ROADMAP

for

FURTHER DEVELOPMENT

of the

RWANDA

HEALTH SWAP

August 2010

1 PREAMBLE

The HSSP I evaluation report of /2008 concludes that "… *it seems important to develop as part of the new HSSP a Harmonisation Manual that will define 'the rules of the game' for those that (intend to) participate in the SWAp*."

Also, in March 9-13, 2009. Dr Anthony Seddoh (WHO-Africa Region) submitted his Scoping Report SWAp Manual for Rwanda. MoH and DPs then decided that two assignments were to be carried out, one of documenting the existing legal and regulatory frame work of the health sector (by national consultants) and one on a guide for further harmonisation, i.e. a roadmap for SWAp development.

This report presents the results of a consultancy carried out by Frank Terwindt, public health consultant. The objective of his work was the production of a roadmap for further SWAp development. The consultant's revised TOR foresaw two missions. In the first one,(October / November 2009), a situation analysis was carried out: (i) a general situation assessment on the Rwanda health SWAp, and (ii) the identification of areas that merit further SWAp development. The actual roadmap was elaborated in the second mission (January 2010).

The methodology consisted of (i) document review[1], (ii) interviews of various stakeholder groups, (iii) participation in sector coordination events, (iv) and a field visit. At the end of this first mission, debriefing was done in two meetings: one with MOH staff and one with DPs. Due to MoH's heavy workload in the month of December, the planned discussion between MoH and stakeholder groups on the proposed priority areas could not take place before the end of the year. Early in his second mission, the consultant produced a discussion document with the objective to facilitate joint decision making about priority areas for medium term further SWAp development. This document was discussed at a DPG meeting of January 13th and later at the HSCG meeting of January 21st 2010. Comments have been taken into account in this roadmap.

This document illustrates that there are already many achievements in the transition towards the health sector SWAp. It should be noted that the challenges listed in this document as part of the situation assessment are only meant to identify opportunities and scope for further SWAp development and that they should not be seen as criticism.

The proposed priority areas are: (1) MoH institutional/ organisational framework, (2) human resource development, (3) legal and regulatory framework, (4) sector policy and strategic framework, (5) consolidated and bottom-up planning and budgeting, (6) comprehensive health district development in the context of decentralisation, (7) fiduciary framework, (8) coordination with DPs and of other stakeholder groups, (9) coordination/ partnership non public sector actors, (10) sector monitoring and evaluation; information /knowledge management. The key activities for each of these 10 priority areas are summarised in the last chapter of this roadmap.

Since the roadmap discusses many SWAp related areas, and since the final adopted priority areas need to be worked out into operational steps, its contents should be further discussed in a consultative process and should lead to the adoption of an action plan. This SWAp roadmap is meant as a flexible plan. It is therefore recommended that it is periodically (annually) reviewed, and if needed, updated.

[1] A list of selected key documents can be found in Annex Nr 11

Moreover, since the manual on the legal and regulatory framework for the health sector has not yet been finalised, the roadmap could not take into account any observations and recommendations of the report that is to accompany this manual. This will have to be done at a later stage, notably for the chapter 4.3 (Legal and regulatory framework).

2 ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ART	Anti Retroviral Treatment
BCC	Behaviour Change Communication
BTC	Belgian Technical Cooperation (CTB)
CBD	Community-Based Distribution
CCM	Country Coordination Mechanism (GFATM)
CDC	United States Centers for Disease Control and Prevention
CDPF	Capacity Development Pooled Fund
CEPEX	Central Public Investments and External Finance
CF	Clinton Foundation
CHW	Community Health Worker
CNLS	National AIDS Commission
COC	Code of Conduct
CPAF	Common Performance Assessment Framework
DAD	Development Assistance Database
DDP	District Development Plan
DFID	Department for International Development (UK)
DH	District Hospital
DHC	District Health Coordinator
DHU	District Health Unit
DOTS	Directly Observed Treatment Scheme / Short Course (TB)
DPAF	DP Performance Assessment Framework
DP	Development Partner
EDPRS	Economic Development and Poverty Reduction Strategy
EU	European Union
FBO	Faith-Based Organisation
FP	Family Planning
FY	Fiscal Year
GAVI	Global Alliance for Vaccines and Immunisation
GBS	General Budget Support
GDC	German Development Cooperation
GFATM	Global Fund for AIDS, TB and Malaria
GIS	Geographic Information System
GOR	Government of Rwanda
GTZ	Deutsche Gesellschaft für Technische Zusammenarbeit (German Technical Cooperation)
HC	Health Centre
HF	Health Facility
HIDA	Human Resource and Institutional Capacity Development Agency
HMIS	Health Management Information System
HP	Health Post
HR	Human Resources
HSCG	Health Sector Coordination Group
HSSP	Health Sector Strategic Plan
HW	Health Worker
DHS	Demographic and Health Survey
IEC	Information, Education and Communication
IHP+	International Health Partnership
INGO	International Non-Governmental Organisation
JADF	Joint Action Development Forum
JAPS	Joint Annual Planning Summit

JAWP	Joint Annual Work Plan
JMA	Joint Management Arrangements
JHSR	Joint Health Sector Review
LMIS	Logistical Management Information System
MBB	Marginal Budgeting for Bottlenecks
M&E	Monitoring and Evaluation
MDG	Millennium Development Goal
MICS	Multi-Indicator Cluster Survey
MIFOTRA	Ministry of Public Service, Skills Development and Labour
MINALOC	Ministry of Local Administration, Community development and Social Affairs
MINECOFIN	Ministry of Finance and Economic Planning
MINEDUC	Ministry of Education, Science, Technology ad Research
MoH	Ministry of Health/Minisanté
MoU	Memorandum of Understanding
MSH	Management Sciences for Health
MTEF	Medium Term Expenditure Framework
NASA	National Aids Spending Accounts
NEPAD	New Partnership for African Development
NGO	Non-Governmental Organisation
NHA	National Health Accounts
PBF	Performance-Based Financing
PEFA	Public Expenditures Framework Assessment
PEPFAR	The U.S. President's Emergency Plan for AIDS Relief
PER	Public Expenditure Review
PETS	Public Expenditure Tracking Survey
PHC	Primary Health Care
POW	Programme of Work (rolling, 3-year)
PPP	Public Private Partnership
PRSP	Poverty Reduction Strategy Paper
RH	Reproductive Health
RwF	Rwandan Franc
SBS	Sector Budget Support
SDC	Swiss Development Cooperation
SMM	Senior Management Meeting (MoH)
SWAp	Sector Wide Approach
TA	Technical Assistance
TB	Tuberculosis
ToR	Terms of Reference
TRAC+	Centre for Infectious Disease Control (CIDC)
TWG	Technical Working Group
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nations Children Fund
USAID	United States Agency for International Development
USD	United States Dollar
USG	United States Government
WB	World Bank
WHO	World Health Organisation
WTO	World Trade Organisation

3 TABLE OF CONTENTS

ANNEXES

1. Summary description of the SWAp concept.
2. Types of financial aid (table).
3. DP financing modalities and channels in the Rwanda health sector
4. Proposal for a next phase SWAp MoU; the need for a COC.
5. Suggestions for improvement of the SWAp institutional framework
6. Considerations for Joint Management Arrangements.
7. Suggested DP reporting requirements
8. Discussion document for development of a TA policy.
9. Questionnaire for mapping of procurement practices
10. Validation of priority areas for SWAp by DPs (table).
11. List of selected documents

4 SWAP ROADMAP

THE PURPOSE OF THIS ROADMAP

This document discusses the current stage in the SWAp development process and gives short term and medium term recommendations for further steps towards a full SWAp. It is therefore a prospective document.

Simultaneously, a manual is being produced about the existing legal and administrative framework that governs the health sector for all sector actors. The national consultants who have been recruited for the production of this manual also carry out an analysis of this legal and administrative framework, whereby gaps and possible contradictions in texts are identified.

The GOR/MoH objective to grow towards an environment in the health sector of "***One plan, one budget, one report"*** illustrates the felt need for harmonisation and alignment, so that jointly used systems lead to strengthened MoH leadership, increased effectiveness, efficiency, as well as transparency / mutual accountability.

The process towards achieving that goal is one of joint situation analysis, development of options and negotiation of solutions. Today, all actors in the health sector are bound by an overall GOR/MoH legal and administrative framework. Beyond the respect of these official rules and regulations, the various actors in health use to some extent their own, or adapted, parallel systems. The challenge of getting DPs to adapt to existing national systems is not an easy one, because it requires first a joint assessment of the adequateness and performance of these systems. In some cases this may lead to GoR/MoH and DPs jointly adopting new hybrid systems that are considered particularly appropriate in a SWAp environment. Examples of such hybrid systems, adopted in other countries with health SWAps are the procurement system, M&E system, reporting system, etc.

The purpose of this roadmap is not to replace HSSP strategic framework and ongoing reforms. The adopted roadmap focuses specifically on actions towards enhancing a SWAp environment. This entails recommendations for some additional reforms. Ideally, the MoH adopts a comprehensive reform agenda that becomes an integrated part of HSSP.

This SWAp roadmap can only be a guide; joint and formal decision making on a number of issues will be the next step. The adoption of a SWAp roadmap should facilitate the establishment of an environment of trust and open dialogue between all stakeholder groups, under the leadership of MOH. The more that sector development decisions are based on a consultative process between stakeholders, the more successful the SWAp will be. The required environment of trust and team spirit does not come (and will not stay) automatically. It needs nurturing through extensive and systematic information exchange, consultation and negotiation. This roadmap will therefore have to remain a flexible tool that will periodically need updating.

Since not all sector stakeholders have the same level of understanding of what is SWAp and how it is implemented, an introduction to the concept is attached in Annex Nr 1. Several DPs have suggested to organise a seminar that is to ensure a uniform level of understanding.

THE STRUCTURE OF THIS ROADMAP.

This roadmap starts with a situation assessment, which also looks at the broader context of the administrative decentralisation. The achievements to date in Rwanda health sector SWAp development are briefly mentioned, after which, main challenges for further SWAp development are discussed in ten chapters. Challenges are followed by proposed short term and medium term objectives for these ten priority areas. The last chapter identifies conditions for successful roadmap implementation. There is a large number of annexes that address concern over further implementation issues, e.g. for adapting the SWAp MoU and Joint Financing Arrangements (JFA), etc.

Of the ten proposed priority areas, it can be argued that they are not SWAp-specific; they can also be seen as part of the sector strategic framework. Examples are HR development and health district system development. It is true that these areas do not directly concern changes in the way MoH and other stakeholder groups work together. The reason they have been included in the priority list is that these areas are at the core of sector development and that SWAp cannot succeed if these aspects are not taken into account at all levels and by all actors. The recommendations for these areas are based on the existing overall sector strategic framework, but they go a step further in terms of implementation issues. Ideally, they would be integrated in a sector planning document that is situated between the strategic framework (HSSP) and the operational annual planning (JAWP). This could become a rolling 3-year Programme of Work (POW).

5 THE RWANDA HEALTH SWAP

In the course of the two consultant missions, it transpired that the level of understanding of various stakeholder groups and their actors (MoH staff, district teams, DPs, etc.) varies considerably. For the SWAp roadmap to become a common working document, it is essential that all actors have the same understanding of what is SWAp and how it is shaped for the Rwanda health sector. It is recommended that MoH invests in an information campaign to ensure this.

2.1 WHERE ARE WE NOW? ACHIEVEMENTS TO DATE

The Rwanda health SWAp was developed in 2007 and many related activities are in process. Important achievements are:

- The approach is consistent the orientations of the Rome 2003 and Paris 2005 declarations[2] and with the Accra agenda.
- An overall sector political and strategic framework was jointly adopted.
- EDRSP policy actions for health were defined and are monitored.
- There is a body of laws/sub laws, other regulatory documents and norms.
- There is a public financial management framework.
- There is a process of administrative decentralisation linked to health sector deconcentration.
- There is a detailed, clear aid policy.
- There are a large number of DPs and implementers in the health sector.
- All main stakeholder groups are to some extent involved in the health SWAp.
- Part of DP support already goes through GBS and SBS.
- There are SWAp coordination structures (HSCG, TWGs).

[2] The five key principles of the Paris declaration are *ownership, alignment, harmonization, managing results* and *mutual accountability*.

- MoH structures signed an internal MOU (as part of the CS reform).
- Several MOUs have been signed with DPs (generic SWAp , SBS, CBPF).
- There are several new governmental management mechanisms.
- Cycles for fiscal year and periodicity surveys were harmonised.
- HSSP I was evaluated.
- JHSR took place, which also define next year's priorities.
- Comprehensive bottom-up annual planning takes place.
- District annual planning for health is integrated in overall District Development Plans.
- The JAWP tool not only facilitates planning, but also maps DP contributions and allows monitoring them.
- A sector MTEF that was developed using the MBB model is annually reviewed.
- This MTEF is operational in MoH with consolidated annual sector budgets.
- Off-budget financing is reported to MoH/ MINECOFIN.
- There is a fund for capacity building in the health sector (CDPF).
- A consultant is hired for HR needs forecasting and HR production needs.
- Development of a sector finance policy has started.
- The results of two sector costing studies are used for this finance policy.
- HMIS reporting compliance is high and a M&E framework was adopted.
- District level stakeholder coordination meetings occured.
- District health coordination is linked with the Joint Action Forum for local coordination.
- Efforts are made towards a more rational distribution of resources between districts.
- All health facilities have management autonomy since 2007.
- Annual non-sector specific block grants from GoR budget to the 30 districts are in place.
- PBF pays for all services, not only high impact ones.
- MINALOC initiatiated harmonising the SWAps of line ministries (07/08).

2.2 SOME QUESTIONS ON SWAP OPTIONS

- What specific characteristics should this Rwanda health SWAp have?
- How far can we go with "one plan, one budget, one report"?
- Which are priorities in the development of this SWAp?
- What is the scope for a Joint Management Framework?[3]
- What should be the SWAp institutional framework (different from MoH organigram)?
- Who are the "likeminded" DPs to take the SWAp further?
- For which areas, the existing national systems are not acceptable and need to be strengthened or adapted?[4]
- Can the MOU become more precise on mutual commitments?
- How to ensure comprehensive and decentralised development of the district health system?
- How can planning be made be more bottom up, consolidated and needs based?

It is important to acknowledge that, as in many other SWAps, harmonisation and alignment are difficult to achieve in areas that are particularly sensitive, because of conflicting interests. An example is the harmonisation of data collection and management systems: DPs and vertical programmes are reluctant to reduce/integrate their information needs. Still, for the SWAp to work, settlement on such sensitive areas should not be endlessly postponed. HMIS is a key ingredient of the SWAp overall M&E system and its reform should be tackled courageously through a joint planning process.

[3] Can include e.g. mobilisation of resources, management of resources, control and audit mechanisms, procurement, evaluation, ..

[4] The national system will remain the same, but the SWAp partners use a parallel system that is somewhat adapted from that national system.

A list of selected key documents on the Rwanda health SWAp can be found in Annex Nr 11.

6 COUNTRY DEVELOPMENT CONTEXT

Sector development plans are guided by the GOR's long term overall development vision (Vision 2020), a national Economic Development, and the Poverty Reduction Strategy (EDPRS 2008-2012).

Civil Service reform is in process. In the health sector, amendments are made to allow for different status type of staff.

Government since 2006 made a conscious decision to move towards harmonization and alignment of donor contribution to national development at the national level through the adoption of the Multi-Donor Budget Support mechanism. Also in the health sector, this saw a gradual shift by health sector partners towards SBS.

Another SWAp is already operational for the Education Sector.

The management modalities of aid depend on the types of aid modality (GBS, SBS, pooled funding in CDPF) and on DP specific arrangements. These modalities and arrangements are captured in MOUs, Aide Memoires and bilateral agreements.

Overall GOR planning, implementation and monitoring/ reporting frameworks, notably of MINALOC and MINECOFIN, overrule health sector specific frameworks. This is the case for the:

- Harmonization Calendar of Rwanda of the Rwandan Government and Development Partners: (JBSR);
- The DPAF and CPAF monitoring framework of EDPRS;
- District Development Plans (DDP) in the context of the administrative decentralisation; and
- CEPEX.

More information about the GOR legal and administrative framework, which also regulates the development cooperation in the health sector, can be found in the Health SWAp Manual, which is in the process of being finalised.

7 HEALTH SECTOR CONTEXT

4.1 HEALTH POLICY AND STRATEGIC FRAMEWORK

The Health Sector Policy was adopted in 2005. The HSSP II covers the period 2009-2012 in order to align it with the EDPRS cycle. Following HSSPs will span a five year period. The HSSP II is based on the long term overall development vision of the GoR (Vision 2020) and on a national Economic Development and Poverty Reduction Strategy (EDPRS 2008-2012), which defines policy actions for each sector and monitors them (DPAF and CPAF).

In 2004, the health sector decided to formally adopt SWAp as a framework for effective aid coordination for health development. In July 2006, the Government of Rwanda adopted a National Aid Policy which re-validates the sector's focus.

4.2 HUMAN RESOURCE DEVELOPMENT

SUMMARY DESCRIPTION OF THE CHALLENGES

a) Like other ministries, MOH suffers from understaffing. This phenomenon is a consequence of earlier over all civil service streamlining efforts. One can frequently hear MOH staff complaining that they are trapped in day to day meeting agendas, so that they do not find the necessary time for policy/strategy development, etc. One could argue that insufficient work force is a problem that needs to be addressed at a higher GOR level, since it affects also other line ministries. On the other hand, the Functional Analysis (in 2008 by MSH) was done to address not only needs for institutional/organisational reforms, but also to propose solutions for workforce shortages. In other words, independent from overall civil service reform decisions regarding work force, MOH and its partners could jointly develop intermediate solutions. For instance, the option of contractual staff is already being used in the case of the SWAp Secretariat, but clearly at an insufficient scale.

b) Since SWAP development requires quite some rethinking, reforming, re-organising, the availability of sufficient and qualified staff is paramount, both at MOH level as well as at intermediate (province) and district levels.

c) Responsibilities for various aspects of HR development are situated at several MoH and other structures (e.g. MIFOTRA, universities). This requires intensive coordination.

d) The HR development plan has not yet been finalised, and needs to be accompanied by an action plan. Several strategic aspects are not yet secured (review of staff profiles, projection of staff projection needs, training and recruitment capacity, decentralisation of HR management, etc.). Capacity building requirements and measures (CDPF) are not yet based on comprehensive assessment as part of a HR development plan.

e) Several related aspects will have to be taken into account in the overall HR development plan: consequences of overall civil service reform and streamlining, implications of the administrative decentralisation, the role of the private sector in HR development, the synergy with HIDA.

f) The management of the CDPF is not yet based on an updated / functional plan, but identification of capacity development needs will become much easier when the HR development plan has been adopted.

g) Long term TA is not yet based on a comprehensive needs assessment, with priorities for the sector. In March 2007, GTZ proposed to the HSCG the adoption of a system for better coordinated TA, but this initiative has had no follow-up. With some exceptions, TA is proposed, recruited and managed by the concerned programmes/DPs. TA orientation/management is often insufficient in terms of institutional attachment, supervision/evaluation, definition of tasks and deliverables, approach of skill transfer and exit strategy.

SHORT TERM OBJECTIVES

a) Production and adoption of a HR development strategy and plan (in process)[5].

b) Recruitment needs and training of additional staff will have to take into account the current weaknesses at the district level, in the context of decentralisation.

c) Also, the HR implications of SWAP development, e.g. in case of decentralised financial management of pooled funding and support/ supervision of district teams by central level MoH must be taken into account.

[5] Expected to be ready by March 2010.

MEDIUM TERM OBJECTIVES

a) Capacity building requirements and measures, based on the comprehensive needs assessment, which is part of the HR development plan, will be largely implemented with CDPF financing.

b) Policies and guidelines for better staff management, including performance based financing/incentives and disciplinary action.

c) Review of certain staff profiles will lead to curriculum revision.

d) Develop and adopt a policy on TA. A discussion document on this area, with recommendations, can be found in Annex Nr 8.

4.3 LEGAL AND REGULATORY FRAMEWORK

When this roadmap was developed, the results of the consultancy on the national legal and regulatory framework, governing the health sector, was not yet available. This means that possible contradictions or gaps in this framework can only be taken into account at a later stage.

The health sector is governed by a GOR body of policies, laws/sub laws, other regulatory documents and norms. These, including a regulatory framework for DPs (the Aid Policy) are in the process of being summarised in a SWAp handbook / manual.

Besides sector specific arrangements, there are several new governmental management mechanisms:

- The Common Performance Assessment Framework (CPAF);
- National Health Accounts and Public Sector Expenditure Tracking;
- Public Expenditures Framework Assessment (PEFA); and
- Benchmarks for Country and Development Partner Performance

It is important to distinguish between:

- the existing GOR legal and administrative framework, which regulates all government systems;
- a multitude of DP / project specific administrative systems, which are agreed upon and described in bilateral or multilateral agreements; this situation applies to all off-budget support; and
- current practices in development assistance, which are or are not strictly in line with the national legal framework.

The first of these three situations applies to the management of GBS and SBS and therefore this category of support does not require our attention.

The third situation applies to actors in health who, until now, have not fully observed the rules and regulations of their host country. In most cases this will be due to their lack of knowledge and understanding of that national context. The SWAp Manual that is now in the process of being written, with national TA, should help to avoid this type of situation in the future. The SWAp Manual will be a handbook that makes it easier for all actors in health to make sure that the support management is in accordance with the national “rules of the game”.

The second category is the one that is particularly interesting in the context of further SWAp development, because efforts can be made towards harmonisation and alignment. In which

case, a compromise solution will be jointly adopted by GoR/MoH and DPs participating in SWAp. The DPs will, to the extent possible, give up (part of) their own procedures, while GoR/MoH allows for a SWAp specific management framework that is a modified version of the GoR framework. This would have the advantage of bringing all (or most) off-budget support under a single joint management framework. Depending on several factors, GoR/MoH and off-budget DPs can decide on a harmonisation "package". For instance, DPs may choose to give up their own auditing and reporting systems, but they may not (yet) be prepared to join a common financial management system. For the SWAp roadmap to become successful, MoH and DPs should adopt a joint medium term vision regarding the scope (package) for harmonisation. This joint vision does not yet exist.

SUMMARY DESCRIPTION OF THE CHALLENGES

a) To be worked out when the analysis report of the national consultants on the legal and administrative framework is available.

b) Example: Procurement law, but no procurement procedures manual.

SHORT TERM OBJECTIVES

a) Comprehensive overview and analysis of the legal/ administrative framework governing the health sector (production of a manual is in process).

b) Identification of texts that need updating /harmonisation with other texts, streamlining and/or adaptation for a SWAp joint management framework.

