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November 2010

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1. INTRODUCTION

The 2005 Paris Declaration (PD) sets outs a reform agenda for donors and recipients with the aim to scale up for more effective aid. Commitments are made around five core principles, including 'ownership', 'alignment', 'harmonisation', 'managing for results' and 'mutual accountability' and have been reaffirmed through the 2008 Accra Agenda for Action (AAA). Measurement of progress in the implementation of the PD/AAA is based upon 12 indicators (OECD/DAC, 2005).

The indicator for measuring progess in the 'management for results' principle is the "number of countries with transparent and monitorable performance assessment frameworks to assess progress against (a) the national development strategies and (b) sector programmes" (OECD/DAC, 2005: 10). The indicator is composed of three sub-components, i.e. 'stakeholder access to information', 'quality of information' and 'coordinated country-level M&E'. While commitments of donors in the area of 'results-orientation' are not captured in an indicator, they promised to "link country programming and resources to results and align them with effective partner country performance assessment frameworks, and to refrain from requesting the introduction of performance indicators that are not consistent with partners' national development strategies". Additionally, they committed themselves to "work with partner countries to rely, as far as possible, on partner countries' results-oriented reporting and monitoring frameworks" and to "harmonise their monitoring and reporting requirements, and, until they can rely more extensively on partner countries' statistical, monitoring and evaluation systems, [work] with partner countries to the maximum extent possible on joint formats for periodic reporting" (OECD/DAC, 2005a: 8). Moreover, donors and partner countries jointly committed to "work together in a participatory approach to strengthen country capacities and demand for results based management" (OECD/DAC, 2005a: 8).

Despite these commitments, progress in the implementation of reforms in this area is slow. The last update of the Comprehensive Development Framework (CDF) report (World Bank, 2007), on which indicator 11 is based, reveals that only three out of 54 countries surveyed had result-oriented frameworks that were deemed adequate (OECD/DAC, 2008:58-59). While most countries have a number of monitoring and evaluation (M&E) activities and arrangements in place, there is often a lack of coordination between different components of a system. Donors, from their side, are reluctant to rely on systems which are only partially developed. Their reluctance to align simultaneously blocks the further elaboration and maturing of recipient systems. In order to escape this persistent chicken-and-egg-dilemma, a pragmatic two-track approach could be a possible way forward. It combines the set-up and/or strengthening of recipient M&E systems (long-term) with complementary M&E activities that fulfill the existing M&E needs in the short and middle run (see Holvoet and Renard, 2007; Holvoet and Inberg, 2009).

For a nationally owned and properly functioning performance assessment framework an appropriate organisation of a national M&E system with clear division of responsibilities between different levels and layers of government, with clearly identified information streams and accountability structures between central and line ministries, and between the local and national level, is crucial. This paper focuses on sector M&E arrangements' development in the context of the health Sector Wide Approach (SWAp) in Rwanda. The health sector M&E system is assessed on selected criteria of policy,

methodology, organisation, capacity, participation of non-state actors and use of M&E information. Specific attention is paid to the place of Joint (Sector) Reviews within the M&E system. The assessment mainly draws upon secondary data (e.g. documents from the government of Rwanda, literature on Rwanda and health information systems). The section on Joint Health Sector Reviews is also based upon primary data collected by one of the authors who participated in the November 2008 Joint Health Sector Review.

The structure of the paper is as follows: section two provides background information on monitoring and evaluation in the health sector and focuses in particular on health information systems and joint sector reviews. Section three briefly introduces the Rwanda case study and emphasizes issues related to M&E and development aid. Section four concentrates on Rwanda's health sector and provides information on Rwanda's progress on some health impact indicators, the health policy and –strategy, health systems and health financing. The assessment of the M&E system in Rwanda's health sector in section five demonstrates that the M&E system is so far only partially developed: two out of six dimensions score 'weak', the other four 'partially satisfactory'. Section six concludes and discusses some possible explanatory factors for these low scores.

2. MONITORING AND EVALUATION IN THE HEALTH SECTOR

The concept of Sector Wide Approaches (SWAp) in the health sector was introduced in the nineties as a result of a growing acknowledgement of the limitations of project support (e.g. fragmentation, transaction costs, lack of ownership) and programme aid (e.g. short term, linked to and therefore dependent on macro-economic reforms) (Cassels, 1997) and the belief that progress in health outcomes is not possible without improving health systems (Hutton and Tanner, 2004; IHP+, 2008). Important elements of a health SWAp are a policy framework which is focused on priorities in the health sector, an expenditure framework which budgets these priorities, an institutional framework (strengthening and using national management systems) and a partnership between government and donor agencies (Peters and Chao, 1998). The aim of a SWAp is to ensure a positive link between policies, budgets and institutional arrangements and sector performance, and to adjust the relationship between governments and donors (Cassels, 1997). As most donors and national governments support the Primary Health Care (PHC) approach which includes a decentralisation of delivery of public services and decision-making (Kimaro et al, 2008), the introduction of many SWAps coincides with the initiation of decentralised health delivery systems.

A review of six health SWAps in Africa[1] (Walford, 2007) showcases that SWAps have contributed to better coordination, harmonisation and better policy, planning and resource allocation, but not to lower transaction costs. The review does not draw any firm conclusions regarding the impact on health outcomes. It highlights that, even though a SWAp can strengthen systems "it cannot achieve a transformation of public services and sector performance until there is adequate funding, institutional capacity, and suitably trained, motivated and deployed human resources" (Walford, 2007: 18). Additionally, Walford (2007) emphasizes that the impact of SWAps could be increased if more donors would adhere to the SWAp principles. In Zambia for example, the anticipated contribution of the health SWAp to efficient allocation and use of resources was minimal, which according to Chansa et al (2008) could be related to the fact that the majority of donors who are participating in the health SWAp are still using their own planning, budgeting and reporting formats. The study concludes that in order to achieve a full SWAp all actors in the health sector have to align with sector strategic plans and harmonise implementation and reporting systems. As Chansa et al. (2008: 250) put it, "doing this will not require a modification of the SWAp model itself; it is rather a task of developing systems for planning, funding and monitoring and evaluation which all stakeholders can trust and adhere to".

