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RWANDA HEALTH PRIVATE SECTOR ENGAGEMENT (PSE) ASSESSMENT

May 2015

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USAID/RWANDA HEALTH PRIVATE SECTOR ENGAGEMENT ASSESSMENT

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ACRONYMS

| | |
|-----------|--|
| IFH / OFH | One Family Health |
| AOS | Africa Olleh Services |
| APS | Annual Programs Statement |
| ASH | African Strategies for Health |
| BSC | Broadband Systems Corporation |
| BTC | Belgian Development Agency |
| CBHI | Community-Based Health Insurance |
| CHW | Community Health Worker |
| CSR | Corporate Social Responsibility |
| DCA | Development Credit Authority |
| DH | district hospital |
| DHIS | district health information software |
| DHU | district health unit |
| DP | development partners |
| DPCG | Development Partners Coordination Group |
| EAC | East African Community |
| EDPRS | Economic Development and Poverty Reduction Strategy |
| EG | Enhancement, expansion, and improvement through efficiency gain |
| EPCMD | ending preventable child and maternal death |
| FDI | foreign direct investment |
| FGD | focus group discussions |
| FtF | Feed the Future |
| GDA | Global Development Alliance |
| GOR | Government of Rwanda |
| HC | health center |
| HF | health financing |
| HIS | health information systems |
| HMIS | health management information system |
| HO | United States International Development Agency/Rwanda, Health Office |
| HP | health post |
| HPP | health promotion and prevention |
| HRH | human resource for health |
| HSP | Health Sector Strategic Plan |
| HSSC | Health Sector Skills Council |
| ICT | information and communications technology |
| IP | implementation partners |
| IT | information technology |
| KCB | Kenya Commercial Bank |
| KII | Key Informant Interview |
| KMISC Lab | Kigali Medical Imaging and Supplies Center |
| LA | leadership and advocacy |
| LKM | learning and knowledge management |
| LMIS | logistics management and information system |
| M&E | monitoring and evaluation |
| MDG | Millennium Development Goal |
| MINECOFIN | Ministry of Finance and Economic Planning |
| MINEDUC | Ministry of Education |
| MINICOM | Ministry of Trade and Industry |
| MMI | Military Medical Insurance |
| MOH | Ministry of Health |
| MPPD | Medical Procurement and Production Division |
| MSH/R | Management Sciences for Health/Rwanda |
| NCD | Non-communicable Disease |

| | |
|---------|--|
| NCNM | National Council of Nurses and Midwives |
| NPC | National Pharmacy Council |
| NUDOR | National Union of Disabilities Organization of Rwanda |
| ODA | overseas direct assistance |
| PBF | performance-based financing |
| PEPFAR | President's Emergency Fund for AIDS Relief |
| PHSCC | Private Health Sector Coordination Committee |
| PIH | Partners in Health |
| PMI | President's Malaria Initiative |
| PMTCT | Prevention of mother-to-child transmission of HIV |
| PPCP | public private community partnership |
| PPP | public private partnership |
| PS | private sector |
| PSE | private sector engagement |
| PSF | Private Sector Federation |
| PS-H | Private Sector-Health |
| PS-NH | Private Sector-Nonhealth |
| RAMA | Rwandan Medical and Health Insurance |
| RBC | Rwanda Biomedical Center |
| RDB | Rwanda Development Board |
| RFH | Rwanda Family Health |
| RG | resource generation/financing and effective mobilization |
| RHF | Rwanda Health Care Federation |
| RHSS | Rwanda Health Systems Strengthening |
| RHSSA | Rwanda Health Systems Strengthening Activity |
| RMA | Rwanda Medical Association |
| RPPA | Rwanda Public Procurement Authority |
| RQ | review question |
| RRA | Rwanda Revenue Authority |
| RSB | Rwanda Standards Board |
| RSSB | Rwanda Social Security Board |
| SEDC | Square Entrepreneurship Development Corporation |
| SHOPS | Strengthening Health Outcomes through the Private Sector |
| ST | short-term |
| SWAP | sector-wide approach |
| TA | technical advisor |
| UNFPA | United Nations Population Fund |
| UNICEF | United Nation Children's Fund |
| UOB | Urwego Opportunity Bank |
| USAID | United States Agency for International Development |
| USAID/R | United States Agency for International Development /Rwanda |
| USAID/W | United States Agency for International Development /Washington |
| USG | United States Government |
| WDI | World Development Indicators |
| WHO | World Health Organization |

