Stocktaking and Assessing M&E arrangements in Rwanda's Health Sector: Evidence from Desk and Field Study

Study in the context of the formulation of Belgian Sector Budget Support to Rwanda's Health Sector

July 2011

Nathalie Holvoet and Liesbeth Inberg
O*Platform Aid Effectiveness
Institute of Development Policy and Management
University of Antwerp

Table of content

Acknowledgments

We are grateful to the Ministry of Health in Rwanda, the Belgian Embassy and the Belgian Technical Cooperation for their support during our field mission. We would also like to thank the interviewees from various settings for their valuable input to this study. Findings, interpretations and conclusions in this report are entirely those of the authors and do not represent the views of the Ministry of Health of Rwanda, the Belgian Development Cooperation or the Belgian Technical Cooperation.

Terms/ abbreviations

Akagari	Cell, smallest politico-administrative unit of Rwanda
Akarere	District
Imihigo	Performance contracts
Intara	Province
Umerenge	Sector
Umudugudu	Administrative village

BSHG	Budget Support Harmonisation Group
BTC	Belgian Technical Cooperation
CDC	Community Development Committees
CDF	Comprehensive Development Framework
CHW	Community Health Worker
CLIS	Community Level Health Information System
CPAF	Common Performance Assessment Framework
CSO	Civil Society Organisation
DC	District Council
DDP	District Development Plan
DEC	District Executive Committee
DES	District Executive Secretary
DFID	Department for International Development
DHS	Demographic and Health Survey
DP	Development Partner
DPAF	Donor Performance Assessment Framework
DPCG	Development Partners Coordination Group
DPM	Development Partners Meeting
EC	European Commission
EDPRS	Economic Development and Poverty Reduction Strategy
EFA-FTI	Education for All- Fast Track Initiative
FOSA	Formation Sanitaire
GAVI	Global Alliance for Vaccines and Immunisation
GBS	General Budget Support
GDI	Gender Development Index
GEM	Gender Empowerment Measure
GESIS	Gestion du Système d'Information Sanitaire
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GII	Gender Inequality Index
GNI	Gross National Income
HDI	Human Development Index
HF	Health Facility
HIS	Health Information System
HMIS	Health Management Information System
HRH	Human Resources for Health
HSCG	Health Sector Coordination Group
HSSF-CSP	Rwanda Health Systems Strengthening Framework and the Consolidated Strategic Plan 2009-2012
HSSP	Health Sector Strategic Plan
ICAP	International Center for Aids care and Treatment Programs
ICT	Information and Communication Technology
IBP	International Budget Partnership
JADF	Joint Action Development Forums
JANS	Joint Assessment of National Strategies
JBSR	Joint Budget Support Review
JHSR	Joint Health Sector Review
JSAN	Joint Staff Advisory Note
JSR	Joint Sector Review
MDG	Millennium Development Goals
M&E	Monitoring and evaluation

M&E/TF	Monitoring and Evaluation Task Force
MINALOC	Ministry of Local Government,
MoU	Memorandum of Understanding
MTEF	Medium Term Expenditure Framework
MTFF	Medium Term Fiscal Framework
MSH	Management Science for Health
NDIS	The National Decentralisation Implementation Secretariat
NGO	Non Governmental Organisation
NISR	National Institute of Statistics Rwanda
NSDS	National Strategy for the Development of Statistics
NSS	National Statistical System
ODA	Official Development Assistance
PARIS 21	Partnership in Statistics for Development in the 21st century
PBF	Performance-Based Financing
PEFA	Public Expenditure and Financial Accountability
PER	Public Expenditure Review
PRSP	Poverty Reduction Strategy Paper
RALGA	Rwandese Association of Local Government Authorities
RDSF	Rwanda Decentralization Strategy Framework
SBS	Sector Budget Support
SWAp	Sector Wide Approach
SIS	Système d'Information Sanitaire
SNV	Netherlands Development Organisation
SPIU	Single Project Implementation Unit
SWAP	Sector Wide Approach
TRACnet	Treatment and Research for the AIDS Center
TWG	Technical Working Groups
UK	United Kingdom
UNDP	United Nations Development Programme
WHO	World Health Organisation

1. Introduction

In 2005 donors and recipients signed the Paris Declaration (PD) which sets out a reform agenda for both donors and recipients with the aim to scale up for more effective aid. Commitments are made around five principles, i.e. 'ownership', 'alignment', 'harmonisation', 'managing for results' and 'mutual accountability'. The evaluation of the implementation of the PD (Wood et al, 2008) highlights that improvements in the use of country systems is slow and largely limited to the area of financial management, audit and procurement. When it comes to the use of recipient monitoring and evaluation (M&E) systems, donors are generally more reluctant as they do not have enough confidence in the quality of these systems. This is not so surprising and justified by the fact that only 3 out of 54 countries included in the 2008 PD survey (i.e. Uganda, Tanzania and Mozambique) had results-oriented frameworks that were deemed adequate (OECD/DAC, 2008).

Strengthening of M&E systems has so far not been high on the agenda of donor and partner countries. However, if donors want to make progress on the 'alignment' and the 'managing for results' principles, more efforts are needed to strengthen and use recipient M&E systems. Strengthening recipient M&E systems generally improves accountability and learning which may ultimately lead to increased performance and results on the ground.

Along the same line, it has been observed that the quality of joint sector reviews (JSRs) largely depends on the quality of the underlying sector M&E system (Holvoet and Inberg, 2009). An assessment of the quality of sector M&E systems highlights to what extent JSRs can rely on performance information from the recipient M&E system and indicates which components of the system need further strengthening in order to rely upon these systems in the future. Strengthening sector M&E systems will improve the quality of the JSR in the short run and change its outlook in the long run (JSR could evolve towards a monitoring and evaluation of the existing M&E system including some reality checks on the ground instead of being a monitoring and evaluation instrument of activities and outputs).

A first step in strengthening M&E systems is the assessment/diagnosis of their quality. According to our knowledge, so far no (standard) instrument exists to assess the quality of M&E systems (such as the Public Expenditure and Financial Accountability (PEFA) instrument in the area of Public Finance Management). Therefore, in the context of the O*Platform Aid Effectiveness[1] (see annex 1 for the Terms of References), we elaborated a checklist to diagnose, monitor and evaluate the quality of sector M&E systems (see annex 2). We applied this checklist to the health sector of Rwanda and results of this assessment are provided in chapter four of this report. The assessment draw upon secondary data (e.g. official government documents, policy and academic literature on Rwanda and health information systems) and primary data (interviews with different stakeholders directly involved in and responsible for M&E in the health sector at district and central level as well as users of the M&E output). Interviews were conducted during two field mission: 23-27 May and 6-10 June 2011). Two districts were selected for interviews at district level, an urban district, Nyarugenge (city of Kigali), and a rural district, Gakenke (Northern Province). These two districts were identified by the Belgian Technical Cooperation (BTC) which is providing assistance to both of them. A debriefing was held on the 10th of June in Kigali.

The structure of the report is as follows: a general background on Rwanda is provided in chapter two, an overview of Rwanda's health sector, including information on the health sector's policy and strategy, health systems and health financing, is included in chapter three. Chapter four presents findings of the assessment while chapter five concludes and gives some recommendations for improvements of the health sector M&E system.

[1] O*platforms are policy advisory research platforms initiated by the Flemish Interuniversity Council (VLIR) and constitute a flexible collaboration arrangement between researchers and actors of development cooperation. The objective of Research Platform Aid Effectiveness is to inform, train and advise Belgian policy makers and aid managers and in this way to inspire a more effective development cooperation policy.

2. General background

Rwanda is a low-income country in central Sub-Saharan Africa with a real Gross National Income (GNI)/capita of 1,190 USD in 2010 (ppp 2008). With a Human Development Index (HDI) of 0.385[2] Rwanda is ranked among the countries with a low human development (152 out of 169 countries) (UNDP, 2010). The GNI/capita rank – HDI ranks stands at -1 which highlights that compared to countries with a similar level of GDP/capita, Rwanda is performing less well in translating its growth into human development. Table 2.1 gives an overview of the scores on the HDI's sub-indicators.

Table 2.1. Scores on the sub-indicators of the HDI

Sub-indicator	Rwanda	SSA
Life expectancy at birth (2010)	51.1	52.7
Mean years of schooling (2010)	3.3	4.5
Expected years of schooling (2010)	10.6	9.0
GNI per capita (PPP 2008 $) (2010)	1,190	2,050

Source: UNDP, 2010

In recent years Rwanda realised progress in the area of economic growth, agriculture production, Information and Communication Technology (ICT), health (infant mortality rate and maternal health) and education (enrolment and completion rates) (Government of Rwanda, 2010a).

In the 2010 Human Development Report the Gender Development Index (GDI) and the Gender Empowerment Measure (GEM) have been replaced with the Gender Inequality Index (GII). Rwanda scores relatively well in the GII with a value of 0.638 and it ranks 83/138 (UNDP, 2010). This is mainly due to a relatively low adolescent fertility rate, a high percentage of women in parliament and a high female labour force participation rate. On the other two indicators (maternal mortality rate and population with at least secondary education) Rwanda scores below Sub-Saharan average as is evident from table 2.2.

Table 2.2. Scores on the sub-indicators of the Gender inequality index

Sub-indicator		Rwanda	SSA
Maternal mortality rate (2003-2008)		1300	881
Adolescent fertility rate (1990-2008)		36.7	122.3
Seats in parliament (%) (2008)	F	50.9	17.3
Population with at least secondary education (% ages 25 and older) (2010)	F	7.4	23.9
	M	8.0	38.1
Labour force participation rate (%) (2008)	F	87.9	63.8
	M	85.9	82.3

Source: UNDP, 2010

Between 1998 and 2008 Rwanda made progress in all six categories of the governance indicators of Kaufmann, Kraay and Mastruzzi (2009). While Rwanda used to score well in the more technocratic categories ('governance effectiveness', regulatory quality' and 'control of corruption') and less in the more political categories ('voice and accountability', 'political stability' and 'rule of law') (see Holvoet and Rombouts, 2008), in 2008 it scored above regional average (Sub Saharan Africa) and income category average (low income) for all

[2] In the 2010 Human Development Report, 'adult literacy rate' has been replaced by 'years of schooling', 'gross enrolment rate' has been replaced by 'years of schooling that a child can expect to receive given current enrolment rates' and Gross Domestic Product (GDP) per capita has been replaced by Gross National Income (GNI) (UNDP, 2010: 15).

categories except for 'voice and accountability', which persistently lags behind in the 10th-25th percentile (regional and income group average are in the 25th-50th percentile[3]) (Kaufmann et al, 2009). Various mechanisms are introduced in the context of decentralisation to increase accountability towards citizens, including amongst others the Joint Action and Development Forum (see 2.2.) (Government of Rwanda and Development Partners, 2008). The progress made in the governance indicators for the period up to 2008 is consistent with the findings of the 2008 joint (Government of Rwanda and Development Partners) governance assessment.

However, while progress has been made, there remain important weaknesses in the area of voice and accountability which is also evident from the recommendations of the governance assessment report. The most essential recommendations of this assessment are:

- Institutions need to be further strengthened and rules-based governance more rigorously enforced;
- Vertical accountability between government and citizens needs to be strengthened, in particular by enabling constructive state-society engagement around participatory processes such as budgeting, planning and monitoring;
- Transparency and access to reliable information are essential to nearly all aspects of good governance" (Government of Rwanda and Development Partners, 2008).

In 2009 Rwanda's scores on the government indicators demonstrate less progress. While improvements are still made for two of the three technocratic categories ('regulatory quality' and 'control of corruption'), the score for 'voice and accountability' remains the same and the scores for the remaining three indicators (i.e. political stability and absence of violence', 'governance effectiveness' and 'rule of law') have even slightly declined (World Bank, 2010) (no comparison with the region and other low income countries are provided for 2009).

2.1. Policy cycle

2.1.1 Policy, budgeting and implementation

Vision 2020, elaborated in 2000, describes the long term vision of Rwanda's government and presents a framework for the development of Rwanda; it forms the basis for the elaboration of medium-term national and sector plans. The objective of Vision 2020 is the transformation of Rwanda into a middle-income country by the year 2020. Vision 2020 consists of six pillars: i) good governance and a capable state; ii) human resource development and knowledge based economy; iii) private sector-led economy; iv) infrastructure development; v) productive and market oriented agriculture; and vi) 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 (Republic of Rwanda, 2000).

The medium-term policy framework is described in the second Poverty Reduction Strategy Paper (PRSP) of Rwanda, i.e. the Economic Development and Poverty Reduction Strategy 2008-2012 (EDPRS). The EDPRS consists of three flagships: i) sustainable growth for jobs and export, ii) Vision 2020 Umurenge – poverty reduction in rural areas and iii) governance (Republic of Rwanda, 2007a).

Rwanda scores relatively well on indicator 1 of the Paris Declaration, "number of countries with national development strategies (including PRSs) that have clear strategic priorities linked to a medium-term expenditure framework and reflected in annual budgets" (OECD/DAC, 2005: 9). Indicator 1 (and 11 (see 2.1.2.)) is based on the Comprehensive Development Framework (CDF) report. The last update of the CDF report (World Bank, 2007) highlights that Rwanda has a 'developed' (D) operational national development strategy,

[3] The percentile rank specifies the percentage of countries that score below Rwanda. For 'control of corruption' Rwanda scores in the 50th-75th percentile, for the other four indicators in the 25th-50th percentile (World Bank, 2010).

which means that 'significant action is taken already, although further action is needed'[4]. A score D is also obtained for the three sub-components of the indicator: i) 'unified strategic framework', ii) 'prioritization' and iii) 'strategic link to the budget' (see annex 3 for the guidelines used to score progress). The report furthermore showcases Rwanda as a good practice case in the area of establishing linkages among 'strategies' and 'budgets', which is a key ingredient in the set-up of a results-oriented budgeting system. More specifically, it is stated that "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 sector Medium Term Expenditure Frameworks (MTEF) that form the basis for the Medium Term Fiscal Framework (MTFF)" (World Bank, 2007: 9). The MTEF was introduced in Rwanda in 2000 and provides a three year public expenditure framework, which is updated yearly. The activities which will be financed in the coming year are described in the Annual Action Plan (Republic of Rwanda, 2008a). According to a recent report on the official development assistance (ODA) to Rwanda (Government of Rwanda, 2010a), spending of public expenditure has been more in accordance with the priorities formulated in the EDPRS from 2008 onwards.

In line with the low scores on the 'voice and accountability' governance indicator, Rwanda scores rather low on the International Budget Partnership's (IBP) Open Budget Survey, which assesses the availability of eight key budget documents and the comprehensiveness of the data contained in these documents. The IBP gave Rwanda a score of 11 out of 100 in 2010, which is a slight improvement compared to the 2008 score (1/100), but quite low compared to the average score (42/100) for the 94 countries included in the survey (BTC, 2011). Among the IBP recommendations, the following were listed:

- Publish budget documents that are already produced on government websites;
- Improve comprehensiveness of Year-End Report and the Audit Report;
- Increase the powers of legislature and Auditor General to provide oversight of the budget;
- Provide space for civil society and public to engage in budget process.

(BTC, 2011: 8)

As a result of implementation weaknesses of the first PRSP, which were amongst others caused by limited institutional capacity and limited results-focused objectives and targets, the EDPRS formulates several actions which are expected to steer a more effective implementation of the EDPRS. Actions include the formulation of an implementation framework linking the EDPRS with other elements of the planning system, the extension and consolidation of the decentralisation process and strengthening the inter-sector coordination (Republic of Rwanda, 2007a). Moreover, the EDPRS points out that "putting in place 'user-friendly' systems of monitoring and evaluation at sector and district level will be essential to ensure the effective implementation of the EDPRS" (Republic of Rwanda, 2007a: 102).

2.1.2. Monitoring and Evaluation

The chapter on M&E of the EDPRS (chapter 7) points out the need to develop a system which is suitable for a decentralised public sector. In the meantime, the National Steering Committee, the Technical Steering Committee and Sector Working Groups are responsible for monitoring the implementation of the EDPRS (Republic of Rwanda, 2007a). At the time the EDPRS was released (2007), a new institutional M&E framework was still under discussion. To the best of our knowledge, this overarching M&E framework has not been finalised so far. There is currently an EDPRS M&E Coordination Unit (supported by UNDP)

[4] In order to score the status of the implementation of the Comprehensive Development Framework the LEADS method is 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) (World Bank, 2007).

which is finalising the M&E framework as well as different sector M&E EDPRS focal points. These focal points have been appointed in sectors with the aim to strengthen sector M&E building blocks and ensure the integration of sector and EDPRS M&E. As noted earlier by Holvoet and Rombouts (2008) there is a tendency of continuous restructuring of the M&E framework, which undermines actual implementation and try-out.

The EDPRS chapter on M&E focuses in particular on the identification of indicators. The preliminary framework of four indicator matrixes aims "to allow the construction of simple causal chains linking public expenditure in the budget to desired EDPRS output and outcomes" (Republic of Rwanda, 2007a:142). The four indicator matrixes are: i) a matrix with strategic outcome indicators (no more than 20) which will be used to evaluate the strategy at the end of the EDPRS period, ii) a matrix with intermediate indicators (no more than 30) which are more or less directly linked to the actions of the government, iii) the summary policy matrix (no more than 30) which should serve as the triggers for the release of budget support funds and iv) the second generation matrix for which adequate data are not yet available (Republic of Rwanda, 2007a). 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 should be elaborated and discussed during annual Joint Sector Reviews (JSRs).

The 2008 Joint Staff Advisory Note (JSAN) assesses the monitoring framework of the EDPRS as follows: "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), staff of the International Monetary Fund and the World Bank recommend that the monitoring framework should also present indicators by regions to monitor the effectiveness of interventions" (IDA and IMF, 2008: 8).

The overall score for the establishment of a result-oriented M&E framework for Rwanda in the last update of the CDF report (World Bank, 2007) is A ('Action taken'). It points at the fact that progress is being made, and whereas this is not yet enough, the basis exists for more substantive progress. The CDF indicator on results-orientation is composed of three sub-components, i.e. i) 'stakeholder access to information', ii) 'quality of information' and iii) 'coordinated country-level M&E'. The first sub-component has obtained a 'D' score, meaning that significant actions have already been taken, but further action is still needed. The other two sub-components have obtained a score 'A' (see annex4 for the guidelines used to score progress). Generally, there is a slight improvement compared to the 2005 CDF progress report when all three criteria were rated 'A'.

National Statistical System

An important component of an M&E system is the National Statistical System (NSS), which is a combination of institutions that provide statistical information and services. The Rwandan NSS consists of five main components:

- The National Institute of Statistics of Rwanda (NISR)
- Various state institutions that provide statistical data (data producers)
- Entities that provide statistical data (e.g. public and private institutions, nongovernmental organisations (NGOs), households and individuals)
- Institutions that use statistical data (data users)
- Research and training institutions that provide education/ training on statistics (National Institute of Statistics of Rwanda, 2009)

The NISR, established in 2005, is the overall coordinating agency of the NSS. It is responsible for i) the provision of official statistics to the government, the business community and the public, ii) defining and ensuring the respect of standards and methodologies applied by the NSS, iii) conducting national censuses and surveys and iv) coordinating and gathering statistical information and methodologies of sector departments in charge of statistical activities in the country (National Institute of Statistics of Rwanda, 2007).

In the context of the Partnership in Statistics for Development in the 21st century, i.e. PARIS 21[5], Rwanda elaborated a National Strategy for the Development of Statistics (NSDS) for the period 2009-2014. The NSDS should ensure harmony, consistency and accountability in the NSS and has the aim to "provide relevant, reliable, coherent, timely and accessible statistical information and services to various sectors of society in a coordinated and sustainable manner" (National Institute of Statistics of Rwanda, 2009: 22).

In 2007 a basket fund, with financial contributions of the United Nations Development Programme (UNDP), United Kingdoms (UK) Department for International Development (DFID), European Commission (EC) and the World Bank, was established to support the NISR programme. This has supported the organisation of some major surveys as well as capacity development at the NISR and other institutions of the NSS (National Institute of Statistics of Rwanda, 2009).