Monitoring and evaluation systems are one of the areas a SWAp is supposed to strengthen[2] (Hutton and Tanner, 2004). Within the health sector, the M&E system should provide information on inputs (e.g. funding, plan), processes (e.g. capacity building), outputs (e.g. service delivery, health system), outcomes (e.g. service utilisation, equity) and impact (e.g. child mortality, maternal mortality, morbidity) (IHP+2008). The institutionalisation of an M&E system is important as, compared to project aid, donors are no longer able to attribute their financial inputs to specific outputs, they rather have to justify their individual contributions in terms of progress against jointly agreed sector objectives (Cassels, 1997). As financial means

[1] Ghana, Malawi, Mozambique, Tanzania, Uganda and Zambia.
[2] Other areas include country leadership and ownership, institutional and management capacity and flow of resources (Hutton and Tanner, 2004).

and activities to attain the health related Millennium Development Goals (MDGs) are scaled up, the need to invest in a well-functioning M&E system in the health sector is recognised by diverse health partners (IHP+, 2008; Chan et al, 2010), including global health initiatives (GHIs), which are traditionally known for using parallel M&E systems and processes (Biesma et al, 2009). Recently, eight agencies working in the area of global health[3] committed themselves to reserve funding for M&E system strengthening and to support countries in the development of a coherent M&E plan (Chan et al, 2010).

Health information systems are an essential supplier of data for M&E activities (in particular data related to coverage and utilisation; for impact evaluation other data is needed as well, see e.g. Alliance for Health Policy and System Research, 2007). Because health information systems in developing countries are often not integrated and well- functioning, M&E in ministries of health tends to be ad hoc and dependent on demand and resources (Hornby and Perera, 2002). Strengthening sector M&E systems will thus logically entail strengthening of the health information systems. This chapter will further elaborate on health information systems strengthening in section 2.1. Section 2.2. focuses on Joint Sector Reviews (JSRs), a newly created M&E instrument in the SWAp context.

2.1. Health Information System

Donors involved in SWAps, but also global health initiatives such as the GAVI Alliance and the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM), which use results based financing mechanisms, increasingly demand health information for accountability and learning purposes (Health Metrics Network, 2008; World Health Organisation, 2009; Chan et al, 2010). However, health information systems which are expected to produce this information are often very fragmented as a result of the involvement of many different institutions in the production and demand of health information and the various requirements of disease-focused programmes (Health Metrics Network, 2008; IHP+, 2008; Kimaro et al, 2008). As a consequence, information is not easily accessible and health workers responsible for data collection are overloaded with reporting demands from several poorly coordinated subsystems (Health Metrics Network, 2008). Moreover, as these fragmented and weak health information systems are not able to produce the locally relevant data needed for local decision making, decentralisation of health systems is often undermined (Kimaro et al, 2008). In order to draw data from different sources and store information in a way accessible for various users, an integrated health information system is needed with sufficient capacity at all levels to produce, analyse and use information (Kimaro et al, 2008).

Two core requirements of health information systems' strengthening are: (i) a focus on the improvement of the entire health information and statistical system and not only those related to specific diseases and (ii) a concentration on strengthening country leadership for the production and use of health information (Health Metrics Network, 2008). In 2005 the World Health Organisation (WHO) initiated the Health Metrics Network (HMN) with the intention to assist low and low-middle income countries in meeting these two requirements through the 'Framework and Standards for Country Health Information Systems' (i.e. the HMN Framework). The objectives of the HMN Framework are to focus investment and technical assistance on

[3] World Health Organisation, Global Fund to Fight AIDS, Tuberculosis and Malaria, Global Alliance for Vaccines and Immunisation (GAVI), United Nations Population Fund (UNFPA), Human Development Network, UNAIDS, UNICEF, Global Health Program.

standardizing health information system development and to permit access to and better use of improved health information at country and global levels (Health Metrics Network, 2008).

As the HMN framework is supposed to function as “the universally accepted standard for guiding the collection, reporting and use of health information by all developing countries and global agencies'” (Health Metrics Network, 2008: v) it is important to pay attention to this framework in the context of this study. The HMN framework describes six components of a health information system, subdivided into inputs, processes and outputs. The input component encompasses 'health information system resources' and refers to coordination and leadership, information policies and financial and human resources. The three process components are 'indicators', 'data sources' and 'data management'. Indicators are necessary to assess changes in the determinants of health (socioeconomic and demographic factors, environmental and behavioural risk factors), health systems (inputs, outputs and outcomes) and health status (mortality, morbidity and well-being) (Health Metrics Network, 2008). Factors which need to be taken into account when selecting indicators include validity, acceptability, feasibility, reliability, sensitivity to change and predictive validity[4] (Fretheim et al, 2009). Data sources in the health sector mainly include surveys, birth and death registration, census, health facility reporting systems and surveillance and administrative systems (Chan et al, 2010). Strong data management is necessary to ensure data of good quality, which meet some criteria including timeliness, periodicity, consistency, representativeness and disaggregation (Health Metrics Network, 2008). The last two components of a health information system are related to outputs: 'information products' and 'dissemination and use', meaning that data should be compiled, managed and analysed to become information which can subsequently be used for decision-making (Health Metrics Network, 2008). In order for information to be used, however, a well-functioning health information system is not sufficient. For this end the second requirement of health information systems strengthening, country leadership, is essential, as the case of Malawi demonstrates. Even though Malawi’s health information system is considered as one of the best in Africa (Chaulagai et al., 2005), information from this system is still hardly used for decision-making, due to amongst others a lack of skills, resources, leadership and incentives (Chaulagai et al., 2005).

2.2. Joint Sector Reviews

An M&E instrument which is increasingly used within the SWAp context is a joint sector review (JSR). While there is so far no standardised definition, a JSR could be described as “a type of joint periodic assessment of performance in a specific sector with the aim to satisfy donor and recipient's accountability and learning needs” (Holvoet and Inberg, 2009: 205). 'Performance' is to be interpreted broadly and may include a focus on substance at various levels (i.e. inputs, activities, output, outcome and impact) and on underlying, systemic and institutional issues. JSRs are most common in the health and education sector.

[4] Validity is “the extent to which the indicator accurately measures what it purports to measure”; acceptability is “the extent to which the indicator is acceptable to those who are being assessed and those undertaking the assessment”; feasibility is “the extent to which valid, reliable and consistent data are available for collection”; reliability is “the extent to which there is minimal measurement error, or the extent to which findings are reproducible should they be collected again by another organisation”; sensitivity to change is “the extent to which the indicator has the ability to detect changes in the unit of measurement”; predictive validity” is the extent to which the indicator has the ability to accurately predict relevant outcomes” (Fretheim et al, 2009: 3).