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I. EXECUTIVE SUMMARY

Introduction

Known as “the land of a thousand hills,” Rwanda is a small but dynamic country, characterized by the rapid adoption of dynamic vision, new approaches, strategies, and programs. The nation has made remarkable progress since the 1994 genocide. Poverty has dropped from 56.7 percent of the population in 2006 to 44.5 percent in 2011, and GDP per capita almost doubled to \$639 in 2013.¹ Key factors, such as improved delivery of public health services, high levels of external financing, and universal health insurance contributed to Rwanda’s tremendous strides in improving the health and well-being of its citizens over the past decade. The country has realized significant progress towards achieving the Millennium Development Goals, although problems persist. One child in 13 dies by the age of five in Rwanda; the entire population is at risk for malaria, which is the fourth major cause of mortality; and it also faces a complex HIV/AIDS epidemic, with a relatively low prevalence of 3 percent among the general population but as high as 46 percent among the most-at-risk populations, and women and girls are disproportionately affected, representing nearly 60 percent of adults living with HIV.^{2,3,4}

As Rwanda looks to sustain its hard-earned gains in health, it faces a few vital constraints. Donor funding is declining (net overseas direct assistance, or ODA, per capita was down to \$77 in 2012 from \$113 in 2011) and the Health Sector Strategic Plan III (HSSPIII) is underfunded with a likely gap of \$372 to \$697 million.^{5,6} Private sector investment, which could potentially help fill this gap, is only 1.7 percent. The Government of Rwanda (GOR)’s goal of increasing this investment to 5 percent (or approximately \$260 million/year) would cover almost 50 percent of annual total health expenditure (THE).⁷ In an effort to address these issues, the GOR, its development partners (DPs), and key stakeholders recognize the urgent need to have increased, strong, and sustainable private sector engagement (PSE) for accessible, equitable, efficient, and improved health services that would contribute toward the desired health outcomes. To support the GOR in assessing the landscape and identify opportunities and obstacles related to increased and sustained PSE in health, USAID/Rwanda (USAID/R) commissioned the African Strategies for Health (ASH) project to carry out the Rwanda Health PSE Assessment between January and March 2015, with a field work period of January 26 to February 21, 2015.

Country Context

Macroeconomic Situation and Investment Climate: Rwanda’s economy has expanded at an impressive average rate of almost eight percent between 2010 and 2012.⁸ However, the projected higher growth rate assumed for the HSSP III will not be met, making the funding gap increasingly likely. The World Bank, Transparency International, and others have reported improved business climate indicators for Rwanda over the last five years. However, foreign direct investment (FDI) in Rwanda was about 1.5 percent of GDP in 2013, worth only \$110 million.⁹ Potential and current investors cite a number of constraints, including high transport and energy costs, a small domestic market, limited access to financing, inadequate infrastructure, and a lack of skills in the workforce.

¹ World Development Indicators (WDI) database, The World Bank Group

² HSSP III

³ HSSP III

⁴ Gender Assessment of Rwanda’s National HIV Response (UNAIDS)

⁵ OECD

⁶ HSSP III

⁷ HSSP III

⁸ WDI database

⁹ WDI database

The GOR Health Goals, Structure, and Organization: The Ministry of Health (MOH)'s mission is to “provide leadership of the health sector to ensure universal access to affordable promotive, preventive, curative, and rehabilitative health services of the highest attainable quality.” Services are provided at different levels: within the community, health posts (HPs), health centers (HCs), district hospitals (DHs), and referral hospitals, and by different types of providers, such as public entities, faith-based organizations (FBOs), private-for-profit groups, and nongovernmental organizations (NGOs).

Rwandan Private Health Sector: The private health sector in Rwanda is relatively small, young, and fragmented. It is comprised of private hospitals, polyclinics, clinics, dispensaries, HPs, faith-based hospitals, HCs, pharmacies, pharmaceutical wholesalers, private insurance companies, private professional associations, private medical training institutions, and NGOs specializing in health. There are 177 private-for-profit health facilities and 216 pharmacies and wholesalers, most of which are located in Kigali.¹⁰ The rest of the country is underserved by the private sector. The five private insurance companies cover about 10 percent of the population. There are limited examples of private sector engagement and public-private-partnerships (PPPs) in the health sector. Several key initiatives include the PPP with One Family Health for health posts, the planned privatization of King Faisal Hospital, the inclusion of some private providers in the tuberculosis (TB), malaria, and immunization programs, and private pharmacies under contract with the Medical Procurement and Production Division (MPPD).

