	Decrease by 50%
12.	Prevalence of neglected tropical diseases	Decrease by 50%
13.	Diarrhoeal disease rate in children under five	10%
14.	Airborne infection rate in children under five	target to be set

Source: HSSP II

To measure the purpose of HSSP-II, 'healthier lifestyles adopted and rational utilization of health services at all levels increased', eight indicators and targets were selected:

Table 3.2 purpose indicators and targets

	<b>PURPOSE INDICATOR</b>	<b>TARGET</b>
1	Utilisation rate PHC services per person per year (HCs and private dispensaries)	1
2	Number of group health sessions conducted by CHWs	Target to be set
3	Number of individual counselling or care sessions by CHWs	Target to be set
4	Contraceptive Prevalence Rate (CPR)	From 27% to 70%
5	Number of child survival and maternal/RH services	Target to be set after baseline has been established
6	% of children fully vaccinated	85%
7	% of pregnant women with 4 ANC visits	50%
8	% of deliveries in accredited HFs over all deliveries	>60%

Source: HSSP II

In the terms of reference for the elaboration of Sector Strategic Plans a format is prescribed for the monitoring framework, which should form the basis for the annual JSR. A second table should provide information on the way the indicators are measured, the data source, the collection of the data, the responsibility for the data collection, the timing of the data collection and the cost of the data collection

(Republic of Rwanda, Ministry of Finance and Economic Planning, 2008: 57). The second table is not (yet) included in the HSSP-II.

A self-evaluation report of the EDPRS Sector Working Group ‘Health, Population and HIV/AIDS’ (2006) indicates that the use of the M&E framework of the HSSP is hindered by a number of factors. Firstly, due to the change of objectives and corresponding indicators during the review period, it is difficult to track the progress of all indicators. Secondly, the analysis of data has not always been coherent and finally, there is no coherence between financial monitoring tools and technical monitoring tools, because they are not integrated.

The HSSP II emphasizes the need to streamline and harmonize all the data systems. Constantly updated and revised data collection instruments leads to confusion among stakeholders about which version is the most recent and about which version needs to be used. Moreover, HSSP II mentions an overkill of data collection tools and a limited use of the information for local level decision-making.

The main sources of data for monitoring, review and evaluation of the sector are: the Health Management Information System (HMIS), sentinel site surveillance systems, household surveys such as DHS, EICV, SPA, MICS, CWIQ, supervision reports, specially commissioned surveys and studies such as NHA, PETS and Health PER, citizen report cards, and disease program reports.

#### *HMIS*

One of the four outputs of the institutional capacity building program of HSSP I was: ‘health management information system fully functional in public and private sectors’. Four indicators were identified and nine activities<sup>9</sup> were related to this output. The table below presents the four indicators and the progress made between 2005-2007.

Table 3.3 progress on indicators for HMIS

Indicator	Progress between 2005-2007
% of monthly health facility reports returned to central level on time	Being recorded (85-95%), but not functional in 2008
availability to all stakeholders of quarterly HMIS bulletin	3 bulletins in 2005; none in 2006 and one in 2007
availability of data and analysis of private sector and national referral hospitals	Data collection tools developed; not yet functional
Supervise HMIS at all levels	Supervision carried out twice (50%) in

1) Conduct an assessment of the data needs of Ministry of Health programmes and districts (annual report 2005: ToR, preparatory work is going on), 2) Integrate recommendations of assessment into HMIS by updating data collections tools and computer systems (2005: none); 3) Produce and distribute data collection tools at all levels (2005: completion); 4) Publish quarterly HMIS bulletin for all stakeholders and as feedback down to districts (2005: target 4, result 75%); 5) Carry out formative supervision of HMIS at all levels (2005: target 2, result 50%); 6) Train selected personnel in analysis of health data at central and provincial level (2005: target 130, result 50%); 7) Put in place a dynamic mapping of health information (2005: target 1, result 100%, ONUSIDA, WHO provided technical and financial assistance); 8) Develop data collection tools to integrate private sector and national referral hospitals into HMIS (2005: target completion of action, result 25%, one meeting for contact with the private sector sponsored by PNILP); 9) Train personnel in national referral hospitals and private sector for integration into HMIS (2005: none)

Source: Evaluation Report HSSP I, 2008: 47

The external evaluation report of HSSP-I concludes that the strengthening of the M&E system was not adequately addressed, with has led to a fragmented and ill-performing health information system (External Evaluation Team, 2008). Not surprisingly, the reinforcement of the HMIS, as an integral component of the overall monitoring, review and evaluation system, is still considered a priority in HSSP-II.