In most countries JSRs are organised once or twice a year and engage a broad range of state and non-state stakeholders who are spread over several working groups which focus on specific topics, including quantity and quality of outputs and outcomes, public finance management, human resources and management information systems. The most important input in the JSR is often the sector performance report, prepared by the sector ministry and including financial reporting from the sector finance department or ministry of finance. Information from the sector performance report is sometimes combined with additional in-depth studies on specific topics as well as information from 'project' donors or civil society organisations active in the sector. In some countries field missions are included in the JSRs. Evidence from the different sources subsequently feeds into several working groups for discussion. Conclusions and recommendations from these discussions are usually shared with stakeholders at the Annual Review Meeting (ARM). The main documentary output of the JSR is the Aide Mémoire.

A review of JSRs in the education sectors in Burkina Faso, Mali and Niger (Holvoet and Inberg, 2009) highlighted that the JSRs mainly focused on substance (mainly sector activities and outputs), while institutional and systemic issues (i.e. the underlying health processes, including the HIS) were largely neglected. While this is understandable in the short run as stakeholders are primarily interested in sector 'substance' results, failing to invest in systemic issues runs counter to the increased awareness of the importance of institutional capacity for the successful implementation of SWAps and the sustainable achievement of sector outcomes and impact in the long run (see Cassels, 1997). In spite of these country findings, JSRs have, in principle, the potential to function as M&E exercises that reconcile short and longer term objectives, at least if they make room for M&E system strengthening in the short run. While this necessitates additional investments, it may also lead to more donor alignment with recipient M&E systems and less laborious complementary M&E exercises in the long run. It may also generate a gradually evolving outlook of a JSR; from an assessment of 'substance' to a monitoring and assessment of the quality of sector M&E systems, their main outputs as well as their actual degrees of feedback and usage (i.e. a kind of meta-evaluation instrument[5]). In a similar vein, a recent WHO report refers to JSRs as the key entry point to assess progress and performance of the M&E system (World Health Organisation, 2009). According to Walford (2007), JSRs could not only contribute to the realisation of key principles of 'results-orientation' and 'alignment' but also to the improvement of mutual accountability by also assessing donor performance against Paris Declaration targets, including the transparency and predictability of donor funding.

2.3. Assessment of an M&E system

Prior to the development of an M&E system, it is crucial to start with an assessment of the existing system or arrangements, taking into account both the M&E supply and demand side. So far there does not exist a harmonised M&E diagnostic instrument. There are, however, some interesting independent and donor-led assessments and studies which may provide inspiration. Examples include the evaluation capacity building diagnostic guide and action framework (Mackay, 1999), the highly similar readiness assessment (Kusek and Rist, 2002), the diagnostic instrument elaborated in Bedi et al. (2006), the checklist used by Booth

[5] A meta-evaluation is "a systematic review of evaluations to determine the quality of their processes and findings" (Leeuw and Cooksy, 2005: 95).

and Lucas (2002) in their diagnosis of Poverty Reduction Strategy Paper (PRSP) related M&E systems in 21 countries and the checklist used by Holvoet and Renard (2007) in their diagnosis of PRSP M&E of 11 SSA countries. While these tools are mainly used for the assessment of central M&E systems, they could also guide assessment exercises of sector M&E systems. The scope of a sector diagnosis is obviously more limited but key components and guiding principles of a sector M&E system largely overlap with those of a central M&E system. An important specific issue within a sector diagnosis is the contribution of sector M&E activities to a central M&E system (Mackay, 2007).

In our own desk-based assessment of the health sector's M&E system in Rwanda (chapter 5) we used the checklist of Holvoet and Renard, which consists of six criteria: i) policy, ii) methodology, iii) organisation, iv) capacity, v) participation of actors outside government and vi) use of information. These six areas are further subdivided into 23 questions (see annex 1) and assessed using a four-point scoring system: weak (1), partially satisfactory (2), satisfactory (3) and excellent (4).

3. RWANDA: GENERAL BACKGROUND

Rwanda is a low-income country in central Sub-Saharan Africa with a real GDP/capita of 866 USD in 2007. With a Human Development Index (HDI) of 0.460 Rwanda is ranked among the countries with a low human development (167 out of 182 countries). The GDP/capita rank – HDI ranks stands at 1 which highlights that compared to countries with a similar level of GDP/capita, Rwanda is doing relatively well in translating its growth into human development. The Gender Development index (GDI) is slightly lower with a value of 0.459 (rank 139/ 155) (UNDP, 2009). The HDI rank – GDI rank stands at 1 which indicates that compared to countries with a similar level of human development, Rwanda is doing relatively well in terms of the equal division of human development over men and women. Table 3.1 gives an overview of the scores on the sub-indicators of the HDI and GDI.

Table 3.1 scores on the sub-indicators of the HDI and GDI.

	Female	Male	Total
Estimated real GDP per capita (PPP USD) 2007	770	970	866
Life expectancy at birth 2007	51.4	47.9	49.7
Adult literacy rate 1999-2007	59.8	71.4	64.9
Combined gross enrolment ration for primary, secondary and tertiary education (%) 2007	52.4	52	52.2

Source: UNDP 2009

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 (Subsaharan Africa) and income category average (low income) on all categories except for 'voice and accountability' which persistently lags behind in the 10^{th}-25^{th} percentile (regional and income group average are in the 25^{th}-50^{th} percentile) (Kaufmann et al, 2009).

In 2000 the Rwandan government initiated a decentralisation process, which entered its second phase in 2005 when the number of provinces were reduced from 15 to 4 and the number of districts from 106 to 30 (Government of Rwanda, 2009). The decentralisation process has led to a transfer of staff and funds from central to decentralised levels. From 2006 onwards each district has signed a performance contract with the central government which acts as a kind of yearly action plan (Holvoet and Rombouts, 2008).

3.1. Policy cycle

3.1.1 Policy, budgeting and implementation

Vision 2020, developed 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 6 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 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, 2007).

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 3.1.2.)) is based on the CDF report. The last update of the CDF report (World Bank, 2007) highlights that Rwanda has a 'developed' (D) operational national development strategy, which means that 'significant action is taken already, although further action is needed'[6]. 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 2 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, 2008).

As a result of implementation weaknesses of the first PRSP, caused amongst others 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

[6] 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).

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-sectoral coordination (Republic of Rwanda, 2007). Moreover, the EDPRS points out that "putting in place 'user-friendly' systems of monitoring and evaluation at sectoral and district level will be essential to ensure the effective implementation of the EDPRS" (Republic of Rwanda, 2007: 102).