2.2. Decentralisation

With the adoption of a National Decentralisation Policy in May 2000 the Rwandan government initiated a decentralisation process with the aim to promote good governance, to reduce poverty and to have an efficient, effective and accountable delivery of services (Republic of Rwanda, 2007b)[6]. The decentralisation process entered its second phase in 2005 when the number of provinces (Intara) was reduced from 15 to 4 and the number of districts (Akarere) from 106 to 30 (Government of Rwanda, 2009). Lower levels in the new structure are sectors (Umurenge, 416), cells (Akagari, 2.148) and administrative villages (Imidugudu) (Coopération Belge au Développement, 2010). Table 2.3 provides an overview of the roles and responsibilities of the different administrative units.

Table 2.3. Roles and responsibilities of the administrative units

Administrative unit	Roles and responsibilities
Central government	Formulation of policies and the regulatory framework and support to local governments in strengthening their capacities, financing and M&E.
Provinces	Coordination, supervision and M&E of the application of Districts' development plans.
Districts	Supply of public services, planning of local development, execution of government development programs and coordination of actions of local partners.
Sectors	Supply of services to the population and organisation of community participation.
Cells	Evaluation of the population's needs and their priorisation and mobilisation of community actions.

[5] 'PARIS21's goal is to develop a culture of evidence-based policy making and implementation which serves to improve governance and government effectiveness in reducing poverty and achieving the Millennium Development Goals. PARIS21 pursues this goal by encouraging and assisting low-income countries to design, implement, and monitor a National Strategy for the Development of Statistics. An NSDS is expected to provide a country with a strategy for strengthening statistical capacity across the entire national statistical system (www.paris21.org)

[6] Specific objectives of the Decentralization Policy are: (i) To enable and encourage local people to participate in initiating, devising, implementing and monitoring decisions and plans that consider their local needs, priorities, capacities and resources by transferring power, authority and resources from central to local government and lower levels. (ii) To strengthen accountability and transparency in Rwanda by making local leaders directly accountable to the communities they serve and by establishing a clear linkage between the taxes people pay and the services financed through these taxes. (iii) To enhance the sensitivity and responsiveness of public administration to the local environment by placing the planning, financing, management and control of service provision at the point where services are provided and by enabling local leadership to develop organization structures and capacities that take into consideration the local environment and needs. (iv) To develop sustainable economic planning and management capacity at local levels that will serve as the driving motor for planning, mobilization and implementation of social, political and economic development to alleviate poverty. (v) To enhance effectiveness and efficiency in the planning, monitoring and delivery of services by reducing the burden from central government officials who are distanced from the point where needs are felt and services delivered (Republic of Rwanda, 2007b: 7).

Villages	Construction of cooperation and solidarity between the community members.

Source: Coopération Belge au Développement, 2010

The district is the basic administrative political-administrative unit. The district's management structure consists of the District Council (DC), responsible for policy and legalisation, the District Executive Committee (DEC), responsible for day-to-day contact between the population and the DC, and the District Executive Secretary (DES), who is the head of administration. Seven management and technical units fall under the direct responsibility of the DES: Planning and Project Coordination; Area Development; Economic Development; Health and Family Promotion; Education, Youth, Sport and Culture; Administration, Good Governance and Social Affairs; and Taxation and Resource Mobilization **(**http://www.minaloc.gov.rw/spip.php?article16***)***.

The decentralisation process has led to a transfer of staff and funds from central to decentralised levels. However, studies have highlighted that fiscal decentralisation is not yet realised and pointed at the fact that local authorities have little discretion in terms of spending. When it comes to upward accountability from the local to the central government level, each district has signed, since 2006,a performance contract (imihigo) with the central government which acts as a kind of yearly action plan (Holvoet and Rombouts, 2008). The indicators included in the Imihigo are the same for all districts; only the targets differ and are dependent on the baselines. Every July the results of the districts are broadcasted on radio and television and published in newspapers (interviews).

In order to facilitate a better implementation of the Decentralisation Policy, the Rwanda Decentralisation Strategy Framework (RDSF) was adopted in 2007 (Republic of Rwanda, 2007b). The five interdependent strategic areas elaborated in the framework with the corresponding expected outcomes are presented in the table below.

Table 2.4. Strategic Areas of the RDSF with expected outcomes

Strategic Area	**Expected outcomes**
Effective management and implementation of Decentralization Policy	Decentralization process is efficiently managed and fully embedded in development programs and plans
Citizen participation, transparency and accountability	Citizens effectively participate in local governance; local government's resources are managed in a transparent and accountable manner
Efficiency and effectiveness of Local Governments in local economic development, poverty reduction and service delivery	Local Governments efficiently sustain socio-economic development and deliver accessible and affordable quality services that respond to people's needs
Fiscal and financial decentralization	Local governments fiscally and financially empowered to fulfil their roles and responsibilities
Monitoring, evaluation and management information system	A robust M&E system and Management Information System established for effective evaluation of decentralisation implementation and informed decision making

Source: Republic of Rwanda, 2007b

In the context of the decentralisation process, Community Development Committees (CDC) at district, sector and cell level and Joint Action Development Forums (JADF) at district and sector level have been established. The CDCs are responsible for the technical coordination of community development from grassroots to district level and the JADFs are responsible for the coordination of representatives from project units, donors, religious organisations, private sector, civil society and district CDCs (Republic of Rwanda, 2008b). Activities of the CDCs and JADFs at district level are provided in the table below.

Table 2.5. Activities of CDCs and JADFs at sector level

	CDCs	JADF
Activities	- Design of District Development Plans; - Control and supervision of development activities and projects in the district; - Supervision of the administration and management of development funds in the district; - Development and preparation of the district's development budget; - Organisation of training sessions for the population in development activities.	- Participation in the community based planning process; - Coordination of the district action plans and determination of implementation strategies; - Monitoring of the implementation of the Poverty Reduction Programmes; - Resolving of possible conflicts between projects; - Facilitating of exchange of opinions on development questions concerning the province, the City of Kigali, or districts and sectors; - Promotion of transparency and accountability; - Discussion on basic actions and priorities in the promotion of poverty eradication programmes; - Harmonisation of community development interventions; - Promotion of the culture of participation.

Source: Republic of Rwanda, 2008b

The National Decentralisation Implementation Secretariat (NDIS), a semi-autonomous institution under the Ministry of Local Government (MINALOC), started a programme to strengthen the JADFs. This programme is funded by the Rwandese Association of Local Government Authorities (RALGA) and the Netherlands Development Organisation (SNV).
NDIS expects that the JADFs will contribute to a better performance on the 'voice and accountability' governance indicator (NDIS, sd). The SNV documented experiences with the implementation of the JADFs (SNV, 2009) and observed that JADFs are operational in all districts and in some sectors. SNV concludes that the JADFs were helpful in the distribution of activities, avoidance of duplications and making development interventions more effective and efficient. However, SNV refers as well to the fact that "a lot has to be done before the JADF will be a true forum for accountability where the citizens as users of public services can voice their needs and enter into constructive dialogue with open and responsive leaders" (SNV, 2009: 39).

A third decentralisation phase, which should make the decentralisation process effective at sector level, should start in 2011(Coopération Belge au Développement, 2010). Details of the third phase are not yet known (interviews).

In what follows we provide general information on the selected districts, Nyarugenge and Gakenke.

Nyarugenge and Gakenke

Nyarugenge is one of the three districts of Kigali City, Gakenke is one of the five districts in the Northern Province. The numbers of sectors, cells, villages and inhabitants in both districts are presented in table 2.6.

Table 2.6. Number of sectors, cells and villages in Nyarugenge and Gakenke

District	Nyarugenge	Gakenke
Number of sectors	10	19
Number of cells	47	97
Number of villages	355	617
Number of inhabitants	266,734 (est. 2006)	316,025

Sources: République du Rwanda, 2007a and 2007b

Agriculture is the most important economic activity in Gakenke. The majority of the households are dependent on small farmlands between 0.2 and 0.5 hectares and important crops are coffee, pineapple and passion fruit (République du Rwanda, 2007b). In Nyarugenge the agricultural sector is hardly developed, except for the more rural zones. In the urban zone of Nyarugenge only individual small agricultural activities such as the cultivation of vegetables exist. The most important economic activity in Nyarugenge is formal and informal business (République du Rwanda, 2007a).

Both districts have formulated a District Development Plan (DDP) for the period 2008-2012, which were elaborated on the basis of information collected at village, cell and sector levels. Gakenke formulated one development objective in its DDP: increase income and improve the population's standard of living by promoting socio-economic and cultural activities while preserving the environment in a sustainable way (République du Rwanda, 2007b). The development objectives of Nyarugenge are:

1. Strengthen good governance at all levels;
2. Strengthen capacities of human resources for a better service to the public;
3. Reduce unemployment with non-agricultural employment and with professional training adapted to the labour market;
4. Promote a decent habitat in the strict compliance with land management and master plan of the city by making allotment (des parcelles lotis) possible and by implementing the habitat group "imidugudu" in rural and semi-urban zones;
5. Improve the business environment in order to attract new investors and to allow the best development of the private sector;
6. Establish modern infrastructure and ICT to make Nyarugenge a mirror for the cities in the sub region;
7. Control population growth while improving population health and well-being of families;
8. Assure free education to students from primary to secondary education;
9. Develop agriculture and livestock adapted to urban development and respecting the environmental protection (République du Rwanda, 2007a: 23).

In Nyarugenge and Gakenke JADFs are operational. In Nyarugenge a JADF coordinator was appointed by the NDIS in June 2010. Every three months an Assemblée Générale is organised for all actors in the district. Input for the Assemblée Générale comes from meetings of sector commissions, during which the functioning of different actors is discussed (in case of malfunctioning, advice is given for better performance). The way the JADF in Nyarugenge is presently functioning reflects one of the weaknesses formulated by SNV in their documentation of JADF experiences and which more particularly points at the fact that the i.e. "JADF is seen as a means of controlling the development partners. Accountability of CSOs (Civil Society Organisations) and NGOs towards the local government is overshadowing the accountability of the local government towards the citizens" (SNV, 2009: 25). As regards Gakenke, according to the 2008 District Health System Strengthening (DHSS) Framework Implementation Plan the JADF has been successful in bringing partners together at the discussion table and in mapping and distributing the work of NGOs in the district (Government of Rwanda, 2008). The recently appointed president of the Forum, however, acknowledges that a database of all activities in the district still needs to be consolidated. Moreover, according to him the JADF is still not functioning (his aim as new president is to make the JADF alive).

2.3. Development aid

Rwanda is highly aid dependent. In 2008 the ODA to Rwanda totalled USD 931 million, which is an increase of 60.2% compared to 2006 (581 USD) and which constitutes 21.1% of the GNI (www.oecd.org/dac/stats). The social sectors, and in particular the health sector, are mainly responsible for the increase in ODA. In 2008 60% of ODA was provided to the social sectors (Government of Rwanda, 2010a).

Budget support is provided by the African Development Bank, the EC, Sweden, the UK, the World Bank, Belgium, Education for All- Fast Track Initiative (EFA-FTI), Germany and the

Netherlands (Ministry of Finance and Economic Planning and Development Partners, 2007). In 2009/2010, 41% of ODA was disbursed through budget support. Both the amount of General Budget Support (GBS) and the amount of Sector Budget Support (SBS) have been increasing since 2007. The amount of SBS has even quadrupled (16.5 million in 2007, 124.4 million in 2009/10) (Government of Rwanda, 2010a: 16). To monitor progress in the context of GBS, a Common Performance Assessment Framework (CPAF) was developed, selected from the EDPRS Results and Policy Matrix (Republic of Rwanda and Development Partners, 2008). Progress is discussed during bi -annual Joint Budget Support Reviews (JBSRs). During JBSRs budget priorities, execution progress and results from reviews at sector level (the JSRs) are discussed (Government of Rwanda, 2010b).

In order to enhance the coordination, harmonisation and alignment of aid in Rwanda, the Government of Rwanda and the Development Partners (DPs) have elaborated a Rwanda Aid Effectiveness Report from 2005 onwards. It documents key achievements in all joint activities of the past year and highlights forthcoming developments. In 2006, Rwanda's Aid Policy was formulated which stimulated aid harmonisation and alignment (Ministry of Finance and Economic Planning and Development Partners, 2007). Between 2005 and 2007 donors made moderate progress in Rwanda on most of the PD alignment and harmonisation indicators, as is obvious from table 2.7.

Table 2.7. Scores on alignment and harmonisation indicators in PD monitoring surveys

	Indicators	**2005**	**2007**	**2010 Target**
Alignment				
3	Aid flows are aligned on national priorities	49%	51%	85%
4	Strengthen capacity by co-ordinated support	58%	84%	50%
5a	Use of country PFM systems	39%	42%	59%
5b	Use of country procurement systems	46%	43%	64%
6	Strengthen capacity by avoiding Parallel Programme Implementation Units	48	41	16
7	Aid is more predictable	66%	67%	83%
8	Aid is untied	82%	95%	More than 82%
Harmonisation				
9	Use of common arrangements or procedures	42%	38%	66%
10a	Joint missions	9%	21%	40%
10b	Joint country analytic work	36%	42%	66%

Source: OECD/DAC, 2008

The more generally noted observation that there does not necessarily exist a correlation between the strength of a partner country's systems and their use by donors (see 2006 Baseline Survey), also applies to Rwanda. Donors limitedly use the public financial management and procurement systems, despite Rwanda's efforts to strengthen these systems (OECD/DAC, 2008). While capacity constraints are often cited as a reason for not aligning with Rwanda's systems, in practice regulations from donor's headquarters and domestic legislative constraints seem to be a more important reason for not aligning with Rwanda's systems (Hayman, 2009). Another challenge related to the alignment principle is the low reporting of aid in the budget. Priority actions formulated in Rwanda country chapter of the 2008 PD survey are in line with these observations and refer to the need for increasing donor use of public financial management systems and the improvement of data on aid commitments and disbursements (OECD/DAC, 2008). While the decline in indicator 9 is probably caused by the use of a stricter definition of programme based approaches in the 2008 survey, a challenge with regard to the harmonisation principle is the continuous reliance on stand-alone project aid in most sectors. In order to remedy this, the 2008 PD progress report strongly advises the use of sector-wide approaches (OECD/DAC, 2008).

While mutual accountability mechanisms did not yet exist in Rwanda at the moment of the 2006 and 2008 PD surveys (which explains the scoring 'no' on PD indicator 12[7]), from 2008 onwards the performance of Rwanda's development partners is monitored through a Donor Performance Assessment Framework (DPAF). The indicators in the DPAF are derived from international and national agreements on the quality of development assistance to Rwanda. Progress on the DPAF indicators is monitored by the Development Partners Coordination Group (DPCG) (Government of Rwanda, 2010a)[8], which is the highest-level aid coordination body in Rwanda (Government of Rwanda, 2010b). Other coordination mechanisms include the Development Partners Meeting (DPM)[9], the Development Partners Retreat[10], the Budget Support Harmonisation Group (BSHG)[11] and Sector Working Groups[12] (Government of Rwanda, 2010b).

Initiatives of the Government of Rwanda which are in line with the PD principles include the elaboration of an Aid Policy Manual of Procedures (aiming at improving the effectiveness and efficiency of aid), the Division of Labour (aiming at enhancing the quality of development cooperation by rationalising and redistributing aid) and the establishment of a Single Project Implementation Unit (SPIU) (replacing parallel project/programme Implementation Units and thus contributing to harmonisation) (Government of Rwanda, 2010a).

[7] PD indicator 12: "Number of partner countries that undertake mutual assessments of progress in implementing agreed commitments on aid effectiveness including those in this Declaration" (OECD/DAC, 2005).

[8] The DPCG is the highest-level coordination body in-country and responsible for overseeing the entire aid coordination system. All development partners (bilateral and multilateral donors) are invited to attend quarterly meetings chaired by the Rwandan Ministry of Finance to discuss high level progress and successes, obstacles to better performance, improving donor coordination, and improving coordination with the GoR and relevant line ministries (24/25).

[9] The Development Partners Meeting (DPM) is an annual high-level strategic forum for dialogue between the GoR and its Development Partners (bilateral and multilateral donors, international and local NGOs, private sector). The DPM is focused upon a central theme to frame the discussion. The main objectives of the DPM are to provide a space for: (i) Policy dialogue - between the GoR and its Development Partners. The Government openly engages in dialogue with donors on major policy issues and the strategic orientation of their partnerships. (ii) The Government - to showcase its major achievements and constraints in implementing its development programs; and to present its policies and strategic priorities for national development. (iii) Open discussion with regard to the management of external aid, including the extent to which that aid is moving toward the Paris Declaration Principles (24/25).

[10] The Development Partners Retreat (DPR) is an annual senior-level, two-day retreat aimed at bringing together stakeholders in Rwanda's development to review and discuss different mechanisms to make aid more effective in Rwanda. The DPR is attended by senior-level representatives of the Government of Rwanda, multilateral and bilateral donors, local and international NGOs and the local and international private sector (24/25).

[11] The Budget Support Harmonization Group (BSHG) is a technical working group of the DPCG formed in 2003 under the GoR's Partnership Framework for Harmonization and Alignment of Budget Support, open exclusively to donors that provide budget support or who are considering budget support. The Partnership Framework outlines commitments in three overarching areas: macroeconomic stability and the establishment of an economic environment conducive to growth and employment generation, comprehensive and effective public financial management, and strong policy formulation informed by M&E (24/25).

[12] Sector Working Groups are technical teams for GoR line ministries and their respective donors to coordinate and discuss programs and projects within a given sector. Their purpose is to discuss how to coordinate resources provided by donors to a single sector, in order to create the high-level impact without redundancies and to identify strategic priorities. The current Sector Working Groups are:
1. Financial Sector Development and Employment; 2. Private Sector Development; 3. Infrastructure 4. Agriculture and Animal Husbandry; 5. Environment and Land Use Management; 6. Education, Science and Technology, R&D; 7. Health, Population and HIV/AIDS; 8. Water and Sanitation; 9. Social Protection; 10. Justice; 11. Decentralization, Citizen Participation, Empowerment, Transparency and Accountability; 12. Security; 13. Cross-Cutting Issues Working Group
In some instances, Sector Working Groups are divided into sub-sectors and even sub-sub-sectors, to create more manageable units for technical and strategic discussion (24/25).

3. Rwanda's Health Sector

An external evaluation of the Health Sector Strategic Plan I (HSSP) 2005-2009 highlights impressive improvements between 2005 and 2007 in a core set of health impact indicators: the infant mortality rate (/1000 live births), for instance, declined from 86 to 62 (target 61), the under five mortality rate (/1000 live births) declined from 152 to 103 (target 110) and the total fertility rate (%) declined from 6.1% to 5.5% (External Evaluation Team, 2008). Additionally, compared to the regional average for Africa, Rwanda scores better for most of the health-related Millennium Development Goals (MDGs) indicators. Table 3.1. shows that there are also a number exceptions, i.e. the maternal mortality rate, unmet need for family planning and tuberculosis mortality rate among HIV-negative people. As the government of Rwanda makes efforts to reduce the maternal mortality rate (e.g. maternal output indicators are selected for the performance-based financing system, see 3.3.), it is expected that new data will demonstrate a reduction of maternal mortality. The most recent Joint Health Sector Review (JHSR) (October 2010) already reports significant progress in this indicator (from 750/100,000 in 2005[13] to 383/100,000 in 2008) (BTC, 2010).