Health Financing and Expenditures: Rwanda's health sector has four main funding sources: 1) GOR revenues, including revenues generated from loans, grants, taxation, donations, and DP contributions 2) health insurance pooled funds, (CBHI or *Mutuelle de Santé*) from household expenditures; 3) private and internationally generated funds from health facilities; and 4) other donor funds. Donor contributions make up 61 percent of THE.¹¹ Despite increases to the GOR health budget in recent years, 2013 saw a drop to only 9.5 percent in favor of greater resources towards growth and job creation.¹²

USAID PSE Policies: USAID has a long history partnering with the private sector across the globe to achieve social and economic development goals. USAID/R is fully embracing a strategy to increase PSE and PPPs across different sectors, including health, and has a number of tools, which are described in this report, to create partnerships that will contribute to HSSPIII priorities. This assessment is also an important step to help guide USAID in supporting the GOR toward increased PSE.

Assessment Approach

Overall Goal: The overall goal of this assessment is to formulate concepts and recommendations in the identified key strategic areas of the conceptual framework (CF) for increased and effective PSE in the Rwandan health sector to help sustain and build on current achievements, especially at the primary and secondary care levels (from community to district level).

Purpose and Objectives: The primary purpose and objectives of this assignment are to:

- Conduct a landscape analysis of the private sector space and actors as it relates to the sustenance and further development of the health sector;
- Identify key opportunities, what works, gaps, challenges, and barriers in the strategic areas that exist for PSE in the Rwandan health sector (especially at the primary and secondary levels);

¹⁰ Rwanda Healthcare Federation

¹¹ Rwanda Health Resource Tracker

¹² WDI database

- Recommend which strategic areas/subsectors show the most promise for public-private collaboration to achieve complementary public-private objectives.

The Conceptual Framework: In developing an approach, the team looked at five strategic areas (SAs) and the critical components for creating an overall environment (including political and institutional) for promoting and sustaining PSE in the health sector: Leadership and Advocacy; Policy and Planning; Investment and Access to Finance; Corporate Social Responsibility; and Health Sub-sectors, comprised of Service Delivery, Health Financing, Human Resources for Health, Medical Products (including medicine), Equipment, and Technology, Health Information Systems, Health Promotion and Prevention, and Learning and Knowledge Management.

Key Results Areas: The team used two results lenses to assess, analyze, and formulate recommendations toward an increased and sustained PSE in the Rwandan health sector:

1. Enhancement, expansion, and improvement through efficiency gain (EG)
2. Domestic resource generation/financing and effective mobilization (RG)

Methodology: The team used a mixed methods approach, including, document review, stakeholders analysis, key informant interviews (KIIs), focus group discussions (FGD), and field visits. Using the conceptual framework, this combination of methods enabled the team to better understand various opportunities, weaknesses, gaps, challenges, and barriers that exist for PSE in the health sector.

Select Findings/Conclusions and Recommendations

Overall Umbrella Recommendation: *Foster an enabling environment that promotes the growth of PSE in health over the longer term - while facilitating, developing, and implementing targeted “quick wins/rapid results initiatives,” and broader PPPs that will help sustain and build further on the current gains, especially at the primary and secondary levels of the health system*

Select findings and recommendations are highlighted below. Please refer to the report for a complete list of findings and recommendations.

| Key Findings/Conclusions | Key Broad Recommendation |
|---|--|
| Leadership and Advocacy | |
| <ul style="list-style-type: none"> ▪ There is strong leadership and political will at senior levels, which is a critical success factor for PSE. ▪ The level of understanding/support for PSE, however, varies within the GOR. ▪ There is a lack of systems and knowledge about how to engage the private sector, especially to develop PPPs. ▪ There is a lack of effective coordination and clarity of roles and responsibilities between key stakeholders (MOH, RDB, RBC) that is limiting effective PSE. ▪ There is a lack of adequate capacity within the MOH, RDB, and RBC for effective PSE and PPP development. ▪ There is limited dialogue and no formal platforms or systems for public and private engagement. | <ul style="list-style-type: none"> ▪ Identify and support key health PSE leadership with critical “business” thinking and understanding at all levels ▪ Strengthen overall PPP and business development capacity at MOH and RBC ▪ Intensify public expression of support, advocacy, and communication from senior government decision-makers on the importance of increasing resource allocation for heightened and sustainable PSE interventions |
| Policy and Planning | |
| <ul style="list-style-type: none"> ▪ The overall tax and investment environment in Rwanda is favorable for private sector development. ▪ A new PPP legal framework has been approved but not disseminated. ▪ The MOH, RBC, and RDB all have units or positions designed to | <ul style="list-style-type: none"> ▪ Prepare a detailed, evidence-based, and prioritized implementation action plan for key PSE activities ▪ Use the action plan to ensure efficient and equitable allocation of all types of different |