MEDIUM TERM OBJECTIVES

a) Revision of legal and other texts regulating the health sector (both for MoH and DPs), according to a commonly agreed agenda.

b) In the case for future expansion of pooled funding Joint Management Arrangements (JMA) need to be developed. It is important that this is done in close collaboration with MINECOFIN.

c) Negotiate with DPs their adherence to a set of JMA.

d) Stipulate the implications of adherence to these JMA in a revised (more explicit) MoU and COC.

8 STATUS OF THE SECTOR STRATEGIC FRAMEWORK

Based on the National Health Policy, the overall sector strategic framework is provided by the HSSP. The HSSP I was to present the strategies of all sub-sectors in a standardised format. Therefore, guidelines were adopted (2005-2009). Each sub-sector strategy was to be developed by a TWG, using the same methodology and format. The standardisation of sub-strategy formulation is an important improvement. The identified sub-sectors were initially split into two major categories (control of major health problems and development of health system). Initially, a Health Sector Technical Committee was to oversee the work of the TWGs in sub-

strategy development. That committee does not exist anymore. As a result, all contributions towards sub-strategy revision and development now are to be approved by the HSCG[6].

SUMMARY DESCRIPTION OF THE CHALLENGES

a) Apparently, all sub-strategies are all reviewed together periodically. This is not an ideal situation. While a relatively new sub-strategy may need a frequent review in the first few years, others may have proved appropriate over time. TWGs need to be able to plan their review work. Therefore, it would be better to adopt an agenda, in which the review of each sub-strategy may be planned at a different interval, depending on the likeliness of the need for review.

b) There is also a need to complete the set of sub-strategies. For some areas there does not seem to exist a sub-strategy, or the strategy that was once developed, was never validated or translated into action. Examples of areas for which a more precise sub-strategy is required, are maintenance and collaboration with non-public sector stakeholders/ actors.

c) Innovative strategies need to be tested and evaluated systematically, before they are adopted for sector-wide implementation. Example: community health services. The function description of Community Health Workers (page 9 of the *Guide de Mise en Oeuvre de la Santé Communautaire*) spans an ambitious range of services to be provided, which includes curative services: Pneumonia, DOTS, HIV/AIDS, malaria first line treatment, injectable contraceptives, etc.). Not all of these activities are already being implemented systematically, but the question is whether this is all part of an already formally adopted sector strategy, or whether some aspects are still subject to proof of feasibility in pilots.

d) Extended co-existence of multiple strategies (or hybrids) can lead to confusion and can become counterproductive. The example of district health system development is described elsewhere in this roadmap. Lessons learned from time-limited pilots must be brought together for comparison and subsequent decisions.

e) As part of the sub-strategy development approach, it is necessary to translate sub-strategy objectives into annual operational objectives. Moreover, implementation, coordination and oversight responsibilities for sub-strategy implementation need to be carefully defined, especially for complex areas, like district health system development.

f) The MoH structure that is responsible for sub-strategy development must also ensure that (i) all documented innovative field experiences and studies on sub-strategies are validated and (ii) that all stakeholder groups at all levels are informed whenever a change of strategy is adopted. Follow-up with new guidelines and/or training may be required.

g) The above recommendations are equally valid for development and review of national norms and standards.

SHORT TERM OBJECTIVES

a) Assess the status of all sector (sub) strategies and adopt a calendar for their periodic updating and further development.

b) Systematically plan development/revision and operationalisation of priority strategies and policies.

[6] The SWAp MOU says: "Any significant changes to the HSSP will be endorsed by the GOR and DPs who have signed the MOU at the JHSR."

MEDIUM TERM OBJECTIVES

a) Development/revision of strategies and policies.

b) Improve the steering by MoH of the development and testing of innovative strategies in the field.

c) Testing and evaluation of new or revised strategies

d) Dissemination and training related to these.

9 OVERARCHING SECTOR PROCESSES AND GOVERNANCE

For the SWAp to become more effective, the process of joint decision making should be better defined. The consultative processes must be accompanied by structures for systematic joint decision making and levels for SWAp overall steering, annual joint planning, and coordination of implementation. However, it is inherent with SWAP that when DPs join in decision making, they must also become more concrete about their commitments in terms of phased and timed harmonisation/alignment.

The health SWAp takes into account several international initiatives. Whether related to international development policy (the Accra Agenda for Action, NEPAD), to objectives of increased coverage (MDGs, GFATM, Rapid Gains Initiative), or to specific strategies (GAVI), these are cited in the HSSP II and often represented in the M&E framework with specific indicators. In many cases, these international initiatives are accompanied by specific methodologies and tools (e.g. for IHP+: Compact). While there is no doubt that the Rwanda health sector can often benefit from adherence to these initiatives, it remains necessary to carefully assess the need to adopt the specific procedures and tools, because they can duplicate and destabilize the existing national systems.

It is important to distinguish between GoR/MoH institutional issues and the SWAp institutional framework. While the ongoing MoH reforms are an internal GoR responsibility, the structures put in place for SWAp implementation are of concern to all stakeholder groups. They must all feel part of that SWAp institutional framework and assume responsibility. A major challenge of this consultative and decision making framework is that all these stakeholder groups come with their own culture, logic, goals/objectives and systems.

Even though the internal GOR/MoH institutional reform and the SWAp institutional framework are distinct processes, it is important to define the working relations between the revised GOR/MoH organigram and the institutional framework of the SWAp. Example, for each TWG, a specific MoH unit/department is responsible.

All main stakeholder groups are to some extent involved in SWAp[7]. Of the large number of DPs active in the health sector, most are actively involved, while the civil society is hardly represented or involved in the SWAp orienting and piloting process[8]. Also, the implication of service providers in the health sector and district health authorities is mostly limited to bottom-up planning. For NGOs, this situation is partly explained by the fact that they are organised under various umbrellas, which complicates their representation and coordination.

[7] A list annexed to the HSSP, identifies 14 other ministries, 15 agencies, 46 major implementing partners and 18 major DPs.
[8] A MOU will soon be signed with 8-10 umbrella organisations representing the civil society (laws still to be passed).

The degree/intensity of involvement of DPs varies. Some DPs are often only represented in consultation forums by a "related" DP (e.g., under the One UN initiative, WHO and UNFPA are the lead health sector coordination organizations, and GTZ is the coordinating agency for all German implementing agencies in health). Other DPs, like USG, are often represented by several of their agencies or partner organisations.

The participation of huge but rather vertically oriented actors (e.g. GFATM) in the joint stakeholders sector dialogue is still less than expected. The linkages between the SWAp coordination forums and parallel systems such as the CCM (for managing Global Fund programmes) are still weak. This problem cannot be solved through a programme-specific TWG, because TWGs are not created for that purpose.

6.1 MOH REFORM

SUMMARY DESCRIPTION OF THE CHALLENGES

a) The results of the functional analysis of central level MoH have not yet been presented to the DPs and it would be useful to inform the wider stakeholder group about GOR/MoH's reform plan (which is already in process).

b) MOH signed an internal MOU as part of the overall Civil Service Reform. Other stakeholder groups should have access to this document, as it defines in detail the various roles and responsibilities these structures have towards each other. For the first time, it provides details on what other structure each agency, unit, task force, cells or desk has to collaborate and coordinate with. The need for each unit to collaborate in what activities, together with its obligations have been laid down and this will certainly in the long run improve the internal cohesion and coordination.

c) The new MoH organigram should be accompanied by a description of the working relations and the lines of authority between all MoH structures and with the SWAp coordination framework (HSCG, TWGs etc.). To whom does each structure respond and report for its performance? The sharing of such a document with other stakeholders would be welcome for the better understanding of the overall lines of responsibility.

d) The much needed HR policy and plan have the attention of a TWG and a WHO consultant is being recruited for HR needs forecasting and staff production needs. This work should take into account factors like expansion of facility network, staffing norms and skill mix per facility level, staff profiles, as well as the objective to reduce as much as possible the civil service workforce in favour of performance contract staff.

e) Need to strengthen MOH leadership, notably in terms of firm but rational based decision making, in consultation with other stakeholders, notably regarding new or revised strategies and SWAp management arrangements. Currently, there are too many simultaneously implemented pilots and initiatives, of which the M&E and validation process is not sufficiently clear. An example is the approach of district health system development in the context of decentralisation. There are several DPs who work at district level and who all have their own methodology and approach. The districts are lagging behind and are at risk of becoming confused by all the frequent changes imposed on them by MOH. Systematic and timely capitalisation of all those experiences is to be better ensured, so that best practices can be formally adopted for the whole health sector and subsequently introduced in all districts.

6.3 INSTITUTIONAL ARRANGEMENTS FOR SWAP

SUMMARY DESCRIPTION OF THE CHALLENGES

a) Since SWAp development requires rethinking, reforming and re-organising, the availability of sufficient and qualified staff is paramount; both at MoH level, as well as at district level, especially in the absence of an intermediate (province) level. Line ministries, such as the MoH, still suffer from understaffing, which was the result of streamlining as part of a macro-economic reform. This problem needs to be solved if the GoR maintains its ambition regarding SWAp development. DPs and global funds also attract highly qualified managerial staff and delivery personnel away from underserved and priority areas.

b) On the one hand, national leadership needs to be strengthened, notably in terms of firm but rational based choice and decision making. On the other hand, the SWAp characteristic of prior broad consultation with stakeholder groups is not yet sufficiently developed. This is notably the case regarding new or revised strategies.

c) The MoH reforms are directly related to the question of availability of sufficient and qualified manpower. In the process of SWAp development, the staff shortages and reshuffles in the MoH (as in other ministries) are a major draw-back. This is also very much the case for the meagrely staffed SWAp Secretariat, which initially used to be responsible for the management of the CDPF, with additional responsibilities related to DP coordination (analysis, negotiation and management of all new DP programme proposals). At the same time, it is not quite clear what the scope of its responsibilities is for SWAP development; the Secretariat does not appear to have a work plan.

d) There is no shared comprehensive plan for MoH reform measures towards strengthening the ministry's leadership in SWAP implementation (institutional /organisational reforms and capacity strengthening).

e) "*The organization of the various forums is also not clearly designed as a standard output-to-purpose framework: In other words, the agenda is emergent and the outcomes loosely shape the sector over the long term. In effect these meetings do not serve as firm commitments to elicit change in work organization and sector stakeholders conduct to be consistent with the Paris declarations*." (Quote report Dr A. Seddoh). For the SWAp to become more effective, the functions of broad consultation and of joint decision making should be better defined. The consultative processes must be complemented with structures for systematic joint decision making processes and levels (SWAp overall steering, annual joint planning, and coordination of implementation.) For instance, there is today no specific mechanism for overall tracking of the SWAp development process. An example of possible duplication/overlapping of roles is the Expanded Sector Budget Support Group: this platform was created to capture the off-budget donors in negotiation of their moving towards SBS. Participants are SBS DPs (DFID, Belgium, Germany) plus off-budget donors: WB (which gives GBS), GFATM, and the UN. The question is whether this constitutes duplication with the HSCG.

f) The coordination of MoH with other ministries is not yet optimal. The inter-ministerial working groups, established by MINECOFIN should provide a good mechanism. But for an area like decentralisation, this link is still insufficiently developed.

SHORT TERM OBJECTIVES

a) MoH to inform stakeholders about the planned reforms and initiate a consultation process with DPs in the spirit of SWAp development. It would be useful to share with all stakeholders also the internal MOU that MoH has signed an as part of the overall Civil Service Reform.

This type of information can be shared in the Harmonisation Manual, which is now being edited by national consultants.

b) Finalisation of the MoH organigram, detailed in terms of functions, structures, mandates, links, required capacities and profiles, as well as well as staff levels and numbers. Communication to all stakeholder groups about these reforms.

c) Analyse and decide on completing the SWAp institutional framework. This does not necessarily entail the creation of additional structures. However, as a principle, it is not advised to attribute different functions to one single structure. Therefore, it would seem useful to review once more all key functions in SWAp. Core functions in SWAp management are:

- Steering (orientation and piloting) of SWAp;
- Senior Executive Management;
- Stakeholder implementation consultation;
- Joint coordination /decision making on implementation
- Strategic development;
- Annual review of SWAp progress;
- Annual bottom-up consolidated planning;
- Day to day facilitation of SWAp implementation, and
- Management of common finance modalities.

Then, assess existing structures regarding their mandates, tasks, links, and members. In the analysis, following questions should be answered:

- Do structures exist for all core functions? If so:
- Do these structures have the necessary power/ clout and capacity? Are stakeholders involved?
- Does their mandate reflect the defined core function?
- Is the structure manageable (the group not to big)?
- Do the members of these structures have the time for carrying out the tasks assigned to them?
- Is the functional and hierarchical link with other structures clear and logic?

Then check whether structures match with functions. If needed, modify, replace or create new structures. The table at the end of this chapter *on core functions and structures in SWAp development* that was presented at the debriefing of mission 1 could serve as a basis for further discussion. For suggestions regarding the ToR of various SWAp steering bodies, see Annex Nr 6.

d) Review the Draft terms of reference of the document "*New Rwanda Coordination Mechanisms in the Health Sector*" in the light of the above mentioned functions, because these TOR seem to combine many functions in one single large structure.

e) Since they have a strategic technical advisory role to play, it is paramount that TWGs take into account the experiences of the field/districts. This means that the M&E department must systematically make available to TWGs research, evaluation, and other reports on field experiences.

f) The HSCG and TWGs could become more effective by adopting a quorum rule similar to the one of CCM (GFATM): if MoH is not present/chairing and/or if less than half of the DPs (members in the case of TWGs) are present, the meeting can't start (which happens quite rarely in the case of CCM). The chairmanship by MoH is to ensure its lead function.

g) Re-organise old and, if necessary, create new structures for the SWAp institutional framework in accordance with GOR legislation and in consultation with concerned other ministries (MINECOFIN, MINALOC, MIFOTRA)

h) Plan, budget, resource and implement the HR capacity building required for these reforms and integrate the results of the above in the Human Resource Development Strategy and Plan.

i) The final SWAp institutional framework should be visualised in an organisational chart and lines of interaction with MoH permanent structures to clarify relationships.

j) Negotiate with DPs and mobilise the necessary resources (human and financial) for the activities related to the transition towards SWAp (in addition to what the CDPF already covers).

k) Improve the functionality of the inter-ministerial working group MoH-MINALOC.

l) IHP+: Rwanda signed onto the IHP Global Compact in February 2009. Following the discussion on IHP+ at the latest JHSR, it has not yet been decided whether MoH will undertake a full stocking exercise (Joint Assessment Tool). Advantages of IHP+ may be (i) strengthening health systems towards the attainment of the MDGs; (ii) adherence to this type of international initiatives may increase credibility of the Rwanda health sector development plans; (iii) Compact may become a format for sector development programmes that is acceptable to all main DPs; (iv) additional funding may become available. However, the need for doing another comprehensive sector analysis is less obvious. This conclusion is based on the following considerations:
    - A sector assessment (HSSP I evaluation) was carried out recently (2008) and has led to the formulation of HSSP II.
    - The mid-term evaluation of HSSP II would be a more appropriate moment for a next comprehensive sector assessment.
    - MoH is already in the process of being restructured /reorganised and cannot afford to be distracted by an IHP + learning process.
    - Efforts should now be concentrated on implementation questions regarding HSSP II. This is already a major challenge with the very limited MoH manpower.
    - If any assessment at this moment is to be carried out, it should focus on the situation with regard to the health district development in the context of decentralisation.
    - The JAT has not yet been tested for a whole sector. Experience to date is limited to sub sector assessments.
    - It is unlikely that adherence to IHP+ will automatically lead to simplification of the process and methodology of project/ programme proposal formulation.
    - There may well be a potential for IHP+ in terms of accelerating the alignment of DPs at a global level, since IHP+ has a global forum, but this should not mean that a full IHP+ process has to be implemented in each member country.
    - If IHP+ turns out to facilitate the mobilisation of additional financial resources, then the Rwanda health sector can also become a candidate for those resources without having to go through a second health sector assessment.
    - IHP+ is said to have potential in revitalising “sleeping” SWAps, but this is not the case for the Rwanda health sector.
    - IHP+ builds on the principles of SWAP, of the Paris declaration and Accra. In principle, this does not require a new partnership framework, procedures and instruments.

MEDIUM TERM OBJECTIVES

Examples of some other areas for reform/strengthening:

- Working relations with other ministries like MINECOFIN, (Local Government/Decentralisation, Gender, Youth, Education).
- Support and supervision link with district teams.
- Working relations between central level MoH structures.

CORE FUNCTIONS AND STRUCTURES IN SWAP DEVELOPMENT

CORE FUNCTION	RESPONSIBILITIES	CURRENT SITUATION	SUGGESTION
Joint Steering of SWAp	Highest governance authority which decides, guides, oversees and facilitates the implementation of HSSP. Overall orientation and piloting of the SWAp process.	A Steering Committee exists (MOH + a few DPs. Also the CCM (GFATM) and such a committee for SBS.	In the SWAP Steering Committee all stakeholders groups should be represented. This makes it to a major event, with broad participation. One or 2 annual statuary meeting(s), after the JHSR (and after the JAPS), where is decided on overall SWAp orientation issues: Chaired by MOH.
Senior Executive Management	Overall leadership in health sector development and SWAp implementation.	MOH SMM (general and core group)	
Stakeholder implementation consultation	Promote dialogue and regular exchange of information; enhance spirit of partnership facilitate the implementation, monitor / evaluation.	HSCG, Quarterly meetings In which supposedly participate MoH and all stakeholder groups. (In practice only DPs).	Ensure participation of all major stakeholder groups, but keep the maximum number of participants under 30. Decide whether to give this body a decision making mandate regarding matters of SSP implementation. In that case, define those areas clearly, as well as the procedures for decision making.
Day to day coordination	Advising technical arm of the stakeholder implementation consultation. Follow-up with decisions by SMM or HSCG. Implementation by the Swap secretariat.	Role partly played by TWGs and HSCG Quarterly meetings	The HSCG is a too heavy structure for this function, since it requires ad hoc consultation and fast decision making processes. Consider a small group of MOH with a troika of 3 DPs (lead/chair DP plus 2 co-chairs) and PS/Department Directors for a monthly meeting. Define communication channels with wider DP community.
Strategic development	Time limited task force responsibility for reviewing, updating, developing strategic and policy issues. Agendas, deadlines and deliverables.	TWGs (some sleeping)	Review the landscape, flexible composition, streamline and review working methods. Assure that the concerned MOH departments actively chair and lead the work of these TWGs. TWGs only to do specific tasks for concerned MoH Departments (analyses, proposals, problem solving strategies,.)
Annual review of SWAp progress	Joint annual summit for assessing implementation and performance in year N. Preparation with progress reports, analysis reports, study results, results of joint supervision missions, etc. Recommends adjustments and priorities for year N+1.	JHSR is prepared by MOH and TWGs. DPs/ stakeholders receive the annual report on beforehand and comment. Review both general and focused on key theme(s)	Focus in JHSR more on discussion/ review of overall sector and strategy developments (instead of focussing mostly on presenting SBS related indicators. Start with district level annual reviews and ensure ample representation of district stakeholders in the JASR. Envisage the possibility of commissioning studies and evaluations to external experts. Allow ample time after definition of priorities for year N+1 to

Roadmap for further development of the Rwanda Health Sector; 05/05/2011

CORE FUNCTION	RESPONSIBILITIES	CURRENT SITUATION	SUGGESTION
			have them taken into account in the bottom up planning process.
Annual planning	Joint approval by stakeholders of the consolidated sector Annual Activity Plan, budget, financing plan and disbursement schedule.	The planning process start immediately after the JASR and is finalised without a stakeholder summit	Organise a Joint Annual Planning Summit* (JAPS) where the prepared consolidated sector plan/ budget is validated (or amended)
Day to day facilitation of SWAp implementation	Secretariat for coordination and facilitation of SWAP implementation. Prepares annual summits and ensures adequate follow-up of all decisions taken there. Problem solving role in case of implementation hick-ups. Ensures documentation and dissemination of Swap related processes.	Poorly staffed SWAp Secretariat which also has other responsibilities: management of the CDPF and management of contracts with DPs.	Review the role, composition and working methods of the current SWAp Secretariat.
Management of common finance modalities	Basket management : analyse funding proposals and recommend; authorise disbursement; monitor implementation and expenditure and report	There are Steering Committees, but no structure exists specifically for day to day management. This is due to the fact that there is, as yet, no large scale pooling. Only CDPF.	If, at the medium term, a larger finance pooling mechanisms would be created (e.g a district pooled fund), it will probably become necessary to create small unit of qualified contract staff, with each a specific area of competence, like planning & monitoring, financial management. This function could be combined with the one of the SWAp secretariat, but this structure would then have to be staffed accordingly.

* The question when exactly these two Summits will take place has to be prepared in function of (i) the requirements of the overall GOR budgeting cycle, as defined by MINECOFIN, (ii) the planning activities undertaken by the district administration and by the district health authorities and (iii) the available information on budget ceilings as available from the MTEF.