The MoH has already made some progress in 2008. Some achievements include: the increasing engagement of the M&E Task Force in oversight of the broader health information system design, the integration of most routine data reporting requirements into standard report formats for Health Center and District Hospital levels (monthly, quarterly and annual) since January 2008 and the introduction of computerized database for data capture of new formats introduced in July 2008 (ppt MoH, 2008). Problem areas identified by the MoH are (ppt MoH, 2008):

- Too many data are reported: Integrated SIS (Système d'Information Sanitaire) reports are too complex and time consuming (26 pages for CS, 36 pages for HD) and at least 8 other reports are required monthly
- Since decentralization, SIS reporting compliance has been poor and the role of Administrative Districts in HIS is unclear.
- Selected routine health data are still collected using parallel systems:
  - PBF, Mutuelle, TracNet (HIV data)
  - Pharmacy logistics, Equipment, HR
- MOH data center currently doesn't have capacity to support data warehouse or web-based data sharing
- Use of data is very limited at all levels – needs to be addressed to improve data quality as well.
- District and FOSA level staff don't have adequate training in data analysis and use and are frequently required to perform other tasks unrelated to HIS.
- Inadequate mechanism for maintenance and repair of computers in districts and FOSAs.

### 3.3.3 Organization

#### *Planning, Policies and Capacity Building Unit*

The Planning, Policies and Capacity Building Unit (formally the unit of Planning and Research) of the Ministry of Health is among other things responsible for M&E in the health sector. The Unit has seven desks: Planning, Health care, Public Hygiene, Nutrition, Private medicine, Community and traditional medicine and Human Resources Development.

The main responsibilities of the Planning, Policies and Capacity Building Unit are:

- Coordination of the elaboration of policies, sector strategies and standards within the Ministry of Health;
- Coordination and evaluation of the application of the national policies within the Ministry;
- Coordination of the drafting of the legal and lawful texts as regards health care;

- Conduction of the monitoring and evaluation related to the application of policies and programs;
- Exploitation of reports on the functioning of health Districts, hospitals and national reference services.

(www.moh.gov.rw)

As a consequence of the decentralization process, the staff of the former Unit of Planning and Research was reduced from twelve to nine with only one person (previously nine) remaining with the responsibility for the oversight of the HMIS. This is assessed as insufficient by the authors of the Rwanda HMIS Assessment Report (RTI International, 2006) as even in a decentralized system capacity is needed at central level to manage the health information system in terms of policies, national standards, updating data collection forms and procedures, analyzing and distributing national level data and providing feedback, guidance to the district and coordination and following-up the integration of private facility and reference data into the national HMIS.

Furthermore the Rwanda HMIS Assessment Report indicates that staff at district and central level have no database management skills and nobody can manage the GESIS<sup>10</sup> software. Any changes in the GESIS software are made by external consultants. At the local level, health facilities produce and report a lot of data, but they do not have time, resources, capacity and incentives to analyze and use them (RTI International, 2006).

#### *Monitoring and Evaluation Task Force*

As recommended by reviews of the Management Science for Health (MSH, 2007) and the Human Resources and Institutional Capacity Development Agency (HIDA), the MoH created a new Monitoring and Evaluation Task Force (M&E/TF) in February 2008. The aim is to develop and strengthen the existing HMIS and M&E system at national level in order to be better used for decision-making in planning and for improvement of the service delivery system in the country (Ministry of Health, 2008: 16). Specific objectives are (ppt MoH, 2008):

- To strengthen the national system collection, analysis, reporting, storage, retrieval and utilization of health data as a tool for monitoring and control;
- To monitor and evaluate the implementation of policies, strategies, MoUs and PoA in the Sector;
- To monitor and evaluate the implementation of sectoral norms, standards and guidelines;
- To monitor and evaluate the progress of core health indicators in the prevention and management of communicable and non communicable diseases.