Table 3.1. Performance of Rwanda and average of Africa on the health-related MDG indicators (for which a regional average is available)

Indicators (a)	Rwanda	Africa average
Under-five mortality rate (per 1000 live births), 2008	112	142
Measles immunization coverage among 1-year-olds (%), 2008	92	73
Maternal mortality (per 100,000 live births), 2005	1300	900
Births attended by skilled health personnel (%)	52	47
Contraceptive prevalence (%)	36.4	23.7
Adolescent fertility rate (per 1000 girls aged 15-19 years)	40	118
Antenatal care coverage (%): at least 1 visit	96	73
Unmet need for family planning (%)	37.9	24.3
Prevalence of HIV among adults aged 15-49 years (%), 2007	2.8	4.9
Males aged 15-24 years with comprehensive correct knowledge of HIV/AIDS (%)	54	30
Females aged 15-24 years with comprehensive correct knowledge of HIV/AIDS (%)	51	23
Antiretroviral therapy coverage among people with advanced HIV infection (%) 2007 (b)	71	44
Malaria mortality rate (per 100,000 population), 2006	59	104
Children aged <5 years sleeping under insecticide-treated nets (%)	24	17
Tuberculosis mortality rate among HIV-negative people (per 100,000 population), 2008	71	51
Population using improved drinking-water sources (%), 2008	65	61
Population using improved sanitation (%), 2008	54	34

Source: World Health Organisation, 2010

(a) For the indicators for which no specific year is given, the World Health Organisation's report mention 'the latest available data since 2000'

(b) The regional average is based on 2008 updated data

Rwanda has five types of public health facilities (HF/ FOSA: Formation Sanitaire): referral hospitals, district hospitals, health centres, health posts and dispensaries. The total number of

[13] The DHS 2005 refers to a maternal mortality rate of 750/100,000, which is significantly lower than the maternal mortality rate of the WHO (1300/100,000 in 2005), see table 3.1 and of the UNDP (1300/100,000 in 2003-2008), see table 2.2.

health facilities is 497, of which the majority (83%) are health centres. The table below shows the minimum of package of services provided by each type of health facility.

Table 3.2. Minimum of package of services provided for each health facility

Health facility	Minimum package of services provided
Reference hospital	Inpatient/outpatient services, surgery, laboratory, gynaecology, obstetrics, radiology
District hospital	Inpatient/outpatient services, surgery, laboratory, gynaecology, obstetrics, radiology
Health centre	Prevention activities, primary health care, inpatient, referral, maternity
Dispensary	Primary health care, outpatient, referral
Health post	Outreach activities: immunisation, family planning, growth monitoring, antenatal care

Source: Republic of Rwanda, 2009a

67% of the non-private health facilities are managed by the public sector, 32% by faith-based organisations and 1% by communities (Republic of Rwanda, 2009a).

With regard to decentralisation in the health sector, it is observed that although the process is evolving, the role and division of tasks between the district's health unit and its steering committee and the district administration are not yet clearly defined (see annex 5 for an overview of the roles and responsibilities of local administration in the health sector after the reforms). Other weaknesses are the low level of understanding of leadership and management principles at district level as well as insufficient harmonisation of DDPs and its annual operational plans with the strategic health plan and financial means (Cooperation Belge au Développement, 2010).

Both DDPs of Nyarugenge and Gakenke include a section with information on the health sector. An overview of the number of different health facilities in the districts is provided in table 3.3.

Table 3.3. Number of different public health facilities

Health facility	Nyarugenge	Gakenke
Referral hospital	1	0
District hospital	1	2
Health centers	8	18
Dispensary	2	1
Health posts	1	5

Sources: République du Rwanda, 2007a and 2007b

Besides public health facilities, Nyarugenge also has 62 private health facilities. An insufficient coordination of the activities of these private health facilities and a weak integration of their data in the health information system (HIS) are highlighted as weaknesses in the DDP (République du Rwanda, 2007a). Both districts also identified a lack of staff as an important problem (Republique du Rwanda, 2007a and 2007b). Specific problems for Gakenke include geographic inaccessibility to health services, insufficient equipments as compared to the norms and poor quality of the health services provided (République du Rwanda, 2007b).

The main causes of morbidity, hospitalisation and mortality in Nyarugenge are malaria, infection diseases and AIDS (République du Rwanda, 2007a). In Gakenke the main causes of morbidity are malaria and infections of superior respiratory tract. In health centres the principle causes of mortality are infections of inferior respiratory tract, malaria and AIDS (presumed or confirmed), in district hospitals these are undefined illnesses, malaria and pneumonia (République du Rwanda, 2007b).

3.1. Health Policy and Strategy

The 2005 Health Sector Policy is based on Vision 2020, the first PRSP and the decentralisation policy. The Health Policy has seven policy objectives (Government of Rwanda, 2005a):

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

The format of the HSSP II (July 2009-July 2012) is based on the sector strategic plan outline, as 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 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 general objective of HSSP II is "to operationalise the EDPRS in the health sector to help attain national priorities and international targets, including the MDGs, which Rwanda is committed to achieving" (Government of Rwanda, 2009: 9). Three strategic objectives are formulated in HSSP II:

- To improve accessibility to, quality of and demand for maternal and child health, family planning, reproductive health and nutrition services and to improve the availability of human resources;
- To consolidate, expand and improve services for the prevention of diseases and promotion of health;
- To consolidate, expand and improve services for the treatment and control of diseases.

These three objectives are supported by seven strategic programmes, which all relate to health system strengthening: i) institutional capacity; ii) human resources for health; iii) health sector financing; iv) geographical accessibility; v) drugs, vaccines and consumables; vi) quality assurance; and vii) specialised services, national referral hospitals and research capacity. The HSSP II will be implemented through national joint annual work plans which are developed annually by the Ministry of Health and all partners.

The DDPs of Nyarugenge and Gakenke include strategic/global objectives, strategies/specific objectives and projects for the health sector, see annex 6 for an overview. Project fiches in the annex of both DDPs provide more information on each project including e.g. justification, specific objectives and budget.

3.2. Health systems

In recent years several initiatives have been elaborated to strengthen health systems. However, these initiatives have not always been consistent, which resulted in gaps and overlaps. An evaluation of health system strengthening by the Global Alliance for Vaccines and Immunisation (GAVI) in Rwanda, for example, concluded that GAVI is hardly harmonised with SWAp arrangements (Martinez and Karasi, 2009). Therefore, in 2010 the government of Rwanda decided to create one consolidated document which contains all health system strengthening initiatives (Ministry of Health, 2010a). Together with a team of technical assistants (USAID through Management Science for Health, MSH), the Ministry of Health produced the Rwanda Health Systems Strengthening Framework and the Consolidated Strategic Plan 2009-2012 (HSSF-CSP) (Meloni and Sijtzema, 2010a).

The HSSF-CSP is conform the World Health Organisation (WHO) framework for health systems strengthening[14] and formulates four long term goals for Rwanda's health system: i) improving the health status of the Rwandan people in an equitable way, ii) assuring social and financial risk protection so that no Rwandan becomes impoverished as a result of illness, iii) improving efficiency in the delivery of services in order to achieve the maximum results with the fewest resources, and iv) assuring that the health system is responsive to the needs of the Rwandan population (Ministry of Health, 2010: 3).

Health information system

Rwanda's health information system (HIS) includes several data sources, including:

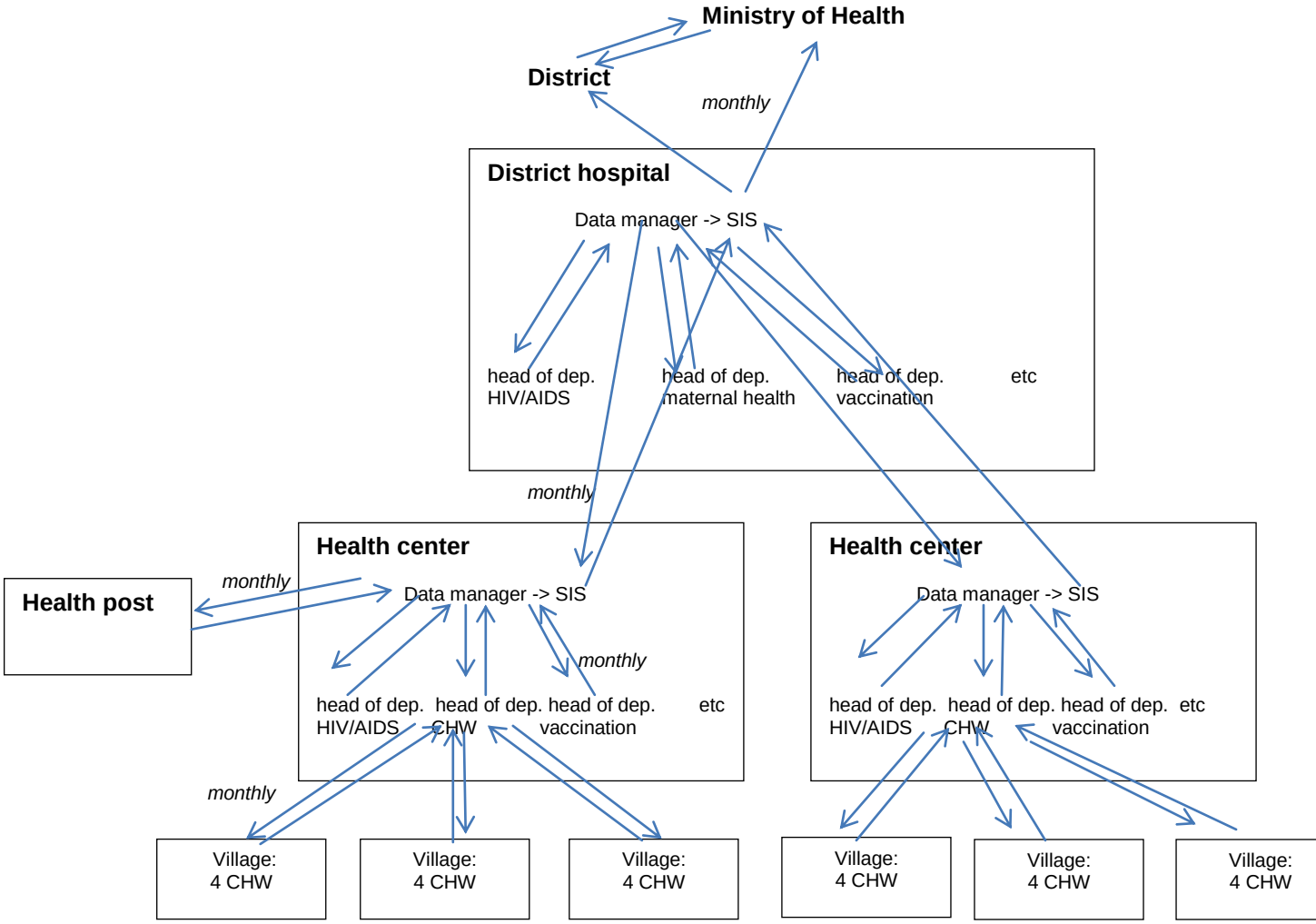
- Census;
- Surveys (e.g. Demographic and Health Survey (DHS), Malaria Indicator Survey and Public Expenditure Review);
- Routine Information Systems (e.g. SIS (Système d'Information Sanitaire = HMIS), community level health information system (CLIS), Tracnet and Performance-based Financing (PBF);
- Routine Administrative Systems (e.g. Human Resources Information System)

(M&E Task Force, 2009)

The SIS is an important source of information in the health sector and has been set up and managed by the government of Rwanda to collect and provide national information on health (RTI International, 2006). From 1997 onwards, SIS data gathering, data entry and queries are supported by a database application, the GESIS (Gestion du Systeme d'Information Sanitaire) which will be replaced in 2012 by a new database application.

The diagram below demonstrates how the data which is collected at the levels of community health workers, health posts, health centres and district hospitals are aggregated and reported to higher levels.

[14] The WHO framework for health systems strengthening contains six building blocks crucial for a well functioning health system: i) human resources for health; ii) medicines, vaccines and technology; iii) health care financing; iv) leadership, management and governance; v) health information; and vi) health service delivery.



Source: interviews

At the lowest level, in the villages, four community health workers (CHWs) (one for maternal health, one for social affairs (elected) and two for general health) keep information on their activities in a register. At the beginning of the month a compilation of the data of the four community health workers is sent to the staff member responsible for the community health workers at the health centre level. This staff member compiles the information of all the CHWs who fall under the responsibility of the health centre. The objective of data collection at community level is to be sure that no household is excluded from the health system (Republic of Rwanda, 2009b). Recently, key components of the CLIS were harmonised and include now standard recording and reporting formats for the CHWs (and other community health volunteers like e.g. traditional birth attendants, Red Cross volunteers and traditional healers) (Republic of Rwanda, 2009b). Every month the staff member responsible for CHW, the data manager and the head of the health centres meet with all the CHWs in order to discuss progress, re-stock their medical supplies and to receive feedback. While the 2006 HMIS assessment highlights that there is limited feedback, it seems that this feedback has become stronger nowadays, at least in the districts we have visited. As some CHWs have to cover many households (up to 170) the reporting burden for them is still quite unrealistic, despite the fact that data transmission has been facilitated by the introduction of the use of cell phones (Republic of Rwanda, 2009b).

The data manager of the health centres selects from the CHW reports the information which is needed for the SIS and combines this information with data collected at all departments (the head of departments send this information on the basis of the registers they keep). Each month the data manager sends the information to the data manager of the hospital, and from January 2011 onwards, directly through GESIS. At district hospital level the data manager compiles the data from the health centres with the data collected from each department in the

hospital (send to the data manager by the heads of departments). Each month feedback is provided to the health centres (data managers and heads). During these meetings the reports of the health centres are discussed and analysed. At the end of each meeting a report is written which includes recommendations for the upcoming months. Progress on these recommendations is discussed in the next meeting. Health centres are obliged to be present and to be on time (punishment of 5,000 rwf for late arrival) at the meetings (interviews). Besides these monthly meetings there is also a meeting with all the heads of the health centres, the director and the M&E coordinator of the hospital and the director of the health unit of the district every three months. During these quarterly meetings issues like coordination and the organisation and performance of the health centres are discussed.

The district hospital transfers the data directly to the Ministry of Health. A copy is sent to the health unit of the district. Analyses made at hospital level are not automatically shared with the Ministry of Health. According to M&E staff of the district hospitals in Nyarugenge and Gakenke they only receive limited feedback from the Ministry of Health on the data they transfer upwards (interviews).

While the reporting rate through GESIS by the health facilities is high (93%), data of public and private facilities are not yet integrated and national referral hospitals do not report their data through the HMIS (Republic of Rwanda, 2009b). Moreover, collaboration of M&E units of vertical programs with the SIS is still an issue (Diallo, 2007). Recently the district of Nyarugenge, within the framework of a program financed by the BTC[15], has taken action to include the activities of private health facilities in the SIS.

3.3. Health financing

The HSSP II is financed by external resources (62%), government resources (29%) and facility based revenues (9%). The total costs of the implementation of HSSP II are estimated to be 1,445.2 million USD (29.9% for objective 1, 17.8% for objective 2 and 52.3% for objective 3). However, it is unlikely that there are sufficient financial resources to cover these costs[16] (Government of Rwanda, 2009).

Over 40% of the domestic health budget is transferred to the districts. Transfers from central government include a block grant, which is especially used to pay salaries of district staff, earmarked sector grants (four health programmes: human resource development; financial accessibility to health services; geographical accessibility to health services; quality and demand for services in the control of diseases) and other transfers e.g. resources from the Common Development Fund. Other resources of districts are own revenues (taxes and administrative fees) and direct donor funding (Baeten, 2011).

At district level, district hospitals and health centers benefit most from the earmarked sector grants and direct transfers. While districts are the budget agencies for the earmarked sector grants, in practice they only transfer the money to the hospitals and health centres and have no power to defend the district's needs directly to the Ministry of Finance. The district's needs have to be communicated to and through the Ministry of Health, which discusses these needs with the districts, including with the hospitals and health centres. The earmarked sector grants, however, are allocated to the district through a predefined formula which is unknown by the district and health facilities, making it impossible for districts to really respond to their specific needs (Baeten, 2011).

From 2008 onwards, Rwanda has made health insurance (mutuelles) obligatory for the entire population (Rusa et al, 2009)

[15] The Institutional Support Program to the conception and implementation of a strategic health development plan for the city of Kigali. This programme works with the three districts of Kigali city.
[16] HSSP II elaborated three scenarios and only in one scenario, which is the most unlikely one as both external and government resources are supposed to increase significantly, enough resources will be available (Government of Rwanda, 2009).

3.3.1. Performance Based Financing

As a result of positive experimentation with Performance Based Financing (PBF) initiatives of some NGOs (e.g. Memisa/Cordaid and HealthNet International (KIT, 2009)), the Government of Rwanda decided to implement a national PBF scheme in 2006. PBF is a performance-based financing system for health facilities based upon performance on fourteen maternal and child health care output indicators (Basinga et al, 2010). Recently HIV/AIDS and tuberculosis indicators have been added to these fourteen indicators (interviews). The indicators are the same for each health facility; however, as baselines for these indicators differ per health facility, targets are different (targets are set in yearly business plans). The monitoring of PBF takes place at three levels: district (district hospital), sector (health centre) and cell (CHWs). On the basis of this monitoring the allocation of funds are decided. District hospitals and health centres can decide how to use the money received through PBF. In practice PBF money is to the largest extent used for topping up of salaries and for the functioning of the hospital (interviews). At cell level PBF funds are paid to the CHW cooperatives, which use it for income generating activities (Baeten, 2011). A CHW cooperative in the district of Nyarugenge for example initiated a small kiosk, which is run by one of the members of the cooperative. This cooperative e.g. also plans to start a project for garbage collection in the sector (interviews).

The conclusions of a first impact evaluation of PBF in Rwanda are largely positive: e.g. the use and quality of some maternal and child health care services have increased (Basinga et al, 2010). Other sources link the introduction of PBF in Rwanda with strengthened health systems at peripheral level (BTC, 2011:18), improved responsiveness of health facilities to users, a reform of human resource management and an improved alignment of donors initiatives with country frameworks (Meessen et al, 2011). Kalk et al (2010), however, question if progress can only be attributed to PBF. Furthermore, they also point at risks associated with PBF such as the 'crowding-out' effect (diminishing or erasing of intrinsic motivation due to external rewards) and 'gaming' (too much focus on indicators that are in the system hereby neglecting non rewarded indicators or falsification of results to maximise reward). While Rusa et al (2009) also point at other important factors that contributed to the achieved results, such as strengthening of data collection, monitoring and integrated supervision, according to them over-reporting happened only in the first months. They also point at the fact that over reporting was rather due to mistakes than to deliberate falsification and mistakes were also immediately corrected by district and central level monitoring and supervision structures (Rusa, 2009). For example, the introduction of the quarterly qualitative monitoring, which takes the performance of the hospital and health centres in all areas into consideration, was a reaction to this initial over-reporting (interviews).

3.3.2. Development partners in the health sector

The health sector receives 12% of ODA, from 16 DPs[17] (Ministry of Finance and Economic Planning and Development Partners, 2007). Most of the funding is used for vertical programmes, which focus on specific diseases and not on the entire health system. Moreover, not all aid is on budget (Government of Rwanda, 2009).

DPs in the health sector are organised in 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, 2009). The HSCG 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 to better align development partners behind the Health Sector Strategic Plan with an enshrined principal of mutual accountability" *(*www.devpartners.gov.rw*).*

[17] Belgium, Germany, Italy, Luxembourg, Switzerland, United Kingdom, United States, European Commission, Global Fund, World Bank, UNAIDS, UNFPA, UNHCR, UNICEF, WFP and WHO.

In 2007 a Memorandum of Understanding (MoU), signed by all major DPs, officially launched a 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).

In order to address particular technical issues and priorities of the HSSP a number of technical working groups (TWG) have been set up over the years such as the TWGs on family planning, human resource development, disease control and health system strengthening. During the 2008 Joint Health Sector Review (JHSR) a reconstruction of the HSCG was proposed in order to diminish the number of members to five GoR representatives, five DPs, two members from Civil Society and two members from the private sector. In order to allow all DPs to provide their input in the JHSR, meetings are organised prior to the JHSR (Meloni and Sijtzema, 2010a). The present TWG structure consists of seven main groups and sub-groups resulting in a total of 33 TWGs, which is a doubling of the number of TWGs as compared to the previous structure. While some of the DPs are positive about the new set up, others (such as BTC) are more critical about the doubling and more in favour of the creation of TWGs according to needs and the winding up of TWGs when the needs have been satisfied (Meloni and Sijtzema, 2010b).

In addition to the MoU, the Belgian Government, German Cooperation and DFID signed an agreement with the Ministry of Health to provide SBS. These three DPs and the Swiss Development Cooperation also made financial commitments to install a pooled fund for technical assistance. The priorities of SBS are family planning, maternal health, financial access, human resources for health and equipment of health facilities (Ministry of Health, 2009c).