3.1.2. Monitoring and Evaluation

At the time the EDPRS was released (2007), a new institutional M&E framework was still under discussion. 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, Technical Steering Committee and Sector Working Groups are responsible for monitoring the implementation of the EDPRS (Republic of Rwanda, 2007). Holvoet and Rombouts (2008) mention that due to continuous reconstruction of Rwanda's M&E framework, actual implementation and try-out is constantly undermined. They highlight three weaknesses which should get attention in the strengthening of the institutional M&E framework: i) the problem of vertical (relation central and decentralised levels) and horizontal (relation between central and line ministries) integration, ii) the lack of institutional independence and iii) unclear mandates and relationships of different units involved in M&E (see Holvoet and Rombouts, 2008).

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, 2007:142). In order to have a manageable framework, sectors are supposed to report only on a few key indicators to the national level. Within each sector more detailed indicators should be elaborated and discussed during annual Joint Sector Reviews. The four indicator matrixes are: i) a matrix with strategic outcome indicators (no more than twenty) which will be used to evaluate the strategy at the end of the EDPRS period, ii) a matrix with intermediate indicators (no more than thirty) which are more or less directly linked to the actions of the government, iii) the summary policy matrix (no more than thirty) 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, 2007).

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), the IMF/WB staff would recommend that the monitoring framework also present indicators by regions to monitor the effectiveness of interventions" (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, although not yet enough, but the basis exists for more substantive progress. The indicator 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 is assessed with a D, meaning that significant actions have been taken already,

although further action is needed. The other two sub-components have obtained a score A (see annex 3 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 assessed with an A.

According to Holvoet and Rombouts (2008) the decentralisation process in Rwanda has the potentail side effect of weakening monitoring and evaluation. While local entities are expected to play an important role within the M&E framework, a clear vertical integration and division of responsibilities is still absent and local capacities for data collection and analysis are limited. Moreover, due to a strong top-down party system, M&E practice at the local level is unlikely to be open and unrestricted (Holvoet and Rombouts, 2008).

3.1.2.1 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, 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[7], 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

[7] '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 (NSDS). An NSDS is expected to provide a country with a strategy for strengthening statistical capacity across the entire national statistical system (NSS)' (www.paris21.org)

well as capacity development at the NISR and other institutions of the NSS (National Institute of Statistics of Rwanda, 2009).

3.2. Development aid

Rwanda is highly aid dependent. In 2008 the Official Development Assistance (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 Gross National Income (GNI) (www.oecd.org/dac/stats). 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). To monitor progress in the context of general budget support, 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 the Joint Budget Support Review.

In order to enhance the coordination, harmonization and alignment of aid in Rwanda, the Government of Rwanda and the Development Partners (DPs) have elaborated a Rwanda Aid Effectiveness Report 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 harmonization 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 alignment and harmonisation indicators of the Paris Declaration, as demonstrated in table 2.2.

Table 2.2 summary table of PD monitoring survey

	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 PIUs	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

In line with global findings of the 2006 Baseline Survey that there is no correlation between the strength of a partner country's systems and their use by donors; despite Rwanda's efforts to strengthen the public financial management and procurement systems, donors limitedly use 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. Corresponding priority actions formulated in the Rwanda country chapter of the 2008 PD survey are an 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).

4. 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 MDG indicators. Table 4.1. 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 4.3.), 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 (BTC, 2010).

Table 4.1. 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 WHO report mention 'the latest available data since 2000'
(b) The regional average is based on 2008 updated data

4.1. Health Policy and Health Sector Strategic Plan

The Health Sector Policy of 2005 is based on Vision 2020, the first PRSP and the decentralization 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 an external evaluation of HSSP I were taken into account. The HSSP II is in line with the Vision 2020, the EDPRS, the Good Governance and Decentralisation Policy, the Health Policy, the MDGs and the Africa Health Strategy. The 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 disease 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 (JAWP) which are developed annually by the MoH and all partners.

4.2. 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 GAVI's health system stengthening 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 (RHSS-CSP, July 2010 draft version) (Meloni and Sijtzema, 2010).

The RHSS-CSP is conform the WHO framework for health systems strengthening[8] 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)

[8] 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.

assuring that the health system is responsive to the needs of the Rwandan population (Ministry of Health, 2010a).

4.3. Health financing

The HSSP II is financed by external resources (62%), government resources (29%) and facility based revenue (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[9] (Government of Rwanda, 2009). As far as external resources are concerned, the health sector receives 12% of ODA, from 16 DPs[10] (Ministry of Finance and Economic Planning and Development Partners, 2007). Most of the funding is used for vertical programmes, which are focusing on specific diseases and not on the entire health system. Moreover, not all aid is on budget (Government of Rwanda, 2009).

In 2006, the Government of Rwanda decided to implement a national P4P scheme as a result of positive experimentation with Payment for Performance (P4P) initiatives of some NGOs. The P4P is a performance-based financing system for local health care centres based upon performance on fourteen maternal and child health care output indicators (Basinga et al, 2010). While the conclusions of a first impact evaluation are largely positive (the use and quality of some maternal and child health care services have increased) (Basinga et al, 2010; Kalk et al, 2010) question if progress can only be attributed to the P4P. Furthermore, they also point at risks associated with P4P such as the 'crowding-out' effect (diminishing or erasing of intrinsic motivation due to external rewards) and 'gaming' (too much focus on rewarded indicators hereby neglecting non rewarded indicators or falsification of results to maximise reward).

In 2007 a Memorandum of Understanding (MoU), signed by all major DPs, officially launched the 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). Additionaly, the Belgian Government, German Cooperation and DFID signed an agreement with the MoH to provide sector budget support (SBS). These three DPs and the Swiss Development Cooperation also made financial commitments to install a pooled fund for technical assistance. The priorities of SBS are family planning, maternal health, financial access, human resources for health and equipment of health facilities (Republic of Rwanda, 2009a).

[9] 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).
[10] Belgium, Germany, Italy, Luxembourg, Switzerland, United Kingdom, United States, European Commission, Global Fund, World Bank, UNAIDS, UNFPA, UNHCR, UNICEF, WFP and WHO.