10 HEALTH DISTRICT DEVELOPMENT

SUMMARY DESCRIPTION OF THE CHALLENGES

a) In operational terms, the health district concept has not yet been sufficiently worked out and this requires strong MoH leadership and consultation with district level actors and DPs working in districts. SCF UK uses the WHO manual for district development (adapted for Rwanda) and assists districts in 3-year strategic planning. Other bilateral programmes use other approaches. The pace and approach of this process depend largely on the factor whether or not a locally present DP is actively involved in overall system development. There being no comprehensive plan for district health system development, these efforts are to be harmonised[9].

b) The strategic area of "health district development" stands out as needing much more reflection, discussion and working out in operational terms. Strengthening of the district health system is the key to improved health services. If there is no adequate comprehensive strengthening of the health districts, health system indicators will not improve in the SWAp. This concerns the aspect of health sector deconcentration, the link with administrative decentralisation, the roles and capacities of DHUs and mayors, the working relation between the DHC and the DH Director, the methodology and process of strategic planning, the reference framework for annual planning and budgeting, etc.

c) The decentralisation process is still changing shape. However, independent from what will ultimately be decided about the respective roles of local government and the Hospital Director, MOH and partners must invest in a robust mechanism for systematic and intensive coaching of district health managers / teams.

d) The coaching concerns the institutional and organisational changes. District teams also need to develop the capacity to develop with a considerable degree of autonomy their systems and capacities, based on a medium term strategic vision. This is to be done in a comprehensive way, with active participation of all local stakeholders. Another aspect to take into account is that the respective responsibilities of DHC and District Hospital Director are still to be worked out in detail, because there appears to be some risk of overlapping.

e) Since there is no longer an intermediate level between central level MOH and health districts[10], responsibility for the mentoring and support of the health district development process is in the hands of only four MoH based Hospital Managers of the Quality Assurance Unit. Apart from the question whether their profile is adequate for an overall district system development (public health would seem more in line), the district system development in the context of decentralisation is a complex process that needs intensive coaching of District Health Directors, Hospital Directors, facility staff and further stakeholder groups. The sheer volume of work that comes with coaching 31 districts is immense.

f) Quality district owned medium term strategic health system plans, which are to become integrated part of overall district development plans (DDP), are not yet available. The first district assessments (survey) was based on the Health System Development Tool, introduced by CF. The survey was done by outsiders, was too superficial and not in line with the HSSP structure/logic. The second generation of this survey tool is more detailed and in line with HSSP. However, the planned assistance to all 31 districts with this questionnaire is again to be done in so little time, that it is

[9] A table by MoH from 2008, shows that 63 projects/partners are active in district health support.
[10] The idea of an intermediate level has become a non-issue, since the GOR has decided to eliminate the provincial level Still, the abandonment of Provinces as an intermediate health sector level has not yet been officially confirmed.

difficult to imagine, that the resulting strategic plans will be based on sufficient in depth analysis. Besides, there seems to be no process of validation of these plans. For instance, planning of extension of the HP network is simply based on locally perceived needs, in line with the principle of one sector, one Health Post. In other words, infrastructure proposals are not based on an agreed health map, based on public health principles (including sustainability).

g) Although there is now in all districts stakeholder coordination (form), co-existence persists of JAWP with individual DP annual planning.

h) Currently, there are many simultaneously implemented pilots and initiatives at district level, of which the M&E and validation process is not sufficiently clear[11]. There are several DPs who work at district level and who all have their own methodology and approach. Systematic and timely capitalisation of all those experiences is to be better ensured, so that best practices can be formally adopted for the whole health sector and subsequently introduced in all districts. Districts without the support of a system development project are lagging behind and are at risk of becoming confused by the multitude of approaches and frequent changes.

i) There is no platform at national level that allows district teams to share periodically their experience with district system development and to learn from each other.

j) District health system development and its financing are of paramount importance for improving the overall performance of the health sector. It is currently very difficult to manage adequately the financing of district health systems (mostly due to scattered DP financing). The huge variations in per capita spending among the poor and the rich districts have been addressed only to a limited extent since the introduction of the Community Based Health Insurance/Mutuelles. District resource allocation criteria have to be defined as a matter of urgency, if equity concerns are to be taken into account.

k) Management capacity of district hospitals appears to be insufficient. Examples: presence of a variety of financial management tools that were not always used adequately; lack of standardisation; absence of a HR Plan (lack of clarity of attributions, job descriptions and irregular supervision); absence of a practical maintenance plan in most DHs; all recording systems still manually operated.

l) The data collection (HMIS and other sources) is under the Hospital Director's responsibility, but the results should be used by the Health Coordinator. This does not yet work well.

SHORT TERM OBJECTIVES

a) Refine the concept of health district development in principles and approach. Aspects of health district development include planning, budgeting, resource allocation, financial and HR management, M&E, training and supervision, stakeholder coordination, PP partnership, etc. Norms and standards may need to be reviewed in the light of the decentralisation context. Example: Is there a need, justification to plan systematically in all sectors a health facility?

b) Work out the operational aspects of health district development: methodology, organisation, monitoring, etc., taking into account the lessons already learned in various district level projects. This means that all DPs working at district level must systematically document and share their experiences. Examples: the attribution of responsibilities and mandates to local administration and

[11] There are several DPs providing support at district level: CTB has a new program in three urban and three rural districts. USG will support 30 districts with approximately $35 million. Other actors involved include: GTZ (5 districts), Lux Development, and the Swiss Cooperation (2 districts).

deconcentrated MoH staff, as well as their required capacities. This is to be done in close collaboration with MINALOC.

c) Complete district health system mapping as a tool for further district development. The GPS-based district health mapping tool that has now been introduced, now only gives an image of the current situation, but should become an instrument for planning and monitoring of infrastructure extension. While the methodology and tools can be provided by central level, the maps should be used by the districts themselves for further planning, with respect of national norms and standards and in a participative manner with all local stakeholder groups. District plans for extension of the health service network are to be validated by central level MoH.

d) MoH to develop, in close collaboration with DPs a medium term action plan for health district development, which includes strengthening of district hospital management and capacity building of local administrative authorities. (Here it is important to coordinate training at district level. This does not mean that this system development is to be started at an equal pace in all districts, because that would overstretch the available technical support and monitoring capacities.)

e) Invest in a campaign for the introduction of the health district development concept and the process/methodology of its implementation.

f) Assure central level MoH capacities for systematic and intensive technical coaching as well as monitoring of the district development process.

MEDIUM TERM OBJECTIVES

a) Implement district health system development phase wise, starting with strong and dynamic districts.

b) Build in incentives for districts to become eligible for comprehensive district development support.

c) Introduction of need based strategic medium term planning.

d) Verification and strengthening of the district health service pyramid: attribution of service packages, role of community based services, referral system, etc.

e) Measures towards strengthening coordination and integration of all stakeholder groups (already mentioned in the recommendations of the JHSR 2008 “decentralised SWAp”)

f) Improve regulation and management of (proposals for) creation of new health services.

g) Strengthen the management capacity of district hospitals:
- The presence of a variety of financial management tools that were not always used adequately; lack of standardisation;
- Differences in income and expenditure figures depending on the tools used;
- Difficulties to provide figures for the annual audits;
- Absence of a HR plan (lack of attributions, job descriptions, irregular supervision);
- Absence of a practical maintenance plan in most DH;
- Recording systems still manually operated.

11 THE CONTEXT OF DECENTRALISATION:

SUMMARY DESCRIPTION OF THE CHALLENGES

a) Health sector deconcentration needs to be worked out in more detail for operational aspects regarding the link with administrative decentralisation, the working relation between the DHC and the DH Director, the methodology and process of strategic district planning, the reference framework for annual planning and budgeting, etc. These changes are to be introduced and guided jointly by MOH, MINALOC and MIFOTRA.

b) The administrative decentralisation and the related reform of the district health system are in process. The reforms are based on the law on decentralisation, but in their implementation, the landscape is still changing. These days, one can hear complaints of confusion: decentralisation is perceived as "a moving target". And there are lingering conflicts about responsibilities and resources. Examples: (i) The roles and required capacities of DHUs and mayors needs to be defined in more detail. (Can we still talk of "district teams" (units) and if so, who is member?) . (ii) Staffing at district level was reduced: Health in Charges have now 4 sectors to cover: health education, social security and local administration. (iii) Hierarchy of competence: The required education level for Health in Charges is BA (license level) is lower than the education level of the Hospital Director. (iv) The required education level of the Coordinator having a master degree in a health/social or social science area, and for the Health in Charge a license in any health area, it is then theoretically possible that there is no expertise in Public Health in district health management. (vi) There is talk of creating a new position between the Coordinator and the in Charge, called Health Director.

c) The change from a local health system that was completely managed by local health authorities (deconcentrated MoH) to a system in which overall decision making responsibility is situated at the mayor's office has been relatively abrupt. It is therefore paramount to closely monitor the effects of this transition, to accompany the process, to provide guidance and support to the actors in assuming their new role, and to allow for adjustments, in case that the actual health service provision and its performance would suffer dramatically from these changes. One factor to be acknowledged is that the earlier mentioned technical positions are subject to considerable local political pressures. The risk of such perverse effects should be monitored closely. Example: irrational creation of new health structures.

d) The MoH and its deconcentrated district level authorities should have a keen interest in playing an active role in the transition. It is not simply a matter of relinquishing responsibilities to local administration, but also of assuring that those with new responsibilities in health system management have a good understanding of the complexity of the organisation of public health functions in a district. The Joint Action Forum provides an opportunity for this dialogue. This is an important lesson learned in many countries, where the health sector went already through a deconcentration process and enhanced community participation, before administrative decentralisation started.

e) NDIS (National Decentralisation and Implementation Secretariat) has the responsibility to develop all "District SWAps". While coordination decentralised sector plans is certainly useful, the term "District SWAps" is un unfortunate misnomer: The abbreviation SWAp stands for "sector wide", and this means that the coherence of the whole system, at all levels, and with all actors is at stake. It would be more correct to talk about aggregated district level sector plans.

f) A recent presidential order for third phase decentralisation included the instruction to transfer responsibilities further from districts to sectors. This decision will have consequences in terms of e.g. resource allocation formula for the five year District Development Plans (DDP), extra staffing, job descriptions and lines of command. However, as long as district level decentralisation is not yet well established and operational for a sector like health, it would seem better to wait a bit.

g) Careful attention however needs to be paid to the national decentralisation framework and private/civil society participation so as to retain the comprehensiveness of a pluralist sector.

SHORT TERM OBJECTIVES

a) Intensification of the MoH/MINALOC dialogue on implementation of health sector decentralisation.

b) Situation assessment of the functionality and performance of the new district level health system organisation: structures, capacities, links, etc.

c) Based on the results of this assessment, MoH and MINALOC may consider the need of adjustments (review of profiles, job descriptions, links).

d) Specify the reporting relation between the district health units, MINALOC and the MoH

e) Production of a manual with clear explanation of all the roles, responsibilities and links at district level (pointing out also possible inconsistencies). In close cooperation with MINALOC.

f) The strengthened role of MoH in the support and coaching of district health system development should also include the aspect of transfer of competence and capacities to the district administrative authorities.

MEDIUM TERM OBJECTIVES

a) Plan for training and recruitment for filling district level positions which are not yet filled or filled by under qualified staff (coordinator, health in charge, hospital director).

The following table proposes steps for further comprehensive district system development.

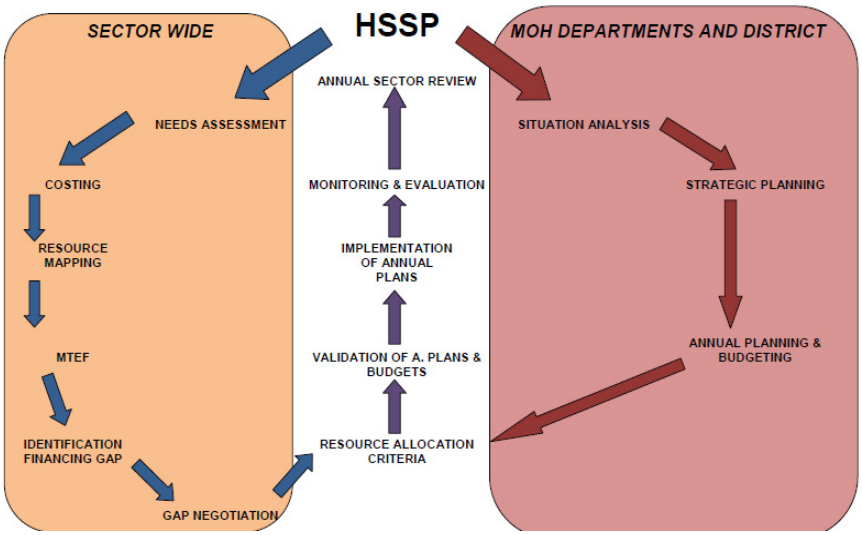
Roadmap for further development of the Rwanda Health Sector; 05/05/2011

ASPECT	SITUATION ANALYSIS	THE WAY AHEAD
Institutional and organ-isational framework	• Responsibility health system development: Mayor's office. • Capacity Health & Family Unit is being severely reduced. (too many sectors, too little staff) • PH qualification and experience of Health Director • Technical responsibility district health services: Hospital Director. • Does he have the right profile to direct overall health system development?	• Keep overall district health system development under MoH. • Ensure solid PH expertise for related posts. • Let mayor's office approve and control. • Limit HD's responsibility to quality assurance service delivery, also HC (supervision, training)
Concept of system development	• Is currently too much based on a fragmented and vertical logic of programmes and DP support packages (not holistic)	• Elaborate a document/guidelines on holistic district system development, that takes into account district specific issues (flexibility!)
Situation assessment of each district	• The database developed with support from CF is useful, but: • Was not sufficiently prepared with district authorities to ensure their ownership. • Was carried out by external interviewers. • Its format was not in line with HSSP structure. • The database cannot substitute for an in depth situation analysis,	• Continue using the database is a reference for available resources per activity and source and level. • Develop a methodology for in depth situation analysis by districts, based on a health map and providing TA /guidance. (start with few districts)
Medium term strategic planning	• Has not been done yet. • The results of a situation analysis should guide the planning, but the existing database is not sufficient for that. • The planning is more based on MoH norms than on specific district characteristics. • The capacity at MoH to guide the strategic planning process is insufficient (4 Hospital managers). • Strategic planning at HC level is not very useful and distracts from service delivery.	• Develop a methodology and format for district ne based strategic planning based on HSSP, involving all local partners/actors. • Start with a few strong districts. • Ensure intensive guidance/TA by central level. • Validate the plans at central level. This validation means a commitment of MoH and DPs to support implementation of the strategic plan.
Annual planning/ budgeting	• Annual plans should be based on strategic plans, which do not yet exist. • There is no real need-based planning, since the instrument used is resource based and fragmented (project and programme input from DPs). • GoR budget allocations do not yet use a set of rational allocation criteria.	• Annual plans are to be based on the strategic plans, developed jointly with local stakeholders. • They are holistic and consolidated. • Once validated at central level, DPs "buy in".
Implementa-tion of district system development	• Is based on scattered support packages as per DP input and geographical coverage: so rational and equitable distribution is not guaranteed.	• Districts receive block grants (quarterly) for implementation of annual plans. • There is a basket for district funding that guarantees rational and equitable distribution.

Deleted:

12 PLANNING AND BUDGETING

The following diagram shows two processes: sector and per level.



The following table shows where there is room for further improvement. The ideal approach in a SWAp and in the decentralisation context is compared with the current practices in the Rwanda health sector.

Nr	BEST PRACTICES IN SWAP	CURRENT PRACTICE IN THE RWANDA HEALTH SECTOR
	MEDIUM TERM PLANNING	
1	Comprehensive sector analysis	Done: evaluation of HSSP I, MoH functional analysis and other studies
2	Comprehensive sector strategic plan	Available: HSSP II
3	Planning guidelines and formats for MoH departments and districts, plus calendar	Guidelines can be approved. Further alignment to be achieved (continued co-existence of planning systems and formats). There is a sector Annual Planning, Budget Preparation, and Policy Review Calendar
4	Individual district analysis and strategic plans (by local stakeholders, but with guidance and support)	Analysis of version 1 was done by externals (survey) according to a format that does not match with HSSP (principles, goals). First version plans were more or less automatically generated on the basis of survey results. Not produced and owned by districts (due to insufficient know-how, largely by national level project staff. The database tool is still to be adapted to the decentralisation context (with exact definition of responsibilities of Chargés de Santé and Hospital Directors). This second generation database tool will be used by the four Hospital Managers at MoH in their support to districts in the elaboration of their strategic development plan.
5	Comprehensive sector costing (basis for MTEF)	Done: by the WB (approach of MBB) and by CF. And: MBB and input-based costing by a mixed MoH based team (not

Nr	BEST PRACTICES IN SWAP	CURRENT PRACTICE IN THE RWANDA HEALTH SECTOR
		HSSP needs based)
6	Negotiation of financial input from all sources (GVT, DPs, etc.)	Not done in a comprehensive way (Round Table), but more based on bilateral, DP cycle based negotiations. The latest NHA reports indicate a problem of skewed financing, with relative overspending in the area of HIV/AIDS. Government is also increasingly concerned that a large amount of health sector financing is not reported. Of the GoR finances, unspent funds are retired at the end of the fiscal year and cannot be rolled over. Until now, cost recovery fees, are fixed on a yearly basis. They are neither based on an overall sector finance policy /principles (in process), nor on the result of costing studies.
7	MTEF as a medium term consolidated Sector Finance Plan (more or less realistic, based on likely resources)	Exists as an incomplete, not needs based finance plan: is limited to the government consolidated fund (includes multi-donor budget support funds, so the majority of resources is not included (because off-budget). A health sector finance policy is in the process of development. This, together with increased willingness of DPs to inform about their aid projections, will help to improve the quality of the MTEF. For districts, medium term financing plans do not yet exist.
8	A health sector 3-year rolling plan of which the costs, available resources and financing gaps are reflected in the 3-year sector MTEF.	Non existing. Operational planning is in line with HSSP, but a three year rolling Plan of Work would be a better guarantee that annual plans are in line with the strategic choices of HSSP.
9	M&E of overall sector orientation, strategies and performance	Yes: Mid-term HSSP evaluation, DHS, MICS.
		ANNUAL PLANNING
1	Joint annual reviews that inform annual prioritisation and planning.	JHSR results inform planning, but there is no stakeholder consultation forum for the adoption of annual plans. Prioritisation in terms of "policy actions"
2	Consolidated needs based annual sector budget commitments, based on jointly adopted resource allocation criteria.	For GoR budget: yes. For all other resources: determined by the support packages that have been negotiated with DPs and which reflect their priorities. Annual plans are developed within the national decentralisation framework and a national MTEF document that has health components spanning a three year plan horizon.
3	Instructions to MoH departments, districts and health services (annual priorities, targets, budget ceilings, etc.)	Partially done. MINECOFIN scheduled a planning summit for the month of April (their calendar). MINALOC uses a Joint Action Development Forum at district level to do annual planning for all sectors (DDP), but MOH proceeded with an annual planning for the health sector, based on JAWP, HSSP and updated MTEF. This duplication is considered problematic for MINECOFIN.
4	Bottom up annual needs based planning and budgeting (drawn from strategic plans. By individual districts and individual MoH departments.	As for the sector annual budget, it is based on the MTEF. JAWP is a list of available resources from almost all (60-80) sources (GoR and DPs, including those who are off-budget). Districts use this software to plan activities and investments of which they are sure that resources are available for them. JAWP has several advantages: it not only facilitates planning, but also maps DP contributions and allows monitoring them. In June (new fiscal year) MoH organises a national forum where it checks priorities and feasibility of annual planning, taking into account the orientations/instructions given by MINALOC (also ceilings).
5	Aggregation and	The sector annual plan exists only in terms of very big number of

Nr	BEST PRACTICES IN SWAP	CURRENT PRACTICE IN THE RWANDA HEALTH SECTOR
	validation of consolidated sector annual plan/budget	activities, investments, and available/allocated amounts per source. It would be difficult to mirror such a plan with a needs based strategic plan. National budget allocations to districts are only based on population size and not yet based on budgets prepared by districts[12].
6	Plan budget execution based on a sector disbursement schedule	Such a system does not exist or is not yet functioning adequately
	budget execution	GVT and DPs should better respect the disbursement schedule.
7	M&E	Can be easily monitored on the basis of the big list of approved and financed activities (JAWP) and budget tracking practices. However, reporting is incomplete and there are problems of data reliability.

SUMMARY DESCRIPTION OF THE CHALLENGES

a) While the annual planning and budgeting procedure for facility and district level is clearly established in a bottom-up manner, there is no systematic aggregation of their validated plans.(The '09-'10 district plans/budgets have not taken into account the facility plans). In other words, the annual plan/budget, as adopted by MoH does not necessarily reflect the priorities and needs identified at district level.

b) There is no detailed annual agenda for sector reforms, based on a medium term reforms plan in HSSP and integrated in the sector annual plans (JAWP). Areas to be covered would be e.g.: HMIS, HR development, CDPF manual, etc.

c) Planning approach at district level: (i) each year DPs visit each districts that they support (e.g. USG visits the 30 districts where its partners work) to determine the package of their support for that year; German Cooperation has TA based in five districts plus visits; the Belgian Cooperation does the same. This is an approach which is more in line with project logic than with SWAP logic. It is vertical, bilateral between the district and each DP, and inefficient. (ii) The approach is based on individual DP assessment of needs rather than an approach that is coordinated with all district partners. (iii) The approach is not based on equitable and rational criteria for resource allocation (depending on DP /project geographical and area coverage, as proposed by MoH). (iv) In the JAWP, certain lines are supposedly based on needs, but these demands are not necessarily "norms-based". Also MBB will be used.

d) Different medium term planning cycles of many partners make it difficult to ensure effective adherence to the agreed medium term sector plan.

e) Co-existence of several annual planning formats: Primature, CNLS, JAWP for annual planning.

f) If MOH departments and desks have elaborated annual operational plans, these have not been shared with DPs.

g) The validation of district annual plans is combined with MOH's support in this matter to districts: an MOH delegation travels to each of the 30 districts to elaborate with district teams the contents of the annual plan. The contents of the JAWP are at that moment already available. This means that districts can plan accordingly, based on MOH unit/desks' and DPs' availability of resources and plans for investments and activities.

[12] Efforts towards a more rational distribution of resources between districts cannot be left to the Joint Action Forum for local coordination of stakeholders (non sector specific).

The result of this joint work of the MoH missions and district teams informs the JHSR, which takes place shortly afterwards.

h) There is still in existence multiple programme based annual planning and budgeting systems based on various funding mechanisms. At district level, the INGO, Intrahealth, had 67 different planning and budgeting templates, related to various local partners (report 12/08). Also templates for sector wide planning still need to be harmonised: MoH template, MINALOC and MINECOFIN template (based on DPPs 07-'12 updates, MTEF, performance contracts. There is also a risk that PBF system is going to be considered an alternative for the existing district level annual planning and budgeting.

i) There is no formal stakeholder consultation forum for approving the annual sector plan.

j) The current budget structure is based on (i) programmes and (ii) cost categories. It cannot at the same time be presented according to a third dimension, like e.g. resources/expenses for lowering the MMR. Furthermore, the budget structure is different from the one MINECOFIN uses. Instead of basing the budget on programmes, it could also be presented according to cost centres.

SHORT TERM OBJECTIVES

a) Ensure that all MoH level structures develop their own annual action plans, with benchmarks for performance evaluation. Example: action programme for the Decentralisation and Integration Unit. Even health facilities are asked to develop a strategic plan. While this is certainly useful for hospitals, it is not very useful for HCs and would take considerable guidance and valuable staff time.

b) Improve the decentralised annual planning process and methodology according to HSSP logic. Bottom up planning: Experiences in other countries (Ethiopia and Kenya) show a very positive effect from such a bottom-up process, as it enhances ownership and commitment by the DH and HC in-charges to reach their stated targets and thus fulfil their performance based contracts.

c) Ensure that the annual planning process at district level is genuinely participative, with the active implication of civil society/private sector activities.

d) Ensure that these annual plans are really consolidated, i.e. that they include all interventions and resources, also civil society/private sector activities to be financed with government lead programmes.

e) CDPF planning should respect overall EDPRS planning.

f) Provide guidelines, a plan format and training of district teams for annual planning.

g) Adopt a planning and budgeting calendar, culminating in a joint annual planning and budgeting summit, following the MINECOFIN overall planning and budgeting calendar[13].

h) Before MINECOFIN and MoH start their annual update of the sector MTEF, MoH and DPs should agree on (an update of) the volume of DPs' financial support. Prior agreement should also be reached on sector resource allocation criteria. (These may be

[13] The 2008-2010 DP Harmonized Calendar by MINECOFIN gives a useful overview of planning processes at various levels, that must be respected by line ministries. It is very well possible to integrate a joint sector planning summit in this calendar (after "Consultations with DPs, …, in February and before the approval of the "Annual Action Plan & Imihigo", in May).

reviewed annually e.g. for system levels, programmes and geographical areas.) The result of the annual MTEF review is then presented to the DPs for joint approval.

i) Adopt validation procedures and criteria. There should be a joint country-level arbitration and validation process with participation of all stakeholders groups, under the joint auspices of partner coordination mechanisms. The validation of annual sector plan also includes inputs from the big funds, like GFATM.

j) Elaborate a guideline for district level medium term strategic planning.

k) It is recommended that the JHSR on fiscal year A takes place by September – October, involving all stakeholders to discuss outcomes and agree priorities for the next fiscal year. The bottom up planning process at Districts and at central level Departments for FY B would take place between December to and of February, following a validation and aggregation in an overall consolidated sector annual plan (March and April). This sector plan would be presented at a joint Annual Planning summit (April/May), where plans, budgets and expenditure frameworks should be discussed and agreed upon. The annual plan /budget, including the national budget, is then finalised with MINECOFIN in June.

l) TA is foreseen for improving the budget structure. DPs would like to see the added value of their financial support.

m) The presentation of the budget execution figures is to be accompanied by a narrative report.