The budget support DPs meet with the government in the Sector Budget Support Group. During the 2008 JHSR a proposal was made to broaden the membership of the Sector Budget Support Group to also include the World Bank, the US government and the United Nations. The report of the Joint Budget Support Review of November 2009 refers to the inclusion of the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) as well (Ministry of Finance and Economic Planning and Budget Support Harmonization Group, 2009). The extended Sector Budget Support Group particularly aims to address the issue of 'off-budget' aid in the health sector.

Despite the fact that a SWAp structure exists, support to the health sector is still largely through projects (which is in contrast to the situation in the education sector) (Government of Rwanda, 2010a).

4. Assessment of the health sector's M&E system

In this chapter the health sector's M&E system will be assessed on six dimensions including i) policy, ii) methodology, iii) organisation (structure and linkages), iv) capacity, v) participation of actors outside government and vi) use of information. In doing this, a five-point scoring system is used: weak (1), partially satisfactory (2), satisfactory (3), good (4) and excellent (5). The assessment draws upon secondary data, including a number of documents on M&E policy and strategy (including the Health Systems Strengthening Framework and Consolidated Strategic Plan 2009-2012 (HSSF-CSP), the non-validated Health Policy and Health Sector Strategic Plan, the EDPRS sector building blocks), Joint Sector Performance Reports, Annual Reports and information presented during Joint Health Sector Reviews, and primary data collected during the two field missions (May and June 2011).

The assessment shows that none of the elements of the M&E system of Rwanda's health sector scores excellent and only four elements are assessed as good (alignment planning and budgeting; selection of indicators; ownership; and 'vertical' upward integration). Generally issues in the area of M&E policy, methodology and capacity score slightly better than those related to organisation, participation of actors outside government and use of M&E outputs.

The different sections in this chapter combine a quantitative assessment with a more qualitative discussion on each of the six M&E key areas. Annex 7 provides the disaggregated scores for each of the 34 topics while annex 8 gives an overview of the SWOT analysis which was used during the debriefing on June, 10th.

4.1. Policy

Assessing the quality of the M&E policy is done through an analysis of five components. More specifically, we have checked the quality of 'the evaluation plan', analysed whether a clear distinction is made between the more descriptive 'monitoring' activities on the one hand and the more analytical 'evaluative' activities on the other hand, whether and how policy addresses the main M&E objectives of 'accountability' and 'feedback' and whether and how policy tackles the issue of M&E alignment with planning and budgeting.

M&E plan (score 2)

There are currently several documents circulating which describe components of the M&E policy and strategy, without however having one clear oversight document which is currently validated and considered as the M&E plan of the Ministry of Health. Useful documents which circulate include: the 2010 Health Sector System Strengthening Framework and Consolidated Strategic Plan 2009-2012 (HSSF-CSP), the M&E chapters in the HSSP II and the EDPRS (sector components), the 2009 M&E policy and M&E strategy. Whereas the last two documents provide the most comprehensive and clear information on the M&E policy, strategy and plan, they have so far not been validated by the Ministry of Health and some of the staff interviewed were not even aware of the existence of the two documents. It is highly likely that the final M&E policy, strategy and plan will consist of elements from these various documents and we thus base our discussion on the different sets of documents circulating.

An M&E policy and plan is supposed to give an overview of what to monitor and evaluate, how, why and for whom as well as to identify the role and mandate of the different actors involved in M&E. The HSSF-CSP indicates why a strong M&E and health information systems is important :

- Having accurate, timely, and comprehensive information available for decision-making and performance improvement at all levels of the health system;
- Measuring the effectiveness and impact of health policies, programs, and health care services; and
- Promoting accountability within the health sector (Ministry of Health, 2010: 42).

The Health Sector Policy and the HSSP II both refer to the accountability and learning function of M&E. While the Health Sector Policy does not specifically refer to M&E, it does state that the HMIS, one of the most important sources for M&E, will be reinforced to better inform decision-making in the health sector (learning). In its section on M&E, the HSSP II

emphasises that a monitoring, review and evaluation mechanism should urgently be put in place as "stakeholders increasingly use health sector performance indicators to measure the returns on their investment" (Government of Rwanda, 2009: 58) (accountability). According to the HSSP II the reason to undertake JSRs is "to take stock of progress made in the sector, identify challenges and the reasons for them" (Government of Rwanda, 2009: 58), which refers to both accountability and learning objectives.

As far as the 'what' question is concerned, the Health Sector Policy (2005) mentions that monitoring and evaluation of the Health Sector Policy will be focused on specified input and process indicators (human and financial resources, utilisation of services etc)[18]. The non-validated M&E strategy is more specific and mentions that:

- inputs (human resources, capital, facilities, equipment and information systems) and the quality and efficiency of health care processes will be monitored, outputs (hospital space, number of consultations with service providers, provision of medication and diagnostic services, preventive actions and rehabilitation services) will be measured and
- outcomes and impact will be evaluated (through change of health status of individuals, groups and communities) (Republic of Rwanda, 2009b).

The HSSP II is assessed during the JSRs and will be evaluated externally during a mid-term and final evaluation. The SWAp MoU indicates what should be assessed during a JSR, including (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 on the agreed performance indicators; (ii) the budget execution reports for the previous year, including analysis of outputs achieved as well as resources expended; (iii) additional reports and analysis which may have been commissioned by the cluster in order to inform the review; (iv) resources likely to be available from domestic and donor sources in the coming year and (v) policy and expenditure priorities to guide budget and MTEF preparation (Ministry of Health, 2007). Which methods will be used in these evaluations or in the JSRs is not described in the documents. Neither is it specified for whom exactly (except for 'stakeholders' in general) the outputs of M&E are supposed to be.

M versus E (3)

While the M&E chapter of HSSP II does not clearly spell out the differences and relationship between monitoring and evaluation, the M&E policy and M&E strategy do clearly make a distinction between monitoring and evaluation. The M&E policy provides the OECD/DAC definitions of both monitoring and evaluation and in the strategic and core functions described for the M&E unit evaluation and monitoring are split (Republic of Rwanda, 2009c, see also 4.3.1. for an overview of these strategic and core functions). It is explicitly mentioned that evaluation will be conducted to understand the cause of observed variation between actual performance and desired performance targets (Republic of Rwanda, 2009c: 5). As highlighted on the previous page, the non-validated M&E strategy distinguishes between monitoring of inputs and processes, measuring of outputs and evaluation of outcomes and impact. The relationship between monitoring and evaluation, however, are not specifically mentioned in none of the documents. On the ground, the focus is so far predominantly on monitoring (and more specifically on the identification of indicators, targets and data collection sources).

At district level people do not really distinguish between monitoring and evaluation and the notion of 'evaluation' is used for activities which may rather be classified under the heading of 'monitoring' or 'review'. In the context of monitoring of PBF data, some analysis are done at hospital level and health centre level which are discussed with health centres and CHWs but these analyses are mainly limited to a comparison of actual achievements with targets without probing into reasons for achievement or non-achievement.

[18] The Health Sector Policy includes 'utilisation of services' as an example of a process indicator whereas this is normally considered an outcome indicator.

Autonomy § impartiality (accountability)(2)
While the HSSPII M&E chapter does not refer to the need for autonomy and impartiality (accountability)[19] (which are key evaluation principles of evaluation and amongst others included in the African Evaluation Guidelines[20] (particularly within the propriety guidelines, see AfrEA, 2002), the non-validated M&E policy and strategy give considerably more attention to the issue of accountability. The non-validated M&E policy identifies 'support to accountability' as one of the strategic objectives of having a strong health sector M&E (see above) and highlights in particular the contribution of M&E to transparency and evidence-based accountability (Republic of Rwanda, 2009c). In the non-validated M&E strategy one of the priority interventions relates to the promotion of accountability (measuring health sector gains, improving performance and promoting accountability). Five specific actions are included in this priority intervention[21], the total budget for the entire priority intervention is 332,870 (currency not indicated). The largest part is budgeted for the third sub-component which refers to the conduct of evaluations: 63,090 for HSSP II mid-term evaluation (2010/11), 63,090 for HSSP II final performance evaluation (2012/13) and 164,150 for evaluations of individual programmes supporting HSSP II implementation (2010/11, 2011/12 and 2012/13) (Republic of Rwanda, 2009b: 29).

Feedback (2)
The HSSPII includes a short paragraph on communication, which informs us that reports with findings and recommendations of the yearly JSR, external reviews and evaluations will be distributed to all partners and stakeholders (national and district level). Routine data are, however, not published or disseminated systematically (M&E Task Force, 2009).

The non-validated M&E strategy includes under the strategic intervention of strengthening the health information system several activities related to dissemination and feedback, with a total budget of 56,450 (currency unspecified)[22].

Reporting at local level has been formalised recently: the CHWs, the health posts, the health centres and the district hospitals report monthly. Feedback on the reports is given by the health centres to the CHWs and the health posts and by the district hospitals to the health centres. Feedback from the Ministry of Health or the health unit of the district to the hospitals is limited (interviews).

Alignment of M&E with planning & budgeting (4)
When it comes to alignment of M&E with planning and budgeting, HSSP II mentions that results from the JSR will be used to inform future strategies and plans and to make plans conform available budgets by deciding on the most urgent priorities (Government of Rwanda, 2009). An assessment of the HIS indicates that data is indeed used for planning, but not yet

[19] The M&E chapter in HSSP I mentions that a monitoring, review and evaluation framework addresses the need for accountability (Government of Rwanda, 2005: 72).
[20] The African Evaluation Guidelines are based on the Program Evaluation Standards of the Joint Committee on Standards for Educational Evaluation (1994) and are formulated around four categories: utility, feasibility, propriety and accuracy. The Rwandan Evaluation Network was involved in the formulation of the guidelines (AfrEA, 2002).
[21] The five actions are (i) Establish performance goals/targets for all levels that can be measured and linked directlyto international (e.g. MDGs) and national goals (e.g. EDPRS, HSSP II) and can be used to implement performance based financing mechanisms currently in place. (ii) Conduct regular performance assessments to identify gaps between actual and desired performance using data collected by the M&E system. Performance comparisons between districts can encourage learning between and within districts. (iii) Conduct evaluations to ensure that goals have been attained and that performance gaps are closed through clear articulation of the root causes and identifying appropriate interventions to close the performance gaps. (iv) Provide decision makers with policy alternatives to accomplish the set goals and to assist with the prioritization of interventions. The M&E function will be a key tool to weigh costs and benefits in order to manage health sector investments. (v) Enhance the use of M&E data during sector wide reviews to encourage transparency and accountability" (Republic of Rwanda, 2009b: 18).
[22] The activities are: (i) Establishment of mechanism for data and information dissemination and review, (ii) Development of feedback mechanisms for sharing results, (iii) Data warehouse and internet based dashboard implemented, and (iv) Patient/ client satisfaction survey institutionalised in all districts (linked to QA project) (Republic of Rwanda, 2009b)

well linked to resource allocation, with exception of the PBF system in which HIS data is used to derive performance payments to each health facility (see 3.3.1.) (M&E Task Force, 2009). Moreover, the Ministry of Health is making efforts to apply gender budgeting in the health sector (Ministry of Health, 2010b), which implies the use of sex-disaggregated data.

At central ministry level, there is currently a close connection between 'planning' and M&E given the fact that the EDPRS M&E focal point is located in the Planning Department (as the oversight M&E Department/Directorate has not been installed so far, see also 'organisational and systemic' issues). At district and health facility level M&E is also very close to planning: the director of planning at the district is responsible for M&E as well and the M&E coordinator of the district hospital is also responsible for planning. District hospitals and health centres use their data for their planning.

In the non-validated M&E policy the support to the planning function is one of the three strategic values of having a functioning M&E system. Moreover, the policy describes key functions of M&E which will facilitate results-based planning, including:

- "Establishing desired performance goals and targets that can be measured and that link directly to health sector goals;
- During implementation determining the variation between actual performance and desired performance targets;
- Conducting evaluative studies to understand the cause of the observed variation; and if the variation negatively affects the achievement of the desired target level, enable provide decision makers with alternative options in order to close the performance gap;
- Determining potential obstacles during implementation to attain desired performance;
- Promote shared accountability and transparency with respect to delivering health outcomes" (Republic of Rwanda, 2009c: 5).

4.2. Methodology

In our review of the quality of M&E 'methodology', we focus on indicators (selection, quality, disaggregation, selection criteria, priority setting, vertical logic and horizontal logic) and the specific M&E methodologies and sources of data collection used.

Selection of indicators (4)

The National Planning, Budgeting and MTEF Guidelines (Republic of Rwanda, 2008a) emphasise that the M&E section of any Sector Strategic Plan should include a sector monitoring framework in which key performance indicators and targets, at output, purpose and impact levels are included and which should form the basis for the annual JSR. A second table should provide meta-data on sector key performance indicators (divided in output, outcome and impact indicators). Meta-data includes the way the indicators are measured, the data source, the collection of the data, the institution responsible for the data collection, the timing and cost of the data collection. The M&E section of the HSSP II includes a table with key indicators and targets (see annex 9)[23]; however, the table with meta-data is absent.

The key indicators included in the HSSP II are used to measure sector performance in the period 2009-2012 and are taken from and informed by Vision 2020 (10/47 indicators relate to health[24]), the MDGs and the EDPRS (six strategic outcome indicators[25] and five intermediate

[23] As data for two of the indicators are not collected annually (collected through Demographic Health Survey, conducted every 3-5 years), the JHRS of April 2011 approved the amendment of these indicators: percentage of children fully immunised -> percentage of children vaccinated against measles (last vaccination) to children vaccinated against BCG (first vaccination); percentage of children under-five using insecticide treated long lasting mosquito nets -> percentage of under-5 mortality attributable to confirmed malaria (target 10% 2012/2013).

[24] Women's 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.

indicators[26] relate to health). There are also some indicators which are not included in the Vision 2020, MDGs or the EDPRS and which are either specific for Rwanda (utilisation rate of curative services outside Kigali) or more detailed (e.g. Infant Mortality rate in the bottom wealth quintile per 1000 live births). Only three indicators are included in all four documents: maternal mortality rate, infant mortality rate and HIV prevalence.

Both the non-validated M&E policy and strategy indicate that the HSSPII indicators will be revised. The M&E strategy further mentions that a revision will take into account central needs (focused on Vision 2020, EDPRS, HSSP II and MDGs) and local needs[27] (Republic of Rwanda, 2009b).

Quality of indicators (3)
The HSSP II key indicators are specific, measurable, achievable (although quite ambitious), relevant and time bound (although timing differs for the different documents). In the overview of the key indicators a baseline and targets for Vision 2020, MDGs (2015), EDPRS (2012), CPAF (2012), SBS and HSSP are included. While the targets for the EDPRS and for the CPAF are determined for the same year, they are not the same for all indicators. Of the six indicators which are included in both the EDPRS and the CPAF, the targets are the same for the three impact indicators: total fertility rate, maternal mortality rate and infant mortality rate. For two indicators the EDPRS is more ambitious (women 15-49 using modern contraceptive methods and % of deliveries in health facilities), for one the CPAF is more ambitious (% of children fully immunised).

Disaggregation (2)
Three HSSP II key indicators are disaggregated, one by sex (condom utilisation rate) and two by adult/ children (children and pregnant women using insecticide-treated nets; % of adults and children still alive and on treatment 12 months after initiation of antiretroviral therapy. The indicators in the logical framework include two other disaggregated indicators, one by socio-economic status (infant mortality in poorest quintile) and one by age and sex (% of people with advanced HIV covered by antiretroviral combination therapy by age and sex).

While data in hospital's and health centre's registers and in SIS are available by (at least) sex and age, the available analyses at hospital and health centre level are not disaggregated by sex or age which lowers their analytical quality.

Selection criteria (2)
The HSSP II does not specify the criteria used for the selection of the 18 key indicators. While the non-validated M&E policy and strategy neither provide selection criteria, the M&E strategy indicates that the HSSP II indicators were selected in collaboration with the NISR, the Treatment and Research Centre for AIDS Plus Program, other ministries, professional organizations, sub-national experts and major disease-focused programs. District health units and health care providers were not involved in the selection of indicators, which resulted in a lack of ownership and negative effects on data quality (Republic of Rwanda, 2008b; M&E Task Force, 2009). Even though the non-validated M&E strategy acknowledges the importance of the involvement of all levels in the selection of indicators, in ongoing discussions on the selection of indicators to be included in the successor of GESIS, the district level and health care providers are still not involved (interviews).

[25] The health related strategic indicators are: infant mortality rate, incidence of stunting (height for age) (%), maternal mortality rate, total fertility rate, malaria prevalence, HIV incidence (% of adults aged 15-24).
[26] 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 km 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, Ministry of Health and private insurance bodies).
[27] Corresponding verifiable indicator: minimum package of indicators developed for each level and program of health sector. Means of verification: indicator list with clear definitions (Republic of Rwanda, 2009b: 22).

Priority setting (3)
The key indicators selected for the monitoring of HSSP II are limited, which is indicative of the fact that the Ministry of Health acknowledges the need to set priorities. Health facilities, however, have to collect data on many indicators (more than 200 for SIS alone). Presently, discussions are underway to limit the number of indicators in the successor of GESIS (one of the activities included in the non-validated M&E strategy is the development of a minimum package of indicators developed for each level and program of health sector, Republic of Rwanda, 2009b).

Causality chain (vertical logic) (2)
The HSSPII key indicators are outcome and impact indicators. In HSSP II's logical framework no distinction is made between the different levels of indicators (input, output, outcome, impact). The logical framework links programme objectives, strategic interventions, outcomes and indicators and reveals which indicators measure which programme objectives, but output and outcome indicators are included in the same column and are not specified for the underlying strategic interventions. For example, the first programme objective, "to improve the accessibility to, quality of and demand for FP/MCH/RH/ Nutrition services" has nine underlying strategic interventions, four outcomes and nine indicators, but it is not clear which strategic intervention leads to which outcomes and which indicator is used to measure which outcome.

Methodologies used (1)
The HSSP II and the non-validated M&E policy and strategy do not include information on the methodologies (to be) used for monitoring and evaluation. A BTC report mentions the decision made by the HSWG to use an evaluation instrument developed by the IHP+ (i.e. the Joint Assessment of National Strategies, JANS) for the HSSP II mid-term evaluation (Meloni and Sijtzema, 2010b). The JANS instrument helps to assess strengths and weaknesses of five sets of attributes, which are regarded as fundamental for a strong national strategy situation analysis and programming; process; finance and auditing; implementation and management; and results, monitoring and review. The last set of attributes analyses the soundness of the review and evaluation mechanisms and the use of their results[28] (IHP+, 2009). However, the five attributes included under the results, monitoring and review (see footnote) are too narrowly focused on the existence and content of an M&E plan, while, the existence of a well defined M&E plan or strategy does not automatically mean that this plan or strategy is really implemented. Therefore, an evaluation with the use of the JANS instrument might give a positive score on the results, monitoring and review attributes, while the reality on the ground is less positive.

Data collection (3)
As mentioned in §3.2, the health sector data is collected through several sources including census, surveys, the Routine Information System (including SIS) and Routine Administrative Systems. The non-validated M&E strategy includes an assessment of Rwanda's data sources, which had been adapted from a planning workshop on HIS in December 2008 and which is summarised in table 4.1.

Table 4.1. Assessment of Rwanda's data sources

Data Source	Contents	Capacity & Practices	Dissemination	Integration and use	Total
Census	Highly adequate	Highly adequate	Highly adequate	Highly adequate	Highly adequate

[28] Five attributes are included under results, monitoring and review: 'Plan for monitoring and evaluation that includes clearly-described output and outcome/impact indicators, with related multi-year targets that can be used to measure progress and make performance based decisions', 'plan for monitoring and evaluation includes sources of information for indicators and description of information flows', 'plan for monitoring and evaluation that includes descriptions of data collection/data management methods, tools and analytical processes (including quality assurance)', 'there is a plan for joint periodic performance reviews (reporting of results against specified objectives and respective targets explaining any deviations) and processes for the development of related corrective measures' and 'monitoring and evaluation plan describes processes by which monitoring results can influence decision making (including financial disbursement) (IHP+, 2009)

Population-based surveys	Highly adequate	Highly adequate	Highly adequate	Adequate	Highly adequate
Vital statistics	Not adequate	Present but not adequate	Not functional	Not functional	Not functional
Health and disease records (incl. disease surveillance sys.)	Not adequate	Not functional	Not functional	Present but not adequate	Not adequate
Health service records	Present but not adequate	Present but not adequate	Highly adequate	Not adequate	Present but not adequate
Administrative records	Adequate	Present but not adequate	Present but not adequate	Not adequate	Present but not adequate

Source: Republic of Rwanda, 2009b

Important data collection sources for M&E are the SIS, the Community Level Health Information System (CLIS) (see §3.2 for more information on the SIS and CLIS) and various surveys (some preliminary results of the 2010 DHS were recently made public) and census data administered through the National Institute of Statistics Rwanda (NISR).