---

<sup>10</sup> The GESIS (Gestion du Systeme d'Information Sanitaire), is a database application designed and implemented by AEDES (Agence Europeenne pour le Developpement et la Santé) in 1997, with funding from the CTB. The GESIS was developed to provide the MoH with a tool to support SIS data gathering, data entry, and queries. Data reported to and maintained in the GESIS tracks national health indicators for the country, determined at the central level, and constitutes the main operational component of the SIS (RTI, 2006: 23).

The M&E/TF has five desks: data management, audit and quality control, research and special studies, capacity building and reporting and distribution (External Evaluation Team, 2008).

The future of the M&E/TF is not clear, given the fact that in the new proposed organization chart of the MoH the M&E taskforce is not specifically included and only one expert is foreseen for M&E, placed directly under the Permanent Secretary. Besides, two experts are foreseen for medical research and two experts for the HMIS.

#### *Health Sector Coordination Group*

The Health Sector Coordination Group (HSCG), which is chaired by the Minister of Health and co-chaired by the Health Sector Coordination Counsellor of the Belgian Embassy (Ministry of Health, 2008: 9), is involved in the monitoring of progress in the health sector. It is a formal forum for the Government of Rwanda and other stakeholders to discuss the planning and priorities in the sector. The HSCG was initiated by the Belgian Embassy and the German Technical Cooperation and became fully operational in September 2004. The goal of the Health Sector Cluster Group is 'to improve the effectiveness and efficiency of aid in the health sector and better align development partners behind the Health Sector Strategic Plan with an enshrined principal of mutual accountability' ([www.devpartners.gov.rw](http://www.devpartners.gov.rw)). In order to address particular technical issues and priorities of the HSSP a number of technical working groups (TWG) have been set up in the field of: Family Planning, Mutuelles, Mapping, Contractual Approach, Human Resources Development, Disease Control, and Integration of HIV/AIDS funds in the health system. The technical working groups have initiated some comprehensive thematic analyses, like for example human resource development (MoH/ BTC) and integration of HIV/AIDS funds in the health system (MoH/USAID) ([www.devpartners.gov.rw](http://www.devpartners.gov.rw)).

However, the HSCG and the TWGs have a large workload, poorly defined work plans, and little coordination with corresponding MoH desks/ units. Moreover, 'cluster and TWG meetings are still largely donor managed and do not have enough leadership of the MoH. There are various understandings and interpretations of the SWAp, ongoing differences of opinion and lack of agreement on budget support versus project support and on capacity building strategies and financing. There continues to be vertical programming and financing and inadequate harmonization of approaches between partners and stakeholders' (Ministry of Health, 2008: 21).

During the JHSR of 2008 a reconstruction of the HSCG was proposed; the HSCG should diminish the number of members to five GoR members, five DPs, two members from Civil Society and two members from the private sector. Meeting with the DPs would be held before the HSCG meetings in order to have the input of all DPs.

Besides the HSCG there is a Sector Budget Support Group (SBSG) for the DPs who provide sector budget support: Belgium, German Cooperation and DFID. A proposal is made to extent membership of the SBSG to the World Bank, the US Government and the United Nations.

### **3.3.4 Capacity**

One of the seven programs of the first HSSP was concerned with institutional capacity building<sup>11</sup>, with the overall objective to strengthen the institutional capacity of the health sector in planning, management, monitoring and evaluation (Government of Rwanda, 2005b). The outputs of this program did not specifically refer to M&E. Under HSSP II this program changed into ‘institutional strengthening and governance’.