5. ASSESSEMENT OF THE HEALTH SECTOR'S M&E SYSTEM

In this chapter the health sector's M&E system will be assessed on six criteria including i) policy, ii) methodology, iii) organisation, iv) capacity, v) participation of actors outside government and vi) use of information. In doing so a four-point scoring system is used: weak (1), partially satisfactory (2), satisfactory (3) and excellent (4) (see 2.3). Documents used for this assessment include the Health Policy and Health Sector Strategic Plan, Joint Sector Performance Reports, Annual Reports and information presented during Joint Health Sector Reviews.

As table 5.1 shows, none of the M&E key areas is considered 'satisfactory' or 'excellent'; 'organisation' and 'capacity' are assessed as weak, whereas the other four criteria are considered 'partially satisfactory'. The different sections in chapter five further substantiate the quantitative assessment with more qualitative and detailed information on each of the six M&E key areas, annex 4 provides the disaggregated score for each of the 23 indicators.

Table 5.1 assessment of the health sector's M&E system

Criteria	Score
Policy	2
Methodology	2
Organisation	1
Capacity	1
participation of actors outside government	2
Use of information	2

5.1. 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.

The health sector in Rwanda does not have a specific evaluation plan indicating what to evaluate, why, how and for whom. The Joint Sector Performance Report of the mini budget January – June 2009 mentions that a draft M&E policy and a strategic plan are being elaborated (Ministry of Health, 2009), but these are not yet finalised (September 2010)[11]. Some information, however, is provided in the Health Sector Policy, the HSSP II and the MoU of the health SWAp; yet these documents do not present the information in a structured way.

[11] The Rwanda Health Systems Strengthening Framework and Consolidated Strategic Plan 2009-2012 refer to M&E Guidelines which are not yet validated and which need to be updated and/or integrated into the E-Health Strategic Plan (April 2009-2014) or Health Information System Strategic Plan (May 2009-2013 (still in draft form) (Ministry of Health, 2010: 60).

Concerning the 'what' question, 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, utilization of services etc)[12]. The HSSP II will be assessed during the Joint Sector Reviews and evaluated externally during a mid-term (2010) and final evaluation (2012). The SWAp MoU indicates what should be assessed during a JSR, namely (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).

Answers to the 'why' question can be found in the Health Sector Policy and HSSP II and these documents refer to both accountability and learning needs of M&E. While the Health Sector Policy does not specifically refer to M&E, it does state that the Health Management Information System (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 emphasizes 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.

As far as 'independence' is concerned, the Health Sector Policy indicates that both internal and external evaluations will be conducted in cooperation with the Ministry of Health's partners. 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.

The assessment on the above-mentioned components of the M&E policy is mixed. Whereas the M&E chapter of HSSP II distinguishes between monitoring, review and evaluation of HSSP II, the differences and relationship between monitoring and evaluation are not clearly spelled out. Neither does the chapter refer to the need for autonomy and impartiality (accountability)[13], elements which are amongst others included in the African Evaluation Guidelines[14], particularly within the propriety guidelines (AfrEA, 2002). There is 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). 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

[12] The Health Sector Policy includes 'utilisation of services' as an example of a process indicator whereas this is normally considered an outcome indicator.
[13] 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).
[14] 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).

and plans and to make plans conform to available budgets by deciding on the most urgent priorities (Government of Rwanda, 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.

5.2. Methodology

In our review of the quality of M&E 'methodology', we focus on the selection of indicators, selection criteria used and priority setting, on the linkage among the indicators and data sources as well as on the degree to which indicators formulated at different levels (input-activity-output-outcome-impact) are integrated into one causal chain. Finally, we also review specific M&E methodologies used.

The National Planning, Budgeting and MTEF Guidelines (Republic of Rwanda, 2008) emphasize 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; however, the table with meta-data is absent.

The key indicators included in the HSSP II will be 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[15]), the MDGs and the EDPRS (six strategic outcome indicators[16] and five intermediate indicators[17] related 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. The HSSP II does not specify the criteria used for the selection of the 18 key indicators, but the limited number of indicators selected reveals that the ministry of health acknowledges the need to set priorities.

The HSSPII does not distinguish between the different levels of indicators (input, output, outcome, impact). The inclusion of the indicators in the logical framework of the HSSP II, in which programme objectives, strategic interventions, outcomes and indicators are linked, 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,

[15] 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.
[16] 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).
[17] The health-related intermediate indicators are: % of women aged 15-49 years using modern contraceptive techniques (DHS, HMIS), % of women giving birth in health centres (no data source), % of population living within 5 kms of a functioning health centre (HMIS, annual), number of insecticide treated bed nets distributed annually (Population Service I (PSI), MINISANTE), % of population covered by health insurance (HMIS, MOH and private insurance bodies).

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.

Data sources such as the HMIS, sentinel site surveillance systems, household surveys, PETS and health PER are mentioned in the HSSP II, but they are not linked to 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. Not surprisingly, the April 2010 JHSR concluded that the recommendation previously made during the 2009 JHSR to harmonise health sector indicators was not achieved. The deadline to complete the harmonisation has been extended to December 2010. Information on the methodologies (to be) used to collect data, monitor or evaluate is lacking.

5.2.1. Health Management Information System

An important source of information in the health sector is the HMIS. The routine health information system in Rwanda includes the community level health information system, the SIS (Systeme d'Information Sanitaire) and the TRACnet (Treatment and Research for the AIDS Center). The community level health information system consists of a network of community health volunteers including community health workers (agents de santé communautaire, ASC), traditional birth attendants, Red Cross volunteers and traditional healers. Information collected at this level is mostly not yet integrated with higher levels of the HMIS (RTI International, 2006). The SIS includes paper records at facility level, paper and electronic reporting to district and central levels and electronic aggregation at MoH level. It has been set up and managed by the government of Rwanda in order to collect and provide national information on health (RTI International, 2006). However, M&E units of vertical programmes hardly collaborate with the SIS (Diallo, 2007). From 1997 onwards, SIS data gathering, data entry and queries are supported by a database application, the GESIS (Gestion du Systeme d'Information Sanitaire). The TRACnet receives selected aggregate HIV/AIDS information on management of ARV drugs, laboratory results and program indicators from the participating health facilities (RTI International, 2006).