Several initiatives have been taken to strengthen the HIS and specifically the SIS. The HSSP I (2005-2009) included in its capacity building program the strengthening of the SIS with the aim to make the SIS fully operational in the public and private sector (Government of Rwanda, 2005b). However, despite commitments of the Government of Rwanda to strengthen the SIS (RTI International, 2006), the authors of the external evaluation report of HSSP-I conclude that the strengthening of the M&E system was not adequately addressed, which has led to a fragmented and ill-performing health information system (External Evaluation Team, 2008). Not surprisingly, the reinforcement of the SIS, as an integral component of the overall monitoring, review and evaluation system, is still considered a priority in HSSP-II and in the HSSF-CSP 2009-2012 (see 4.4.).

Improvements made since the external evaluation include the integration of most routine data reporting requirements into standard report formats for Health Centre and District Hospital levels (monthly, quarterly and annual) and the introduction of a computerised database for data capture of new formats introduced in July 2008 (Ministry of Health, 2008).

Neither the HSSP II nor the non-validated M&E policy link data sources with specific indicators (i.e. lack of horizontal logic). Linkages among key indicators, data sources and periodicity are provided in the health chapter of the NSDS 2009-2014 (Republic of Rwanda, 2009b). However, these key indicators are taken from the EDPRS and the MDGs and do not completely correspond with the key indicators included in the HSSP II.

The non-validated M&E strategy highlights that a metadata dictionary does not yet exist. A metadata dictionary should provide for each indicator a definition, the data-collection method, periodicity, geographical designation, analysis technique and possible biases. The non-validated M&E strategy does include a budget for the development of such a metadata dictionary (12,835 in 2010/11 for the consultant fee) (Republic of Rwanda, 2009b).

4.3. Organisation

As many actors are involved in data collection, analyses and feedback, an appropriate institutional structure for coordination, support, oversight and feedback is crucial. However, as control over M&E provides power over resources and other institutions, the establishment of an M&E structure is often politically sensitive and therefore difficult (Holvoet and Renard, 2007). This paragraph will analyse the organisation of M&E with regard to its structure (4.3.1.) and its linkages (4.3.2.).

4.3.1. Structure

The assessment of the M&E structure takes into consideration the degree of coordination and oversight in the health M&E system, the functioning of Joint Sector Reviews and Sector Working Groups and the level of ownership and use of incentives.

Coordination and oversight (2)

In line with recommendations from a review of the Management Science for Health (Diallo, 2007) the Ministry of Health created a new Monitoring and Evaluation Task Force (M&E/TF) in February 2008. The aim of this task force was to develop and strengthen the existing HMIS and M&E system at national level in order to better feed into decision-making for planning and with the aim to improve the health service delivery system in the country (Ministry of Health, 2008: 16). Specific objectives at that time were (Karengera, 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.

At the time of the interview (June 2011), the M&E taskforce was not operational anymore and a new M&E oversight department/directorate is in the phase of being set up. There is currently a continuous change in the organigram of the ministry and it is so far not clear whether the oversight M&E unit will rather take the format of an M&E unit with an M&E coordination committee (as described in the non-validated M&E policy) or rather the format of a Directorate for Health Policy Analysis & M&E (as described in the non-validated M&E strategy). It is also not clear yet where the oversight M&E unit will exactly be positioned. The location of the oversight M&E unit is not without consequences: if it is closely linked to the Planning Department, feedback is stimulated but a lack of independence might curtail accountability, whereas more independence might lower feedback of M&E output to planning and budgeting. The BTC identifies in its technical and financial dossier that a general and common policy on the health M&E system and a clarification of roles for each actor within the M&E system are lacking (especially at decentralised level) (BTC, 2010). At any rate, the observation made by Holvoet and Rombouts in 2008 for the central EDPRS M&E system (see 2.1.2.) is currently also applicable to the health sector M&E system: due to the continuous reconstruction of the M&E framework and set-up, actual implementation and try-out is constantly undermined.

While districts do not have someone who is specifically responsible for health M&E, the district hospitals have an M&E team consisting of the M&E coordinator, a data manager, a PBF supervisor, a community health supervisor and a vaccination supervisor. Recently, a data manager has been appointed to each health centre.

Joint Health Sector Review (2)

Joint Health Sector Reviews are organised twice a year, one for looking backwards and one for looking forwards. In the past few years, the duration of the JHSRs varied between 3 days in November 2008 to only 1 day in April 2010. The preparation of the JHSRs has improved over time: since the March 2009 JHSR reports were made available prior to the JHSR, but a BTC report on the period April to June 2010 (Meloni and Sytzema, 2010a) still highlighted the need to improve the JHSR preparation process in order to facilitate the flow of information and the exchange of analyses. The October 2010 JHSR seems to have addressed this issue. A BTC debriefing note explicitly refers to the improved quality of the preparation and the JHSR itself, stating that “the EDPRS health sector performance report and budget execution figures were distributed one week before the meeting which took place in a good atmosphere with open discussions and sufficient time for in-depth presentations and questions” (BTC, 2010: 1).

One of the experiments recently introduced is the organisation of field visits in the context of JHSRs. While some of the interviewees were rather sceptical, field visits in principle offer opportunities to confront the aggregated data provided by the Ministry itself with reality checks

on the ground. Field visits spread over different regions and across possible layers of inequality would be particularly valuable in the context of Rwanda where concerns have been raised over increasing levels of inequality and potentially exclusionary poverty reduction policies and outcomes (see e.g. Evans et al., 2006). The limited time invested in field visits was also one of the major shortcomings of the 2008 HSSP I external evaluation report. As stated by the authors, the two days field visits "provided 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).

Concerning the content of the JHSRs, generally JHSRs are more focussed on issues of substance (inputs, activities, outputs, outcomes and impact) than on the underlying institutional/systemic issues. Even though presentations were given at the October 2010 JHSR on issues like decentralisation and the planning of the mid-term review, EDPRS policy actions are hardly focused on the more fundamental institutional and systemic issues such as e.g. the quality of the M&E system. The minimal attention paid to the quality of the M&E system is somehow counter to what is expected from SBS donors, who in principle should rely upon the health sector M&E system for their own accountability needs towards their constituencies.

From the perspective of the Paris Declaration key principles, JHSRs score high on country ownership, there is a broad-based participation of actors from various settings (both inside and outside government) and attention is being paid to issues of harmonisation and alignment (except for alignment to the M&E system, see above). However, there is limited mutual accountability and interest in capacity building of the M&E demand and supply side.

Generally JHSRs are more forward-looking events focusing mainly on the formulation of recommendations and policy actions 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.

Sector Working Group (2)

As discussed in section 3.3.2.,DPs in the health sector are organised in the Health Sector Coordination Group (HSCG), which is more responsible for policy dialogue, and Technical Working Groups (TWGs), which address particular technical issues and priorities of the HSSP. The present TWG structure consists of seven main groups and sub-groups resulting in a total of 33 TWGs. Various interviewees pointed at major shortcomings in the coordination structure: the linkage among the HSCG and the TWGs is not functioning which puts into perspective the idea of evidence-based policy dialogue. There is so far also little ex-ante information exchange among different actors in the TWGs which seriously downplays the existing potential for triangulation of different types of information. At present the HSCG and its TWGs are also not much involved in the monitoring of progress in the health sector system development and outcomes; they are rather dealing with planning and priority setting. For these activities, however, they are in need of information from the M&E system to support their decision making (Republic of Rwanda, 2009c). A new TWG has been established for health sector policy, planning and M&E but it too early to assess its functioning. So far, it has mainly been dealing with the upcoming mid-term evaluation. Interviewees have highlighted that this TWG also has put on its agenda the discussion of the set-up of the oversight M&E unit as well as the need for finalising the M&E policy, strategy and plan. It is expected that this TWG will also invest in joint analysis/assessment of the sector's policy, planning and M&E systems which might also be useful to improve the level of coordination in system capacity building efforts.

Ownership (4)

According to various interviewees the demand for M&E is not only initiated by development partners, but also by the Ministry of Health itself. One of the nine elements of the guiding principles of the non-validated M&E policy is ownership and leadership[29]. Another actor which

[29] The other eight elements are: coordination and involvement of stakeholders; donor alignment; build

is clearly taking the lead in M&E is MINECOFIN's EDPRS M&E coordination unit which has located different M&E focal points in line ministries in order to strengthen M&E capacity and link sector M&E to central EDPRS M&E (see also 4.3.2.)

Incentives (2)
Incentives are mainly used to stimulate (quality of) data collection at local level. One of the most obvious instruments that are being used is the PBF system. At health facility level PBF (see 3.3.1.) seems to be an incentive for improvement of data quality and for use of data, as a result of PBF monitoring which takes place at three levels. The monitoring of the district hospitals was previously only done by other hospitals each trimester (rotation system). During these visits the focus was in particular put on learning, less on control. Recently the hospitals are controlled by a team of the Ministry of Health as well. This change was stimulated by USAID, who is heavily supporting PBF.

The monitoring of health centres is done by a hospital team headed by the district hospital PBF supervisor (quantity is controlled each month, quality each trimester). During the monitoring missions, data is collected directly from the registers of the health centres and compared with the SIS-data. During the 'qualitative mission' a comparison with SIS and the registers and with the registers and patient fiches is done at random. When data does not match, the score for this indicator is reduced to zero. Another indicator in the qualitative assessment concerns the obligation to have monthly meetings between the health centres and the health hospital, during which the quality of data and progress on the basis of data is discussed. The quantitative and qualitative reports are discussed quarterly and analysed during the Comité de Pilotage, which is presided by the director of the district health unit. Other members of the committee include the director, the PBF supervisor and M&E coordinators of the district hospitals, the pharmacy director, the director of the health insurance, representatives of the heads of the health centres and representatives of donors. On the basis of these analyses the Comité de Pilotage decides on the allocation of funds for each health centre (interviews).

At the lowest level, the person in the health centre responsible for the CHWs compiles a report every three months, which is discussed in a Comité de Pilotage at administrative sector level. This sector Comité de Pilotage consists of the sector staff member responsible for social affairs (president), the staff member responsible for CHW, the president of the CHW cooperative and a fourth independent (not related to health centre or cooperative) inhabitant of the sector (interviews). At this level monitoring is not based on the output indicators linked to service delivery, but to indicators related to timeliness, completeness and accuracy of the monthly reports.

Another incentive that is being used is the system of contracts between the local authorities and the president (Imihigo). These contracts include a set of targets on which the different districts are yearly evaluated during a presidential ceremony. These contracts might become a useful instrument of accountability of local authorities towards citizens, at least when citizens are also involved in the identification of objectives and targets.

4.3.2. Linkages

This part assesses the linkage of health M&E with the national statistical office, with the central EDPRS M&E unit ('vertical' upward integration), the level of integration of the M&E units in sub-sectors and semi-government institutions (horizontal integration), the level of integration of the central health M&E unit with M&E units at decentralised level ('vertical' downward integration) as well as the linkage with donor project M&E.

Linkage with statistical office(2)
Coordination mechanisms exist between the Ministry of Health and the NISR (Diallo, 2007, Republic of Rwanda, 2009b). While the role of the NISR in the health sector's M&E is not

---

on existing systems and initiatives; data availability; data use; confidentiality and safety of patient data; harmonisation of M&E subsystems; and ease of use, flexibility and adaptability of the data system (Republic of Rwanda, 2009c).

made clear in the HSSP II nor in the non-validated M&E policy and strategy, the HIS assessment report of the M&E Task Force refers to the fact that the NISR is responsible for the conduction of the national census, vital events registration and several health-related population-based surveys. Especially with regard to the design and implementation of these health-related surveys, the Ministry of Health has a good working relationship with the NISR. However, the M&E Task Force report refers as well to the fact that there are no formal routine mechanisms to link the HMIS unit and the NISR (M&E Task Force, 2009).

The National Strategy for the Development of Statistics includes a section on the health sector, in which it is mentioned that the oversight of the Health Sector Statistical System is within the mandate of the Ministry of Health (Republic of Rwanda, 2009b), but no references are made to the HSSP II, the M&E/TF or the HMIS unit. So far, there is also relatively few cross-reading among sources of information which are mainly administrated at the Ministry of Health (HMIS) and surveys (such as the demographic and health surveys) administrated at the NISR. The M&E Task Force report refers to the fact that problems with data sharing exist (M&E Task Force, 2009). Triangulation among these sources of data might be particularly useful to increase the analytical quality of the reports and to feed into improvement of policies and implementation.

'Horizontal integration' (2)
The non-validated M&E strategy acknowledges that coordination between the Ministry of Health and the M&E staff of its institutions like the National AIDS Control Commission and TRAC-plus could be improved. It is likely that this will happen in the short run through the instalment of the e-health system which aims at facilitating exchange among different data sources.

'Vertical' upward integration (4)
Whereas the non-validated M&E policy and the M&E strategy do not explicitly refer to links with the central EDPRS M&E unit, serious efforts are being done from the side of MINECOFIN to establish a unified M&E framework which links sector M&E units with the central EDPRS M&E Coordination Unit. In doing this, EDPRS M&E focal points have been installed within line ministries with the aim to assist sectors in the establishment and strengthening of a unified M&E system. As mentioned in the ToRs of the EDPRS M&E focal points, "they need to assemble and collect information on the EDPRS indicators, analyze changes in the indicators/targets, ensuring feedback from this analysis into policy making and propose measures to stakeholders for improving the monitoring system over time"). In the Ministry of Health the EDPRS M&E focal point is located within the planning unit and it is currently the only person with a specific M&E mandate. Some interviewees hinted at the fact that there might be some tension among the line ministry level and the MINECOFIN EDPRS M&E Coordination unit as they might have different priorities in terms of M&E as well as partly overlapping mandates. It will be particularly important to clarify division of mandates, roles and leadership between the MoH and MINECOFIN in the context of the set up of the M&E oversight unit in the health sector.

'Vertical' downward integration (2)
In the proposal for a functional M&E Unit for the MoU (Diallo, 2007) it is emphasised that the involvement and full participation of the districts and the programs, projects, sub units and allied organisations currently developing and implementing M&E activities is necessary in the development of an M&E system at central level. The non-validated M&E policy includes local government entities in the list of stakeholders involved in the implementation of the policy. Their roles should be:

- "Ensure data capture at health centre, district hospital and referral hospital level; conduct periodic review of routine data for accuracy, completeness and quality; conduct periodic supervision of health facilities to ensure completeness of data; and mentor health care staff in use of data for decision making at service delivery points
- Ensure private sector participation in M&E activities
- Contribute to policy development.
- Identify areas for and conduct operational research" (Republic of Rwanda, 2009c: 22, 23)

The non-validated M&E strategy acknowledges that M&E coordinators and data managers still need training and on the job capacity building (Republic of Rwanda, 2009b). The Ministry of Health already organised some training for the M&E coordinators and data managers. Training of data managers at health centre level are organised by the district hospitals (see 4.4.). Relations of M&E staff with the Ministry of Health are, however, nowhere clearly specified. M&E staff/ data managers in the health facilities visited in Nyarugenge and Gakenke indicated that relations with the Ministry of Health are weak; information flows are mainly upwards and the ministry hardly provides any feedback.

Link with project M&E (2)
It is not clear to what extent the Ministry of Health coordinates in a systematic way with donor M&E of projects. There are some instances of linkages being created such as the one with the International Center for Aids care and Treatment Programs (ICAP). The ICAP wanted to improve its data collection at health centre level and started to finance data managers. As the advantage of these data managers were recognised by the Ministry of Health and by e.g. Global Fund (who presently finances data managers of health centres and data managers and M&E coordinators of district hospitals), these data managers became responsible for all data collection.

It is highly likely that the set up of a Single Project Implementation Unit (SPIU) within the MoH will stimulate linkages among project M&E and the ministry's M&E. The SPIU will be responsible for the management of all domestic and external projects, with the aim to enhance harmonisation, facilitate better coordination and oversight and reduce transaction costs through sharing functions of finance, procurement and M&E (Government of Rwanda, 2010a).

4.4. Capacity

The assessment of the M&E capacity in the health sector is based on capacity that is currently present, the degree to which capacity weaknesses are identified and plans for remediation elaborated.

Present capacity (3)
At Ministry of Health level, six staff members are working on the HIS and one staff member is appointed as the M&E EDPRS focal point (see 4.3.2.). The aim is to increase the existing M&E capacity through the set up of the M&E oversight unit. It is so far not clear how many staff members would be included within this specific unit.

In November 2008 the District Health System Strengthening Framework Implementation Plan for Gakenke was finalised. This implementation plan provides an overview of current as well as needed capacity. According to the 2008 plan only Nemba District Hospital had a computer available for HMIS and Electronic Medical Records (EMR), but the software for HMIS and EMR were not yet available. Moreover, only the two district hospitals had a data manager responsible for the collection and reporting of statistical information. Ruli district hospital had a HMIS manager as well, responsible for supervising the data collection in the health centres (Government of Rwanda, 2008). In line with the implementation plan, in June 2011 all health centres in Gakenke have a computer with software for HMIS and a data manager (financed by either Global Fund or ICAP). Both district hospitals have a data manager and an M&E coordinator (financed by Global Fund) and all health centres have a data manager (financed by Global Fund or ICAP). All M&E coordinators and data managers of hospitals have recently been trained in data quality and data use. They are now supposed to train the health centres' data managers under their responsibility (interviews). Data managers also started to use tables and graphs to present data which is an improvement as compared to the 2009 HIS assessment which highlighted that graphs were not used to display data (M&E Task Force, 2009). A recurrent problem is the staff turnover as a result of which trainings should be repeated regularly in order to train newly appointed data managers.

Problem acknowledged (3)
The different documents on health M&E particularly refer to weaknesses in the health information system. With the support of the Health Metrics Network (HMN)[30], the Ministry of health assessed the HIS in the period between December 2006 and December 2008.
The assessment identified several weakness, including in the areas of HIS resources, some data sources (vital registration and epidemiological surveillance), data management, use of data for decision making at all levels and the decentralisation of use of data and management of HIS to the district level. Strong aspects of the HIS include the high quality census and population surveys, the collection of key indicators according to international norms and the use of data for planning and priority setting (M&E Task Force, 2009).

Capacity building plan (2)
Besides specific initiatives to strengthen the HIS (included in the HSSP II, the HSSF-CSP and the M&E strategy, see 3.2.), some elements of M&E capacity building can be found in the HSSP II, in the non-validated M&E strategy and the HSSF-CSP. If anything, similar to the M&E policy/strategy/plan, the M&E system, several documents circulate which include interesting elements of an M&E capacity development plan but there is a lack of coordination among these various fragmented building blocks.

The HSSP II institutional strengthening strategic programme includes e.g. three M&E related interventions: 'develop capacity for planning and M&E at central and decentralised level', 'develop a harmonised planning and M&E framework' and 'strengthen and harmonise all HMIS systems at all levels from the community to the central level' (Government of Rwanda, 2009).

The non-validated M&E policy aims at being the key guiding document for capacity development for all M&E functions within the health sector and refers to the need of harmonisation of capacity strengthening efforts. The implementation schedule of the M&E strategy includes five activities related to capacity strengthening: capacity gap at all level identified; training programmes developed for data management and use; pre-service training programme implemented within nursing and medical schools; in-service training programme implemented through district hospitals; and district staff and health centre data managers trained in data quality assessment procedures. The total budget for these five activities is 77.620 (currency not specified) (Republic of Rwanda, 2009b). However, in the meantime, the HSSP-CSP has been elaborated which includes several strategies, including:

- Develop an improved legal and operational framework with effective coordination mechanism;
- Increase resources and capabilities for infrastructure, finance, and human resources to meet HIS and ICT needs for the health sector;
- Strengthen information systems and ICT use;
- Enhance M&E and health information system;
- Transform clinical and business practices through the introduction of information and communications technologies;
- Enhance the development, dissemination and use of vital statistics (Ministry of Health, 2010).