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|---|---|
| <p>engage the private health sector.</p> <ul style="list-style-type: none"> ▪ Specific health incentives are lacking in the tax and investment code. ▪ There is slow implementation of PSE policies and plans. ▪ PPP mechanisms and PSE/PPP planning processes have not been finalized. ▪ Financial, human, and other resources are not adequately aligned to support effective PSE and PPP development. ▪ National- and district-level managers do not have adequate skills and business know-how to implement PSE and PPPs. ▪ The private sector and other key stakeholders are not adequately engaged in policy development and planning. ▪ There is limited communication and confidence between the public and private sectors. ▪ The GOR tariff structure is a barrier to investment. ▪ Complex regulatory requirements (e.g. procurement, licensing, and customs) create inefficiencies and can impede PSE. ▪ The new electronic single window system may facilitate trade by speeding up and simplifying information flows between traders and government institutions. ▪ There are opportunities to increase revenue collections on the importation and registration of new pharmaceutical products. ▪ Most private sector associations have limited capacity for effectively advocating for their members. ▪ Most hospitals are not autonomous, which creates accountability, management, and efficiency issues. | <p>resources for implementation at all levels</p> <ul style="list-style-type: none"> ▪ Strengthen national- and district-level PSE policy and planning capacity ▪ Promote and increase meaningful participation of all stakeholders in formulation of PSE policies, strategies, and plans, and ensure ownership and alignment ▪ Review current regulations and amend/introduce new ones in line with international and regional practices to develop PPPs, generate revenue, and gain efficiency ▪ Propose, dialogue, and advocate for possible adaptation of law(s) that will give the hospitals management autonomy with an appointed board of directors ▪ Strengthen various private sector associations toward making themselves self-sustaining and more efficient to serve and represent their members |
| Investment and Access to Finance | |
| <ul style="list-style-type: none"> ▪ There is currently some financing for the private health sector. ▪ Loan terms (collateral requirements, interest rates, and borrower contributions) and lack of start-up capital, however, restrict borrowing. ▪ There is minimal domestic and foreign investment in the health sector. ▪ The RDB has limited knowledge of the health sector and institutional capacity to increase investment in this sector. ▪ Limited business skills in the health sector are barriers to increased access to finance and investment. | <ul style="list-style-type: none"> ▪ Create or buy into existing Health Sector Challenge Funds ▪ Structure Development Credit Authority (DCA) supported by TA to financial institutions to increase lending to PS ▪ Develop additional sources of financing through the GOR, other international financial institutions, and donors ▪ Strengthen RDB's capacity to facilitate private health sector investment ▪ Devise and support a TA mechanism to support private health care businesses to obtain financing |
| Corporate Social Responsibility (CSR) | |
| <ul style="list-style-type: none"> ▪ There are some examples of CSR (including PPPs) for the health sector in Rwanda, including GlaxoSmithKline's support for the One Family Health HP model and Bralirwa's support for the local manufacturing of mosquito nets and workplace programming. ▪ Currently most CSR funding is in the agricultural and ICT sectors by multinational companies mainly due to GOR and DP-led investment promotion activities. ▪ There are some constraints to the development of CSR for the health sector. | <ul style="list-style-type: none"> ▪ Strengthen CSR to support PSE, PPPs, and increased funding for the health sector |
| Health Subsector: Service Delivery | |
| <ul style="list-style-type: none"> ▪ The private health sector is interested in expanding and partnering with the public sector and some public facilities are actively exploring PPPs. ▪ The private service delivery sector is small and fragmented. | <ul style="list-style-type: none"> ▪ Develop and implement a private HP model ▪ Create a risk pooling fund to ensure HPs are located throughout the country ▪ Develop and institutionalize business and |