MEDIUM TERM OBJECTIVES

a) All levels have been asked to elaborate medium term strategic plans. While this is certainly useful for central level structures, hospitals and districts, this is not evident for primary health facilities (HCs, dispensaries), since there is no need to develop strategies at such a basic operational level. Moreover, it would take considerable guidance and it would be a waste of valuable staff time in primary health care.

b) Adopt a clear policy and guidelines for cost recovery (fees), based on the results of the 2 costing studies that have been carried out recently, taking into account equity considerations and taking into account the new overall health sector financing policy.

c) Consider the usefulness of a sector 3-year rolling plan of which the costs, available resources and financing gaps are reflected in the 3-year sector MTEF. This "intermediate" plan will make it easier to assure that annual plans and budgets are consistent with medium term plans and MTEF.

13 HEALTH FINANCING

OBSERVATIONS

a) A sector MTEF (period 1/08 to 12/12.) with several scenarios was developed, using the MBB model. MSH did a costing study for Performance Based Financing (PBF).

b) About 80% of health sector financing is still not included in the MTEF (off-budget), which therefore has very limited planning and monitoring value. Non-government/SBS funds constitute the largest proportion of the recurrent service budget. USG support (off-budget and not reflected in the MTEF), coupled with GFATM funds dwarf the rest of the

contributions. Still, this MTEF is operational in MoH with consolidated annual sector budgets and an annual update/adjustment is done. Apparently, the early 2010 updated MTEF is to show also off-budget financing. In addition to the inclusion of this off-budget support in planning, it is also necessary to better reflect off-budget expenditure in consolidated reporting on health financing and to clarify any legal issues regarding this type of financing. MTEF cannot be monitored for expenditure, because, although MTEF is a negotiated finance plan, it is not based on firmly committed resources. There is no plan yet of how to get there.

c) The JAWP gives a more correct picture of the resource availability (annually). This info should show the incongruence between proportions of national level and district level funding. The financial cycle systems have also meant that unspent funds are retired at the end of the fiscal year and cannot be rolled over. In this system, funds that were not spent in a particular fiscal year are not available even if the Ministry of Health desires so.

d) GoR is increasingly concerned that a large amount of health sector financing is not reported and that there is a real risk of over funding at the expense of other sectors. The resources of those DPs who work under the Finance Law (on-budget) report both in CEPEX format and MINECOFIN format: GFATM, CTB, CDD (Swiss), ESTHER project and Lux Development. For the monitoring of all DP programmes (since 2008 including the off-budget financing), the Central Public Investment and Internal Finance Bureau (MINECOFIN) uses the CEPEX. This consolidated, but not very detailed format is used by all multi- and bilateral organizations. MINECOFIN also uses an Excel-based Development Assistance Database (DAD) instrument that can generate reports for the health sector (web-based). The link that is developed between CEPEX and other GoR databases (through SMARTGOV), is now established for CNLS. This link will be expanded for the health sector.

e) The current MTEF is a resource-based cost scenario for scale-up. A real needs-based or results-based cost scenario is still to be developed.

f) No joint, comprehensive negotiation of financial contributions towards the MTEF is negotiated in a round table, in order to fill the financing gap. Financial input from DPs is still negotiated bilaterally according to DP specific planning cycles.

g) There is since 1 year a TWG that develops a sector financing policy. On request of MoH, WB has provided TA. After having created a database, a draft policy was produced, which was recently discussed in a national workshop (1/2010). This policy will also clarify the relation between the national health insurance objectives (CBHI) with the national policy on mutuelles development.

h) For annual prioritisation budgeting at districts, orientation and ceilings are provided by MINALOC. There are earmarked transfers by MINECOFIN for specific areas, like maintenance, CHWs and per programme.

i) The absorptive capacity of the Ministry and the resulting cash flow sequence of both the government and donors are not yet sufficient.

j) The latest NHA reports indicate a problem of skewed financing, with e.g. .relative overspending in the area of HIV/AIDS. Resource allocation is not yet fully in line with HSSP principles.

k) Current proportions in district financing (JAWP) are: GoR 31%, USG (incl. PEPFAR) 26%, Global Fund (GFATM) 5%, and remaining: revenues, multi- and bilateral 38%. Recently, the joint Budget Support Review found that up to 70% of the recurrent funds are allocated to Districts. The district budget for national funding knows the following

main activities: salaries, health financing/Mutuelles, infrastructure, community health, and hospital functioning.

l) Until now, cost recovery fees, are fixed on a yearly basis. They are neither based on an overall sector finance policy /principles, nor on the result of costing studies.

m) The World Bank in collaboration with some partners finance Performance Based Financing (PBF) as part of a sector improvement project. Each of these process required separate planning, disbursement and reporting systems and sequencing. As a consequence these earmarked funds add administrative workload to government systems and structures through their separate planning process, financing, implementation, accounting and reporting systems.

n) Some partners have set other indicators as 'conditions' or 'triggers' for fund release outside the agreed health sector performance indicators with government which require separate reporting mechanisms. This is a reflection of their separate planning and financing systems or requirements.

o) MINECOFIN has proposed a policy on national health insurance. The draft was amended and is being discussed at MoH level. A lot of work still needs to be done.

OBJECTIVES

a) There is an urgent need to refine resource allocation criteria (finance policy).

b) All DPs who signed the principles of the Paris Declaration must commit themselves to full disclosure of financing plans, with on-plan/on-budget spending; and adequate expenditure tracking and reporting. This orientation is also consistent with the Accra Agenda for Action, 2008

c) A round table could be organised for mobilising jointly the gap in MTEF, i.e. when the MTEF includes also off-budget resources.

d) To the extent possible, develop a health sector specific 3-year rolling plan of which the costs, available resources and financing gaps are reflected in the 3-year sector MTEF. This health sector specific MTEF should help both government and partners plan and commit to a clear expenditure pattern and cash flow planning. It may be agreed that two MTEFs will operationalise one HSSP allowing the last year to roll over while the next 5-year HSSP is being negotiated. This will increase predictability.

e) A clear policy and guidelines for cost recovery (fees), based on the results of the two costing studies that have been carried out recently and taking into account equity considerations.

14 FINANCING MODALITIES

For an overview of different types of finance modalities, see Annex Nr 2.

OBSERVATIONS

a) Over time, six main financing modalities have emerged in the Rwanda health sector, which on a scale, have a decreasing degree of integration and alignment:

- Government budget which is on-plan, on-budget, including GBS;

- Sector Budget Support (SBS) which are earmarked funds at the national level;
- PBF pays for all services, not only high impact ones.
- Pooled funding (CDPF) for capacity development at all levels.
- Project funds that are earmarked to specific programmes such as funding from GFATM and to some extent managed by the national systems
- Direct funding by partners who finance and manage their own programmes directly e.g. USG agreements

b) SBS is provided by the German and the Belgium Cooperation, as well as by DFID. The first two have signed an Aide Mémoire on terms and conditions, while DFID has not. The SBS disbursement schedule is formally aligned with country planning and budgeting cycle. Earmarked transfers (with ceilings for specific areas like maintenance, CHWs) directly transferred to Districts by MINECOFIN. In practice however, it seems that there are sometimes delays in their disbursement.

c) The Capacity Development Pooled Fund (CDPF) is a real basket (not virtual). As such, this Fund is an expression of a SWAp environment. Several DPs contribute (GTZ, KfW, Swiss Cooperation, CTB, DFID). The CDPF is managed by the SWAp Secretariat (SS). The fund's operation is piloted by a Steering Committee. So far, only DFID is the only contributing DP who has actually disbursed, because the other DPs are still negotiating more refined criteria and conditions, so that the procedures manual is not yet approved. The CDPF disburses via MINECOFIN, which is chair of the Steering Committee.

d) There is a bottleneck of an increasing number of projects and parallel reporting conditions.

e) Harmonization means working together in a jointly adopted system that ensures integration and synergy. For instance, ideally, resources would be channelled through one system. Sometimes this degree of harmonisation and alignment with national systems is not possible, e.g. because a government system is not yet considered strong enough, or certain DPs are not allowed to comply with this system.

f) For the question whether or not it is useful to aim for a more limited number of finance modalities, it is important to map them also in terms of proportion of the overall health budget. The table[14] in Annex Nr 3 shows the relative importance of each DP financing modality per level. This allows us to estimate the scope for expansion of pooled funding. Most of the district level aid comes from a few DPs who have been rather hesitant in alignment/harmonisation. There is persistent co-existence of many different finance and aid management modalities, support which is to a large extent off-budget. Dialogue should be continued to see how stepwise more may be achieved. (The UN family was initially also very reluctant regarding adherence to SWAp, but has meanwhile made courageous steps).

g) As a starting point, it is useful to acknowledge diversity in a realistic manner while encouraging a movement towards increased harmonisation and alignment. Also, in certain circumstances, there may be valid arguments for the continuation of project mode.

11.1 JOINT MANAGEMENT ARRANGEMENTS

A good starting point is the harmonisation manual for all sectors, produced by MINECOFIN[15].

[14] Table compiled by A. Fischer (GTZ) and G. Williams (MSH)
[15] Existing document; title?

A specific document on Joint Management Arrangements (JMA) for the health sector becomes necessary when GoR/MoH and a number of DPs have agreed to harmonise certain management aspects in the SWAp, with the objective to improve the effectiveness and efficiency. The JMA should help to streamline the overall SWAp implementation and can help to reduce transaction costs. JMA are the next step after CoC and MoU.

Therefore, the JMA mention, as a reference, these existing collaboration documents: MoU, CoC, bilateral agreements, specifying the hierarchy between these. (DPs usually prefer legal precedence to the contents of their bilateral arrangements. The DPs who agree on joint arrangements for audit, monitoring and evaluation, can still claim the right to retain their bilateral arrangements in these areas.)

The goals of and scope of JMA are to specify common provisions, conditions and procedures.

Harmonisation and alignment opportunities are: reporting, auditing system, annual planning, planning cycles and TA, per diems and incentives, procurement, and pooled funding.

After introduction, the JMA starts with general statements regarding underlying principles for collaboration (as short as possible). Then, responsibilities, specific accountabilities and representation issues are specified, as well as the role of lead donor, if applicable. It is also stated that GoR is solely responsible for implementing the programme and for accounting for use of funds. If applicable, pre-conditions to be met by GoR are stipulated. It is useful to explain the principle and mechanism for sharing info, communication and transparency; to give info on aid flows, activities, procedures, reports and results of M&E. The level of harmonisation and tasks with regards to the modality of financing are described.
The representative for the GoR may be MINCOFIN, while the MoH is responsible for day- to-day operations.

The JMA normally do not contain a precise indication of the value of the respective DP contributions. A rough indication suffices, with number of years. If possible, settle on a common currency and arrange for specific provisions on the exchange of foreign into local currency, including exchange rate/date.

If MoH and the concerned DPs have chosen for a joint financing mechanism (pool, basket), this can be managed in different ways. Fully aligned would be a foreign exchange account, maintained by the Central Bank, with indication on whether interest bearing or not. It should be clarified whether other proceeds supplement the pooled funds. Some DPs require that interest generated is returned to them on a pro-rata basis. The advantage of a non interest-bearing account would be that there is no incentive to under spend. Alternative system: DP funds are deposited in a separate foreign exchange account, preferably managed by the GoR. Alternatively, that account could be the responsibility of the donor(s) or a third party (e.g. a contracted banking institution).

Consultations and decision making process consist mainly of regular consultation meetings with transparent procedures. A solid performance framework enhances a more “businesslike” type of dialogue. Policy dialogue is critical, allowing discussion on the focus of the support. Timing of consultation has to be aligned with GoR’s planning, budgeting and review process. Review of progress covers conditions for disbursement, review of future action plans, corrective measures, review of concerned reforms (e.g. procurement system), review of priorities, level of budget execution. Decisions of the DPs on disbursements should be taken preferably jointly, based on dialogue.

In the JMA, decision-making procedures are defined: about compliance with the provisions of the JMA and how a common position is reached. It is specified who is eligible to vote and

within what time frame decisions should be taken. It is also stipulated what decisions may be as consequences of major slippage relative to the agreed performance indicators.

In the case of a parallel management system (i.e. when the GOR system was not considered acceptable), organisational structures are defined: e.g. a Joint Steering Committee, a Technical Committee, an Implementation Unit, a Financial Committee. Signatories, responsibilities and joint working and coordination arrangements are mentioned. There is a description of main procedures. It is clear that, in the spirit of the Paris Declaration and in line with SWAp principles, the role of DPs in these structures should remain modest.

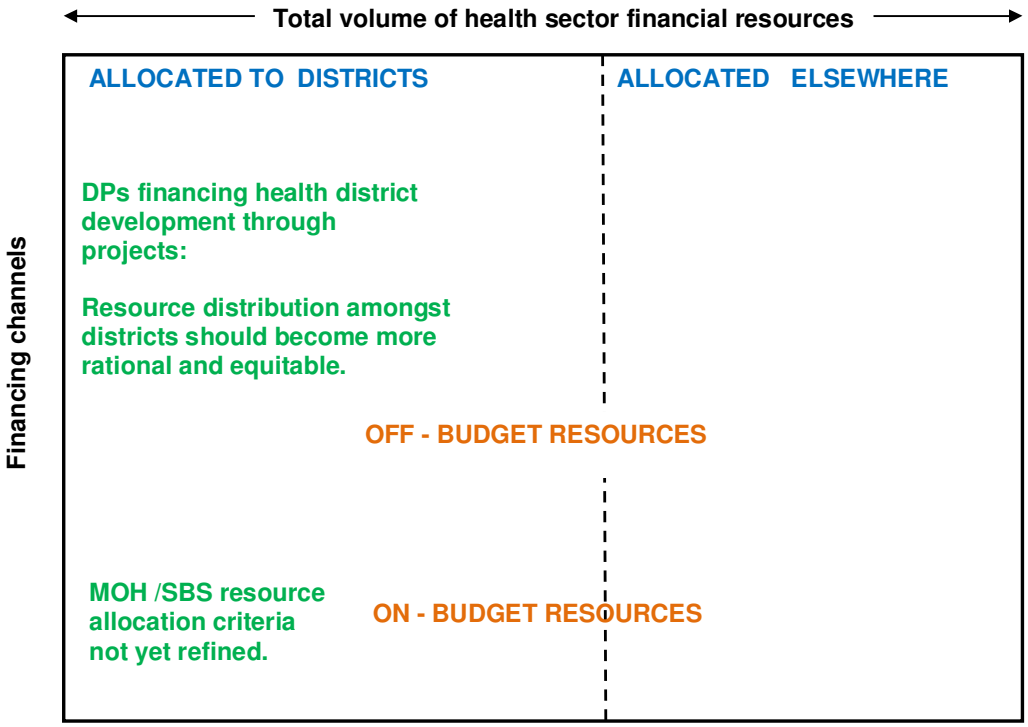
In Annex Nr 6 further considerations for developing JMA are discussed.

11.2 POOLED FUNDING FOR DISTRICTS

The successful operationalization of the CDPF should be the litmus test to paving the way for broader pooled funding, as a way to the further harmonisation/alignment of financing modalities. There are several arguments in favour of creating, at the medium term, a district pooled fund:

- District system development is a key element for improving overall health system performance, but it is not yet receiving the attention it merits, in terms of organisation, methodology and financing.
- There are currently many financing channels for district financing, causing inefficiency, risks of overlapping, problems of transparency, irrational and inequitable resource allocation.
- Apart from the existing "SWAp-friendly" financing modalities of SBS and the CDPF, I do not see any medium term scope for other joint financing mechanisms. If guaranteeing adequate public finance management at district level will be already an important challenge, I think this would be even more the case for a sector wide basket.

However, whether this idea of a district pooled funding is relevant and feasible depends very much on whether the volume of financing for such a pool would be sufficiently big to justify such a new set-up. In other words, are there enough DPs who are willing to join and is their proportion of external financial support big enough?
The following diagram illustrates the situation of fragmented district funding.



In the current landscape of district financing, it would not yet make much sense to push directly for a district basket, because:

- The administrative capacity of many districts is probably not strong enough to ensure adequate management of pooled funds.
- The bilateral DPs who are, in principle, interested in further pooled funding, are the same as those who contribute to the CDPF: Belgium, Germany, SDC and DFID. However, apart from DFID, they all still have direct interventions (TA and in kind contributions). They also have different partners: health centres, hospitals, districts) and contractual arrangements.
- The majority of district funding comes from USG financed projects, which, at this stage, are not permitted to pool funds.
- There may be also NGOs, interested in district pooled district funding (e.g. SCF UK, who is active in 2 districts, but their financial contribution to district funding is relatively modest.

MOH and DPs can jointly decide whether to explore options for creating such a pooled fund and aim for the creation of a district fund at the medium term. Of course, such a pool would somehow have to be merged with the CDPF, because having several pools would not make things easier. One understands MoH's wish to have only one single fund manager, instead of several. In fact, in several other countries, a single broader management mechanism or all pooled funding was adopted, based on one of the already existing mechanisms.

Some principles for the management of a district pool:
For a district to become eligible for support through this pooled fund, its medium term strategic plan for health system development must have been formally approved by the MoH. Secondly, its general capacity in public finance management must have been judged by MINECOFIN as acceptable (human resources, procedures, tools, accounting practices). Thirdly, the district's consolidated annual plan for health must have been approved by the annual sector health planning summit. The district will receive a first tranche based on the expected volume of expenses as indicated in the approved district annual plan/budget. Subsequent tranches are released on the basis of submitted accounting reports and returns. After approval of a (quarterly) disbursement tranche by MoH, funds would be transferred by MINECOFIN, to the district bank account. So the funds would pass by the same channel as for SBS and the MoH budget.

What can and should be achieved, even if district pooled funding is not going to be considered an option, is further improvement of the bottom-up and consolidated planning and budgeting process in order make it more needs based (founded on a validated and feasible medium term vision), while guaranteeing a more rational and equitable distribution of resources.

15 FIDUCIARY FRAMEWORK

The HSSP II includes a chapter on Fiduciary Risk Management, with a matrix in which good practices are compared with the current situation in the GOR systems, and followed by proposed risk mitigation measures. This is a very good starting point, provided that systematic and periodic monitoring of progress is ensured and results of various assessments are shared (ex ante capacity assessment of procurement and financial management rules, procedures and practices, impact assessment of mitigation measures, ex post reconciliation of expenditure, and, if applicable, remedies implemented for ineligible expenditure.)

SUMMARY DESCRIPTION OF THE CHALLENGES

a) The concept of "mutual accountability" is not yet sufficiently developed and the accountability of "off-budget" financial resource execution is to be improved.

b) Although the GOR uses a comprehensive framework of public finance management procedures, and all health facilities have management autonomy since 2007, the evaluation HSSP I observed that districts still have to cope with a multitude of different bank accounts, and accounting systems, related to the funding by different DPs. Districts cannot open an account in a commercial bank. MoH has asked MINECOFIN to open for each district an account at the national bank. Moreover, district financial management is still "paper-based" and therefore cumbersome and liable to errors. Financial management at district /facility level is also still weak due to lack of training and budget indiscipline (quote MINECOFIN). While there is qualified staff at district level (1 administrator and 1 accountant), accountants at HC level are not all qualified.

c) Supervision and control by central GOR of financial management of districts health systems is insufficient.

d) The management of the CDPF is based on an agreed functional concept but not yet detailed in a procedures manual. Moreover, the CDPF is not yet functioning well. Account reports with returns are reaching MOH with delay and TA recruitment is delayed. This is why most participating DPs have not yet started disbursement and tend to insist on more conditionalities than exist for the education sector pooled fund. This is a sign that dialogue and information exchange must be intensified so that an environment of mutual trust is strengthened.

e) The GOR procurement system was apparently evaluated recently, but experience with GFATM procurement showed that there is still a major problem. Remaining questions are: (i) What was the outcome of this evaluation? (ii) Is there a need to find alternatives or adaptations of certain national procedures which are too cumbersome in decentralisation? (iii) What is the status of the draft procurement manual? DPs in SWAp should be informed about this review process.

f) PBF: a fiduciary risk is the tendency to produce "nice" data. There are 140 parameters, which is far too much and validity is difficult to verify. Even communities, receiving PBF are supposed to do data collection for their M&E. Are they capable of doing this?

SHORT TERM OBJECTIVES

a) Do an external assessment of the functionality and performance (also at district level) of the GoR/MoH public finance management framework, including the auditing system and procurement system, in order to have a clearer view on fiduciary risks and what can be done to solve them. This approach will foster mutual trust and willingness of DPs to seek further alignment with national management systems. Some progress was already

made: a procedures manual for public finance is used and an MOU was signed for management of resources from SBS and GFATM. CTB procurement uses the national Tender Board. On the other hand, finances of bilateral DPs like USG and GTZ funding are managed completely by DP-specific systems. The accountability of such "off-budget" financial resource execution is to be improved.

b) Use sector-wide annual procurement plans and calendars and organise systematic monitoring of their implementation for early detection of long delays in certain phases of the tendering process.

c) Existing financial management instruments like MTEF, National Health Accounts, PER, Public Sector Expenditure Tracking and the Public Expenditures Framework Assessment should be harnessed to generate increased DP confidence in GoR/MoH's public finance management system and capacity. Some of these concerns will be met by a new resource tracking tool for the health sector which is currently being developed.

d) Explore the potential and options for further alignment of financing modalities, financial and procurement management framework. This assessment will take into account (i) that a part of donor money is already channelled through SBS and (ii) that off-budget financing comes from a few DPs. In other words: is there sufficient critical mass to justify further development of the pooled funding or basket modality?

e) Have a CDPF manual developed and adopted.