Recently, the Ministry of Health elaborated a new Human Resources for Health (HRH) Strategic Plan for the period 2011-2016 with the aim to direct the effective planning, development, management and utilisation of human resources in Rwanda (Republic of Rwanda, 2011). One could expect to find in this document the M&E capacity strengthening interventions included in the HSSP II, the HSSF-CSP and the non-validated M&E strategy, but no references are made to these interventions. M&E activities are included, but these relate to the M&E of the HRH strategy plan.

[30] HMN was initiated by the World Health Organisation (WHO) in 2005 with the intention to assist low and low-middle income countries in strengthening health information systems through the 'Framework and Standards for Country Health Information Systems' (i.e. the HMN Framework), which includes six components of a health information system, subdivided into inputs, processes and outputs. The input component encompasses 'health information system resources' , the three process components are 'indicators', 'data sources' and 'data management' and the output components are 'information products' and 'dissemination and use' (Health Metrics Network, 2008).

4.5. Participation of actors outside government

This section analyses the participation of actors outside government (including development partners, civil society and parliament) in the health sector M&E.

Parliament (1)
The documents at hand lend us to believe that parliament does not participate in health sectors' M&E. Both M&E policy and M&E strategy do not refer at all to the parliament. This is not unique to the health sector and in line with the general observation of the joint governance assessment that oversight capacity of parliament is limited (Government of Rwanda and Development Partners, 2008).

Civil society (2)
Civil society organisations (national as well as international) participate in the HSCG, in the JHSR and in the Comités de Pilotage. The non-validated M&E policy specifies their roles in the implementation of the policy and these include :

- Participation in the policy development implementation and review processes; provision of technical and financial support to the policy development process, under the guidance of the Ministry of Health.
- Support to the alignment of M&E systems of their sub-partners and facilities to Ministry of Health M&E system.
- Contribution to policy development
- Identification of areas for and conduction of operational research (Republic of Rwanda, 2009c: 22)

However, their actual level (and intensity) of participation is less straightforward. Various interviewees pointed at the fact that while CSOs are invited to participate in fora such as the TWGs, they often do not effectively participate. Mugisha et al (2005), in an article on the participation of Non Governmental Organisations (NGOs) in the health SWAp of Uganda, highlight that most NGOs are not yet able to engage in Uganda's health SWAp due to weaknesses in their own systems (strategic planning, marketing, managing human resources) and lack of capacity to generate own funds from various sources. It is likely that these impediments are applicable to NGOs in Rwanda as well, particularly given the fact that most of the NGOs in Rwanda were established just after the genocide. They are thus relatively young and according to the 2008 joint governance assessment (Government of Rwanda and Development Partners, 2008) they lack depth and experience. Moreover, Rwanda's low scores on the 'voice and accountability'[31] governance indicators (see chapter 2) (Kaufmann et al, 2009) and the fact that there is generally limited room of manoeuvre for NGOs (see e.g. Holvoet and Rombouts, 2008) might as well explain the fact that NGOs participating in the HSCG and JHSR are not adopting a critical stance. The Joint Governance Assessment of the Government of Rwanda and Development Partners (2008), however, refers to an improvement in the relationship between civil society and government (e.g. through civil society participation in JADFs) and recommends to support the advocacy role of civil society organisations. It is also not that spaces for critical reflection are entirely absent: there exist a limited number of outside government actors which do provide analysis and data collection on sensitive issues and who seemingly have found the balance between extreme self-censorship on the one hand and confrontation on the other hand. Strengthening the capacity of such instances of non-government M&E and research is particularly important and an area where donors might invest in more.

Donors (2)
Development partners play a significant role in Rwanda's health sector. Existing fora for the participation in the M&E of health sector performance include the HSCG, the Sector Budget Support Group (only the SBS development partners) and the JHSR. However, as highlighted above these fora did not function optimally so far. Donors who operate at different levels

[31] The 'voice and accountability' indicator captures "perceptions of the extent to which a country's citizens are able to participate in selecting their government, as well as freedom of expression, freedom of association, and a free media" (Kaufmann et al, 2009: 6).

(project, sector) did e.g. not fully exploit the fact that they have access to different types of information. Notwithstanding these shortcomings, there are a number of promising evolutions related to the establishment of a SWAP approach, the resource tracking tool and the set up of the TWG on health policy, planning and M&E. As far as Belgian DC is concerned, the fact that it is itself moving towards a more deliberate portfolio approach, including a component of action research which involves local researchers, might increase its evidence base and its capacity to take a more active stance in evidence-based policy and technical dialogue.

4.6. Use of information

This section reviews the outputs of the M&E system and the degree to which M&E is used by donors, by actors at central and local level and by actors outside government.

M&E outputs (2)
In order to assess to what extent M&E is effectively used in progress reports, we have reviewed the March 2009 Health Sector Performance Review, the 2008 Annual Report (published in April 2009), the 2009 Joint Sector Performance Report and the EDPRS Implementation Report of the Ministry of Health for the period June 2009 – July 2010. While all reports provide a lot of data and information on achievements which are compared to targets, analyses of discrepancies are not included. Moreover, the focus is predominantly on monitoring of activities and to a lesser extent on achievements at the level of outputs, outcomes and impacts.

The focus on 'monitoring' and downplay of evaluation is also evident from the format of the Health Statistical Booklet published by the Ministry of Health in October 2009. As explicitly highlighted in the document itself, the booklet shows key statistics in the health sector from 2008 in a concise, easily accessible manner to ensure valuable statistics are readily available to all interested users" (Republic of Rwanda, 2009a: 13) while "no analysis of figures and no comparison with previous years are given" (Republic of Rwanda, 2009a: 13).

Health centres and hospitals produce reports on the basis of their data, which are intended for internal use.

Effective use of M&E by donors (2)
Interviews highlight that different types of donors use M&E output in a different way. SBS donors are to a larger extent dependent on the M&E provided by the MoH (complemented by some ad hoc data collection on realities on the ground) while non-SBS donors rely to a much larger extent on their own additional data collection (which is not necessarily organised in a systematic way). There are also instances of project donors (vertical programmes) which rely more on routine government data collection systems (e.g. the Global Health Initiative which uses TRACnet data). This might further increase and expand to other project donors when the SPIU will become fully operational. At any rate, the majority of the donor staff interviewed felt that their access to data is restrained (see also 4.3.1. on JHSR) and that their room of manoeuvre to hold government accountable on the basis of M&E is limited. It seems that there are very few donors who find the right balance between 'self-censorship' and 'confrontation'.

Effective use of M&E at central level (3)
As already mentioned in 4.1. M&E outputs are supposed to inform future strategies and plans (Government of Rwanda, 2009). At the Ministry of Health level there is a demand for qualitative and timely health information, e.g. in the context of performance-based budgeting (Diallo, 2007). However, the non-validated M&E policy acknowledges that even though a lot of data is collected, these data are not analysed and transformed into information and therefore not used (Republic of Rwanda, 2009c). This was also emphasized by the majority of the interviewees who indicated that this seriously hampers the M&E feedback loop in terms of systematic learning and improving outcomes over time. It is highly probable that the need for (qualitative) analysis and disaggregation will even become more prominent in the future when the achievements in the health sector will slow down and when measures will need to be taken to reach the less accessible sections of the population. The general need for more disaggregation in monitoring indicators was also highlighted in the 2008 WB/IMF joint staff

advisory note (JSAN) which highlighted that in a context of differences in regional poverty rates (where the Eastern region has contributed most to poverty reduction and the South the least), disaggregation is important to monitor possible differential effectiveness of interventions across regions.

While there is so far no systematic analysis and learning, there do exist ad-hoc instances of learning and changes in programmes on the basis of evidence collected on the ground. This is e.g. the case in the area of maternal and child death where Rwanda was lagging behind the SSA-average and where several measures have been taken to successfully redress the situation (under five child mortality has been reduced from 103/1000 in 2007/2008 to 76/1000 in 2010, maternal mortality has been reduced from 750/100,000 in 2005[32] to 383/100,000 in 2008. The effective use of evidence and speed of remediation is particularly strengthened through the strong linkage among planning and M&E, government's strong leadership and the effectively functioning government's institutional apparatus. When it comes to the more sensitive issues (amongst others related to claims of inequality in the health sector), analysis and learning is clearly less straightforward.

Effective use of M&E at local level (2)
Similar to observations in other countries see Kimaro et al. 2008), at lower levels of the health system data is generally merely collected and transmitted upwards and not analysed and used for local decision-making (RTI International, 2006; Diallo, 2007; Republic of Rwanda, 2009c and 2009b; M&E Task Force, 2009). Reasons for lack of data analysis and use include lack of training, time and incentives (RTI International, 2006). As discussed in section 2.2, the currently ongoing decentralisation process has established a number of instruments which might stimulate local-level evidence-based planning and budgeting, including the elaboration of a district development plan, the Joint Action and Development Forum (JADF) and the introduction of performance based financing (PBF). As a result of PBF, monthly meetings between health centres and CHW and hospitals and health centres have been institutionalised. During these compulsory meetings, information submitted from the health centres to the district hospitals is analysed and discussed. District hospitals and health centres also use their data analyses for their own planning. The level of analyses, however, is still rather superficial and is generally limited to presenting data in tables and graphs. Moreover, given the fact that the fiscal decentralisation has been limited there is so far little local discretion in planning and spending.

Effective use of M&E by outside government actors (1)
There is no evidence that the outputs of the health sector's M&E system are used by outside government actors to hold the government accountable.

[32] This data originates from the DHS 2005 and is significantly lower than WHO data that refers to a maternal mortality rate of 1300/100,000 in 2005.

5. Conclusion and recommendations

M&E policy and M&E oversight unit

There is currently no coordinated M&E system or overarching M&E policy and strategy in the health sector. However, there exist several 'fragmented' components of an M&E system and several documents which discuss the establishment of a health sector M&E system, policy and strategy (including the Health Sector Strategic Plan, Health Sector System Strengthening Framework, section on sectors in the EDPRS M&E chapter, non-validated Health Sector M&E policy and Health Sector M&E strategy). Coordinating among these various building blocks and initiatives may feed into the establishment of an M&E system that is able to fulfil functions of learning and accountability. Crucial in this undertaking is the set up of an oversight M&E unit within the Ministry of Health. The M&E policy and the M&E strategy (documents which circulate but which are not validated by the Ministry) refer in this respect to the establishment of an M&E unit or a Directorate for Health Policy Analysis and M&E which should strengthen and coordinate amongst the currently existing Health Management Information System (HMIS) department (which has 6 staff members) and the M&E EDPRS focal point (currently positioned in the Planning Department) which has been appointed by the EDPRS M&E Coordination Unit for M&E capacity development within the health ministry and to ensure the vertical upward integration of the health M&E with the overall EDPRS M&E system.

However, due to amongst others continuous reforms and changes of the ministry's organigram and lengthy procedures related to the appointment of the head of this unit/directorate, the oversight M&E unit/directorate has not been installed so far. The fact that the Technical Working Group (TWG) on Planning and M&E is currently adopting a more pro-active stance on this matter might stimulate the effective set-up of this oversight unit/directorate.

Indicators, targets and data collection

The components of the M&E system that have been established so far mainly focus on the 'monitoring' component of the M&E system and more specifically on the identification of indicators, baselines, targets and the set up of various data collection sources. While there is a continuous tendency of donors and particularly vertical health programmes to push for additional indicators, efforts are currently being made to prioritise and harmonise better among various indicator sets and data collection sources. The Health Sector Strategic Plan for the period July 2009 – June 2012 (HSSP II) gives in its chapter on M&E an overview of 18 key indicators which were selected in collaboration with the National Institute of Statistics of Rwanda (NISR), the Treatment and Research Centre for AIDS plus Program, other ministries, professional organisations, sub-national experts and major disease-focused programs. These HSSP II key indicators were informed by Vision 2020, the MDGs and the EDPRS. Table 1 in annex 9 gives an overview of the key indicators, including baselines and targets of Vision 2020, the MDGs, the EDPRS as well as for the Common Performance Assessment Framework (CPAF), SBS and HSSP. The logical framework of the HSSP II also includes indicators, but no distinction is made between the different levels of indicators (input, output, outcome, impact). The logical framework links programme objectives, strategic interventions, outcomes and indicators and reveals which indicators measure which programme objectives, but output and outcome indicators are included in the same column and are not specified for the underlying strategic interventions.

Different instruments are used for data collection in the health sector, including:

- Census;
- Surveys (e.g. Demographic and Health Survey (DHS), Malaria Indicator Survey and Public Expenditure Review);
- Routine Information Systems (e.g. SIS (Système d'Information Sanitaire = HMIS), Tracnet and Performance-based Financing (PBF);
- Routine Administrative Systems (e.g. Human Resources Information System).

Important data collection sources for M&E are the SIS, the Community Level Health Information System (CLIS) and various surveys and census data administered through the

National Institute of Statistics Rwanda (NISR). SIS data gathering, data entry and queries are supported by a database application, the GESIS (Gestion du Système d'Information Sanitaire), which will be replaced in 2012 by a new database application. Recently, key components of the CLIS were harmonised and include now standard recording and reporting formats for community health workers (and other community health volunteers like e.g. traditional birth attendants, Red Cross volunteers and traditional healers). Data collection at this level aims to include all households in the health information system. Data from the community health workers is compiled at health centre level. As from January 2011 onwards, all health centres have direct access to GESIS, which facilitates the work of data managers of district hospitals who compile the data of the district hospital and all health centres under their responsibility. This compiled data is sent directly to the Ministry of Health. The increased access to GESIS and the appointment of data managers at health centre level (before data was compiled by the health centres titular) increase the potential for data quality improvements. Data of private health facilities are generally not yet included in the GESIS. In order to remedy this shortcoming, a pilot project for data inclusion is ongoing within the framework of the BTC-financed Institutional Support Program in the three districts of the city of Kigali[33].

Another strong building block of the Health Information System (HIS) are the surveys and census data, which provide data on health-related outcomes for the entire population, including as well those that are currently not (yet) using health related services. Preliminary findings of the 2010 Rwanda Demographic Health Survey (RDHS 2010)[34], which draws upon a household questionnaire and a women's and men's questionnaire administrated in a representative sample of 492 villages spread over rural and urban areas, have recently become available. Compared to results of the 2005 and 2007/08 RDHS, progress is observed in the areas of fertility decline, birth delivery in health facilities, vaccination of children 12-23 months and under-five child mortality.

Since the HSSP I (2005-2009) HIS strengthening has been included in different documents, but despite commitments of the government the authors of the external evaluation report of HSSP-I concluded that the strengthening of the HIS was not adequately addressed, leading to a fragmented and ill-performing HIS (External Evaluation Team, 2008). Not surprisingly, the reinforcement of the HIS, as an integral component of the overall monitoring, review and evaluation system, is still considered a priority in HSSP-II and in the HSSF-CSP 2009-2012. Various of the above mentioned evolutions in the development of the HIS may also be understood from this perspective.

Data analysis and use of M&E for learning at central and local level

Whereas there is an increasing move towards more 'integration' and possibilities for exchange of data at the level of the health management information through the e-health system that is currently being established, such exchange and cross-reading among HMIS data and survey data remains currently underexplored. This lack of cross-reading among HMIS and NISR data is one of the elements which is indicative of the fact that compared to the progress in the 'monitoring' component of M&E, there is much less progress when it comes to the more analytical 'evaluation' component. Various interviewees pointed at the fact that there are large amounts of data available at local and central level which are currently not being analysed in a systematic way. This lack of analysis lowers the quality of the M&E outputs (including the health sector performance report, EDPRS annual progress reports), which are mainly limited to an overview of progress made without, however, providing insights into the underlying reasons behind progress or lack of progress. This also hampers the M&E feedback loop in terms of systematic learning and improving outcomes over time. It is highly probable that the need for (qualitative) analysis and disaggregation will become more prominent in the future when the achievements in the health sector will slow down and when measures will need to be taken to reach the less accessible sections of the population. While there is so far no systematic analysis and learning, there do exist ad-hoc instances of learning

[33] The Institutional Support Program contributes to the conception and implementation of a strategic health development plan for the city of Kigali.
[34] The final report of the RDHS is not yet available.

and changes in programmes on the basis of evidence collected on the ground. This is e.g. the case in the area of maternal and child death where Rwanda was lagging behind the SSA-average and where several measures have been taken to successfully redress the situation (under five child mortality has been reduced from 103/1000 in 2007/2008 to 76/1000 in 2010, maternal mortality has been reduced from 750/100,000 in 2005[35] to 383/100,000 in 2008). The effective use of evidence and speed of remediation is particularly strengthened through the strong linkage among planning and M&E, government's strong leadership and the effectively functioning of government's institutional apparatus. When it comes to the more sensitive issues (amongst others related to claims of inequality in the health sector), analysis and learning is less evident. It is in this respect also interesting to monitor and evaluate the upcoming mid-term evaluation (and its underlying process) of the HSSP II which is intended to feed into the formulation of the HSSP III and the EDPRS II.

While there is so far relatively little analysis and use of M&E data at the local (district) level (where data has so far mainly been collected for the central level), the currently ongoing decentralisation process has established a number of instruments which might stimulate local-level evidence-based planning and budgeting, including the elaboration of a district development plan, the Joint Action Development Forum (JADF) and the nationwide introduction of performance based financing (PBF) in 2006. PBF is a performance-based financing system for health facilities based upon performance in the area of maternal and child health care output indicators and (more recently) HIV/AIDS and tuberculosis indicators. While a first impact evaluation of PBF in Rwanda refers to positive results in e.g. the use and quality of some maternal and child health care services, others doubt if these results can only be attributed to PBF. There are also risks being associated with PBF such as the 'crowding-out' effect (diminishing or erasing of intrinsic motivation due to external rewards) and 'gaming' (too much focus on indicators that are in the system hereby neglecting non rewarded indicators or falsification of results to maximise reward).

At local (district) level, there also some efforts to increase participation of actors outside government through the use of participatory evaluation tools such as citizen report cards and community scorecards. However, given the fact that the fiscal decentralisation has so far been limited there is little local discretion in planning and spending which puts the use of information gathered through participatory tools into perspective.

Participation of actors outside government

The potential for participation of actors outside government which exists at local level is less evident at central level. Whereas national NGOs and umbrella organisation are invited to participate in Joint Technical Working Groups (TWGs), the level of effective participation in these fora is low. This observation does not only hold for the health sector and is indicative of the more generally noted fact that there is little room for outside government actors to hold government accountable. Along the same lines, there is no clear dissemination strategy for data and M&E outputs, the oversight capacity of parliament is limited, access to information for all non-governmental actors (including donors) is restrained, the degree of independence of the oversight M&E unit which will be established in the Ministry of Health is not clear, forward looking components of the PFM system (e.g. budget planning) outperform backward looking components (reporting), and there is suboptimal functioning of the coordination and exchange fora among government and non-state actors.

Whereas different fora for technical dialogue (TWGs) and policy dialogue (Joint Health Sector Working Group (JHSWG) and the Joint Health Sector Review (JHSR)) exist in the health sector, they have not been used optimally so far. Several shortcomings have been noted including the lack of linkage among TWGs and the more policy-oriented JHSWG, the lack of exchange and triangulation of data among different donors and non-governmental actors who have access to different types of information, lack of mapping of different donor initiatives, lack of systematic linkage among the day-to-day work of the TWGs and the JHSRs which are organised twice a year (one backward looking and one forward looking). While quality of

[35] This data originates from the DHS 2005 and is significantly lower than WHO data that refers to a maternal mortality rate of 1300/100,000 in 2005.