The HSSP I (2005-2009) included in its capacity building program the strengthening of the HMIS with the aim to make the HMIS fully operational in the public and private sector (Government of Rwanda, 2005b). However, despite commitments of the Government of Rwanda to strengthen the HMIS (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). Problems linked to the HMIS include the use of parallel systems for selected routine health data, the limited use of data at all levels as well as the fact that the integrated SIS reports are too complex and time-consuming (Ministry of Health, 2008). Not surprisingly, the reinforcement of the HMIS, as an integral component of the overall monitoring, review and evaluation system, is still considered a priority in HSSP-II and in the Rwanda Health System Strengthening Framework and Consolidated Strategic Plan (HSSF-

CSP) 2009-2012[18] (see 4.2). Improvements made since the external evaluation include an increasing engagement of the M&E Task Force to take up its oversight function of the broader health information system design, the integration of most routine data reporting requirements into standard report formats for Health Center and District Hospital levels (monthly, quarterly and annual) and the introduction of a computerized database for data capture of new formats introduced in July 2008 (Ministry of Health, 2008).

5.3. 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 degree of coordination and oversight in the health M&E system, the linkage with the national statistical office, the level of integration of the M&E task force with units in sub-sectors and semi-government institutions (horizontal integration) and with M&E units at a decentralised level (vertical integration) as well as the linkage with project M&E.

Within the Ministry of Health the Planning, Policies and Capacity Building Unit is responsible for M&E in the health sector. M&E related responsibilities of the unit include the coordination and evaluation of the application of the national policies within the ministry and the conduct of M&E related to the application of policies and programmes (www.moh.gov.rw). In line with recommendations from reviews of the Management Science for Health (Diallo, 2007) the MoH created a new Monitoring and Evaluation Task Force (M&E/TF) in February 2008. The aim is to develop and strengthen the existing HMIS and M&E system at national level in order to 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 are (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.

Initially, the M&E/TF consisted of five desks, including i) data management (HMIS), ii) audit and quality control, iii) research and special studies, iv) capacity building and v) reporting and distribution (Republic of Rwanda, 2009a). However, the number of desks has over time seemingly been reduced to three, as the website of the Ministry of Health (www.moh.gov.rw) only lists HMIS, reporting and distribution and training and capacity building. The M&E/TF gets technical support from the WHO, Belgian Technical Cooperation (BTC),

[18] The HSSF-CSP formulates several strategies for the strenghtening of health information systems resources, policies and regulations, data collection and quality, data analysis and data use for management, policymaking, governance and accountability (Ministry of Health, 2010).

Management Science for Health (MSH) and Center for Disease Control and Prevention (CDC) (www.moh.gov.rw).

The establishment of a strong coordination mechanism for M&E in the health sector, including a directorate, strategic plan and M&E working group is one of the HSSF-CSP strategic interventions for the health information building block. However, it is immediately added that the establishment of an M&E directorate is not possible within the present structure of the MoH (Ministry of Health, 2009). Coordination mechanisms exist between the MoH and the National Institute of Statistics of Rwanda (NISR) (Diallo, 2007), but the role of the NISR in the health sector's M&E is not made clear in the HSSP II or the Annual Report of 2008. 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 MoH (Republic of Rwanda, 2009b), but no references are made to the HSSP II or the M&E/TF.

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 joint sector performance report for the mini budget of January-June 2009 mentions as one of the achievements of this period that all health facilities have M&E staff. Relations of these staff with the M&E/TF are, however, not clearly specified. Neither is it clear to what extent the M&E/TF coordinates with donor M&E instruments of projects. This leads us to conclude that, on the basis of the documents available, the level of horizontal and vertical integration as well as the coordination between central and project M&E is at present weak. It is one of the areas where field-based research is needed to substantiate desk-based findings.

5.4. Capacity

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

One of the seven strategic programme areas of HSSP II is institutional capacity. Interventions will be undertaken in the areas of planning, M&E and governance. The paragraph on M&E, however, does not include information on current strengths and weaknesses of the M&E system and hardly any information on activities to strengthen M&E capacities. It only mentions that: "In order to facilitate monitoring and evaluation, the M&E system will provide reliable and timely information on key indicators by producing a data dictionary, training health facility staff on data collection and programme managers on analysis and effective use of information. An overall M&E institutional framework and results matrix will be established" (Government of Rwanda, 2009: 31).

As both the Health Sector Policy and HSSP I identified weak capacity as the main challenge for the attainment of quality care and the MDGs, the Ministry of Health decided to elaborate the Human Resources for Health (HRH) Strategy Plan 2006-2010 with the aim to "provide guidance for the staffing of the health services through the training and development of health professionals and management to the year 2010" (Ministry of Health, 2006). One of the five strategic objectives is to monitor and evaluate progress. However, the three M&E activities included in the HRH strategy plan relate to M&E of the HRH strategy plan and not to activities to

strengthen the M&E capacity itself[19]. Activities under other strategic objectives neither include M&E capacity strengthening.

5.5. Participation of actors outside government

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

The development partners play a significant role in Rwanda's health sector. They are involved in the M&E of health sector performance through the Health Sector Coordination Group (HSCG), the Sector Budget Support Group (only the SBS development partners) and the JHSR. The documents at hand lend us to believe that parliament does not participate in health sectors' M&E. While civil society organisations participate in the HSCG and JHSR, not much information is available on their level of participation. 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. Moreover, as Rwanda scores low on the 'voice and accountability'[20] governance indicators (see chapter 3) (Kaufmann et al, 2009) and as other sources have referred to the limited room of manoeuvre for NGOs (see e.g. Holvoet and Rombouts, 2008), it is not very likely that NGOs participating in the HSCG and JHSR will adopt a critical stance.

5.5.1. Health Sector Coordination Group

The Health Sector Coordination Group (HSCG), which is chaired by the Minister of Health and co-chaired by the Health Sector Coordination Counsellor of the Belgian Embassy (Ministry of Health, 2009), is involved in the monitoring of progress in the health sector. It is a formal forum for the Government of Rwanda and other stakeholders to discuss the planning and priorities in the sector. The HSCG was initiated by the Belgian Embassy and the German Technical Cooperation and became fully operational in September 2004. The goal of the Health Sector Cluster Group is "to improve the effectiveness and efficiency of aid in the health sector and to better align development partners behind the Health Sector Strategic Plan with an enshrined principal of mutual accountability" (www.devpartners.gov.rw).

In order to address particular technical issues and priorities of the HSSP a number of technical working groups (TWG) have been set up in several areas such as family planning, human resource development, disease control and health system strengthening. During the 2008 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 would be organised prior to the JHSR. However, it is not clear to what extent the

[19] The three activities are: the establishment of a monitoring system for performance indicators, the improvement of the HR health information system and the regular review of the HRH plan.
[20] 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).

proposed reorganisation has effectively taken place. The BTC highlights in this respect that (too) many TWGs and sub-groups (30) were created during the restructuring and that most of the TWGs were inactive in 2009 and 2010 (Meloni and Sijtzema, 2010).