MEDIUM TERM OBJECTIVES

a) Develop and implement an action plan for strengthening of the GVT/MoH public finance management framework: capacity building, introduction of electronically based financial management system/tools, fine-tunes internal and external control mechanisms, reach agreement on a common auditing system (internal and external).

b) There are currently several steering committees for various financing modalities (SBS, CDPF, GFATM). Efforts could be made to bring the responsibilities of these committees under one single overseeing body for health financing.

16 MONITORING AND EVALUATION

This area encompasses HMIS, data systems for specific areas (HR, health infrastructure mapping, asset management, etc.), DPAF, CPAF, PER, disease surveillance, periodic sector-wide surveys, sector review events, programme evaluations, research, supervision, budget expenditure tracking, etc. Non-health sector specific information systems include the by MINALOC adopted comprehensive M&E mechanism for districts, with 20 indicators.

Some progress has been made with TA; the strategic M&E plan & policy was revised, but it still needs to be disseminated. A logistic management system is being developed. Supply Chain Management Systems (SCMS).The E-health strategic plan was finalised in May 2009 (HMIS, distant learning, telemedicine). The question is to what extent areas for which E-health has not yet been developed (Human Resources, Finance, Logistics and the Private Sector) will be addressed in the new software package that will be introduced in the coming months. Positions were created and filled for a HMIS coordinator and for research. Additional staff for HMIS was financed by GFATM (data base administrator, data quality specialist). HSSP indicator follow-up is done in quarterly reports.

SUMMARY DESCRIPTION OF THE CHALLENGES

a) The need for establishing a comprehensive M&E system was identified as a priority several years ago. DPs saw the establishment of a robust comprehensive M&E framework as a condition for further support to the SWAp process. The functional analysis recommended the creation of the M&E Unit, which covers HMIS, M&E and E-health. However, the M&E framework is not yet comprehensive knowledge management and there is still no adopted master plan with calendar for the implementation of this comprehensive M&E system.

b) While above all, the streamlining of information and knowledge systems is necessary, for some areas a further expansion is necessary. For instance, until now, the inclusion of private sector data in HMIS has not been planned.

c) Similarly, operationalisation and testing is still to be completed. An example is the logistic management system that is being developed (SCMS). It needs to be linked with a firmly established asset management and maintenance system for the health sector.

d) Improvement of HMIS has proved difficult. While previously, HCs had to produce 17 different reports; MoH has chosen in 2007 for one single 26 page monthly report, plus a one page PBF report. For the hospital level, the report to be filled out has 46 pages and districts have 67 reporting requirements. There are still too many different pathologies to be reported on a monthly basis, and that for too many age groups. While reporting compliance of HMIS is good since this was linked with the PBF system, the system is still fragmented, over-burdened and not yet comprehensive, mostly due to conflicting initiatives by some of the major disease control programmes. There are currently 7 HMIS-type information systems operational that each collect their own information and have their own collection tools in place (TRAC+, Mutualism, PBF, CNLS, private-for-profit sector). There is an urgent need to streamline and harmonise all these data systems. The main hurdle that keeps MOH from establishing a leaner, more efficient and effective HMIS is the vertical programmes' lack of willingness to drop their specific detailed indicator reporting. (Malaria, HIV, TB, leprosy.) This is a very common problem that has nevertheless been addressed successfully in a number of countries. In the case of the Rwanda HMIS (and broader M&E system), there seems to be a lack of (i) firm commitment , (ii) of an operational plan with firmly negotiated milestones, (iii) as well as of rigorous monitoring. Instead, there are multiple plans for improving HMIS, related to DPs who work in this area: CDC, UNICEF, CTB, Health Metrics Network. And yet, it is difficult to imagine how the SWAp could become fully operational without an adequate M&E system: overall steering of sector development become illusive if stakeholders do not have access to complete and valid health system and health status data. The tallying for monthly reports is still done manually, leading to too many errors and the software, used for data aggregation is not user-friendly. Therefore, the reliability of data collection is still to be improved with a system of data quality validation. Data from private sector facilities are still to be integrated.

e) Hospital Directors have become responsible for HMIS at district level and the necessary staff, hard- and software is available in all districts. (M&E staff was trained). However, the mayor's office (coordinator, Health in Charge) should become major users of district data for monitoring and planning. This need is acknowledged by MHS, who worked until now mostly on developing M&E at national level. The focus of their new project (Integrated Health System Support Project, IHSSP) is on district level system development.

f) The Common Performance Assessment Framework (CPAF) of the EDPRS uses 6 strategic outcome indicators for the health sector, which are also presented at the JHSR. The system should include benchmarks for Country and Development Partner Performance. Within the HSSP I and the draft HSSP II, a set of key performance indicators and targets for the health sector were agreed. A general system for the

collection, analysis and reporting is in place, but further harmonisation and streamlining of indicator sets is necessary.

g) The health sector has routinely undertaken exercises for the monitoring of sector financing and spending: National Health Accounts and Public Sector Expenditure Reviews, National AIDS Spending Accounts (NASA), Development Assistance Database (DAD), Central Public Investments and External Finance (CEPEX) and specially commissioned review reports. This in addition to the monitoring of sector specific documents like HSP and MTEF. MoH sees the need to harmonise these Resource Tracking Activities and TA has started working on this issue.

h) Some earmarked funds (including SBS) require separate reporting systems agreed outside the health sector based on different indicators or triggers. On the other hand, DPs do not know how to interpret incremental budget expenditure information: they do not know what has led to changes over time in the presented figures. Issues regarding expenditure tracking and reporting and mutual accountability are also discussed under the chapter on the fiduciary framework.

i) The GIS-mapping tool, being developed through the PNLP (national malaria programme) is now used for a one time situation assessment, but it could and should also to be used for monitoring the further development of the facilities network.

j) Currently, the JHSRs are rather one-dimensional, responding to reporting /assessment requirements from EDPRS and SBS. (By some stakeholders, the JHSRs culture was described as too much “ticking the boxes”.) Presentations/reports are prepared unilaterally by MOH, with input from TWGs, but without individual comments by DPs and other stakeholder groups. Some stakeholder groups do not participate actively in JHSRs. How the findings, discussed at the JHSRs fit into planning (including the use of these findings to inform priority setting) is not clear enough. Though annual reporting of partner performance is also to be reviewed at this meeting, the process and standards of such a review are not defined. The JHSR could be made more effective, e.g. with joint preparation by MoH and stakeholder groups, with in depth discussions on the results of specific studies, of which the topics are chosen jointly by the HSCG on beforehand. There should also be a systematic follow-up of mile stones for areas of SWAp development.

k) The independent reviews that are commissioned of which the results are discussed at annual JHSRs could also concern key managerial areas.

l) In line with the adopted principle of decentralisation, the role of districts in M&E could be strengthened.

m) The interpretation of M&E results and their translation into recommendations and systematic follow-up in subsequent operational plans should be based more on a consultative process with all stakeholder groups.

n) There is no specific mechanism for tracking process of SWAp development: a roadmap that has milestones and a calendar would facilitate this.

SHORT TERM OBJECTIVES

a) Finalise the development and adoption of a comprehensive M&E framework. This entails that the knowledge management assures systematic and documented validation of all studies and evaluations, etc. With documentation and follow-up of the adopted recommendations.

b) Adopt the M&E TA's objective to come to a report of four pages maximum for HMIS. The objective to come up with a proposal for a set of key indicators by the end of 2009 should be realised in 2010 and the set is to be officially adopted. Until now, there was no agreed time line for this. (A timeline was proposed at a workshop in December 2008, but it was not formally adopted.)

c) An important challenge is the adequate phasing out the old HMIS system when the new consolidated and streamlined HMIS is introduced, in order to avoid an information gap of several months due to the transition.

d) Review and improve the methodology for JHSR, allowing for a joint preparation by MoH and stakeholders. MoH could involve DPs more actively in JHSR preparation, including in data review and in joint supervision visits. Distinguish between an overall performance review and an in depth review of specific priority strategic or management issues. As per need, an annual external review by a consultant can be planned on a specific area(s), jointly chosen by MoH and DPs. Plan the review for two days: first day with presentations (assessment) and second day for discussing necessary policy actions. Definition of policy actions needs to be followed up systematically by MoH and TWGs for defining implementation aspects (who, when...)

e) Adopt a comprehensive action plan with calendar and milestones for strengthening and harmonising information systems (content, data collection, management and utilisation) for M&E.

f) Link joint annual sector review to a bottom up and consolidated joint annual planning and budgeting cycle: the joint health sector review on fiscal year A could take place by September – October with a national Health Summit involving all stakeholders to discuss outcomes and agree priorities for the next FY B held in November of that year. From then on, the planning process for fiscal year B will start, following a bottom up approach. Districts, Provinces and central level Departments can simultaneously start this planning exercise (December to and of February), whereby district plans are validated and aggregated (March and April) to be merged with department plans in an overall consolidated sector annual plan. This sector plan will be presented at an annual joint planning summit (April/May), where plans, budgets and expenditure frameworks should be discussed and agreed upon. The annual plan/budget is then finalised in June.

g) The exact moment when these summits should take place will depend on (i) the requirements of the overall GOR budgeting cycle, as defined by MINECOFIN, (ii) the planning activities undertaken by the district administration and by the district health authorities and (iii) the available information on budget ceilings as available from the MTEF.

h) The GIS-mapping tool, should also to be introduced for further monitoring and planning of new health facilities. It then becomes a tool for analysis, planning and monitoring of the facilities network. When district facility expansion proposals (as part of their medium term strategic planning) are validated at national level MoH, these prospective maps become a formal reference, to be respected by all actors in the field.

i) Innovative activities are to be systematically evaluated, validated in the consultative process, and followed up by an action plan. Define procedures of how each analysis /recommendation / proposal is to be validated: by which structure? How? Documented? Organisation of follow-up.

MEDIUM TERM OBJECTIVES

a) Finalise the streamlining and harmonisation of HMIS and assure better reliability and completeness of data (including those of the non public sector).

b) Adopt a small number of key indicators for overall sector/SWAp development monitoring. Revise the sector indicators and targets by synchronizing and reflecting the various vertical programme indicators and targets with the national set of indicators. Keep the core set (max 25 recommended) as the main sector indicators that reflect health status, burden of disease, system and process effectiveness indicators. DPs requiring additional information may commission these on their own but organised at the same time as national reviews to reduce administrative and operational burden on staff. The results should be shared with all partners.

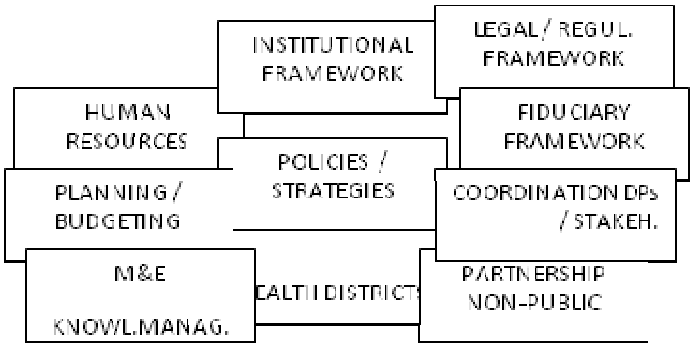
c) Systematic evaluation, validation and follow up (by an action plan) of innovative activities.

d) Complete the master plan for knowledge management in areas that are not yet sufficiently documented. Example: asset management. Apparently support for this was provided by Lux Dev, but it is not clear whether a sector wide system was formally adopted, or whether it is fully operational and supervised.

17 SUMMARY OF PRIORITY AREAS FOR THE ROADMAP

1. MoH institutional/ organisational framework
2. human resource development
3. legal and regulatory framework
4. sector policy and strategic framework
5. consolidated, bottom-up planning and budgeting
6. comprehensive health district development in the context of decentralisation
7. fiduciary framework
8. coordination of DPs and other stakeholder groups
9. coordination/ partnership non public sector actors
10. sector monitoring and evaluation; information /knowledge management.

The following diagram shows above listed priority areas are interlinked. This transpires also from the following paragraphs in which these priority areas are further developed in terms of key activities.



As was already acknowledged in the Preamble of this roadmap, one can argue that *Human Resource Development* (Priority area 2) and *District System Development* (Priority area 6)

do not belong in this SWAp list, since they are overall sector development concerns[16]. The reason why they are included is that they are seen as essential for overall improvement of health system performance, which is also the goal of SWAp. Similarly, one could argue that strategy development is already covered by HSSP. However, in the context of this roadmap it is more the process of further development and periodic review of (sub) strategies, which is of interest in this roadmap.

For an overview, in table format, of how the DPs perceived the relative importance/priority of these 10 areas, see Annex Nr 10.

The need for further prioritisation of these priorities

Obviously, it will not be possible to realise all the hereafter listed short term priorities for all 10 areas in a single year. This is why the duration of *short term* and of *long term* has not been defined. Instead, it is suggested that, when roadmap objectives have been adopted, MoH and various stakeholder groups decide jointly what is to be realised within the current fiscal year, what in the year 2010-2011, etc. Consensus could be attained by ranking all objectives through a simple joint scoring exercise, based on the following criteria:

1. importance of the objective
2. urgency of the objective
3. vulnerability of the problem to be solved
4. capacity available for realising the objective.

14.1 PRIORITY AREA 1: MOH INSTITUTIONAL/ ORGANISATIONAL FRAMEWORK

SHORT TERM OBJECTIVES

1. Strengthen the consultation process with DPs/SH
2. inform stakeholders about the planned reforms
3. finalisation of the MoH organigram
4. Review institutional framework for SWAp.
5. Plan, budget this institutional framework
6. Negotiate with DPs and mobilise resources for this
7. Integrate related capacity build needs in HR Plan
8. Improve the functionality of the inter ministerial working group MoH-MINALOC
9. Postpone IHP+ assessment (JAT) to MT evaluation HSSP

MEDIUM TERM OBJECTIVES

Examples of some other areas for reform/strengthening:

- Working relations with other ministries like MINECOFIN, MINALOC, Gender, Youth, Education).
- support and supervision link with district teams.
- working relations between central level MoH structures.

[16] The opinion of the DPs on this question varies.

14.2 PRIORITY AREA 2: HUMAN RESOURCE DEVELOPMENT

SHORT TERM OBJECTIVES

1. Finalisation / adoption of a HR development plan (in process).
2. Recruitment needs and training of additional staff to take into account the current weaknesses at District level, in the context of decentralisation.
3. Also, the HR implications of SWAp development, e.g. in case of decentralised financial management of pooled funding and support/ supervision of district teams by central level MoH must be taken into account.

MEDIUM TERM OBJECTIVES

1. Capacity building requirements and measures, based on the comprehensive needs assessment, (HR development plan), to a large extent be implemented with CDPF financing.
2. Policies and guidelines for better staff management, including performance based financing/incentives and disciplinary action.
3. Review of certain staff profiles will lead to curriculum revision.

14.3 PRIORITY AREA 3: LEGAL AND REGULATORY FRAMEWORK

SHORT TERM OBJECTIVES

1. Comprehensive overview and analysis of the legal/ administrative framework governing the health sector. (A production of a manual is in process.)
2. Identification of texts that need updating /harmonisation with other texts, streamlining and/or adaptation for a SWAp joint management framework. (A separate report will indicate gaps, outdated texts and contradictions between texts.)

MEDIUM TERM OBJECTIVES

1. Revision of legal and other texts regulating the health sector (both for MoH and DPs), according to a commonly agreed agenda.
2. In the case for future expansion of pooled funding Joint Management Arrangements (JMA) need to be developed. To be done in close collaboration with MINECOFIN.
3. Negotiate with DPs their adherence to a set of JMA.
4. Stipulate the implications of adherence to these JMA in a revised (more explicit) MOU and COC.

14.4 PRIORITY AREA 4: SECTOR POLICY / STRATEGIC FRAMEWORK

SHORT TERM OBJECTIVES

1. Assess the status of all sector (sub) strategies and adopt a calendar for their periodic updating and further development.
2. Plan and start systematic development/ revision of priority strategies and policies.

MEDIUM TERM OBJECTIVES

1. Development /revision of strategies and policies, based on validated tests /pilots

2. Improvement of steering by MoH of the development and testing of innovative strategies in the field.
3. Systematic monitoring and evaluation of new or revised strategies
4. Dissemination of related info and training

14.5 PRIORITY AREA 5: CONSOLIDATED AND BOTTOM-UP PLANNING AND BUDGETING

SHORT TERM OBJECTIVES

1. All MoH level structures to develop their own annual action plans, with benchmarks for evaluation.
2. Improve the decentralised annual planning process and methodology according to HSSP logic.
3. annual planning process to become genuinely participative, with the active implication stakeholders
4. annual plans to become fully consolidated, i.e. that they include all interventions and resources
5. Provide guidelines, a plan format and training of district teams for annual planning
6. Validation in 2 stages (first of district level, then sector planning summit), several months after the JHSR and joint annual prioritising session.
7. Planning and budgeting calendar to culminate in a joint annual planning and budgeting summit,
8. Adopt plan/budget validation procedures and criteria+ joint country-level arbitration.
9. Elaborate a guideline for district level medium term strategic planning .

MEDIUM TERM OBJECTIVES

1. Abandon medium term strategic for primary health facilities (HCs, dispensaries).
2. Adopt a clear policy and guidelines for cost recovery (fees), based on the results of the costing taking into account equity considerations and taking into account the new overall health sector financing policy.
3. Consider the usefulness of a sector 3-year rolling plan of which the costs, available resources and financing gaps are reflected in the 3-year sector MTEF. This “intermediate” plan will make it easier to assure that annual plans and budgets are consistent with medium term plans and MTEF.
4. Review resource allocation criteria.

14.6 PRIORITY AREA 6: COMPREHENSIVE HEALTH DISTRICT DEVELOPMENT

SHORT TERM OBJECTIVES

For health system development

1. Refine the concept of health district development in principles and approach
2. Work out the operational aspects of health district development
3. Complete district health system mapping as a tool for further district development
4. Adopt a medium term action plan for health district development
5. Info campaign for the introduction of the health district development
6. Assure central level MoH capacities for systematic and intensive technical coaching /monitoring

In the context of decentralisation

1. Intensification of the MoH/MINALOC dialogue on implementation health sector decentralisation.
2. Situation assessment functionality and performance of the new district level health system organisation: structures, capacities, etc.
3. Based on results of this assessment, MoH and MINALOC may consider the need for adjustments.
4. Production of a manual with clear explanation of all the roles, responsibilities and links at district level, in close cooperation with MINALOC.
5. The strengthened role of MoH in the support and coaching of district health system development to include transfer of competence and capacities to the district administrative authorities.

MEDIUM TERM OBJECTIVES

1. Implement district health system development phase wise, starting with strong and dynamic districts.
2. Build in incentives for districts to become eligible for comprehensive district development support.
3. Introduction of need based strategic medium term planning.
4. Monitoring and strengthening of the district health service pyramid: attribution of service packages, role of community based services, referral system, etc.
5. Measures towards strengthening coordination and integration of all stakeholder groups (as in the recommendations of the JHSR 2008 “decentralised SWAp”)
6. Improve regulation and management of (proposals for) creation of new health services.

14.7 PRIORITY AREA 7: FIDUCIARY FRAMEWORK

SHORT TERM OBJECTIVES

1. External assessment of the functionality and performance (also at district level) of the GVT/MoH public finance management framework and procurement system.
2. Existing financial management instruments to be harnessed for generating increased DP confidence in GVT/MoH’s system & capacity.
3. Explore the potential and options for further alignment of financing modalities, financial and procurement management framework.
4. Have CDPF manual developed and adopted.

MEDIUM TERM OBJECTIVES

1. Develop and implement an action plan for strengthening of the GVT/MoH public finance management framework.
2. Decide on expansion or additional systems for further alignment and increased utilisation of national systems.
3. Several Steering Committees (SBS / CDPF, GFATM) to come under one single overseeing body for health financing?

14.8 PRIORITY AREA 8: COORDINATION DPS & OTHER STAKEHOLDERS

SHORT TERM OBJECTIVES

1. Create and maintain a database with a mapping of the stakeholder groups. Suggestions regarding reporting requirements on DP support can be found in Annex Nr 7.
2. DPs to commit to full disclosure, with on-plan-budget spending & expenditure tracking/reporting, where possible.
3. DPs' contributions to jointly adopted annual plan (JAWP) become firm commitments (signature), where possible.
4. DPs jointly explore options and opportunities for further harmonisation of aid management.
5. Strengthen the SWAp MOU (new aspects + details). Concrete suggestions towards this end can be found in Annex Nr 4.
6. Besides continued bilateral contracts, area-specific "side-MOUs".
7. MoH/MINECOFIN to commission external assessment of the GOR procurement practices; then decide on jointly accepted system.
8. Replace the often still practiced bilateral consultation between non-public sector actors and MOH, with participation in multi-stakeholder consultation (SWAp).
9. The role of for-profit partnerships (as being developed with Hewlet &Packard and with SAP) need to be integrated in terms of approach and oversight / planning / M&E in the SWAp. The same counts for the partnership arrangements with foreign universities.

MEDIUM TERM OBJECTIVES

1. Continue efforts to achieve further alignment of DP planning and budget cycles
2. Joint and pro-active exploration of potential /options for increasingly harmonised /aligned aid of stakeholders. For an area such as procurement, one could start with a questionnaire as found in Annex Nr 9.
3. Develop and adopt a set of harmonised systems, procedures: Joint Management Arrangements (JMA), acceptable to all main stakeholders.
4. Produce guidelines and instruction manuals for this JMA and test them.
5. MoH /MINECOFIN and DPs to agree on financial and budget report formats /contents.
6. Train staff at all levels in new harmonised systems.
7. Phase out old systems and replace them by new ones.
8. Revise MOU and COC and operationalise them administratively.
9. For a better coordinated, comprehensive and equitable approach in district health system development, explore the option of creating a pooled fund for district health system development

14.9 PRIORITY AREA 9: COORDINATION AND PARTNERSHIP WITH NON PUBLIC SECTOR ACTORS

SHORT TERM OBJECTIVES

1. Clarify which stakeholders/ actors constitute the private sector, since there seems to be a confusion about the meaning of this term (see annex with suggestions for improving the SWAp MOU).
2. Comprehensive mapping.
3. Non-public partners to move more from bilateral consultation to joining broad sector consultation.

MEDIUM TERM OBJECTIVES

1. Further exploration and negotiation of new formal partnership arrangements (contracts) at national and decentralised level.
2. Review coordination mechanisms for developing formal partnership arrangements.
3. Adopt an action plan to further operationalise PPPs, reflecting their importance as highlighted in EDPRS.
4. Orientation of non-public sector service providers to areas where they have a corporate advantage.