Because both the Health Sector Policy as the Health Sector Strategic Plan identified weak capacity as the main challenge for the attainment of quality care and the Millennium Development Goals (MDGs), the Ministry of Health decided to elaborate the Human Resources for Health Strategy Plan 2006-2010. The overall goal of this plan is: Available human resource for health (HRH) that can understand and sustain health reforms for better health outcomes as enshrined in the vision 2020 to improve quality of health care. One of the objectives is: To monitor and evaluate progress.

Related activities are

- Establish a monitoring system for performance indicators
- Improve the HR health information system
- Regular review of HRH plan

Rwanda is involved in the Health Matrix Network (HMN)<sup>12</sup> and signed a Memorandum of Understanding in 2007 in order to secure its role as a Wave One Country, which means that Rwanda will receive priority support from HMN. According to an Executive Secretary’s Report to the HMN Board (2007): “Rwanda appears to have a fully funded plan for health reforms that will require better information systems, including decentralization of management, integration of vertical programs, and incentives to improve performance.’

### **3.3.5 Participation of actors outside government**

As could already be concluded from the paragraphs above, development partners play a significant role in the health sector in Rwanda. Belgium is the lead donor in the health sector and one of the three suppliers of sector budget support. The Belgian Technical Cooperation (BTC) has been active in the health sector in Rwanda for several years. BTC has supported amongst others the Ministry of Health in health care management and coordination, including system strengthening and planning and capacity building (Channel Research: 2008). Since October 2008 a public health expert and a public finance management expert from BTC have supported the Belgian embassy in the follow-up of the sector budget support. The two experts will also support the other SBS donors. In their job description support to the GoR in strengthening M&E in the sector is included, but it is clear that this is/will not be the main focus of their activities.

---

<sup>11</sup> The other six are Human Resources; Drugs, Vaccines and Consumables; Geographical Access to Health Services; Financial Access to Health Services; Quality of and Demand for Health Services in the Control of Disease; National Referral Hospitals and Treatment and Research Centres

<sup>12</sup> HMN is a global partnership that facilitates better health information at country, regional and global levels.

#### 4. Assessment of the Joint Health Sector Review 2008

One of the objectives of the mission was to appraise and analyse the JHSR from an M&E perspective. This paragraph starts with the explanation of the framework of analysis, which was used to assess the JHSR. Subsequently the objectives and organisation of the JHSR 2008 are described and finally the findings are presented.

##### 4.1 Framework of analysis

So far, no standard definition, handbooks or blueprints for JSR exist. A review, defined by the OECD/DAC (2002) as an assessment of the performance of an intervention, periodically or on ad hoc basis, can be seen as an instrument between monitoring<sup>13</sup> and evaluation<sup>14</sup>. While data provided in monitoring do not give insight in causes and attribution of change (World Bank, 2004, 113), the assessment in a review is less comprehensive and in depth than an evaluation and emphasizes operational aspects (OECD/DAC, 2002). Thus, a JSR may be described as a type of joint periodic assessment of performance in a specific sector with the aim to satisfy donor and recipient's accountability and learning needs. 'Performance' is to be interpreted broadly and may include both a focus on substance at various levels (inputs, activities, output, outcome and impact) as well as on the underlying, systemic and institutional issues.

The framework of analysis, developed by Holvoet and Inberg (2008), takes into account the accountability and learning needs of a review. Besides, progress on the reform agenda of the Paris Declaration is included. The following questions are asked:

- *How and to which extent does the JSR cover accountability?*
  - substance of aggregate sector level (inputs, activities, outputs, outcomes and impact)
  - elaboration and functioning of the institutional apparatus at the aggregate sector level
- *How and to which extent does the JSR address learning?*
  - substance at the sector level (linkages among input-activities, linkages among activities-outputs, linkages among outputs-outcomes-impact)
  - operational apparatus at the overall sector level
- *How and to which extent does the JSR promote the reform agenda of the Paris Declaration?*
  - harmonisation/ coordination at sector level
  - harmonisation/ coordination with national (PRSP) review processes & PAF
  - alignment to the existing sector M&E frameworks
  - country leadership/ ownership
  - broad participation of inside and outside government actors
  - capacity building of the M&E supply and demand side
  - mutual accountability

---

<sup>13</sup> OECD/DAC (2002) defines monitoring as a continuing function that uses systematic collection of data on specified indicators to provide management and the main stakeholders of an ongoing development intervention with indicators of the extent of progress and achievement of objectives and progress in the use of allocated funds.