5.5.2. Sector Budget Support Group

The development partners who provide SBS, i.e. Belgium, German Cooperation and DFID, 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 include as well 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.

5.5.3. Joint Health Sector Reviews

One of the authors of this discussion paper participated in the November 2008 JHSR (24-26 November), which had as a general objective to assess, under the leadership of the Ministry of Health, the 2008 health sector performance at all levels and to identify priorities for 2009. Representatives of different stakeholders were present, i.e. the MoH, districts, (I)NGOs, United Nations and bilateral donors. The November 2008 JHSR was more focussed on accountability than on learning and more attention was paid to issues of substance (inputs, activities, outputs, outcomes and impact) than to the underlying institutional/systemic issues. In sharp contrast to what is foreseen in the MoU, no progress report, budget execution report or report on donor performance were provided prior or during the JHSR. As a result, participants were not able to prepare themselves properly and thus the fulfilment of the JHSR's accountability objective was rather weak. It is particularly remarkable that the 2008 external evaluation of the HSSP I (External Evaluation Team, 2008) which could have served perfectly as a base for accountability, particularly in the absence of other documents, was not discussed. While the evaluation report is in general positive about the achievements made in the health sector, it simultaneously concludes that the underlying M&E system is fragmented and not fully operational. The weak M&E system is symptomatic of the fact that issues related to the more fundamental institutional and systemic issues are hardly discussed during the JHSR. 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.

Another distracting element was the fact that the November 2008 JHSR did not include any field visits with the view to confronting the aggregated data provided by the Ministry itself at the moment of the JHSR 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).

From the perspective of the Paris Declaration key principles, the November 2008 JHSR scores high on country ownership which was demonstrated by the continuous presence of the Minister, there was a broad-based participation of actors from various settings (both inside and outside government) and attention was being paid to issues of harmonisation and alignment (except for alignment to the M&E system, see above). However, there was limited mutual accountability and interest in capacity building of the M&E demand and supply side.

In general, the November 2008 JHSR was more a forward-looking event focusing mainly on the formulation of recommendations 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. In addition, the deadlines for the achievement of the new recommendations were set quite optimistically and unrealistically (almost all for the next JHSR in March 2009). When it comes to the quality of more recent JHSRs, evidence is rather mixed. While a review of 2009-2010 JHSRs shows that the duration of the JHSR had even been shortened to only one day (April 2010 only from 9.00 to 15.10), the most recent October 2010 JHSR was again expanded to two days. As far as the preparatory process is concerned, a BTC report on the period April to June 2010 (Meloni and Sytzema, 2010) highlighted the need to improve the JHSR preparation process in order to facilitate the flow of information and the exchange of analyses. The Ocober 2010 JHSR seems to have been 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).

5.6. Use of information

This section reviews the degree to which M&E is used in planning and budgeting (internal use) and in progress reports which are mainly targeted at donors.

In order to assess to what extent M&E is effectively used in progress reports, we have checked 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 discussed. Moreover, the focus is predominantly on monitoring of activities and to a lesser extent on achievements in outputs, outcomes and impacts.

As already mentioned in 5.1. M&E outputs are supposed to inform future strategies and plans (Government of Rwanda, 2009). At the MoH level there is a demand for qualitative and timely health information, e.g. in the context of performance-based budgeting (Diallo, 2007), however, and not unique to the case of Rwanda (see Kimaro et al. 2008), at lower levels of the health system data is generally merely collected and transmitted and not analysed and used for local decision-making (RTI International, 2006, Diallo, 2007, Ministry of Health, 2010a). Reasons for lack of data analysis and use include lack of training, time and incentives (RTI International, 2006).

6. CONCLUSION

In line with the 'managing for results' principle of the Paris Declaration (2005) partner countries are supposed to strengthen their performance assessment frameworks, while donors are expected to align with these frameworks and to collaborate with partner countries in their strengthening. However, progress in this area is slow, due to reluctance of donors to rely on systems which are only partially developed, while the elaboration and maturing of recipient systems is blocked by the same donor reluctance to align. At sector level, and particularly within the SWAp context, but also increasingly by vertical funds, attention is paid to the strengthening of monitoring and evaluation systems (focus on health information system). A first crucial step prior to the strengthening of an M&E system, is the assessment of the existing M&E system/arrangements in order to create an overview of present M&E structures, activities and existing capacity. An in-depth diagnosis of Rwanda's M&E system in the health sector does not yet exist. Our paper aims to address this gap. In doing this, it assesses the health sector M&E system on six dimensions (policy, methodology, organisation, capacity, participation of non-state actors and use of M&E information) using a four-point rating scale. Our analysis is currently based upon a review of relevant documents and literature and will be complemented by field-based research in the future.

Findings from our assessment highlight that the development of Rwanda's health sector M&E system is currently at best fragmentary. Four of the six key M&E dimensions (i.e. policy, methodology, participation of non-government actors and use of M&E outputs) were considered partially satisfactory while the health sector M&E system scored weak on organisation and capacity. As far as M&E policy is concerned, it was observed that the draft M&E policy and strategic plan are still not finalised after 1.5 years. Whereas there is some information on M&E included in the health sector policy and the Health Sector Strategy Plan II, it is to date not entirely clear what to evaluate, why and for whom. Moreover, the documents include some information on dissemination and alignment of M&E with planning and budgeting, but it is silent on the relationship between the more descriptive 'monitoring' activities on the one hand and the more analytical in-depth 'evaluation' on the other hand. Furthermore the need for autonomy and impartiality, which are among the key M&E principles, is not addressed.

Also when it comes to 'methodology', the health sector M&E system scores 'partially satisfactory'. While the indicators to monitor the EDPRS are clearly identified, there are also several weaknesses: information on the underlying selection criteria is missing, different levels of indicators (input/activities/output/outcome/impact) are not clearly distinguished, indicators are not linked to data sources and information on the methodologies (to be) used to collect data, monitor or evaluate is missing. Positively, the HSSP II highlights efforts to strengthen the health management information system.