14.10 PRIORITY AREA 10 : SECTOR MONITORING AND EVALUATION; INFORMATION /KNOWLEDGE MANAGEMENT

SHORT TERM OBJECTIVES

1. Finalise the development and adoption of a comprehensive M&E framework.
2. Review and improve the methodology for joint annual sector review.
3. Adopt comprehensive action plan for strengthening & harmonising information systems.
4. Link joint annual sector review to joint annual planning and budgeting cycle.
5. Schedule of summits depends on overall GoR budgeting cycle, on planning by district teams and on the available information on budget (MTEF).

MEDIUM TERM OBJECTIVES

1. Finalise the streamlining and harmonisation of HMIS and assure better reliability and completeness of data (including those of the non public sector).
2. Adopt a small number of key indicators for overall SWAp development monitoring.
3. Systematic evaluation, validation and follow up (with an action plan) of innovative activities.

18 CONDITIONS FOR A SUCCESSFUL IMPLEMENTATION OF THE ROADMAP

The situation assessment done in Oct/Nov showed that there is plenty of scope for further SWAp development. But it is important to note first that the understanding of the SWAp concept at the level of various stakeholder groups still varies a lot.

It became also clear that, MoH and DPs have a different perception/appreciation of some issues regarding “what has already been achieved and what is functional in the SWAp”. Example: the validation of strategic innovation. This indicates that the consultation process between MOH and various stakeholder groups is not yet optimal. What can be improved?

- Furthering a multilateral collaboration environment (instead of the classical bilateral way of working)
- Systematic sharing of information between MOH and other stakeholders (two way communication)
- And more clarity about decision making processes: at what levels/structures? At what occasions? Through what process? In which format? As well as defining responsibilities for follow-up.

The scope for further SWAp development in terms of alignment and harmonisation depends for each stakeholder on:

- His intrinsic motivation towards this goal.
- His confidence in the existing capacity of national systems and in the system strengthening efforts that are underway.
- His"*marge de manoeuvre*" in harmonisation/alignment.
- His preparedness to come to formal commitments in terms of his role in the reform process, future support, etc.

Only if all main stakeholders share the same goals in the transition towards a full SWAp, significant progress can be made. For instance:

- There must by high level national commitment to make certain reforms take place, also those which are sensitive: sufficient staffing of MOH, harmonisation of sector deconcentration and administrative decentralisation, strengthening PFM at district level, etc.
- There must be sufficient "critical mass" of sector financing that can be harmonised in a SWAp support modality, like pooled funding and Joint Management Arrangements.
- Also in areas that are sensitive, DPs must be prepared to take bold steps towards harmonisation. Other countries have shown that this is possible: integrated planning and management of TA, adaptation of planning/budgeting cycles, joint auditing arrangements, etc.

  The main first challenge that I see is the fostering of a climate in the health sector of mutual trust and confidence; an atmosphere of intensive and open dialogue, based on a shared overall goal. I am convinced that the SWAp roadmap document will only become useful if, under leadership of MOH, sufficient time is taken to discuss its contents with various stakeholder groups and when they then translate it together in an action plan (integrated into HSSP/JAWP)

Further conditions:

- Planning, budgeting and resource identification for implementation of this 3 year roadmap.
- Roadmap activities/investments to be integrated into the HSSP + MTEF.
- Establishment of a small highly skilled team coordination of roadmap implementation.
- Monitoring mechanism for roadmap: indicators, benchmarks and mile stones.
- Definition of temporary arrangements, during the transition phase (keep old systems working as long as new systems are not yet operational).

19 ANNEXES

1. Summary description of the SWAp concept.
2. Types of financial aid (table).
3. DP financing modalities and channels in the Rwanda health sector
4. Proposal for a next phase SWAp MoU; the need for a COC.
5. Suggestions for improvement of the SWAp institutional framework
6. Considerations for Joint Financing Arrangements.
7. Suggested DP reporting requirements
8. Discussion document for development of a TA policy.
9. Questionnaire for mapping of procurement practices
10. Validation of priority areas for SWAp by DPs (table).
11. List of selected documents

20 ANNEX 1 SUMMARY DESCRIPTION OF THE SWAP CONCEPT

A DEFINITION OF SWAP :

"All significant funding for the sector supports a single sector policy and expenditure programme under Government leadership, adopting common approaches across the sector, and progressing towards relying on Government procedures to disburse and account for all funds."
This definition of 2002 still focuses almost exclusively on financing and finance management aspects. Later was acknowledged as equally important:

- Streamlining and rationalisation of the sector (a different way of working for more effectiveness and efficiency).
- Implication of all actors and decentralisation.

WHY SWAP INSTEAD OF PROJECTS?

- Projects have specific priorities and limited horizons: They do not assure a global and coherent sector development.
- Projects choose areas, target populations and interventions: They cannot assure an equal/ equitable distribution of inputs and support.
- Projects are implemented along parallel systems and according to own norms /standards: They therefore make ownership, capitalisation and sustainability difficult to achieve.
- Projects often have external management and control: This makes them inefficient. (High transaction costs.)
- Project activities are often designed in isolation from the general sector development plans. They are therefore difficult to integrate.

SWAP CARACTERISTICS

- A nationally-owned medium term vision, policy and strategic framework for sector development.
- A medium term expenditure framework that reflects the sector strategy[17], that is jointly adopted by all stakeholder groups and actors/levels,
- Under leadership of MOH (stewardship, control tower function). This means that MOH must assure the cohesion, the continued commitment of all actors, the adequate flow of information and of broad consultation.
- Systematic arrangements for a comprehensive programme and budget framework; comprehensive, because it comprises all actors, interventions and contributions.
- Systematic, because it aims at harmonisation of modalities and procedures.
- A formalised process for stakeholder / donor coordination;
- Joint strengthening efforts of national capacities and systems;
- Systematic efforts towards increased harmonisation and alignment;
- A joint Monitoring and evaluation framework

[17] It is first of all based on estimated costs. Then it becomes a finance plan and lastly, the finance gap is identified. In most cases, MTEFs cannot give the complete picture (off plan, off budget). **It is also used to monitor budget execution.**

- Adoption of a common management framework that may include: planning/ budgeting, performance monitoring system of procedures, reporting, financial management and procurement;
- Increasing reliance on the use of local systems.

SWAP IS NOT A SYNONYM FOR:

- a strategic sector plan
- a sector reform
- a DP coordination structure
- a common funding modality, like a basket
- Sector budget Support
- Sector decentralisation

And SWAp is not a blueprint, nor the answer to all problems.

RATIONALE AND EXPECTED ADVANTAGES OF SWAP

- Predictability of GVT and DP funding.
- Strengthens the leadership function of MOH.
- Comprehensive and harmonised approach improve effectiveness and efficiency.
- Reduces transaction costs due to streamlining /reform and alignment.
- Facilitates rationalisation and equitable resource allocation.
- Improves transparency and mutual accountability.
- Regulates conduct of various stakeholders (COC).
- Creates an environment for a continuous joint learning process.

These should lead to improved health service delivery and health indicators.

SWAP AND PARIS DECLARATION (2005)

SWAp characteristics are reflected in the five key principles of the Paris declaration:

- ownership,
- alignment,
- harmonization,
- managing results
- mutual accountability.

THE SWAP DEVELOPMENT PROCESS

- The process has no clearly defined starting point.
- There are 3 main phases: (i) appraisal/design, (ii) preparation, (iii) transition, implementation.
- Based on a comprehensive assessment of the sector, a vision for the sector SWAP can be jointly developed and checked on feasibility.
- SWAp cannot be developed unilaterally: it goes through a negotiation phase and needs the active implication of all actors at all levels.
- The speed and result of the development of individual areas in SWAp may vary greatly.
- It is useful to agree on readiness criteria that will trigger DPs' willingness to take more fiduciary risk with new aid modalities).

REFORMS THAT OFTEN COME WITH SWAP

- Institutional reforms MOH and SWAp management framework.
- Organisation culture and style of management: entrepreneurial and team spirit, performance and client oriented.
- Intensification of communication and collaboration: partnership arrangements with civil society, private sector and other sectors.
- Decentralisation: deconcentration, devolution, delegation, outsourcing.
- Management of the work force: Review qualification requirements and strengthen capacities and systems.
- integration of strategies, programmes: deverticalisation
- Harmonisation: management modalities, instruments, procedures
- Rationalisation: resource allocation criteria, expenditure tracking, internal and external control

THE USUAL STEPS IN SWAP DEVELOPMENT

- Establish a joint stakeholder forum for the development process.
- Assess correctly the potential for a SWAp.
- Agree on the SWAp dimensions and contours.
- Ensure common understanding of the used notions and terminology.
- Do a sector situation assessment.
- Analyse the functionality of working relations with external partners (other ministries, private sector, etc.)
- Assess the motivation and flexibility of DPs for alignment.
- Adopt a vision on where the health sector should be in 3 or 5 years.
- Make sure that all stakeholder groups own the transition process.
- Adopt a roadmap in terms of reforms, systems / procedures to be reviewed /strengthened, etc.
- Present this vision to DPs and negotiate their support for the transition.
- Sign a MOU and a COC (include fall back mechanism) with “first movers”.
- Plan phasing out old systems and putting in place new ones.
- Ensure sufficient technical capacity for transition process.
- Adopt a framework for SWAp development steering functions.
- Develop harmonised systems and introduce these (manuals, training).
- Agree on financing principles and allocation criteria.
- Translate strategic 5 year plan HSSP into a rolling 3 year POW.
- Item for budget: costing, needs based MTEF, gaps identification.
- Put in place comprehensive M&E system for the SWAp process.
- Build in upward, downward and transversal accountability.
- Continue exploration towards further streamlining and alignment.
- Maintain an intensive dialogue avec all stakeholder groups during this whole process.

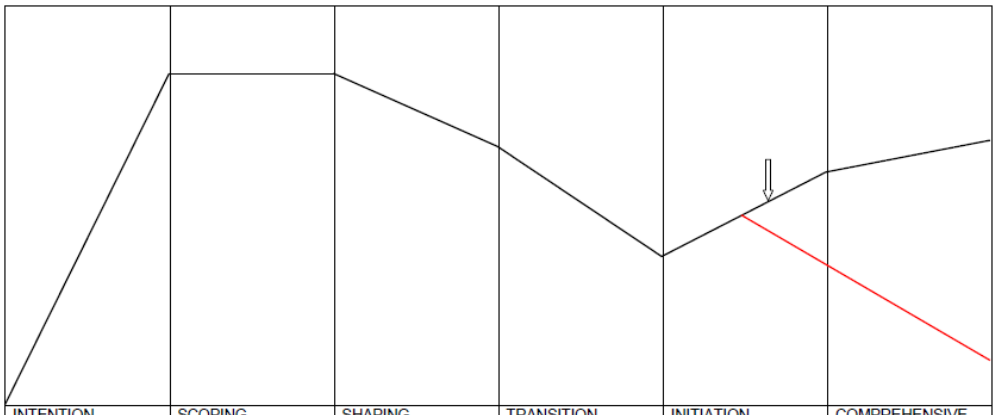
SWAP DOES NOT COME EASY

- A dynamic and time consuming process of several years, with co-existence of “old” and “new” systems: extra workload, loss of efficiency.
- Therefore, success, certainly in the first years is not obvious (reduction transaction costs, reduction of financing flows, etc.)

- Willingness of all stakeholder groups to adopt an entrepreneurial culture /spirit (away from the existing administrative culture.
- MOH willingness to take overall responsibility (driver seat, stewardship)
- GVT /MOH political commitment towards certain (some even sensitive) reforms
- DPs' willingness to relinquish unilateral program orientation, prioritisation, implementation.
- DPs' commitment to make serious efforts to plan and implement harmonise/integrate their parallel support modalities (planning cycles, management, control, norms, etc.)
- Preparedness of all actors to invest extra energy in reform measures (phasing in new systems, while phasing out old systems).

Therefore, there must be an incentive for all stakeholder groups.

STAGES OF SWAP DYNAMICS: DIAGRAM OF THE PROCESS



INTENTION	SCOPING	SHAPING	TRANSITION	INITIATION	COMPREHENSIVE
Enthusiasm of main central level stakeholders (MOH, DPs)	Discussing the options in terms of inclusiveness, reforms, etc.	SWAp options worked out in concrete objectives: Some initial partners express limited flexibility and/or commitment towards reforms.	The initially planned ambitious framework turns into a compro-mise. Phasing out old systems and phasing in new ones requires a lot of energy and perseverance.	Plans for reform, consolidation, harmonisation and alignment are implemented. If reform commitments of Gvt/MoH and/or DP do not materialise, motivation dwindles.	The SWAp now being operational convinces Stakeholders who first had reservations. Due to lack of progress, disillusion sets in: risk of destabilising the system .

The speed of SWAp development may vary for individual aspects (e.g. fast for joint comprehensive planning, but slow for adopting joint financing modalities.
In case of insufficient understanding and intrinsic motivation, the SWAp process risks going only through the motions, producing paper and creating new rules.
When actors "in the field" do not understand the reforms and their justification, and when they do not perceive fairly rapidly incentives /advantages of SWAp, they are likely to abandon the process (especially since the transition process asks extra input from them).
When DPs do not see implementation of certain sector reforms, regarded as crucial for the SWAp, they may loose faith and pick up again the project mode.
When external factors (that can not be controlled within the sector) are not well identified and taken into account, this may undermine the sector reform efforts (example: civil service reform).

SOME LESSONS LEARNED

- Do not work with the SWAp "champions" amongst the DP community. Keep those DPs with reservations or internal restrictions involved in the SWAP process development. They will may well join at a later stage.
- Not all systems need to be changed simultaneously and countrywide. Better incremental: e.g. by progressively increasing the number of districts where reforms and basket financing are introduced.
- Do not discard "old" but working management and steering mechanism, as long as new ones are not yet fully operational.
- Do not underestimate the challenge of bringing and keeping all stakeholder groups and levels on board: intensive information, mobilisation, instructions, and consultation. Confusion at operational level may rapidly lead to erosion of initial enthusiasm and motivation.

SOME EARLY COUNTRY EXPERIENCES

achievements

- Bangladesh: combination of 128 projects into 1 programme Bangladesh: rapid conversion to basket funding (6 months).
- Pakistan: in SWAp, public health budgets increased (35%).
- Ghana: separation Nat. Health Services from civil service.
- Rwanda: performance based management and PBF
- Mozambique: creation of a basket for drugs procurement.
- Tanzania: early focus on revision of sector legislation (hospitals, professional, parastatals)
- Uganda: direct budgetary support to alternative providers of essential services (NGOs).
- Zambia: a district basket as the result of financial reform.

Constraints

- Vietnam: Initially too low level of national capacities.
- Tanzania: SWAp was initially too much donor driven.
- Burkina Faso: special AIDS SWAp too top-heavy.
- Papua New Guinea: key GVT functions instable/ absent.
- Mali: unrealistic time table for transition.
- Kenya: Weak link between central MOH and the field.
- Cameroun: too little progress in strengthening national systems (e.g. PFM)
- Yemen: very limited willingness of Gvt to carry out reforms.

21 ANNEX 2 TYPES OF FINANCIAL AID

TYPE	AIM	CONDITIONS	FEATURES	MANAGEMENT	EXAMPLES
Balance of Payment Support	make available free foreign exchange. correcting problems of non sustainability, trade imbalances, exchange-rate over-valuation	Macro. Usually, IMF and BM agreed (conditionality). Macro orientations: pro-poor, sound public management, ..	may enhance cross-cutting reforms and/or support a national budget strategy.	no specific accountability.	Structural adjustment programmes
General Budget Support	increase domestic currency bank balance: raise spending, reduce borrowing /taxes.	Macro and budget. Agreement to overall budget priorities (MTEF). Central economic authorities must agree.	In purest form: no sector earmarking, otherwise nominal. Attention on local currency counterpart to the foreign exchange.	Gov bank account, audited accounts of Gov revenues and expenditures. Sometimes with nominal accounting against specific budgetary items	Structural adjustment programmes, poverty reduction credits
Aid funded Debt Relief	positive effect on economic incentives by reducing a large debt stock	Possible. Macro and budget.	once granted, cannot be reversed; Usually no earmarking, but possible (poverty).	Gov systems accountability	HPIC (PRSP has become the basis for WB/IMF lending).
Sectoral Budget Support		sector conditions (based on sector policy and MTEF); sufficient capacity to plan, execute and account for.	in purest form not earmarked. But sector earmarking possible: basket funding	disbursed and accounted for through Gov system. Additional sector reporting?	a PHC or district services basket
Project Aid using Government Systems			discrete set of project activities/objectives/outputs. Project can be part of Gov sector programme	can use Gov systems; additional statements of expenditure, specific project accounts	WB projects
Project Aid using Parallel Systems	greater effective-ness in environment where donor dependence is high and capacity weak.	Low degree of national ownership. donor in weak position for project or imposing sector conditions	Total earmarking: donor lead in design and appraisal. Off budget (and off sector plan?)	donor owned procedures, so donor accountable. Advantage: already weak Gov management not further strained.	

Remarks: 1) a mix of several types may be appropriate. 2) Various types can be combined with different forms of TA. 3) conditionality: effectiveness? Ethical considerations? Rewarding past performance instead of buying future promises? 4) For guiding the discussion, the decision tree may be helpful: page 26 of document "Proposed guidance for DFID on the choice of aid instruments."

22 ANNEX 3 DP FINANCING MODALITIES AND CHANNELS IN THE RWANDA HEALTH SECTOR

Financing Modality	Financing Channel	Recipient	On or off-budget	Purpose	Partners
Managed by GoR or decentralized partners					
Sector Budget Support	MoF	MoH	On-budget		CTB
					DfID
					KfW
Earmarked Budget Support	MoF	MoH	On-budget		WB (CLSG grant)
District Grants	district health unit/district	district health unit/district; FOSA	Off-budget	institutional strengthening	USAID implementers, GTZ, SDC
Financial Contribution	MoH	MoH and decentralised health institutions	off		Financing of activities following joint planning (changes subject to prior notice of financing partner)
Basket	MoH		On-budget	Human Resources	GF
Jointly Managed by GoR and DPs					
Pooled Fund	MoH	MoH and related agencies, national and decentralised level	on budget	Capacity Development	MoH
					GTZ
					KfW
					DfID
					SDC
					CTB
Managed by DPs					
In-kind contributions	DPs	MoH and decentralised health institutions	Off-budget	e.g TA, equipment	Bilaterals
					UN
					CHAI
Contracts*	MoH, agencies and districts	e.g MoH, districts or health facilities, staff	Off-budget	eg. running costs, functionning	GTZ
					USAID implementers
Grant*	DPs	MoH and decentralised health institutions	Off-budget	e.g. PBF	GTZ
					CTB
					USAID implementers

* terminologies might change from agency to agency

This table is only a draft. Its authors warn that corrections may be necessary.
The following tables show the situation for each of the DPs who have provided more detailed information.

Belgian Cooperation

Financing Modality	Financing Channel	Recipient	On or off-budget	On Plan	Purpose
Managed by GoR					
Sector Budget Support	MoF	MoH	on-budget	x	HSSP support
Jointly Managed by GoR and DPs					
Pooled Fund	MoH	MoH	on-budget	x	Capacity Development (CDPF)
Managed by DPs					
in kind contributions	CTB		off	x	short term TA, project evaluations, audits

CHAI

Financing Modality	Financing Channel	Recipient	On or off-budget	On Plan	Purpose
Managed by GoR					
Financial Support	CHAI	MoH	off	x	Financial assistance to work of MOH
Managed by DPs					
In Kind Support	CHAI		off	x	Long term TA, programmatic funding

DfID

Financing Modality	Financing Channel	Recipient	On or off-budget	On Plan	Purpose
Managed by GoR					
Sector Budget Support	MoH	MoH	on	on	
Jointly Managed by GoR and DPs					
Pooled Fund	MoH	MoH	off	on	Capacity Development
Managed by DPs					
Financial contribution	DFID	MoH	off	on	Contribution to the White Ribbon Alliance** (earmarked)

German Development Cooperation

Financing Modality	Financing Channel	Recipient	On or off-budget	On plan	Agency	Purpose
Managed by GoR						
Sector Budget Support	MoF	MoH	on-budget	x	KfW	HSSP support
financial contributions	Ruhengeri Hospital	Ruhengeri Hospital	off-budget, on-plan	x	GTZ	PBF
Jointly Managed by GoR and DPs						
Pooled Fund	MoH	MoH	on-budget	x	GTZ, KfW	Capacity Development (CDPF)
Managed by DPs						
local grants	districts	district health units, FOSA	off-budget, on plan	x	GTZ	Financing of activities following joint planning (changes subject to prior notice of financing partner)
in kind contributions	GTZ	district health units, FOSA	off-budget; on plan	x	GTZ	TA (studies, short term consultants etc.)
financing contracts	KFW	hospitals	off-budget, on plan	x	KfW	equipment

SDC

Financing Modality	Financing Channel	Recipient	On or off-budget	On Plan	Purpose
Jointly Managed by GoR and DPs					
Pooled Fund	MoH	MoH	on	x	Capacity Development
Managed by DPs					
Financial Contribution	District, Health facilities	Health Units and decentralised health institutions	off	x	Financing of activities following joint planning (changes subject to prior notice of financing partner) including running costs

WB

Financing Modality	Financing Channel	Recipient	On or off-budget	On Plan	Purpose
Managed by GoR					
Earmarked Budget Support	MoF	MoH	on-budget	x	community health
Managed by DPs					
in kind contributions	WB	MoH	off	x	TA (studies etc.)

WHO

Financing Modality	Financing Channel	Recipient	On or off-budget	On Plan	Purpose
Managed by GoR					
Financial support	MoH	MoH and decentralised health institutions	off	x	Financing of activities following joint planning (changes subject to prior notice of WHO)
Managed by DPs					
Technical Assistance	WHO		off	x	short term TA, salaries and running costs

23 ANNEX 4 REVIEW OF THE RWANDA HEALTH SWAP MEMORANDUM OF UNDERSTANDING (MoU)

Definition of terms

Memorandum Of Understanding (MoU): This document formalises the SWAp collaboration framework between GOR/MoH and DPs in terms of principles, modalities, mechanisms, procedures and operational coordination. In other words, it defines the main rules of the game in SWAp The MoU reflects the commitment of all signatory parties and thereby clarifies and facilitates harmonisation and day to day collaboration in the commonly adopted sector policy and strategic context. Harmonisation and alignment issues do not only refer to procedures: for example, alignment may be obtained on national allowance / per diem rates for civil servants. The ultimate goal is to ensure a better impact of aid. It is important to acknowledge that stakeholders who have not (yet) signed the MoU are not necessarily completely excluded/exclusive of the SWAp. Those DPs who are the first to sign an ambitious MoU (and possible Common Management Arrangements) are often referred to as the *first movers*.