<sup>14</sup> OECD/ DAC (2002) defines evaluation as the systematic and objective assessment of a non-going or completed project, programme or policy, its design, implementation and results.



## 4.2 Objectives and organisation of JHSR 2008

The JHSR 2008, which was the third JSR in the health sector in Rwanda, took place in Kigali from 24<sup>th</sup> until 26<sup>th</sup> November. There were around 100 participants (participation list not (yet) available), representing different stakeholders: MoH, districts, (I)NGOs, United Nations and bilateral donors. The new minister of Health, Dr Richard Sezibera, was present during the whole JHSR. The JHSR was organized by the M&E Task Force in cooperation with the Planning, Policies and Capacity Building Unit. Because translations were available, participants could choose to speak either French or English.

The general objective of the JHSR in 2008 was to assess the health sector performance in 2008 at all levels under the leadership of the Ministry of Health, and to identify priorities for 2009 (ToR).

Specific objectives were:

1. Provide a review of progress on the implementation of recommendations from last year's sector review
2. Generate a common understanding among all stakeholders on the current situation of the health sector
3. Present progress made along the Joint Annual Work Plan (including relevant goals and indicators of MDG 4, 5 and 6; EDPRS (CPAF/Policy Matrix); HSSPI; TWG), identify bottlenecks and provide major options for strategies and future interventions (HSSPII, Joint Annual Action Plan 2009)
4. Present the financial year 01/01/2008–30/06/2009 MTEF and review progress and assess the overall performance of the health sector against budget disbursement
5. Provide an update on the SWAp process
6. Verify the fulfilment of mutual conditionalities set for the Sector Budget Support

During the 2,5 days of the JHSR 2008 PowerPoint presentations were given by different stakeholders, followed by discussion. The JHSR was officially opened by the minister of Health, after which the progress against the recommendations of the JHSR of 2007 was presented. After the introductory session, in which the HSSPII was presented, three plenary sessions followed

- session 1: review of MDGs 4,5 and 6
- session 2: resources (financial, human and infrastructure/ equipment)
- session 3: governance & coordination (SWAp, SBS, CDPF and decentralization)

In the concluding session the participants were split up in four groups in order to formulate main recommendations for each of the three sessions and for the HSSPII. These recommendations were discussed on the last morning of the JHSR. The JHSR was closed by the Minister of Health.

In contrast with what is prescribed in the MoU, no progress report, budget execution report, or report on donor performance were provided in advance or during the JHSR. Thus, the PowerPoint presentations were the only source of information for the participants. Despite guidelines which were sent to presenters in advance, including general presentation guidelines prescribing for example use of font size of at least 20 to 24 points and a maximum of five bullet points on any slide, many PowerPoint presentations were unreadable, especially the ones presenting statistical information.

### 4.3 Findings

When looking at the general objective of the JHSR 2008, one could notice that the focus of the review is not only on looking backwards by assessing the performance of the previous year, but also on looking forward by identifying priorities for 2009.

The table below presents an overview of the findings with regard to accountability needs, learning needs and the Paris reform agenda.