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| <ul style="list-style-type: none"> ▪ There is an opportunity to develop a sustainable private health post model, which may improve efficiencies. ▪ There is significant interest to increase PPPs and other income-generation strategies within facilities. ▪ There is no clear process and legal framework, and there is limited capacity to develop and implement PPPs. ▪ There are limited “business culture” and business skills at the facility level. ▪ There is an interest and opportunity to strengthen and promote specialized services and tertiary care in the private sector. | <p>financial management capacity-building program at the facility level</p> <ul style="list-style-type: none"> ▪ Develop and institutionalize PSE and business and management training at the central level ▪ Support and incentivize the establishment of private sector specialized/tertiary care |
| Health Subsector: Health Financing | |
| <ul style="list-style-type: none"> ▪ Rwanda has made substantial progress towards universal coverage, overcoming financial barriers and improving equity. ▪ The integration of CBHI under the Rwanda Social Security Board (RSSB) poses an opportunity for improved efficiencies. ▪ A high dependency on donor funding, which is declining, and the low purchasing power of the population is creating stress. ▪ The integration of CBHI under the RSSB poses an opportunity for improved efficiencies. ▪ The current GOR tariff is low and a deterrent to private sector investment. ▪ A costing exercise has been completed to revise the GOR tariff structure, which is now awaiting approval. ▪ CBHI claim processing and payment inefficiencies and delays negatively impact private HPs. ▪ There are opportunities to better integrate private insurance into the health financing system. ▪ The majority of CHW cooperatives are operating income-generation activities, although profit is low and income generation at the district hospital level is limited. There is keen interest in expanding income generation and improving efficiencies, but DH managers lack the skills and business mindset. | <ul style="list-style-type: none"> ▪ Establish an integrated health insurance system and review the functioning of the system for its impact on quality of services, payments, equity, and sustainability ▪ Strengthen RSSB structural and institutional processes to successfully integrate CBHI ▪ Strengthen income generation of CHW cooperatives and evaluate loss of performance-based financing (PBF) ▪ Establish a national association of HPs and support income generation ▪ Roll out strategies for income-generation and efficiency gain at the district hospitals ▪ Explore partnerships with private health insurance industry to increase coverage and their contribution to the CBHI |
| Health Subsector: Human Resource for Health (HRH) | |
| <ul style="list-style-type: none"> ▪ The lack of skilled health care workers is a constraint to PSE, to the development of specialized private health services, and to the privatization of medical equipment maintenance. ▪ The GOR is aware of the HRH problem and has a long-term vision and plan in place for developing a skilled workforce. ▪ Retention is a major issue, particularly in rural areas. | <ul style="list-style-type: none"> ▪ Continue to promote the development of specialized health workers ▪ Increase the resources and access to health |
| Health Subsector: Medical Products (including medicine), Equipment, and Technology | |
| <ul style="list-style-type: none"> ▪ There is an active private pharmaceutical sector and a relatively active private pharmacy sector. ▪ There are plans to strengthen biomedical engineering skills and the GOR is creating a Center of Excellence for biomedical engineering that will serve as an East African regional resource. ▪ There is insufficient funding and planning for medical equipment maintenance and management and a culture of replacement rather than repair due to donor dependency. ▪ There is a lack of skilled biomedical engineers and technicians. ▪ There are complex procurement and customs requirements for medical equipment and spare parts. ▪ There is almost no medical product/equipment manufacturing. | <ul style="list-style-type: none"> ▪ Devise and implement a parallel and phased approach on equipment management and maintenance ▪ Explore and support production and expansion of select medical products ▪ Explore potential for increased privatization of drug procurement and distribution, and improve current planning |
| Health Subsector: Health Information System (HIS) | |
| <ul style="list-style-type: none"> ▪ The GOR has made significant strides in e-health but there are | <ul style="list-style-type: none"> ▪ Increase efficiencies through expanded use of e- |

| | |
|---|--|
| <p>more opportunities to increase efficiencies through increased use of technology and PSE.</p> | <p>health; activities including but not limited to:</p> <ul style="list-style-type: none"> - Exploring outsourcing of basic IT support, help desk functions, etc. - Increasing PSE in building various interfaces to support interoperability between systems - Developing software and mobile phone interface for CBHI claims management and electronic drug procurement at health post level - Using mobile money for health posts and CHW cooperatives payments |
| <p>Health Subsector: Health Promotion and Prevention (HPP)</p> | |
| <ul style="list-style-type: none"> ▪ Rwanda has made remarkable progress in improving health outcomes through effective HPP in areas such as malaria, TB, HIV/AIDS, neglected tropical diseases, non-communicable diseases (NCDs), and family planning. ▪ Outreach and demand-creation activities can improve the viability of small-scale private providers. ▪ PPPs related to HPP are working well, but there is significant room to improve and expand. ▪ There is an increased number of registered CHWs with high commitment to work in HPP work. ▪ There has been limited corporate engagement related HPP/CSR. ▪ New training programs being developed for community health technicians on NCDs in collaboration with the Workforce Development Authority (WDA). ▪ There are inadequate resources and access to HPP relevant trainings. | <ul style="list-style-type: none"> ▪ Increase PSE activities with targeted HPP strategies to help strengthen private sector contribution to health outcomes; activities including but not limited to: <ul style="list-style-type: none"> - Promoting use of new health posts (HPs) - Supporting HPs with targeted outreach (including m-health campaign) focused on ending preventable child and maternal death (EPCMD) - Increasing private service provider engagement and PPPs in HPP, including TB, HIV/AIDS, family planning, and NCDs |
| <p>Health Subsector: Learning and Knowledge Management (LKM)</p> | |
| <ul style="list-style-type: none"> ▪ There are a number of existing PPPs geared toward training facilitation, education and knowledge transfer. ▪ There is limited knowledge within the GOR about health PPPs and PSE; no central location for data on the private health sector; and no evidence base. ▪ There is low clinical and operational research capacity (public and private), and inadequate PS involvement. | <ul style="list-style-type: none"> ▪ Test different PPP models, disseminate findings, and scale up successful models ▪ Strengthen operational and clinical research ▪ Develop and disseminate information and evidence to facilitate PSE and income generation |