JHSRs is improving over time through the inclusion of field visits, the more timely availability of data, etc., there is so far little focus in the JHSR on analysis of the health M&E system itself. This is somehow counter to what is expected from donors (certainly SBS donors) who in principle rely upon the health sector M&E system for their own accountability needs. Joint assessment of the quality of health sector (M&E) systems might also feed into less fragmented M&E capacity building plans. At this moment, several donors (most prominently USAID through Management Science for Health and UNDP) are involved in highly similar health sector M&E capacity building efforts without ensuring the necessary coordination amongst each other. There are a number of interesting ongoing and upcoming opportunities to improve the functioning of the existing arena: the recent TWG reform and the SWAP structure can help to strengthen the coordination structure, the resource tracking tool can facilitate a better overview of who is doing what and the establishment of the Single Project Implementation Unit (SPIU) within the Ministry of Health might improve coordination among donor project M&E. Also the set up of (Belgian sponsored) action research which involves local researchers and the feedback of this evidence in different arena such as the district health forum, the JWG, the JHSWG, the JHSR is an interesting experiment for follow up. Given the fact that all these initiatives are recent, it is too early to make any firm judgements regarding their implementation and effectiveness.

Use of M&E for accountability

It is also not that spaces for critical reflection are entirely absent: there exist a limited number of outside government actors which do provide analysis and data collection on sensitive issues and who seemingly have found the balance between extreme self-censorship on the one hand and confrontation on the other hand. Strengthening the capacity of such instances of non-government M&E and research is particularly important.

While accountability towards outside government actors (both upward and downward) is limited, accountability inside the government system is strong, particularly at the level of upward accountability from the local to the central level. This is amongst others evident from the system of performance contracts (based on *Imihigo*) which district mayors have signed with the president. These contracts include a set of targets on which the different districts are yearly evaluated during a presidential ceremony. These contracts might also become a useful instrument of accountability of local authorities towards citizens, at least when citizens are also involved in the identification of objectives and targets. The ongoing decentralisation process might be an opportunity to stimulate such type of citizen participation in the future. Another instrument which adds to the instalment of a results-based management culture is the system of performance based financing. As highlighted above, similar to any system of performance based management there are also shortcomings which are mostly related to the fact that ‘management for results’ becomes ‘management by results’ which leads to a focus on ‘quick wins’, ‘gaming’, etc. While there has already been some research on the issue, it remains important to monitor and evaluate ‘performance contracts’ and ‘PBF’ further over time through independent research to remediate possible negative side effects.

References

AfREA (2002) “The African Evaluation Guidelines: 2002”, AfREA.

Baeten, S. (2011) “Health Financial Mechanisms at districts in Rwanda. Study on financial resources made available by the Ministry of Health at the district level”, Consultancy commissioned by the Belgian Technical Cooperation - Joint Health Sector Support – March-April 2011.

Basinga, P., Gertler, P.J., Binagwaho, A., Soucat, A.L.B., Sturdy, J.R., Vermeesch, C.M.J. (2010) “Paying Primary Health Care Centers for Performance in Rwanda”, *Policy Research Working Paper No. 5190,* World Bank, Washington.

BTC (2010) “Debriefing revue santé 5-6 octobre 2010 – Gisenyi”, BTC, Brussels.

BTC (2011) “Technical Note”, first concept May 2011, BTC, Kigali.

Coopération Belge au Développement (2010) “Dossier Technique et Financier: Appui Institutionnel au Ministère de la Santé Phase IV Rwanda”, Code DGCD: 3006009, code Navision: RWA 08 066 11.

Diallo, T. (2007) “Monitoring and evaluation within the Ministry of Health, Rwanda”, publication for review by the United States Agency for International Development.

External Evaluation Team (2008) “Rwanda Health Sector Strategic Plan I 2005-2009 Evaluation Report”, Republic of Rwanda, Kigali.

Government of Rwanda (2005a) “Health Sector Policy”, Government of Rwanda, Kigali.

Government of Rwanda (2005b) “Health Sector Strategic Plan 2005-2009”, Government of Rwanda, Kigali.

Government of Rwanda (2008) “District Health System Strengthening Framework Implementation Plan: Gakenke”, Government of Rwanda, Ministry of Health, district of Gakenke.

Government of Rwanda (2009) “Health Sector Strategic Plan July 2009 – June 2012”, July 2009, Government of Rwanda, Kigali.

Government of Rwanda (2010a) “Offical Development Assistance (ODA) Report”, Government of Rwanda, Ministry of Finance and Economic Planning, External Finance Unit, Kigali.

Government of Rwanda (2010b) “Public Financial Management Performance Report (PFM-PR), Final Report”, Government of Rwanda, Ministry of Finance and Economic Planning, Kigali.

Government of Rwanda and Development Partners (2010) “Rwanda: Joint Governance Assessment”, adapted by Cabinet on 12/09/08.

Hayman, R. (2009) “From Rome to Accra via Kigali: ‘Aid Effectiveness’ in Rwanda”, *Development Policy Review* 27 (5): 581-599.

Health Metrics Network (2008) "Framework and Standards for Country Health Information Systems, (second edition)", World Health Organisation, Geneva.

Holvoet, N. and Rombouts, H. (2008) "The Denial of Politics in PRSP's Monitoring and Evaluation. Experiences from Rwanda", *IOB Discussion Paper No. 2*, Institute of Development Policy and Management, University of Antwerp, Antwerp.

IHP+ (2009) "Joint Assessment of National Health Strategies and Plans. Joint Assessment Tool: the attributes of a sound national strategy", draft July 2009, IHP+.

IMF (2008) "Joint Staff Advisory Note of the Second Poverty Reduction Strategy Paper Economic Development and Poverty Reduction Strategy", IMF, Washington.

Kalk, A., Paul, F.A., Grabosch, E. (2010) "'Payment for performance' in Rwanda: does it pay off?" *Tropical Medicine and International Health* 15 (2): 182-190.

Karengera, S. (2008) "M&E overview of the health sector", powerpoint presentation during a retreat of the Ministry of Health, 23/11/2008.

Kaufmann, D., Kraay, A. and Mastruzzi M. (2009) "Governance Matters VIII Aggregate and Individual Governance Indicators 1996–2008", Policy Research Working Paper No. 4978, World Bank, Washington.

KIT (2009) "Learning Lessons on Implementing Performance Based Financing, from a Multi-Country Evaluation", KIT in collaboration with Cordaid and WHO, Amsterdam.

Martinez, J., Karasi, L. (2009) "Gavi Health System Strengthening Support Evaluation. Rwanda Case Study", HSLP, Londen.

Meessen, B., Soucat, A. and Sekabaraga, C. (2011) "Performance-based financing: just a donor fad or a catalyst towards comprehensive health-care reform?", *Bull World Health Organ* 89: 153-156.

Meloni, R. and Sijtzema, J. (2010a) "Joint Health Sector Support Rwanda", draft report no7: April to June 2010, BTC, Kigali.

Meloni, R. and Sijtzema, J. (2010b) "Joint Health Sector Support Rwanda", report no8: July to December (Q3 and Q4) 2010, BTC, Kigali.

M&E Taskforce (2009) "Rwanda Health Information Systems Assessment Report", M&E Taskforce, Ministry of Health.

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

Ministry of Health (2007) "Memorandum of Understanding between the Ministry of Health and Health Sector Development Partners", Ministry of Health, Kigali.

Ministry of Health (2009) "Annual Report", Ministry of Health, Kigali.

Ministry of Health (2010) "Rwanda Health Systems Strengthening Framework and Consolidated Strategic Plan 2009-2012", version 1.c, 27 August 2010, Ministry of Health, Kigali.

National Institute of Statistics of Rwanda (2007) “National Institute of Statistics Strategic Plan 2007-2011”, Republic of Rwanda, Kigali.

OECD/DAC (2005) Paris Declaration on Aid Effectiveness, Paris, OECD/DAC.

OECD/DAC (2008) *2008 Survey on Monitoring the Paris Declaration. Effective Aid by 2010? What it will take*, Paris, OECD/DAC.

Republic of Rwanda (2000) “Rwanda Vision 2020”, Republic of Rwanda, Kigali.

Republic of Rwanda (2007a) “Economic Development and Poverty Reducation Strategy”, Republic of Rwanda, Kigali.

Republic of Rwanda (2007b) “Rwanda Decentralization Strategic Framework. Towards a sector-wide approach for decentralization implementation”, Republic of Rwanda, Ministry of Local Government, Good Governance, Community Development and Social Affairs, Kigali.

Republic of Rwanda (2008a) “National planning, budgeting and MTEF guidelines”, Republic of Rwanda.

Republic of Rwanda (2008b) “Community Development Policy”, revised version, April 2008, Republic of Rwanda, Ministry of Local Government.

Republic of Rwanda (2009a) “Rwanda Health Statistical Booklet”, Republic of Rwanda, Ministry of Health.

Republic of Rwanda (2009b) “Health Sector Monitoring and Evaluation Strategy 2009/10 - 2012/13”, Republic of Rwanda, Ministry of Health.

Republic of Rwanda (2009c) “Health Sector Monitoring and Evaluation Policy”, Republic of Rwanda, Ministry of Health.

Republic of Rwanda (2011) “Human Resources for Health Strategic Plan 2011-2016”, Republic of Rwanda, Ministry of Health.

Republic of Rwanda and Development Partners (2008) “Memorandum of Understanding governing the provision of direct budget support in the implementation of Rwanda’s Economic Development and Poverty Reduction Strategy”, Kigali.

République du Rwanda (2007a) “Plan de Développement du District de Nyarugenge 2008-2012”, République du Rwanda, Ville de Kigali, District de Nyarugenge.

République du Rwanda (2007b) “Plan de Développement Quinquennal du District de Gakenke 2008-2012”, République du Rwanda, Province du Nord, District de Gakenke.

RTI International (2006) “Rwanda HMIS assessment report”, publication produced for review by the United States Agency for International Development.

Rusa, L., De Dieu Ngirabega, J., Janssen, W., Van Bastelaere, S., Porignon, D. and Vandenbulcke, W. (2009) “Performance-based financing for better quality of services in Rwandan health centres: 3-year experience”, *Tropical Medicine and International Health* 14 (7): 830-837.

SNV (2009) “Joint Action Development Forum in Rwanda. Experiences and lessons learned”, SNV.

UNDP (2010) Human Development Report 2010. The Real Wealth of Nations: Pathways to Human Development, New York, UNDP.

World Bank (2007) Results-Based National Development Strategies. Assessment and Challenges Ahead, Washington, World Bank.

World Bank (2010) "Worldwide Governance Indicators. Country Data Report for Rwanda, 1996-2009, World Bank, Washington.

World Health Organisation (2010) "World Health Statistics 2010", World Health Organisation, Geneva.

http://www.devpartners.gov.rw
http://www.minaloc.gov.rw/spip.php?article16
http://www.oecd.org/dac/stats
http://www.paris21.org

Annex 1: Terms of Reference O*Platform Aid Effectiveness: assessing sector M&E systems

Background
The recent OECD/DAC peer review of Belgian DC emphasizes the need to increase efforts in the area of 'strengthening and using country systems' (see OECD/DAC, 2010, p. 72-73, 80). Belgium is not unique in this respect. The evaluation of the implementation of the Paris Declaration (PD) (Wood et al, 2008) highlights that improvements in the use of country systems is slow and largely limited to the area of financial management, audit and procurement. When it comes to the use of recipient M&E systems, donors are generally more reluctant as they do not have enough confidence in the quality of these systems. This is not so surprising and justified by the fact that only 3 out of 54 countries included in the 2008 PD survey had results-oriented frameworks that were deemed adequate (OECD/DAC, 2008).

While strengthening of M&E systems does not seem to be a priority of many donors and partner countries, if donors, and in particularly Belgium, want to make progress on the 'alignment' and the 'managing for results' principle, more efforts are needed to strengthen and use the recipient M&E systems. Strengthening recipient M&E systems generally improves accountability and learning which may ultimately lead to increased performance and results on the ground.

Along the same line, it has been observed that the quality of joint sector reviews largely depends on the quality of the underlying sector M&E system (Holvoet and Inberg, 2009). An assessment of the quality of sector M&E systems highlights to what extent further JSRs could rely on performance information from the recipient M&E system and indicate which components of the system need further strengthening in order to rely upon these systems in the future. Strengthening sector M&E systems will improve the quality of the JSR in the short run and change its outlook in the long run (JSR more as a monitoring and evaluation of the existing M&E system including some reality checks on the ground instead of being a monitoring and evaluation instrument of activities and outputs).

Objectives:
A first step in strengthening M&E systems is the assessment/diagnosis of their quality. According to our knowledge, so far no (standard) instrument exists to assess the quality of M&E systems (which is in strong contrast to the existence and use of PFM assessment instruments). Therefore, the first objective of the study is

- To elaborate an assessment tool to diagnose/monitor/evaluate the quality of sector M&E systems.[36]

The second objective is:

- To apply this tool to a number of selected number of cases where Belgium is providing sector budget support.

Results of the assessment exercise should contribute to the M&E aspects of the Technical Notes and could be an input in Joint Sector Working Groups (in line with the harmonisation principle, it would also be a good idea to discuss the exercise ex-ante within the sector working groups dealing with M&E) and Joint Sector Reviews.

Methodology and time estimation

Elaboration of assessment tool

[36] As far as we can judge from the technical note, our study will in particular help to tackle issue 2.5 in a more in-depth and systemic way. Results of the assessment will highlight to what extent the entire assessment exercise (e.g. assessment of performance) may rely upon the information from the recipient M&E system.

On the basis of the checklist used by Holvoet and Renard (2007) in their diagnosis of PRSP M&E of 11 SSA countries, we will elaborate an assessment tool for sector M&E systems. For the elaboration we will consult several existing documents on assessment tools and scrutinize if other donors might already use tools to assess sector M&E systems.

Days: 2

Application of assessment tool
The methodology of the application of the assessment tool in countries where Belgium is providing sector budget support will consist of both desk and field study. In consultation with BTC two sectors in four countries have been selected: the health sector in Niger and Rwanda, the education sector in Uganda and Vietnam.

For each country we will examine documents available on the health respectively education sector, the (sector) M&E systems, the indicative cooperation programs etc. During the field study we will interview people directly involved in and responsible for sector M&E (preferably at central and district level), donors involved in strengthening the M&E system and users of sector M&E products.

The estimated days needed per country are:

Preparation	5
Fieldwork	5
Writing report	5
Debriefing	0.5
Total	**15.5**

Thus the total estimated days for the study are 64 days (4x15.5 +2).

We will start with the desk studies for the health sector in the end of 2010, field studies in Niger[37] and Rwanda will take place in the first half of 2011. Decisions on the exact timing for the education sector studies are not yet made.

[37] The field study to Niger has been postponed because of security issues.

Annex 2: Checklist M&E system at sector level

	Topics	Question
1. Policy		
1	M&E plan	Is there a comprehensive M&E plan, indicating what to evaluate, why, how, for whom?
2	M versus E	Is the difference and the relationship between M and E clearly spelled out?
3	Autonomy & impartiality (accountability)	Is the need for autonomy and impartiality explicitly mentioned? Does the M&E plan allow for tough issues to be analysed? Is there an independent budget?
4	Feedback	Is there an explicit and consistent approach to reporting, dissemination, integration?
5	Alignment planning & budgeting	Is there integration of M&E results in planning and budgeting?
2. Methodology		
6	Selection of indicators	Is it clear what to monitor and evaluate? Is there a list of indicators? Are sector indicators harmonised with the PRSP indicators?
7	Quality of indicators	Are indicators SMART (specific, measurable, achievable, relevant, time-bound)? Are baselines and targets attached?
8	Disaggregation	Are indicators disaggregated by sex, region, socio-economic status?
9	Selection criteria	Are the criteria for the selection of indicators clear? And who selects?
10	Priority setting	Is the need acknowledged to set priorities and limit the number of indicators to be monitored?
11	Causality chain	Are different levels of indicators (input-output-outcome-impact) explicitly linked (program theory)? (vertical logic)
12	Methodologies used	Is it clear how to monitor and evaluate? Are methodologies well identified and mutually integrated?
13	Data collection	Are sources of data collection clearly identified? Are indicators linked to sources of data collection? (horizontal logic)
3a. Organisation: structure		
14	Coordination and oversight	Is there an appropriate institutional structure for coordination, support, oversight, analyses of data and feedback at the sector level? With different stakeholders? What is its location?
15	Joint Sector Review	Does the JSR cover accountability and learning needs for both substance and systemic issues? What is the place/linkage of the JSR within the sector M&E system? Does the JSR promote the reform agenda of the Paris Declaration?
16	Sector Working groups	Are sector working groups active in monitoring? Is their composition stable? Are various stakeholders represented?
17	Ownership	Does the demand for (strengthening of the) M&E system come from the sector ministry, a central ministry (e.g. ministry of planning or finance) or from external actors (e.g. donors)? Is their a highly placed 'champion' within the sector ministry who advocates for the (strengthening of the) M&E system?
18	Incentives	Are incentives (at central and local level) used to stimulate data collection and data use?
3b. Organisation: linkages		
19	Linkage with Statistical office	Is there a linkage between sector M&E and the statistical office? Is the role of the statistical office in sector M&E clear?
20	'Horizontal' integration	Are there M&E units in different sub-sectors and semi-governmental institutions? Are these properly relayed to central sector M&E unit?
21	'Vertical' upward integration	Is the sector M&E unit properly relayed to the central M&E unit (PRS monitoring system)?
22	'Vertical'	Are there M&E units at decentralised levels and are these properly

	downward integration	relayed to the sector M&E unit?
23	Link with projects	Is there any effort to relay with/ coordinate with donor M&E mechanism for projects and vertical funds in the sector?
4. Capacity		
24	Present capacity	What is the present capacity of the M&E unit at central sector level, sub-sector level and decentralised level (e.g. fte, skills, financial resources)?
25	Problem acknowledged	Are current weaknesses in the system identified?
26	Capacity building plan	Are there plans/activities for remediation? Do these include training, appropriate salaries, etc.?
5. Participation of actors outside government		
27	Parliament	Is the role of Parliament properly recognised, and is there alignment with Parliamentary control and oversight procedures? Does Parliament participate in Joint Sector Reviews and/ or sector working groups?
28	Civil Society	Is the role of civil society recognised? Are there clear procedures for the participation of civil society? Is the participation institutionally arranged or rather ad-hoc? Does civil society participate in Joint Sector Reviews and/ or sector working groups?
29	Donors	Is the role of donors recognised? Are there clear procedures for participation of donors? Do donors participate in Joint Sector Reviews and/ or sector working groups?
6. Use of information from M&E		
30	Outputs	Is there a presentation of relevant M&E results? Are results compared to targets? Is there an analysis of discrepancies? Is the M&E output differentiated to different audiences?
31	Effective use of M&E by donors	Are donors using the outputs of the sector M&E system for their information needs? Is the demand for M&E data from donors coordinated?
32	Effective use of M&E at central level	Are results of M&E activities used for internal purposes? Is it an instrument of policy-making and/or policy-influencing and advocacy?
33	Effective use of M&E at local level	Are results of M&E activities used for internal purposes? Is it an instrument of policy-making and/or policy-influencing and advocacy?
34	Effective use of M&E by outside government actors	Are results of M&E used as an instrument to hold government accountable?

Poor (= 1)
Partially satisfactory (= 2)
Satisfactory (= 3)
Good (= 4)
Excellent (= 5)

Annex 3: Assessment criteria used to score progress towards operational development strategies (*www.oecd.org*)

Score	Unified strategic framework	Prioritization	Strategic link to the budget
L	Government action is not guided by a long-term vision linked to a medium-term strategy, and there is little to no effort within the country to develop or update these strategic instruments.	There is little to no effort within the country to define long-term objectives and medium-term or short-term targets.	There has been little or no attempt to cost a medium-term strategy and link it to the budget, including through devising a medium-term fiscal framework.
E	A medium-term strategy is under preparation, but may not yet be derived from a long-term vision. Sector strategies are few, and may not yet be tied into a medium-term strategy. A strategic framework may be guiding short-term government action.	Initial efforts are underway to define holistic long-term objectives and prioritized medium-term or short-term targets.	There has been a preliminary attempt to cost a medium-term strategy and link it to the budget, including through initial efforts to prepare a medium-term fiscal framework.
A	There is a long-term vision and a medium-term strategy or strategies that may not be linked. Strategies in key sectors may not yet be integrated into national development strategy. The role of different strategy instruments in guiding policy is unproven, unclear, or provisional. Where they exist, efforts to align local with national strategy are preliminary.	There is a preliminary set or sets of specific long-term objectives and medium-term targets, and some prioritization of sequenced actions including attention to cross-cutting issues.	The medium-term strategy has been costed, linked to the medium-term fiscal framework and has some limited influence over the budget.
D	There is a long-term vision and medium-term strategy derived from the vision that is a reference point for policymakers, nationally, locally and at the sector level. Sector strategies and local development planning stem from the medium-term strategy and are sequenced with it.	The long-term vision and medium-term strategy identify objectives and targets linked to the MDGs but tailored, with some specificity, to country circumstances. The medium-term strategy focuses on a prioritized set of targets. It adequately addresses cross-cutting issues such as gender, HIV/AIDS, the environment, and governance.	A results framework is in place linking long-term goals to outcomes and outputs. The government is progressing toward performance-oriented budgeting to facilitate a link of the strategy with the medium-term fiscal framework and the budget, and helps focus capacity and resources at the national and local level on national objectives.
S	There are no warning signs of possible deterioration, and there is widespread expectation that the progress achieved is sustainable.		