The 'organisation' of the M&E system is one of the dimensions which is considered weak. Despite the fact that an M&E taskforce has been installed within the Ministry of Health, it has recently again been downsized. Horizontal linkages among the M&E unit within the health ministry and the national statistical office, units in sub-sectors and semi-government institutions are not clearly outlined which leads us to believe that there is currently (at least on paper) a low level of horizontal integration. This also holds for the degree of vertical integration with M&E units at decentralised level, whereas also the linkage with M&E of health projects is not adequately addressed. 'Capacity' is also considered weak because the HSSP II does not clearly

point out weaknesses of the M&E system that need to be addressed and hardly any information is given on activities to boost M&E capacity. Moreover, strengthening of M&E capacity is not included in the Human Resources for Health Strategy Plan 2006-2010.

'Participation of actors outside government' within the health sector M&E system is assessed as 'partially satisfactory'. While no information is available on the participation of parliament, participation of donors and civil society is organised through the technical working groups of the Health Sector Coordination Group and the Joint Health Sector Reviews (JHSR) (and for SBS donors in particular through the Sector Budget Support Group). However, the technical working groups have been dormant in 2009 and 2010 and up to April 2010 the JHSRs had become extremely condensed. Moreover, no field visits were included in spite of the fact that these are valuable reality checks, particularly in a context of budget support where donors' activities are moving upfront, alienating them from implementation realities on the ground. In practice the JHSRs are more forward-looking ad-hoc events than a sound M&E exercise where different stakeholders triangulate information from various sources in order to review and analyse progress in the health sector, satisfying in this way accountability and learning needs. While it is too early to make any final assessment, the most recent October 2010 JHSR seems to have improved significantly in terms of preparatory process and quality of discussion. This progress deserves close follow-up as it might open interesting opportunities for the strenghtening of the entire M&E system.

Finally, our desk-based assessment shows that the use of M&E outputs is so far partially satisfactory. While monitoring data supplied by the M&E system is used in progress reports, analyses of this data is generally lacking. The low analytical quality of progress reports is not entirely surprising: the M&E system currently focuses more on 'descriptive' monitoring activities, at the detriment of the more analytical evaluative exercises. The deficient quality of data analysis neither stimulates its use to inform future strategies and plans.

The reason why the M&E system in Rwanda's health sector is partially satisfactory for some criteria and weak in others might to some extent be related to the lack of urgency felt by the Government of Rwanda and donors to remedy the current shortcomings. From the perspective of the Government of Rwanda investments in M&E systems are even counterproductive as it currently already receives significant aid volumes (ODA increased with 60.2% between 2006 and 2008) including substantial amounts of budget support without strong evidence about poverty impact on the ground (see also Holvoet and Rombouts, 2008). As Pritchett (2002:268) puts it "if a program can already generate sufficient support to be adequately funded then knowledge is a danger". Proxies which showcase the lack of interest in strengthening the health M&E system include the slackening in the finalisation of the health M&E policy and strategy, the downsizing of the M&E task force as well as the absence of reality-check field missions in JHSRs or other evaluations. At the same time, there is also no evidence that donors are using their room of manoeuvre to push for the strengthening of the health sector M&E system. Lack of pressure is possibly related to the positive results Rwanda is demonstrating in most of the health MDG indicators as well as in the area of Public Finance Management. Without leadership from the government of Rwanda and demand from donors strengthening of Rwanda's health sector M&E system is highly unlikely.

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ANNEX 1: CHECKLIST FOR QUALITY ASSESSMENT OF AN M&E SYSTEM (SECTOR)

Policy

	Topics	Question
1	The evaluation plan	Is there a comprehensive evaluation 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

Methodology

	Topics	Question
6	Selection of indicators	Is it clear what to monitor and evaluate? Is there a list of indicators?
7	Selection criteria	Are the criteria for the selection of indicators clear? And who selects?
8	Priority setting	Is the need acknowledged to set priorities and limit the number of indicators to be monitored?
9	Causality chain	Are different levels of indicators (input-output-outcome-impact) explicitly linked (program theory)? (vertical logic)
10	Methodologies used	Is it clear how to monitor and evaluate? Are methodologies well identified and mutually integrated?
11	Data collection	Are sources of data collection clearly identified? Are indicators linked to sources of data collection? (horizontal logic)

Organisation

	Topics	Question
12	Coordination and oversight	Is there an appropriate institutional structure for coordination, support, oversight and feedback at the sector level? With different stakeholders?
13	Linkage with Statistical office	Is there a linkage between sector M&E and the statistical office? Is the statistical office in sector M&E clear?
14	'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?
15	'Vertical' integration	Are there M&E units at decentralised levels and are these properly relayed to central sector M&E unit?
16	Link with projects	Is there any effort to relay with/ coordinate with donor M&E mechanism for projects in the sector?

Capacity

	Topics	Question
17	Problem acknowledged	Are current weaknesses in the system identified?
18	Capacity building plan	Are there plans for remediation? Do these include training, appropriate salaries, etc.?

Participation of actors outside government

	Topics	Question
19	Parliament	Is the role of Parliament properly recognised, and is there alignment with Parliamentary control and oversight procedures?
20	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?
21	Donors	Is the role of donors recognised? Are there clear procedures for participation of donors?

Use of information from M&E

	Topics	Question
22	Effective use of M&E in progress reports (donor oriented)	Is there a presentation of relevant M&E results? Are results compared to targets? Is there an analysis of discrepancies?
23	Effective usage of M&E (within country)	Are results of M&E activities used for internal purposes? Is it an instrument of national policy-making and/or policy-influencing and advocacy?

ANNEX 2: 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 3: 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 4: RWANDA'S SCORE ON THE CHECKLIST FOR QUALITY ASSESSMENT OF AN M&E SYSTEM (SECTOR)

Policy

	Topics	Score
1	The evaluation plan	2
2	M versus E	1
3	Autonomy & impartiality (accountability)	1
4	Feedback	2
5	Alignment planning & budgeting	2

Methodology

	Topics	Score
6	Selection of indicators	3
7	Selection criteria	1
8	Priority setting	3
9	Causality chain	2
10	Methodologies used	1
11	Data collection	1

Organisation

	Topics	Score
12	Coordination and oversight	2
13	Linkage with Statistical office	1
14	'Horizontal' integration	1
15	'Vertical' integration	1
16	Link with projects	1

Capacity

	Topics	Score
17	Problem acknowledged	1
18	Capacity building plan	1

Participation of actors outside government

	Topics	Score
19	Parliament	1
20	Civil Society	2
21	Donors	2

Use of information from M&E

	Topics	Score
22	Effective use of M&E in progress reports (donor oriented)	2
23	Effective usage of M&E (within country)	1

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