Table 4.1 overview of findings

<b>Accountability needs</b>	
<i>Substance</i>	<ul style="list-style-type: none"> <li>• Real accountability difficult without any input documents</li> <li>• Little attention to the quality of the new policy</li> <li>• Relatively much attention to achievements of targets of indicators at the impact and outcome level (focus on health MDGs: 4, 5 and 6). Outcomes, outputs and inputs are not systematically linked (no programme theory).</li> <li>• More attention to input (financial and human) than to content issues</li> <li>• More attention to access than to quality; coverage by mutuelles and use of community health workers (CHG). For example, no attention to the probable decrease of quality with the shift of tasks from doctor to nurses and from nurses to CHGs.</li> <li>• Only in presentation on decentralisation information is disaggregated by districts: distribution of external funds and distribution of care personnel. The need for disaggregated data is acknowledged.</li> <li>• No discussion on the recent external evaluation of HSSP I</li> </ul>
<i>Institutional/ Systemic issues</i>	<ul style="list-style-type: none"> <li>• New organization chart not presented during JHSR, thus no point of discussion.</li> <li>• Attention to the need for clarification of roles and responsibilities after decentralisation.</li> <li>• Human resources/ capacity building is an important issue, especially on district level, but focus on health professionals, no attention for the need for capacity in M&amp;E</li> <li>• It is acknowledged that M&amp;E coordination and data collection needs to be improved, but not an important subject during the JHSR.</li> </ul>
<b>Learning needs</b>	
<i>Substance</i>	<ul style="list-style-type: none"> <li>• A lot of data are presented, but analysis of the data is generally lacking.</li> <li>• There is attention for bottlenecks</li> <li>• A demand for operational research by the districts; they want to know what is happening.</li> <li>• Within the new organisation chart two positions for research will be created</li> </ul>
<i>Institutional/systemic issues</i>	<ul style="list-style-type: none"> <li>• No focus on learning regarding the institutional and systemic issues</li> </ul>
<b>Paris reform agenda</b>	
<i>Coordination and Harmonisation at sector level</i>	<ul style="list-style-type: none"> <li>• Attention for the need for harmonisation of indicators</li> </ul>
<i>Harmonisation with other national review processes</i>	<ul style="list-style-type: none"> <li>• One of the reasons to start with HSSP II one year in advance is a better harmonisation with the EDPRS</li> </ul>

<i>Alignment</i>	<ul style="list-style-type: none"> <li>• Focus on alignment of planning and reporting</li> <li>• No attention for alignment of M&amp;E</li> </ul>
<i>Leadership/ ownership</i>	<ul style="list-style-type: none"> <li>• JHSR is organised by MoH</li> <li>• Each session is (co) presided by different actors -&gt; inclusion</li> <li>• No close relationship with lead donor</li> </ul>
<i>Broad participation of actors</i>	<ul style="list-style-type: none"> <li>• A broad participation of actors, including (international) NGOs, districts, bilateral donors, UN agencies and other ministries</li> <li>• Due to absence of a participant list it is not possible to identify all different stakeholders</li> </ul>
<i>M&amp;E capacity building of demand &amp; supply side</i>	<ul style="list-style-type: none"> <li>• Besides one remark in which the link was made between the need for local use of information and strengthening of capacity to supply the data, there was no attention for this issue.</li> <li>• One of the recommendations is to elaborate an M&amp;E plan</li> </ul>
<i>Mutual accountability</i>	<ul style="list-style-type: none"> <li>• Presentation of progress in SWAp but lack of mutual accountability is questioned during the JHSR</li> <li>• No information on progress on Paris Declaration indicators</li> </ul>

The table shows that the JHSR was focussed more on accountability than on learning, with more attention to substance than to institutional/ systematic issues. However, without the possibility for participants to prepare themselves properly, due to the absence of a performance report and a financial report, one could conclude that also the accountability aspect of the JHSR was rather weak. Most remarkable was the lack of attention to the recent external evaluation of HSSP I (2008), which could have served, by absence of other reports, as a base for accountability. While the evaluation report is positive on the achievements made in the health sector, it concludes for example that the M&E system is fragmented and currently not operational. The attention for the M&E system during the JHSR was nevertheless quite minimal, also from the SBS donors, who should in principle rely on the M&E system of the health sector for their own accountability towards their constituencies.

One of the limitations mentioned in the external evaluation report is the limited time set aside for field visits (only two days), ‘thus providing limited information on the actual achievements and constraints in the districts, the Health Centres and on the performance of various programmes’ (External Evaluation Team, 2008: 2). Also the JHSR could have benefited from field visits, particularly given the fact that most of the data presented were not disaggregated.

Concerning the Paris reform agenda, one could observe that there is attention for harmonisation and alignment (except M&E system, see above), ownership of the ministry of health is strong (also demonstrated by the continuous presence of the Minister) and there is a broad participation of actors. However, there is a limited mutual accountability and interest in M&E capacity building of demand and supply side is lacking.