2. INTRODUCTION AND OVERVIEW

Known as “the land of a thousand hills,” Rwanda is a small but dynamic country, characterized by the rapid adoption of dynamic vision, new approaches, strategies, and programs. It is a landlocked country in Central/Eastern Africa with a population density that is among the highest in Africa. It is one of the world’s poorest countries, but much has changed since the 1994 genocide. A transitional government established after the genocide took extensive crisis prevention measures. It introduced fundamental changes that opened doors for reconciliation and helped the country to move forward. Rwanda has made remarkable progress in developing national and local government institutions, maintaining security, promoting reconciliation, and strengthening the justice system. In large part due to agricultural growth over the last five years, the number of people living below the poverty line has dropped from 56.7 percent in 2006 to 44.5 percent in 2011, and GDP per capita almost doubled to \$639 in 2013.¹³

Rwanda’s Vision 2020 development strategy sets an ambitious goal of becoming a middle income country by 2020 with GDP per capita of \$1,240 and a growth rate of 11.5 percent. Vision 2020 aims for developing comprehensive human resources in education, health, and information and communications technology (ICT) within the public sector, private sector, and civil society, and taking into account demographic, health, and gender issues. Rwanda’s Economic Development and Poverty Reduction Strategy II (EDPRS II, 2013–18) serves as a roadmap to help Rwanda attain the aspirations of Vision 2020. EDPRS II aims to improve the quality of, demand for, and accessibility of healthcare. Some of the main cross-cutting issues are capacity-building, family and gender, HIV/AIDS, and non-communicable diseases (NCDs). The Health Sector Strategic Plan (HSSP III 2012-18), which is closely aligned with the EDPRS II, aims to “continually improve the health of the people of Rwanda, through coordinated interventions by all stakeholders at all levels, thereby enhancing the general well-being of the population and contributing to the reduction of poverty.” In order to achieve these objectives and targets, and transform Rwanda into a middle-income country, it needs to have a healthy and productive population where all children and sick people are well nourished and cared for, so they can meaningfully contribute to the country’s progress.

Achievements in Five Years (2005-2010)

- ❖ Fertility declined from 6.1 to 4.6 children per woman
- ❖ Birth in facilities increased from 28% to 69%
- ❖ Maternal mortality decreased from 610 to 390 (per 100,000 live births)
- ❖ Acute malnourishment decreased from 5% to 3%
- ❖ Infant mortality rate decreased from 86 to 50 (per 1,000 live births)
- ❖ Child mortality rate decreased from 152 to 76 (per 1,000 live births)

Source: *Demographic and Health Survey*

Rwanda has made tremendous strides in improving the health and well-being of its citizens over the past decade. The country has realized significant progress towards achieving the Millennium Development Goals (MDG), especially regarding child health (MDG4), maternal health (MDG5), and disease control (MDG6).

The improved delivery of public health services, high levels of external financing, and universal health insurance are significant factors in this progress. However, poverty remains high and education levels low for

almost 50 percent of the population, making them more vulnerable to poor health and illness. Despite the level of poverty, Rwanda has utilized innovative health financing to provide almost universal access to health services, resulting in a steep decline in out-of-pocket payments for health care and consequently improved access to health services. Strong planning in the GOR and MOH through the Health Sector Strategic Plans (HSSP) has been instrumental in these remarkable successes. Despite the