Annex 4: Assessment criteria used to score progress towards developing a results-orientated framework

Score	Quality of development information	Stakeholder access to information	Coordinated country-level monitoring and evaluation
L	Data collection is sporadic and outdated. Data have little relation to tracking the goals and targets in the long-term vision and medium-term strategy.	Little information on the long-term vision or medium-term strategy is available publicly, either in hard copy or electronically.	The government does not have a strategy or an action plan to develop a country-level M&E system. M&E is still largely fragmented, supported largely by external partners at the project level.
E	Data collection is improving but largely restricted to limited geographic or sectoral areas. Data may not cover key goals and targets in the long-term vision and medium-term strategy.	Some information on the long-term vision or medium-term strategy is available publicly, but may not be updated regularly or widely accessible.	The government has begun developing an M&E strategy and action plan to work toward the development of a country-level M&E system. M&E is still largely fragmented, supported largely by external partners at the project level.
A	Data collection has become more systematic and efforts to extend its geographic or sectoral scope are underway. Data are increasingly related to tracking goals and targets in the long-term vision and medium-term strategy.	Some information on the long-term vision or medium-term strategy and some public expenditure data are publicly available and regularly updated. Efforts may be underway to actively disseminate information.	A country-level M&E system has been at least preliminarily designed and its action plan is in the early stages of implementation but may be without fully coordinated support. The system is not yet functioning at all levels of government or sectors. There may be parallel country-level systems housed in different institutions.
D	Data are generally timely and comprehensive, and directly related to tracking the achievement of country goals and targets identified in the long-term vision and medium-term strategy. There is coordinated and systematic data gathering and analysis.	Information on the long-term vision and medium-term strategy, and progress in implementation, including public expenditure data, is made systematically available, including in local languages and through various media.	Implementation of an action plan for a country-level M&E system is well underway. This system tracks a manageable number of input, output and outcome indicators identified in the medium-term strategy, and produces unified reports used by country policymakers and external partners. Institutional responsibilities for M&E across government are clear.
S	There are no warning signs of possible deterioration, and there is widespread expectation that the progress achieved is sustainable.		

Annex 5: Roles and responsibilities of local administration in the health sector after the reform (MINISANTE)

Level of administration		**Basic health**	**Fight against AIDS and other pandemics**	**Promotion of basic hygiene**	**Promotion of health nutrition**	**Specialised medical care**	**Medical insurance scheme**
National	Objective	Determine basic health care and best it can be delivered.	Determine best method of fighting AIDS.	- Determine way of promoting basic hygiene; - Promotion of general Hygiene.	Determine method of promoting healthy nutrition.	Establish hospitals which give specialised treatment.	Determine method by which medical insurance schemes can deliver better services.
	Responsibility	Determine policy, laws, decrees, regulations and basic medical equipment.	Determine policy, laws, decrees, regulations and equipment to fight AIDS.	- Determine policy, laws, decrees, regulations, equipment and to promote hygiene; - Determine where all waste materials shall be assembled and disposed of.	Decide policy, laws, decrees, regulations, equipment that would promote proper nutrition.	- Put in place, laws, decrees, regulations which govern institutions that give specialised medical care; - Determine procedures to monitor specialised medicine.	- Decide policy, laws, decrees, regulations, equipment to promote health insurance schemes; - Determine, put in place and monitor a health insurance scheme emergency fund.
City of Kigali	Objective	Monitor the implementation of policy, laws, and decrees which promote basic health care.	Monitor the implementation of policy, laws, decrees which fight AIDS.	- Monitor the implementation of hygiene policy, laws and decrees; - Monitor the improvement of hygiene; - Promote hygiene in general.	Monitor the implementation of policy, laws, decrees which promote healthy nutrition.		Monitor the implementation of policy, laws, decrees, which promote health insurance schemes.
	Responsibility	- Explain to Districts policy, laws, and decrees; - Assist Districts to integrate the official policy into District planning.	- Explain to Districts policy, laws, and decrees; - Assist Districts to integrate the official policy into the District planning.	- Explain to Districts policy, laws, and decrees; - Assist Districts to integrate promotion of hygiene policy	- Explain to Districts policy, laws, and regulations; - Assist Districts to integrate official policy into		- Explain to Districts policy, laws, and decrees; - Assist the Districts to integrate official policy into planning.

				into planning; - Monitor hygiene in higher institutions; - Determine where products should be dumped.	District planning.		
Province	Objective	Monitor the implementation of primary health policy, laws and decrees.	- Monitor the implementation of policy, laws and decrees to fight AIDS.	- Monitor the implementation of policy, laws and decrees to promote hygiene.	- Monitor the implementation of policy, laws and decrees to promote better nutrition.		- Monitor the implementation of policy, laws and decrees to promote health insurance schemes.
	Responsibility	- Explain policy, Laws and decrees to Districts; - Assist Districts in the implementation of planning policies.	- Explain policy, laws and decrees to Districts; - Assist Districts in the implementation of planning policies.	- Explain policy, laws and decrees to Districts; - Assist Districts in the implementation of planning policies.	- Explain policy, laws and decrees to Districts; - Assist Districts to implement planning policies.		- Explain policy, laws and decrees to Districts; - Assist Districts in the implementation of planning policies.
District	Objective	Enhance good functioning of hospitals.	- Assist health centres to fight AIDS; - Treat AIDS patients transferred from health centres.	- Enhance general hygiene.	- Assist Sectors to promote better nutrition.		- Establish a health insurance scheme institution.
	Responsibility	- Put in place Executive Council for hospitals; - Monitor the functioning of hospitals through these Executive Committees; - Mobilise resources for hospitals; - Sign contracts with hospitals and approve those of health centres; - Monitor the	- Train employees of health centres in AIDS related programmes and monitor their work; - Give support to health centres; employees/nurses to implement AIDS prevention activities; - Give special attention to AIDS patients transferred from health centres.	- Designate special zone for waste products.	- Train employees of health centres; - Monitor how they work; - Mobilise equipment.		- Recruit and train employees; - Mobilise equipment; - Ensure there is office space and other related work places; - Instal Executive Committee; - Instal leaders; - Monitor the development of health centres and insurance schemes.

		functioning of health centres at technical level.					
Sector	Objective	Enhance the functioning of health centres.	Test and give treatment to AIDS patients.	Enhance general hygiene.	Assist "Imidugudu" to enhance proper nutrition.		Assist "Imidugudu" to promote health insurance schemes.
	Responsibility	- Establish Executive Committee for health centres; - Monitor the functioning of health centres through these Executive Committees; - Mobilise resources for health centres.	- Instal in health centres AIDS testing kits; - Build health centres capacity to treat AIDS related deseases; (Train staff, mobilise equipment).	- Designate area where waste products should be dumped.	- Train Sector health councillors; - Monitor how they work; - Mobilise equipment.		- Train health Councillors; - Monitor how they work; - Mobilise equipment.
Cell	Objective	Integrate and harmonise Cell and "umudugudu" activities.	Integrate and harmonise Cell and "umudugudu" Activities.	- Integrate and harmonise Cell and "umudugudu" activities; - Enhance general hygiene.	Integrate and harmonise Cell and "umudugudu" activities.		Integrate and harmonise Cell and "umudugudu" activities.
	Responsibility	Monitor the functioning of health councillors and other volunteers in the "umudugudu".	Monitor the fight against AIDS activities in the "umudugudu".	- Monitor and enhance hygiene activities in the "umudugudu"; - Evaluate hygiene activities; - Designate zone where waste products must be dumped.	- Monitor good nutritional activities in the "umudugudu".		- Monitor how health insurance schemes are working and the frequency of joining by the population;
Umudugudu	Objective	- A healthy nation; - Enhance health insurance schemes; - Reduce child mortality rate; - Reduce death rate among pregnant mothers.	- Fight against AIDS, malaria, tuberculosis and other pandemics; - Home care for AIDS victims; - Fight against domestic child mortality.	- Enhance personnel and domestic hygiene; - Promote hygiene in general.	- Promote proper nutrition;		- Insurance the number of people joining health insurance schemes.
	Responsibility	- Avail health councillors;	- Mobilise the population to fight	- Promote personal and domestic hygiene;	- Sensitise the population about		- Sensitise the population to join health

		- Create awareness among the population about hygiene and primary health care; - Mobilise the population to join health insurance schemes; - Select those to be assisted to join health insurance schemes; - Give children basic, emergency health are before taking them to hospitals; - Sensitise pregnant women to go for antenatal health care and deliver children in health centres or hospitals; - Register deaths and submit reports on death rate.	AIDS, malaria, and other pandemics; - Distribute condoms; - Visit and assist AIDS victims; - Give children emergency drugs to fight malaria and other child diseases; - Distribute mosquito nets; - Mobilise parents to have children vaccinated; - Mobilise people suffering from tuberculosis to access drugs.	- Collect data on homes without latrines and waste pits; - Designate zone where to dump waste materials.	healthy feeding; - Assist the population monitor the growth of their children.		insurance schemes; - Collect data on people who are not in health insurance schemes and encourage them to join.

Source: Republic of Rwanda, 2007b

Annex 6: Strategic/global objectives, strategies/specific objectives and projects for the health sector in Nyarugenge and Gakenke

	Strategic/global objectives	Strategies/ specific objectives	Projects
Nyarugenge	1. Strengthen, in an innovative and sustainable way, mechanisms for financial access to qualitative health care for the most disadvantage population; 2. Improve the geographical accessibility of qualitative health services; 3. Increase the availability and accessibility of qualitative drugs, vaccines and consumables; 4. Improve the quality and demand for services in disease control; 5. Strengthen the institutional capacity of health facilities; 6. Improve human resources (quality and quantity) in the health sector.	1.1 Facilitation of access to health mutuelles; 1.2 Extension of services covered by the health mutuelles; 1.3 Harmonisation of health interventions; 2.1 Construction and equipment of health facilities; 3.1 Regular supply of drugs, vaccines and basic consumables of health facilities; 4.1 Strengthening maternal health services; 4.2 Strengthening reproductive health services and family planning in order to reduce demographic growth; 4.3 Reducing the incidence of infectious and child diseases by improving the promotion, prevention, care and treatment of malaria, tuberculosis and HIV/AIDS: 4.4 Reducing the incidence and prevalence of child diseases through Integrated Management of Childhood Illness; 4.5 Improving the quality of care; 4.6 safeguarding hygiene and sanitation; 4.7 Consolidating the organizational structures of health facilities 5.1 Capacity building of health facility staff; 6.1 Stimulation (motivation) of staff.	1. Awareness and increase the number of adherents to health mutuelle (224 million rwf) 2. Making a district hospital of the Muhima hospital (350 million rwf) 3. Construction and equipping of health centres (1,770 million rwf) 4. Organise activities to safeguard hygiene in households and health facilities (300 million rwf) 5. Strengthen the fight against HIV / AIDS (1,000 million rwf) 6. Strengthen capacity of health facilities and hospital staff (340 million rwf) 7. Construction and equipment district pharmacy (300 million rwf)
Gakenke	Promote and ensure the health of the population by providing qualitative preventive, curative, promotional and rehabilitative health services	1. Increase the quantity and improve the quality of human resources; 2. Improve the availability of quality drugs, vaccines and consumables; 3. Expanding geographic access to health services; 4. Make health services financially accessible; 5. Improve the quality and demand for services in disease control; 6. Strengthen the institutional capacity of the health sector.	1. Rehabilitation of health facilities, equipment of all health facilities and capacity building (407,350,000 million rwf) 2 Construction of 30 community health posts in cells further away from health centers (132,998,400 rwf) 3 Construction of health infrastructure (1 hospital and 4 health centers) (1,850,550,000 rwf) 4 Intellectual and financial capacity building (740 million rwf)

Sources: République du Rwanda, 2007a and 2007b

Annex 7: Rwanda's health sector M&E system: assessment results for the different topics

	Topics	Question
1. Policy		
1	M&E plan	2
2	M versus E	3
3	Autonomy & impartiality (accountability)	2
4	Feedback	2
5	Alignment planning & budgeting	4
2. Methodology		
6	Selection of indicators	4
7	Quality of indicators	3
8	Disaggregation	2
9	Selection criteria	2
10	Priority setting	3
11	Causality chain	2
12	Methodologies used	1
13	Data collection	3
3a. Organisation: structure		
14	Coordination and oversight	2
15	Joint Sector Review	2
16	Sector Working groups	2
17	Ownership	4
18	Incentives	2
3b. Organisation: linkages		
19	Linkage with Statistical office	2
20	'Horizontal' integration	2
21	'Vertical' upward integration	4
22	'Vertical' downward integration	2
23	Link with projects	2
4. Capacity		
24	Present capacity	3
25	Problem acknowledged	3
26	Capacity building plan	2
5. Participation of actors outside government		
27	Parliament	1
28	Civil Society	2
29	Donors	2
6. Use of information from M&E		
30	Outputs	2
31	Effective use of M&E by donors	2
32	Effective use of M&E at central level	3
33	Effective use of M&E at local level	2
34	Effective use of M&E by outside government actors	1

Poor (= 1)
Partially satisfactory (= 2)
Satisfactory (= 3)
Good (= 4)
Excellent (= 5)

Annex 8: SWOT: Rwanda's health sector M&E system/arrangements (1)

STRENGTHS	**WEAKNESSES**
• **components of M&E policy & plan exist** • **components of M&E system exist** • **MONITORING framework well established** ▪ indicators, targets and baselines ✓ harmonisation efforts ✓ prioritisation efforts • data collection ✓ SIS, Tracnet, NISR (census, surveys), ✓ ↑ quality and exchange efforts	• **no unified M&E policy, strategy, plan** • **no M&E oversight unit** → fragmentation & reformitis block implementation • **lack of EVALUATION (analysis)** ← lack of disaggregation ← lack of causal chains of indicators ← lack of qualitative data ← little cross-reading among data sources →low analytical quality of M&E output →weakens learning →weakens quality of JHSR
OPPORTUNITIES	**THREATS**
• **need for analysis and disaggregation will arise if progress in health sector outcomes slows down**	• **indicatorism** • **renewed proliferation of data collection** • **management by results > management for results**

SWOT: Rwanda's health sector M&E system/arrangements (2)

STRENGTHS	WEAKNESSES
• **↑ of vertical integration among MoH and local level (vertical downward integration) in terms of data collection** • **↑ of vertical integration among M&E at MoH and central EDPRS (vertical upward integration)** ▪ EDPRS M&E focal point at MoH	• **central > local level** ▪ identification of indicators ▪ upwards information flows > downward feedback • **overlapping, unclear division of mandates** → tensions over health sector M&E leadership
OPPORTUNITIES	**THREATS**
• **decentralisation opens opportunities for more autonomous local level (participatory) M&E** ▪ elaboration of district development plan ▪ joint action and development forum (JADF) ▪ use of citizen report cards ▪ use of service satisfaction surveys	• **lack of fiscal decentralisation limits local level discretion in planning and budgeting** • **JADF becomes instrument to control local level NGOs**

SWOT: Rwanda's health sector M&E system/arrangements (3)

STRENGTHS	**WEAKNESSES**
• **several fora for exchange among government & (parallel) donor M&E systems exist**	• **existing fora not optimally used** ▪ limited linkage TWG – JSCG → ↓ evidence-based policy dialogue ▪ linkage TWG – HSCG underexploited ▪ fora focus more on forward looking dimensions (planning) than backward looking (reporting, M&E) ▪ advantage of different aid modalities and access to different types of data not enough grasped ▪ little joint analysis of sector systems (systemic issues not enough on agenda) ▪ lack of coordinated capacity building of M&E system
OPPORTUNITIES	**THREATS**
• **Set up of single project implementation unit might reduce parallel donor M&E** • **TWG reform opens opportunities for improved functioning of exchange fora** • **Set up of TWG health policy, planning, M&E** → might increase focus on systemic issues → might increase coordinated capacity building of system → might increase linkage between TWG as a day to day M&E instrument and the JHSR which is organised twice a year • Start up of action research with local level universities and researchers → increase evidence base & evidence-based policy dialogue → capacity building of local universities & researchers	• **Reduced parallel donor M&E limits evidence base and creates biases if government's M&E lacks independence**

SWOT: Rwanda's health sector M&E system/arrangements (4)

STRENGTHS	WEAKNESSES
• **ad-hoc use of M&E for feedback and learning exists** ▪ commitment to evidence-based decision-making ▪ linkage M&E – planning ▪ strong leadership ▪ strong reactivity	• **no systematic learning** ▪ not on sensitive issues (e.g. claims of inequality) ▪ control blocks innovation ▪ so far more feedback/learning at central level
• **strong internal (government) accountability** ▪ particularly local to central ✓ performance contracts ('imihigo') ✓ PBF	• **limited accountability to the outside (upward and downward)** ▪ level of independence of oversight M&E unit unclear ▪ vague M&E dissemination strategy (limited access to information for actors outside government) ▪ limited parliamentary oversight ▪ limited state-society interaction
• **some spaces for critical reflection outside government exist** ▪ e.g. International Research for Peace and Democracy (IRDP)	• **existing room of manoeuvre not optimally used by actors outside government** ▪ difficult balance between self-censorship and confrontation
OPPORTUNITIES	**THREATS**
• **decentralisation opens opportunities for more local level evidence-based decision-making** • **integration of citizen's voice in performance contracts opens opportunities for local level accountability to citizen's** • **action research increases independent evidence base and may be used in policy dialogue** • **opportunities for networking and bridging among M&E of different actors outside government (CSOs, researchers, national evaluation societies, etc.)**	• **lack of fiscal decentralisation blocks local level use of M&E**

Annex 9: Key indicators and targets in Vision 2020, MDGs, EDPRS, CPAF and SBS

Indicator	Baseline 2005/6/7	Target Vision 2020	Target MDGs 2015	Target EDPRS 2012	Target CPAF 2012	Target SBS	Target HSSP
Utilisation rate curative services outside Kigali (HC and private dispensaries)	TBD 2009 end					0.6	TBD
Total fertility rate (average no. of children per woman)	5.5 (2)	4.5		4.5	4.5		4.5
Women 15-49 using modern contraceptive methods	27% (2)			70%	50%		50%
Maternal mortality rate per 100,000 live births	750 (3)	200	268	600	600		600
% of pregnant women with 4 antenatal visits	23.9% (2)			50%			50%
% of deliveries in HF	45.2 (2)			75%	60%	52%	75%
Infant mortality rate per 1000 live births	62 (2)	50	28	70	70		50
IMR in bottom wealth quintile per 1000 live births	114 (4)			99			99
U5 child mortality rate per 1000 live births	103 (2)		47				70
Children and pregnant women using ITNs	15.8% (children) 12.8% (pregnant women)(3)		85%				85%
% of children <5 stunted (height for age)	45% (3)		24.5%	27.2%			27%
% of children <5 underweight (weight for age)	22% (3)		14.5%	14%			14%
% of children <5 wasted (weight for height)	4% (3)		2%	2.5%			2.5%
% of children fully immunised	75% (3)			85%	95%	92%	85% 95%
HIV prevalence in the population aged 15-24	1.0% (3)			0.5%			0.5%
% of still alive (adults & children) and on treatment 12 months after initiation of ART	89 % children (1) 86% adults			90%			
% of HIV Pregnant women who received ART to reduce the risk of MTCT	5.6% (1)			90%			
Condom utilisation rate by gender	26% women 39% men (1)			35% W 50% M			30%

(1) HMIS
(2) IDHS 2008
(3) DHS 2005
(4) EICV