Code of Conduct (COC): This doc relates more to general issues of behaviour of DPs and GOR/MoH; it can be an annex to the MOU. Both parties agree on the guiding principles in collaboration. It's objective is to create a transparent and constructive environment for collaboration. The COC is also used as a reference document in case of disagreements.

Common management framework (CMF): This document describes the jointly adopted management arrangements of MoH and certain DPs. It is usually partly based on national systems and procedures, which have been adapted, so that, on the one hand, there is increased reliance on national systems, but on the other hand, extra safeguards increase confidence of DPs. Not necessarily all signatories of the MoU will also be willing to adopt the CMF.

Side agreements: These agreements define in detail the organisation and procedures of certain aspects of the MoU or CMF. Example: transitional procurement arrangements.

The above documents are usually not legal documents (binding agreements). They should be flexible enough to allow for adjustments /updates as per need.

bilateral agreements (BA): MoU and COC do not necessarily make BAs redundant. Donor specific issues regarding for instance disbursement modalities, preconditions, etc. may have to be agreed upon between MoH and individual donors. New bilateral agreements may be necessary for the phasing out modalities of existing projects /programmes. For a DP who is willing to sign the MOU, but who cannot except one single aspect (e.g. the joint procurement system), the MOU may refer to alternative procedures, accepted as per bilateral agreements.

The existing SWAp MoU

The existing MoU has been a good starting point by defining a general system for collaboration. However, certain important aspects have not yet been included. Moreover, on some of the issues, it should be possible to agree jointly on a more precise text.

GENERAL REMARKS

It is suggested that the introduction refers to the Paris Declaration and to the Accra Agenda for Action. It is also useful to list all key reference documents together (EDPRS, HSSP, health policy, MTEF)

Mention that the health SWAp is considered to be in place since 2007.

The distinction between some of the terms used should be clearer: "Partners" (page 1), "participants" (page 1), "Development Partners" (page 1), "stakeholders" (page 5), "Private Sector" (page 8[18]), "the Representative" (page 5).

Since the signature of this MoU should not necessarily be restricted to GoR/MoH and to DPs, the term "Partners" may be used to indicate all stakeholder groups who have signed the MoU; in other words, "the MoU Partners". The term *participants* can then be left out.

Clarify who are stakeholder groups: all those who have a stake in the health sector development, i.e. GOR/MoH, certain other ministries, certain parastatal organisations (e.g. a training institute), DPs, NGOs, FBOs, civil society organisations, professional organisations, for profit organisations. (for example see Education sector SWAp MoU, par. 2.2)

The term "private sector" also needs to be better defined (see par.7.1) [1]:

A concise but comprehensive description of the SWAp institutional framework is missing (HSCG, HSCG Secretariat, SMM, JHSR, TWGs, SWAp Secretariat, links with MINALOC and MINECOFIN, DPG meetings, lead donor,

The context of administrative decentralisation is not mentioned in this MoU. It would seem important to include a paragraph on this, because all DPs have to take this context into account if the (intend to) provide support at district level. In their approach and modalities they must be respectful and supportive of the ongoing decentralisation process.

Similarly, it would be useful to refer to an already adopted package of sector reform measures. (The current MoU only refers to the STRATEGIC framework. See remark on par. 1.4)

It would be useful if the MoU refers to the SWAp manual, the SWAp roadmap, the CDPF as well as to existing support reporting and monitoring arrangements (DAD, DPAF, CEPEX).

Page numbers are missing (preferably in the format page n°…/…of total number of pages, including pages with signatures), as well as some paragraph numbers (8.2 and 8.3).

The following remarks and suggestions may raise the fear that the MOU will become much to vast. However, there is also quite a bit of duplication on the first 2 pages, so that this part can be shortened.

<u>DETAILS</u>

In the introduction, the paragraph "Underlining" talks about "their commitment … to "carry out as a joint effort" … Question is whether all DPs who have signed the MoU have indeed aligned their practices regarding e.g. monitoring. (On the other hand, par 2.1 on the objectives does not mention (financial) management as an area to be harmonised. Is there no SWAp ambition with regard to this aspect?)
In the introduction, in the same paragraph, there is reference to a "common Program of Work". It would seem that, until now, this term has not been used in the Rwanda Health SWAp. It usually stands for a rolling 3-year plan, which links the strategic framework (HSSP) with the annual operational sector plans.

[18] If the in the SWAp manual "Private Sector" stands only for "for profit" organisations/ facilities, then this is different from what the MOU indicates: …"FBOs, NGOs, community based organisations and private enterprises are collectively referred to as the private sector."

Par 3.1 This means that MoH will ensure that all agreed pilot activities are focused, time bound, produce clear results and that mechanisms for sharing lessons learnt, both positive nad negative, are in place.

In par. 1.4, the MoU mentions "reform programs". This needs clarification. See also under General Remarks.

Par. 2.2 It is obvious that the HSSP is the overall strategic framework to be respected by all. But an aspect as the progressive integration of vertical programmes with vertical/parallel approaches merits mentioning. Are there jointly agreed objectives, like e.g. the integration of all training activities of such programmes in sector wide capacity building annual plans, or the integration of supervision and reporting modalities/methodologies.

Par. 4 Do GoR/MoH and DPs want to maintain the limited preferred choice of aid modalities (GBS and SBS)? Or should a third, somewhat less ambitious modality of funding be added (CDPF and future extended pooling)? When mentioning the CDPF, one may refer to another specific fund MOU or CMF.

4.1 Mention POW, MTEF, JAWP, annual sector report.

4.6 For signatories of this MoU, insist on "on-plan" and "on-budget"?

5.1 ….. and strive for improved rationality and equity of resource allocation.

5.3 Better to shift under paragraph 3. It is useful to also address the aspect of TIMELY information; e.g. by what date GoR/MoH and DPs will inform each other on the next annual sector budget (for MoH: the version as submitted to MINECOFIN).

5.8 Add resource management mechanisms.

5.9: Is the role of the HSCG only advisory? If so, what is the highest decision making body? Although MoH retains sovereignty in many areas of health sector management, shared decision making is more appropriate for certain aspects in a SWAp partnership arrangement.

5.10 Is relevant, but should it be in this MoU? It is MoH's responsibility to ensure active participation of all stakeholder groups. The reasons for insufficient participation of some stakeholder groups (civil society, for-profit sector, national NGOs) need to be analysed more closely. Are they not sufficiently organised? Do they not perceive the incentive of participating?

6.1.1 Proposal to change this: After a JHSR in January, where next year's annual priorities have been jointly defined, the annual bottom-up planning/budgeting process starts. In April, MoH presents the consolidated annual sector plan/budget to stakeholders to be approved (annual Planning Summit). In May, the sector plan can then, as per need be revised. By the end of June the national budget for health is announced, after which a last revision of the annual plan/budget may be necessary. Of course, this alternative calendar must be made to fit with the overall GoR-DP harmonized calendar. The joint approval by GoR/MoH and all stakeholders, means for the DPs that their resources will serve the investments and activities outlined in this annual plan.

6.1.2 This is too general; see 6.1.1

6.1.3 Refer to JAWP (but also to the 3 year rolling POW, if this idea is adopted).

6.2 It would be useful to start with a paragraph about the commitment of partners (and vertical programmes) to harmonise existing information systems, so that the overload of indicators and reporting mechanisms is reduced.

6.2.1 In short, what does the framework comprise? One gets the impression that it is limited to health status and health services aspects. Are there, beside HMIS not other information systems that are part of the framework? In order to ensure a maximum of objectivity in M&E, the creation of an independent or mixed Monitoring and Review Group may be considered. Such a group would then prepare semi-annual activity and financial sector reports.

6.2.2 What is exactly the purpose of the JHSR? The following sub paragraphs only measuring output, budget execution and indicators. However, the JHSR is also an event where strategic issues be reviewed /addressed; consensus can be gained on contentious issues, specific research and control tasks can be assigned, with adoption of appropriate methodology, etc.

6.2.2 iii It would be useful to give examples, like budget expenditure tracking, NHA.

6.2.2 iv How is this done? Format? Collation? Do all signing DPs indeed provide indications of their future support for at least the MTEF period?

6.2.3 For alternative proposal, with annual Planning Summit, see 6.1.1

6.2.4 Some details on the approach: mixed internal/external?

6.2.5 If the annual sector report is produced by MoH, or If a separate financial report is produced by MINECOFIN, state this. Erase the word "the" before annual report.

6.2.6 "Representative": Adopt one single term for this function: "lead DP"? Refer, if adopted, to the earlier mentioned concept of "DP-troika". (1 chair DP with 2 co-chair DPs. The troika has monthly business meetings with MoH Senior Management. The role of this troika concerns the IMPLEMENTATION of the annual plans
Give name of the DP performance assessment mechanism.

6.3.1 Regarding "GOR disbursement and financial reporting system ": refer to SWAp manual. Add other aspects of financial management: e.g. accounting system? Concrete examples on where progress can be made, are the adoption of a consolidated annual disbursement schedule and an annual procurement plan per level.
Replace "…commit as far as possible.." by "will make tangible efforts towards increasing utilisation of…"?

6.3.2 Replace "Partners" by "DPs"? Change fiscal year cycle.

6.3.3 Would it be feasible, acceptable to jointly adopt an integration calendar for DPs?

6.3.4: If suggestion in 6.3.3 is realised, this become an additional (instead of an alternative) requirement: respect of MINECOFIN reporting requirements: CEPEX.

6.4.1 To what extent are the sector annual reports really consolidated, i.e. reflect all input by non-public sector actors? If not yet realised, identify obstacles and adopt an agenda and methodology for achieving this.

6.5.1 This paragraph seems too weak: it is not specified how, when and by whom needs are identified. I would plead for an annual agenda for priority short term TA /studies.

6.5.2 Also this paragraph strikes me as too general. Annex 8 on Technical Assistance Policy could help to further the debate.

7.1 Is there a common understanding of what "the role" is? Mention partnership arrangements and representation of these sub-sectors in SWAp.

8.1 Here may be referred to more details in the COC annex. It may be useful to add that, in the case of DPs, existing bilateral agreements prevail.
Replace the word "Cluster" by "Coordination".

CODE OF CONDUCT

(can be attached as annex to the MoU)

PROPOSED TEXT

By signing this Memorandum of Understanding, partners confirm their intent to adhere to the following general guidelines for collaboration. The signatories pledge to respect both the spirit and letter of this Code of Conduct (CoC).

General principles

1. MoH and DPs shall work in a spirit of openness, transparency and consultation.

2. DPs and their representatives shall respect the aspirations, policies and sovereignty of the GoR and of the people of Rwanda.

3. Meetings, deliberations and communications between GoR and DPs and among DPs shall be carried out in a mutually respectful manner.

4. Decisions will be taken by institutions and not by individuals. They will be documented and made available to all concerned.

Communication

5. All parties will inform each other on all matters relating to programme execution and of other matters which in their judgement are of common concern. This includes copying of letters or notices for information.

6. All parties will inform each other in a timely manner of new developments which are likely to influence the volume or areas of their resource input (change of medium-term perspectives).

7. DPs will inform MoH in a timely manner about their wish to:

   (1) initiate, modify, suspend or cease support of specific programmes/projects or
   (2) modify arrangements agreed upon in this MoU.

8. DPs will not deal directly with districts and provinces in matters of health service support without the knowledge and consent of MoH.

Resource allocation and utilisation

9. GoR and DPs agree to ensure maximum transparency regarding resource allocation and utilisation.

10. If any of the DPs foresees that for any reason it will not be in a position to meet their commitments to the implementation of MTEF, it shall communicate this at the very earliest moment to MoH.

11. DPs agree not to actively recruit qualified MoH staff for project jobs or for consultancies.

12. DPs will seek to avoid the organisation of parallel events (such as meetings, provincial planning sessions) and the creation of parallel structures (such as Committees and project coordination units).

Resource management

12. All parties will work towards a financial management system that guarantees transparency, honesty and accountability.

13. All parties will keep each other currently informed of all awards of contracts to be financed by them under the consolidated health programme but outside of the common management arrangements, and of all major modifications of terms and conditions of such contracts after their award.

Settlement of disagreements or conflicts

14. In the event of disagreement or conflict, dialogue and consultation will be the first means of resolving the problem. Unilateral actions shall be avoided.

15. In the event of continuing disagreement, a high level meeting shall be arranged between GoR and the DP(s) with two weeks notice.

24 ANNEX 5 SUGGESTIONS FOR IMPROVEMENT OF THE SWAP INSTITUTIONAL FRAMEWORK

Some remarks regarding the role, organisation, composition and working methods of the main existing structures

THE PROPOSED LOGIC

The overall SWAp process must be steered and piloted through periodic broad consultation (maximum twice a year) with all stakeholder groups.

Decisions about the coordination and facilitation of SWAp implementation (HSSP, MTEF, JAWP, reforms) should be made by a smaller group with main stakeholder groups that meets more frequently: a group of up to 30 persons that meets quarterly: the HSCG.

Consultation between MoH and DPs on day to day implementation issues can be done through a monthly meeting of the inner SMM[19] with a troika of three DPs. (The lead donor /chair and two co-chairs). In this DP-MoH coordination meeting, the DP-troika represents the whole DP community, that meets in the Development Partners Group.

The actual facilitation and coordination of the SWAp implementation: collecting reports, writing minutes, ensuring follow-up of decisions by Steering/Piloting Committee, HSCG, JHSR, planning summit, etc. For allowing the SWAp Secretariat to do this work, it needs to be well resourced.

REVIEW OF THE EXISTING STRUCTURES

Swap Steering Committee

The existing Steering Committee for SWAp: is apparently composed of MoH, GTZ, Belgium Coop, Swiss Coop, DFID. (Chaired by the PS), which means that many stakeholder groups are excluded from this overall piloting and steering function. Besides, there is also the CCM as well as a SBS Steering Committee. This multiplication causes too much work load for MoH.

HSCG

The ToR of the HSCG rightly encompass policy, strategy development, planning, prioritisation, financing and M&E. However, its composition and mandate seems somewhat confusing: while the first paragraph talks about " ...*a formal forum, in which GoR and DPs can meet to discuss* ..", the list of members includes other stakeholder groups (unless the term DP needs to be re-defined, because in the SWAp MoU they are a group which is distinct from the private sector stakeholders.) Also, besides the role of "discussing* as mentioned in the first paragraph, the HSCG has a number of Operating Functions, which are more executive in nature: collect information, write ToR, share and disseminate, support and provide input etc.). It is only in the diagram at the end of the HSCG ToR, that a decision making role is mentioned: this concerns the output of the TWGs. All in all, it would seem useful to (i) review the composition of the

[19] The weekly Inner SMM meetings comprise only about 20 people (directors), while in the wider SMM about 50 persons meet monthly.

HSCG, by including stakeholder groups that have so far been left out (civil society, for profit sector), and (ii) to define in more detail on what issues and through what process the HSCG is to have a decision making role. It should then also be stipulated how decisions by the HSCG are to be followed up.

TWGs

The role of TWGs is to give advice on health strategies and health management aspects (e.g. M&E). Therefore, it is logical that they are usually a mix of resource persons of which the status varies: they may e.g. be MoH staff, a DP representative or a TA. Thus, they are not a decision making body: under the leadership (chairmanship) of the concerned MoH department, they advise the SMM or HSCG (depending on the issue at hand).

Secondly, it is important to keep in mind that TWGs cannot compensate for structural MoH staff shortages. Under such circumstances there would be a tendency to refer executive tasks to such loosely shaped advisory bodies (example: the Social Mitigation TWG's task of Approbation of micro-projects).

In many countries, the problems caused by a multitude of technical committees and working groups in the health sector have been experienced. Since the workload is high, there is a tendency to create even more groups and committees, while existing ones loose impetus because of exhaustion. This is not surprising because key actors sit in several of these body's. Question is, to what extent expectations of TWG output is realistic. Because TWGs are not only to meet, but also to produce. To what extent strategic development, analyses and problem solving could be outsourced?

Reduction of the number of TWGs by regrouping them in sub-TWGs can be useful to improve coherence and synergy, but it will not necessarily reduce the agenda and workload. If, across the board, for all areas of MoH responsibility, a (sub) TWG is created, the risk is that these become a sort of "shadow-MoH". In any case, their mandate should be limited to advice and support to MoH units/departments, so that overall responsibility rests with MOH.

When the HSCG, at the JHSR or at another occasion, raises an issue that needs further exploring or problem solving, MoH Senior Management instructs the concerned unit/department director accordingly. The Director can then choose to delegate a specific task (analysis, proposal formulation, etc.) to the concerned TWG. The TWG submits its product to the Director who informs Senior Management, who informs the HSCG.

Regarding TWGs and transversal themes: Is there e.g. a need for a decentralisation "head" (not sub) TWG? An advantage would be that, in this way, this aspect gets the necessary attention. But it would mean that this TWG has to draw from work done by many other (sub) TWGs with regard to decentralisation. The danger of relying only on various subTWGs is that the approach towards decentralisation remains scattered, while an integrated approach is necessary.

In order to avoid that (sub) TWGs produce do sterile, academic solutions, it is important that they explore all documented field experience. This means that the production, collection and dissemination of such documents must be adequately managed by MoH.

For better management of the TWG workload, it would be useful to adopt an annual task package for each (sub) TWG, based on results of the JHSR.

Lead Donor

The role of the lead donor is an important one, especially in fostering more mutual trust between MOH and DPs and establishing a genuine team spirit, based on open dialogue / consultation.

It is proposed that he chair/ lead DP gets 2 co-chairs, one of whom will take over the chair after 2 years (rotating system)[20]. This concept of a DP troika has three important advantages: (i) Since the DP community is heterogeneous, DP representation is better ensured. (ii) The workload of the lead DP, which is considerable with the secretariat of the HSCG, can be shared with two other DPs. (iii) As a team, they are better equipped to solve SWAp implementation issues in monthly meetings with MoH (PS and Directors). While the quarterly DPG meetings will continue for formulating DP standpoints in preparation for HSCG meetings, the meetings of the DP troika with MoH are more to deal with short term issues, in between the HSCG meetings. A clear ToR should be developed for the DP-troika.

SWAp Secretariat

Before it got its current name, this structure already had 2 responsibilities: (i) DP coordination, which involves the analysis and negotiation of all new DP programme proposals, and (ii) management of the CDPF. Currently, it is not quite clear what the scope of its responsibilities is for SWAP development (no work plan). Meanwhile, this structure is hardly staffed. It is suggested that the work load and staff requirements of the SWAp Secretariat are reviewed on the basis of the adopted SWAp roadmap and the subsequently developed plan of action.

[20] The current lead DP has fulfilled this function for the last 5 years, while the HSCG TOR state that this function is to be reviewed annually.

25 ANNEX 6 FURTHER CONSIDERATIONS FOR JOINT MANAGEMENT ARRANGEMENTS

In the most current practice of JMA, the DPs maintain part of the responsibility in terms of accountability for use of funds:

Budget planning by GOV:	yes
Budget execution by GOV:	yes
Budget approval by parliament:	no
Budget control by parliament:	no
Disbursement through GOV system:	yes
No additional reporting required:	no
Links with EDPRS (PRSP)	yes.

Disbursements: disbursement system and calendar, in accordance with bi-lateral plans. Level of predictability of each DP. Multi-year time frame consistent with planning horizon of GoR. Moment in the year when DPs will confirm their next year contribution (or its value). Aligned with GoR cycle. First tranche usually released in 1st month of fiscal year, sometimes conditioned by e.g. positive outcome of a PFM review of preceding year. Subsequent releases decided jointly on basis of results of policy dialogue. Aim for a gradual and consistent flow of funds.

Procurement: Ex-ante assessments of the national Proc system should be aligned with GoR PFM diagnostic tools. WB conducted Country Procurement Assessment Review (CPAR). Procedures conform with international standards: WTO (degree of compatibility with WTO standards and operational capacity to implement them.). Appropriate thresholds and objective criteria for assessing bids and awarding contracts, offering best value for money, principles of transparency, equal treatment of potential contractors, avoidance of conflict of interest. Proper assessment of checks and balances in the procurement system (in high risk environment, anti-corruption arrangements). DPs to have access to all relevant docs. Ensure that all procurements are untied (to DPs interests).
If national system not acceptable: Options: WB procurement guidelines and docs, UN rules and procedures, or regional development bank (BAD). Check if GoR staff have the necessary capacity to apply them. If not; train or targeted TA. Alternative: services of (international) procurement technical advisor who trains, manages and reports.
JFA could include obligation of GOV to report on application of its regulations, and/or to seek no objection from DPs on critical stages of the proc. Process. (tender docs, evaluation of proposals, award of contracts.
Check: is there a need to notify ex ante aid offers exceeding a certain threshold.

Reporting: Keep it simple. Type of reports, periods and terms for submission. To what extent to be reported on minimum /essential improvements in reporting and Monitoring capacity. JMA to refer to other reports used by GOV in budget process and accountability process (EDPRS, MDG reports and indicators).
Financial annual report: submitted to GOV legislature and to the Supreme Audit Institution. In case of SWAp, rely on relevant sector ministry reports, if needed with inclusion of specific data. Specify whether reports would trigger disbursements (or suspension of resource transfers.) If needed, capacity building.

Review and evaluation: Risk of too many, too much time for specific DP needs. Specify about review, joint supervision missions: duration, periodicity, participation. Fit with national cycle. Agree on mutually agreed financial management performance indicators. Refrain from uni-bilateral reviews and evaluations.

Audit: if possible, alignment with the GOV auditing system, if they meet internationally acceptable standards for auditing. (ISA). Need to do an ex-ante assessment of the quality and integrity of the Supreme Audit Institution (Auditor General?). In good practice, reports are submitted within 6 months after the fiscal year. Reports should also reflect the transactions financed by DPs under the JMA. If GOV system too weak: private-sector auditors, TOR to be agreed upon by all JMA partners (can be annexed to JFA). If high risk environment: more frequent audits. Decide on possible consequences of reports and the follow-up. (Implementation of corrective action in response to audit recommendations and mechanism for following up; can be done with TA.) Here DPs may not take the same position. If an alignment is not possible, and DPs undertake independent audits and reviews, specify this in roles and commitments of DPs.

Non compliance:

1) Serious non-compliance: DPs may impose sanctions.(lack of GOV commitment to targeted reforms, unsatisfactory management, misuse of funds, fundamental political/economical/social changes.
2) Force majeure: may also warrant the suspension of further financing, not to be regarded as a sanction, but temporary measure on grounds of efficiency and/or policy.

Type of sanctions in case of serious violations: suspension, reduction of new disbursements, recovery of funds already disbursed. Distinction between direct budget support and other financing modalities. Anyway, reclaiming of funds is a heavy measure and only possible with non GBS modalities. In order to avoid destabilisation of the financing (macro-economic planning and management), gradual reduction or recovery of funds may be considered. Sanctions preferably a joint DP decision.