During the JHSR a great deal of time was devoted to the formulation of recommendations. Thus the focus was more forward looking than backward looking, while one would expect a review to devote major attention to achievements or lack of

achievements in the past as to feed into recommendations for the future. The major attention for the forward looking dimension can be demonstrated by the presentations on Tuesday and Wednesday of the key points of the previous days. These key points were almost all formulated as recommendations, for example: ‘define roles and attributions of all levels regarding Community Health Workers (CHW) to ensure sustainability’, ‘spend existing resources more efficiently’(ppt key points day one) or ‘use existing codes of conduct to guide the SWAp’ (ppt key points day two). Besides, the deadlines for the selected recommendations were set quite optimistically (almost all for the next JHSR in March 2009), which could lead to frustrations if these deadlines will not be achieved.

To sum up, the JHSR was especially focussed on the second part of the general objective, ‘to identify priorities for 2009’ and on the second specific objective: ‘to generate a common understanding among all stakeholders on the current situation of the health sector’. It was more an event than a review fulfilling accountability and learning needs.

## **5. Possibilities for cooperation in the future**

It was agreed upon with the director of the M&E Task Force that the IOB formulates some possibilities for future support. Subsequently, it is up to the M&E Task Force to decide if it will make use of the expertise of IOB. The possibilities are formulated briefly; more elaborated Terms of Reference can be formulated if the supply matches the needs of the demand side. The options are:

- To diagnose the M&E system. The screening could serve as a base for the elaboration of an M&E plan. For this purpose the methodology of Holvoet and Renard (2007) could be used, providing a more in depth analysis than is presented in this report by thoroughly screening the policy, methodology, organisation, capacity, participation of actors outside government and quality.
- To support the organisation of the next JHSR, including field missions, in order to improve the accountability and learning needs and feed into the Paris reform agenda
- To create a format for the follow-up of the sector by the sector working group
- To give an M&E training for the Technical Working Groups, in order to improve their functioning.

## **6. References**

Channel Research (2008) *Evaluation of Belgian Cooperation in Rwanda 1994-2006*

EDPRS Sector Working Group ‘Health, Population and HIV/AIDS’ (2006) *EDPRS Self Evaluation Report*

External Evaluation Team (2008) *Rwanda Health Sector Strategic Plan HSSP I 2005-2009 Evaluation Report*

Government of Rwanda (2005a) *Health Sector Policy*

Government of Rwanda (2005b) *Health Sector Strategic Plan 2005-2009*

Holvoet N., Renard. R (2006) *Monitoring and evaluation under the PRSP: Solid rock or quicksand?* In: *Evaluation and Program Planning* 30 (2007) 66-81

Ministry of Finance and Economic Planning (2000) *Rwanda Vision 2020*

Ministry of Finance and Economic Planning (2007) *Economic Development and Poverty Reduction Strategy 2008-2012*

Ministry of Finance and Economic Planning (2008) *National Planning Budgeting and MTEF Guidelines*

Ministry of Finance and Economic Planning, Development Partners (2007) *Strengthening Partnerships for Economic Development and Poverty Reduction*

Ministry of Health (2006) *Human Resources for Health Strategic Plan 2006-2010*

Ministry of Health (2007) *Memorandum of Understanding between the Ministry of Health and Health Sector Development Partners*

Ministry of Health (2008) *Health Sector Strategy Plan January 2009- Dec 2012*

OECD/DAC (2005) *Paris Declaration on Aid Effectiveness*

OECD/DAC (2008a) *Aid Effectiveness, a Progress Report on Implementing the Paris Declaration*

OECD/DAC (2008b) *2008 survey on monitoring the Paris declaration, Rwanda country chapter*

RTI International (2006) *Rwanda HMIS Assessment Report*

The World Bank (2005) *Enabling Country Capacity to Achieve Results*

The World Bank (2007) *Results-Based National Development Strategies Assessment and Challenges Ahead*