¹³ WDI database

impressive progress made, problems persist in the health arena. In Rwanda, one child in 13 dies by age five.¹⁴ Forty-four percent of children suffer from chronic malnutrition.¹⁵ Although significantly improved in recent years, the fertility rate in Rwanda remains high at 4.6 children per woman.¹⁶ The entire population is at risk for malaria, which is the fourth leading cause of mortality.¹⁷ Rwanda also faces a complex HIV/AIDS epidemic, with a relatively low prevalence of 3 percent among the general population but as high as 46 percent among the most at-risk populations, and women and girls are disproportionately affected, representing nearly 60 percent of adults living with HIV.¹⁸

Key Issues for Sustainability

- ❖ HSSP III underfunded: Gap of \$372-\$697 Million
- ❖ Donor funding makes up over 60% of annual THE
- ❖ Declining donor trend (USG, GF)
- ❖ Declining Net overseas direct investment (ODA) per capita: \$113 (2011) to \$77 (2012) --> 32% drop
- ❖ HSSP III goal: To increase PS investment from 1.7% to 5% --> an estimated \$260 million/year -> covering almost 50% of annual health expenditure

Based on several financing scenarios, HSSP III is underfunded and this could be exacerbated if external financing declines significantly. The total cost of HSSP III is \$3.7 billion over six years, for an average of approximately \$600 million per year.¹⁹ A recent joint USAID-GOR gap analysis showed between a USD \$372 - \$697 million funding gap under pessimistic and mid-level scenarios. While an optimistic scenario showed virtually no gap, after nearly two years of implementation, this scenario appears unlikely. Donor funding to the health sector makes up approximately 61 percent of

the health resource envelope and the largest health sector donors, the United States Government (USG) and Global Fund, are experiencing a declining trend.²⁰ The GOR may need to assume a greater share of health sector recurrent costs through domestic financing as these funding streams decline. In this regard, the GOR sees the private sector as an important partner in mobilizing resources to meet HSSP III goals.

Rwandan private sector investment in health is currently 1.7 percent (HSSP III), while an international benchmark is 5 percent.²¹ If Rwanda could achieve 5 percent private sector investment in health, it would mobilize approximately \$260 million annually, or about 50 percent of yearly health expenditures, which would fill the funding gap foreseen under the HSSP III mid-level scenario. Therefore, the MOH has set a goal to increase private investment in the health sector from 1.7 percent of private GDP to 5 percent. In an effort to address these issues, the GOR, its Development Partners (DPs) and key stakeholders, recognize the urgent need to have increased, strong and sustainable private sector engagement (PSE) for accessible, equitable, efficient, and improved health services that would significantly contribute toward the desired health outcomes.

The MOH has developed a Health Financing Strategic Plan (HFSP) to increase domestic resources for health, which includes private sector investment. The HSSP III and the HFSP identify several potential areas of focus to increase resources for health. These include: creating an enabling environment for private sector investment in health, including medical tourism; promoting corporate social responsibility among local and international companies; engaging the private sector in construction of new health

¹⁴ HSSP III

¹⁵ WDI database

¹⁶ WDI database

¹⁷ HSSP III

¹⁸ Gender Assessment of Rwanda's National HIV Response (UNAIDS)

¹⁹ HSSP III

²⁰ Rwanda Health Resource Tracker

²¹ HSSP III

facilities and the creation of health posts; improving hospital financial performance and the management of existing programs; increased capacity of community health workers cooperatives in financial management; and mobilizing greater district contributions in-cash and in-kind.

In an effort to support the GOR in assessing the landscape and identify both potential opportunities and key obstacles towards increased and sustained PSE in health, USAID/Rwanda (USAID/R) commissioned a team of consultants who worked closely with GOR counterparts to carry out this *Rwanda Health Private Sector Engagement (PSE) Assessment* between January and March 2015, with a field work period of January 26 to February 21, 2015.