Corruption: Re: anti-corruption legislation and EDPRS strategies and policies. Include in the JFA a statement to that extent, to make sure that it remains on the agenda for policy dialogue. Example statement:
" The partner GOV will require that its staff and consultants under projects or programmes financed by DPs will not offer third parties or see, accept or be promised from or by third parties, for themselves or for any other party, any gift, remuneration, compensation or profit of any kind whatsoever, which could be interpreted as illegal or corrupt practice." (OECD/DAC Recommendation on Anti-corruption proposals for aid-funded Procurement).[21]
Useful to add reference to transparency strategy: GOV having the duty to inform DPs about all incidents and suspected incidents of corruption that occur in the relation to the use of DP funding.

[21] Alternative : UN Convention against corruption (31/11/03)

26 ANNEX 7 SUGGESTED DP REPORTING REQUIREMENTS

What information does the health SWAp need from DPs about their contributions?

Support plans:

1. various funding sources of each DP: per project, programme, component
2. Areas of support (if possible, labelled as per national sector plan).
3. Geographical zones and beneficiaries.
4. Items of support: types of hardware and software, if possible labelled as MOH plans.
5. With indication of unit costs (if possible as per national norms).
6. Details on support implementation: public/private sector, health system level
7. Support modalities: contribution in a basket, contracts with health system units (divisions, regional directions, district councils, communes,), etc.
8. Expenditure levels.
9. Support in kind differentiated from financial support.
10. Separate indication of DP-related cost items: TA, project management, overheads.
11. Period of support: specific indication of commitment status: signed financial agreement with national GOR, disbursement tranches, phases, conditions.

Reporting:

1. Periodicity: half yearly? Common format.
2. Differentiated per project, component, implementing partner organisation.
3. Comparison between planned budget amounts, disbursed amounts and utilised/justified amounts.
4. Any changes in planned allocations, with justification and reference to decision level/date (including budgets cuts and additional new funding).
5. All expenditure per level must be linked to mutually agreed plans, budgets.
6. Indications /proof of poor financial management, quantified, status of outstanding cases.

Harmonisation:

The main challenge is to achieve mutual agreement between GOR/MoH/DPs and other actors about harmonisation of:

- plan/budget structure (e.g. according to priority programme lines or according to cost-centres per level)
- general terminology (e.g. what falls under Reproductive Health)
- programme demarcation (e.g. does training fall under HR development or district health system development?).
- Labelling of accredited strategies (e.g. output based, demand based, cost sharing/recovery)
- Labelling of activities and investments (e.g. emergency/essential/basic/ comprehensive obstetric care; community/village/ population based health care)
- Resource allocation criteria (e.g. traditional as per geograpghical coverage of projects, or population based, and or performance based)
- unit costs (e.g. per diems)
- geographical coverage: is complementary or patchwork or performance dependent?
- Budget categories /codes.

27 ANNEX 8 DISCUSSION DOCUMENT FOR DEVELOPMENT OF A TA POLICY

INTRODUCTION

SWAP is about a comprehensive health plan; it is about improving co-ordination" of external support and about leadership by national government.
All these three issues are relevant in the case of technical assistance (TA). In the Rwanda health SWAp the challenge will be to reach an agreement between GOR/MoH and DPs about

- what TA will be needed in HSSP,
- how TA should be provided by DPs,
- how management of TA by MoH can be realised,
- how TA becomes part of the overall HR development strategic plan for sector capacity building.

Such an agreement can become an integral part of a general SWAp Memorandum of Understanding (MOU). However, the first step for GOR/MoH is to adopt a policy on TA.

This discussion paper reviews problems to date with TA, proposes strategies of TA rationalisation, proposes elements for a TA policy, and, finally, discusses pitfalls in harmonisation of TA.

SUMMARY OF PROBLEMS WITH TA

- TA is often a mixture of real capacity building, substitution for shortage of national staff and management of projects;
- In most cases, TA planning is not based on a joint comprehensive needs assessment for the health sector (short and medium term priority needs);
- TA is generally tied to individual projects/programmes/DPs (donor driven);
- TA has often an independent operational budget;
- TA may be linked to executive /management responsibilities, causing an ambiguous situation;
- TA is not always effectively linked to national counterparts;
- TA is often poorly managed: database of current TA, lack of TOR with defined deliverables/milestones, lack of supervision and performance evaluation of TA (impact and output);
- TA is often irrationally distributed (e.g. only in a few districts);
- The phasing out of TA is in most cases not adequately planned;
- Compared with the total budget of a project, he cost of TA is sometimes excessive;
- The proportion of national/regional TAs is often small: existing local competencies may be easily overlooked;
- On the other hand, scarce ministerial capacities may be drained by TA positions created by DPs;
- Although substitution of (temporarily) non available national staff is rarely a primary objective of TA, but TA may turn into substitution, because goals and agendas are to a large extent determined by TAs, who have relatively easy access to resources.

HOW TO RATIONALISE TA

We presume here that GOR/MoH and DPs have jointly expressed their intention to evolve towards TA that is more based on a comprehensive system strengthening approach and that is rationalised. The latter is particularly important, because TA is generally very costly. First, a review of existing TA should enable MoH and DPs to identify technical support:

- which is or becomes redundant with the phasing out of projects;
- which has been extended longer than necessary;
- which duplicates work done by national staff;
- which concerns work that should be done by national staff;
- for which the concerned TA does not have the required qualifications or for which he/she is overqualified;
- which is carried out by expatriate TA, but which could be done by a national consultant or an NGO;
- which overlaps with TA input by other DPs;
- which is labelled TA, but in practice is project management;
- which is not provided by a TA, but by project/programme staff.

This situation analysis should be followed by phased adjustments. This will contribute towards more effectiveness and efficiency in the field of TA. However, it is important to make a clear assessment of the organisational and logistical support that will be required during these reforms. Strengthening of co-ordination and management of TA are to be planned in a flexible medium term plan.

ELEMENTS FOR A TA POLICY FOR THE PNG HEALTH SECTOR

1. Project /programme staff for co-ordination and implementation is to be clearly distinguished from TA. Although in certain cases, project/programme staff do actually provide TA, their role may be too much one of organisational engineering.

2. The policy on TA must be complementary to the policy on human resource development and TA needs identification must take into account the human resource development programme priorities and programme.

3. It must be decided which structure within MoH will be responsible for TA needs assessment, for maintaining a database on national TAs, for planning and programming TA, for ensuring respect of agreed procedures regarding selection and recruitment of TA, and for co-ordination and monitoring of TA.

4. The goal of TA is capacity building and therefore TA will have no responsibilities of programme implementation. In exceptional cases, TA may be recruited for filling in a temporary lack of key national staff, for instance in the case of a medical specialist. However, in those exceptional cases of staff substitution with TA, capacity building must be integrated as one of the TA's tasks.

5. TA must be shaped in such a way that it no longer responds to donor requirements and incentives, but to national demands, priorities and incentives.

6. TA will be needed to help carrying out specific external analyses, for introducing or strengthening specific skills, for testing specific new strategies or procedures, etc. Therefore, in most cases, long term TA will not be necessary. Very often, intermittent technical support is more effective then permanent support. However, when TA is needed for overall strengthening of a structure, like provincial health offices, a long term TA contract may be necessary.

7. There are two important reasons for limiting the total volume of TA, present at any time in NDOH central or provincial services. The first is, that excessive TA tends to destabilise and

paralyse the national structures they intend to support. The second is that TA cost tends to skew the overall cost of the health system. TA is expensive, (especially expatriate TA) and cost effectiveness should therefore be an important concern of both MoH and all DPs. This economic consideration is even more important when TA would be financed through a government loan. Efficiency can also be improved by a better matching of TA qualification with required skills. In certain cases, particularly at decentralised level, NGO staff can provide good and relatively cheap technical support.

8. For the selection of TA, all DPs should agree that, if the required competence is likely to be available in-country, national candidates will be considered to start with. Only if no suitable national candidate can be found, the search will be continued abroad. In the case of the need for an international TA firm, possibilities should be explored for including in the contract a partnership with national TA and research groups.

9. DPs should avoid siphoning of MoH key staff, by offering them TA contracts.

10. A database is to be created and maintained on national TA in the field of health. Ideally, this database would also serve as a registration/ classification of TA.

11. Every TA must have at least one national counterpart. This partnership is the basis for capacity building and should not become a mere administrative arrangement. It is therefore important to define in some detail the working relation between the TA and his national counterpart in the TOR.

12. The timely preparation of phasing out of long term TA is of great importance. Details about final handing over should be included in the TA's TOR.

13. TA provision is to be based on:
- a formal joint comprehensive needs assessment by MoH and DPs ;
- a formal request for the TA by MoH (long and short term)
- Terms of Reference of the TA.

14. The TOR OF TA must include:
- profile description and minimum requirements (qualification/experience);
- duration of the contract and procedures for contract extension;
- TA objectives, tasks and expected results (including indicators, milestones);
- objectives and tasks regarding capacity building and skills transfer are explicitly mentioned;
- indication of the MoH structure to which the TA is attached;
- the MoH counterpart to which the TA is directly responsible for all technical matters;
- the person to which the TA is directly responsible for all administrative and contractual matters;
- the TA's place of work (base);
- the procedures and calendar for monitoring and evaluation of TA performance;
- information about special investments and operation resources related to the TA; information on the utilisation of these resources and their destination after termination of the TA contract.

15. Recruitment of TA:
- Preferably, all TA recruitment is based on a transparent competitive procedure (shortlist or, for big contracts also tendering);
- For any newly identified TA need, the importance of TA experience outside the region must be carefully considered.
- Once MoH has formulated a TA need, the whole process from TOR formulation to TA recruitment is preferably handled jointly by MoH and DPs. The modalities of this process will change over time, depending on the capacity of MoH to manage TA and on the confidence of DPs in the implementation of recruitment procedures.

- In certain cases, it may not be possible (or even wise) to formulate very detailed TA job descriptions on beforehand. In such a case the fine-tuning of TA's TOR/job description may be decided upon jointly by MoH and DP at the end of a (3 months?) inception period.

16. Management of TA:
- In an ideal situation, all DPs would pool the funds they have allocated to TA and MoH would use these funds for recruiting and managing this technical support. However, given limited managerial capacities of MoH and possibly different perceptions of DPs, e.g. TA needs or suitability of candidates, a more cautious approach will be necessary. A lesson that we can learn from countries where the Health Ministry had gained almost complete control over TA, is the danger of TAs not having uninterrupted availability of resources for operational expenses. In such a case, the payment of TA's salary/fees will continue, but the TA's output is minimised.
- In line with SWAp, DPs should agree to move stepwise towards the complete control of TA by MoH. Such a process will take years and must be accompanied by definition of progress indicators and milestones.
-
17. The TA information system elements are based on initial mapping of
- area of expertise
- responsibilities (including non TA functions like project/programme management, financial control)
- profile of the TA (qualification, experience)
- international or national expert
- duration and period of contract (for short term: this year's short term contracts)
- zone of intervention
- national structure the TA was attached to
- counterpart staff
- availability of a budget for TA related activities/investments;
- any particulars (open ended contract, sequence of missions, multiple areas of expertise, multiple attachments/zones, ..)
- In addition, the information system may include a catalogue/ classification of national health consultants.

18. monitoring and evaluation of TA
- Monitoring and evaluation should be done jointly by the MoH responsible unit and by the DP.
- The TA's contract stipulates procedures for any follow-up of performance evaluation.

<u>TA POOLING</u>

TA-pooling is the most advanced form of consolidated TA management.
The notion of "pooled TA" stands for the integration of all TA within a single management and financing framework under recipient country ownership or third party management support.
Three categories of TA pooling, increasingly ambitious, can be distinguished:

- **Loose TA pooling**: the direction of TA personnel is shared between the government and the DPs. Personnel are normally contracted individually by one or more DPs, often on a tied basis. This is the least collaborative of the three categories.

- **Mixed TA pooling**: national authorities manage the TA personnel, but the contracting is done by DPs.

- **Full TA pooling**: resources and control are transferred to the national partners to the greatest extent, who both contract and direct TA personnel.

INTERNATIONAL EXPERIENCE WITH HARMONISATION OF TA

A study that analysed the experiences in countries where harmonisation of TA was attempted observed a consistent pattern of over-ambitious efforts[22] . It was a comparative study of the situation in six countries where TA pooling was introduced. Certain pitfalls were ignored and this has led to disillusionment. The study came to the following conclusions:

- There were serious capacity shortages in most countries for managing a TA pool.
- Although pooling generally reduced fragmentation and created more space for national ownership, such impact on national ownership could not yet been noticed.
- The use of TA pooling, by itself, did not appear to lower overall expenditure on TA. Despite the rhetoric about untying, most DPs are reluctant to untie aid flows.
- Efficiency gains were mixed, because these collaborative initiatives proved to be far more labour intensive and organisationally complex than their advocates had predicted. This was especially true in the cases of SWAps.
- In some cases, TA pooling highlighted the comparative advantages and costs of different providers and thus increased transparency. Pooling can introduce a more subtle competition into TA supply.
- There was some evidence of a correlation between the use of TA pooling and the crafting of better sector strategies and policies.

The general recommendation in the cited report is to favour small context-aware and context-sensitive initiatives, following an incremental approach. The observation that pooling TA, by itself, does not lead to national ownership is an essential one. The pooling is not more than an aid modality; it is just one mechanism within a combination of approaches that come with SWAp.

It is clear from these experiences that TA pooling is not an easy thing to realise. Moreover, TA pooling has more chance of succeeding when DPs have a common vision and a tradition of working in collaborative arrangements. Reluctance of DPs has been mentioned as a constraint, but also national vertical projects may be reluctant to give up their own bilateral TA provision arrangements.

[22] H. Baser and P. Morgan: Harmonising the Provision of Technical Assistance: Finding the right balance and avoiding the New Religion. Published by the European Centre for Development Policy Management on 1 June 2002 (ECDPM Discussion Paper 36).

28 ANNEXE 9 QUESTIONNAIRE FOR THE MAPPING OF PROCUREMENT PRACTICES[23]

Questions to be replied by DPs who finance drugs, equipment, infrastructure, TA/consultants, etc.

type of commodities

1. What kind of commodities are procured for the project/programme?

responsibilities

2. Is the project managed by a) project staff (expatriate or national)?
   b) by a GOR structure?
   c) a third party: a procurement agent?
3. Which structure is responsible for procurement?
4. If project staff is responsible for procurement, has the concerned ministry formally delegated this responsibility to them? To what extent are approvals or signatures of ministries still necessary?
5. If a ministry is responsible for procurement, is technical assistance provided to facilitate and control the process?

procedures

6. Are procurement procedures based on donor regulations or on GOR regulations?
7. What type of procurement procedure is applied for big orders (minimum ….. €) ? (examples and characteristics). Procedure for smaller orders? Distinguish between pre-qualification, international /regional/national open tendering, limited consultation of pre-selected candidates, gré à gré.
8. What are donor specific conditions, requirements?
9. Any specific norms and standards?
10. Who are responsible for tender evaluation?
11. At which moment in the procurement process (for which document), an approval by the donor HQs (or project manager/TA) is required? (Approval of tender documents, approval of tender evaluation results, negotiation results, approval of contract proposal)
12. Particular documents needed? (pre-shipment inspection has been done and a Certificate of Donation, etc.)
13. Payment by MINECOFIN/MoH, directly by donor bank, or through an agent with a commercial bank account in Rwanda?
14. Direct payment procedure? Who signs?
15. How many months does the tender process take from publication of tender documents until delivery (specify mode of transport).
16. Advantages /disadvantages of these procedures?
17. Which approach and which type of procedures would you recommend as for a joint procurement system in line with SWAp?

[23] inspired by an exercise carried out in Kenya

29 ANNEX 10 DP PROPOSAL FOR PRIORITY AREAS IN FURTHER SWAP DEVELOPMENT, HSCG meeting 21/1/2010

PRIORITY	UN	BELGIUM COOP	GERMAN COOP	SWISS COOP	GB COOP	CF	USG
1.MoH institutional/ organisational framework		.		Especially review TWGs			
2.Human resource development	Not specific for Swap develop: need for POW				2-3 year staff dev. plan	planning HR needs & project-tions	
3.Legal and regulatory framework					Not done by national consultants?		
4.Sector policy and strategic framework	Is HSSP, rest is sub-strategies: need for POW				Link policies & strategies with implem framework		
5.Consolidated, bottom-up planning and budgeting					MTEF, resource all, resource track, decentr. Planning, validation ann. plan?	Core business (tools)	
6.Comprehensive h. district development in the context of decentralisation	Not specific for Swap develop-Ment: need for POW	Foundation WHO: PHC.Integrated approach.Link MoH-MINALOC			Not specific for Swap develop-ment , except capture DP district financing and activities with support CF.	Core business	
7.Fiduciary framework					Partnership principles & fid risk management in MOU?		
8. Coordination DPs and other stakeholder groups			Coord.in MOH. MOH -DPs, Between DPs	Need to review MOU and adopt a COC?		database easy; but updating!	
9.Coordination/ partnership non public sector actors					Improve coord NGOs, private sector, faith groups. Joint accountability. Review role lead DP (policy meetings)		
10.Sector M&E, info/knowl. Manag.					Including research	Includingm utual ac-	

						countabil. Exp.suppor t HMIS?	

30 ANNEX 11 LIST OF SELECTED DOCUMENTS

GENERAL

1. Rwanda; A Country Status Report on Health and Poverty, MoH and WB, 2009
2. Functional Reviews And Institutional Audit Of Six Public Sector Institutions To Assess The Impact Of Ongoing Public Sector Reforms, OPM, 2007
3. Interim Demographic and Health Survey 2007-08, MoH, 2009
4. Rwanda Community Health Needs Assessment, USAID, 2008
5. Economic Development & Poverty Reduction Strategy 2008 - 2012
6. HHR Policy Draft One 2009
7. Human Resources For Health Strategic Plan 2009-2012,MoH, 2009
8. 2008 Additional Health Sector Plans Resource Needs
9. Health Sector Politique&Standards&Protocoles, MoH, 2007
10. District Health System Overview Document - Full Draft – 2008
11. Website districthealth.moh.gov.rw.
12. Jobs Profiles Rural District 2009
13. Cadre organique - Rural District , 2009
14. Decentralisation of the health sector (PP Presentation to Decentr. TWG 2009)

SWAP

1. Rwanda Health Sector Strategic Plan (HSSP I 2005 – 2009) Evaluation Report, Chabot, 2008
2. Health Sector Strategic Plan July 2009 . June 2012, GOR/MoH
3. Rwanda Aid Policy endorsed, 2006
4. Aid management in Rwanda (PP presentation MINECOFIN 2009
5. Etat d'avancement des partenaires au développement dans le processus d'harmonisation et d'alignement dans le secteur de santé au Rwanda (Niechzial, EPOS, 2006)
6. Folder MINECOFIN: Development Assistance Database (DAD)Tools for mutual accountability, aid coordination architecture, aid policy, progress towards Paris declaration, swaps in Rwanda
7. Review of donor coordination in the education sector in Rwanda
8. List of major partners active in districts, MoH, 2008
9. List of stakeholders/players, MoH
10. Major Partners List district level, MoH
11. 2008-2010 GOR-DP harmonised Calendar
12. IHP+: "first wave countries". IHP resources for in-country teams
13. IHP+ Guidance note: development of a country Compact
14. IHP+ Joint Assessment of national strategies and plans. FAQ
15. IHP+ : Joint Assessment Tool (JAT): the attributes of a sound national strategy, draft 2009
16. Scoping report Dr A. Seddoh, development of SWAp manual for Rwanda 2009
17. Rwanda Health Sector Fiduciary Risk Assessment, DFID, 2008
18. Key issues and recommendations on donor division of labor, PP Presentation MINECOFIN
20. Operationalisation of SWAp at district level, PP Presentation
21. Rwanda Mission Report Health SWAp Rwanda, Mahon, 2007
22. Documents on sub strategies

SWAP INSTITUTIONAL FRAMEWORK

1. Table reorganisation of TWG: chair, co-chair, subgroups
2. TOR Role of lead donor(s), Rwanda education sector coordination framework
3. Revised TOR TWG
4. MoH TWGs
5. TOR New Rwanda coordination mechanisms in the health sector, draft in discussion, PS/MOH

6. Development Partners Group, monthly coordination meeting, WB, 13/8/09
7. Rwanda MoH organigram: 2 versions
8. Rwanda Health Cluster Terms of Reference July 2009
9. TOR of individual (sub) TWGs
10. Draft Terms Of Reference For Health Budget Development Partners Group
11. EDPRS monitoring institutional framework
12. Role of Lead Donor in the Education Sector
13. Review Of Donor Co-Ordination In The Education Sector In Rwanda

PLANNING

1. Joint Annual Work plan 2009/2010
2. JAWP 2009-2010 PP presentation - JHSR (draft)
3. District Questionnaire- District Level Survey, CF,2008
4. Terms Of Reference For The Elaboration Of The Health Facility Strategic Plan
5. national budget & planning guidelines

HEALTH FINANCING

1. MTEF 2009 to 2012 MoH
2. Rwanda: Performance-Based Financing in Health, extract Sourcebook: Second Edition
3. Report back on the "aid on budget" workshop 2008, MINECOFIN
4. Health financing systems review of Rwanda, options for universal coverage, WHO, final draft 2009
5. Health Financing In Rwanda: An Analysis Using The Preliminary National Health Accounts (NHAS) 2006
6. Health Sector Execution Budget Review 2008
7. Minisante Performance Audit Report; The Effectiveness Of Maternal Health Care Delivery '02-'06, Auditor General
8. Willingness to Pay: A Technique for Helping Programs Balance the Need for Sustainability with Social Mission, Frontiers
9. Rwanda Health Costing Study, MSH, 2008
10. Health Financing Systems Review of Rwanda; - Options for universal coverage -; WHO, final draft 2009
11. Harmonization calendar 2008-2010, MINECOFIN
12. National Planning, Budgeting & MTEF guidelines, MINECOFIN, 2008
13. New Budget Calendar 2010-, MINECOFIN, 2009
14. Grant Agreement CDPF
15. Health Sector Capacity Building Action Plan CDPF 2008-2011
16. Aide Memoire SBS tripartite 2007
17. Partnership Framework Governing The Provision Of Direct Budget Support In The Implementation Of Rwanda's Economic Development And Poverty Reduction Strategy

MONITORING AND EVALUATION

1. Integrated Monitoring and Evaluation Framework-Background Paper-Final Version, 2008
2. Joint Sector performance Report (JHSR) mini-budget, 2009
3. Mid term Evaluation Report GFATM HSS.WB, 2007
4. Agenda for the JHSR 2009
5. Table: aid management: externally financed project performance 2009. (Section 5)
6. JHSR 2008 suivi recommendations (Excel table)
7. CPAF 2009-2010 Metadata
8. DPAF PP presentation March09 DPCG, 2009
9. Sector Reviews and CPAF Process and Update, MINECOFIN, 2009