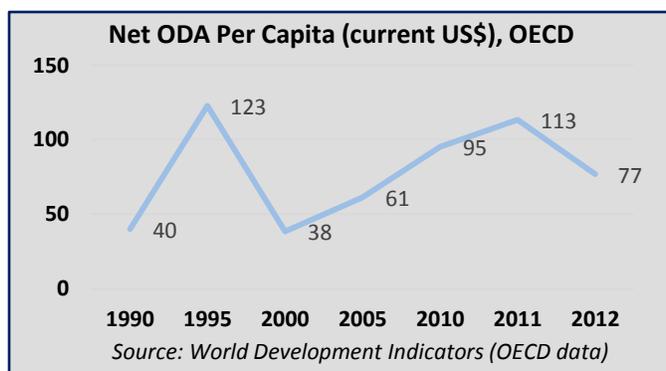
3. COUNTRY CONTEXT

3.1 MACROECONOMIC SITUATION

Rwanda’s economic growth was rapid in the years following the genocide, largely due to determined economic policy and relatively high aid flows. In recent years, Rwanda’s economy has expanded at an average rate of almost 8 percent between 2010 and 2012.²² Production of agricultural and mineral commodities, tourism, and construction are the principal drivers of Rwanda’s economy. Additionally, the GOR maintains a significant focus on improving Rwanda’s energy, telecommunication, and transportation infrastructure. However, real GDP growth slowed to 4.7 percent in 2013 from 8.8 percent in 2012 due to the lower than projected performance in agriculture and the aid-related delays in the implementation of strategic public investments following the suspension of budget support disbursements in 2012. Growth is projected to recover to 7 percent and 7.4 percent in 2014 and 2015 respectively.

| Indicator | 1990 | 1995 | 2000 | 2005 | 2010 | 2011 | 2012 | 2013 |
|--|------|------|------|-------|-------|-------|--------|-------|
| Population, total (millions) | 7.2 | 5.7 | 8.4 | 9.4 | 10.8 | 11.1 | 11.5 | 11.8 |
| GDP growth (annual %) | -2.4 | 35.2 | 8.3 | 6.9 | 7.3 | 7.9 | 8.8 | 4.7 |
| GDP per capita (current US\$) | 353 | 228 | 207 | 274 | 526 | 575 | 630 | 639 |
| Tax revenue (% of GDP) | 8.5 | .. | .. | .. | 12.4 | 13.1 | 13.7 | 13.4 |
| Net ODA received per capita (current US\$) | 40 | 123 | 38 | 61 | 95 | 113 | 77 | .. |
| Current account balance (% of GDP) | .. | .. | .. | -2.53 | -7.26 | -7.45 | -11.37 | -7.47 |

Source: World Development Indicators Database, the World Bank Group



Many reforms have been undertaken in various sectors of the economy, enhancing the efficiency of the business environment. However, Rwanda continues to face significant institutional challenges in furthering its transition to a modern, market-based system. Despite the tremendous effort that Rwanda has made to achieve high levels of economic growth in recent years, the projected higher growth rate assumed for the HSSP III in 2013 and 2014 will not be met, and the pessimistic

scenarios will become more realistic considering that the revised projection is 7.4 percent. Adding to that is a relatively small tax base where average tax revenue was only about 13 percent of the GDP between

²² WDI database

2010 and 2013.²³ Another important factor with serious consequences is the reduction of foreign aid (please see table and chart), and the GOR’s macroeconomic response based on drawing on foreign reserves and increasing domestic borrowing. Between 2011 and 2012, the net overseas direct assistance (ODA) received per capita (current US\$) dropped from \$113 to \$77, or 32 percent in just one year.²⁴ The government also reprioritized spending and maintained a conservative monetary policy aimed at controlling inflationary pressures. But the GOR will not be able to draw on foreign reserves and increase domestic borrowing indefinitely as this is not sustainable in the long run.

If available resources and potential new resources are insufficient to cover HSSP III estimated costs, the funding gaps will be unsustainable; and therefore the projected goals will need to be adjusted accordingly. As such, there is an urgent and critical need for the GOR to prioritize interventions, mobilize new resources focusing on the PS, and to gain efficiency in the health sector.

3.2 OVERALL INVESTMENT CLIMATE AND KEY INVESTMENT INCENTIVES

Rwanda enjoys relatively strong economic growth, high rankings in the World Bank's Ease of Doing Business Index, and a reputation for low corruption (the top ranked country in East Africa in Transparency International's 2013 Corruption Perception Index). The GOR has undertaken a series of pro-investment policy reforms intended to improve

| Indicator | Year | Rank |
|---|------|------------|
| World Bank's Doing Business Report "Ease of Doing Business" | 2014 | 46 of 189 |
| TI Corruption Perceptions index | 2013 | 49 of 175 |
| Heritage Foundation's Economic Freedom index | 2013 | 65 of 177 |
| Global Innovation Index | 2013 | 112 of 142 |

Rwanda's investment climate and increase other FDI. The World Bank, Transparency International, the Heritage Foundation, and the Millennium Challenge Corporation have all reported improved business climate indicators over the last five years. However, FDI in Rwanda lags well behind some of its neighbors in the East African Community (EAC) – about 1.5 percent of GDP in 2013, worth only \$110 million. Potential and current investors cite a number of hurdles and constraints, including high transport and energy costs, a small domestic market, limited access to affordable financing, inadequate infrastructure, and a lack of skills in the workforce.

| Indicator | 1990 | 1995 | 2000 | 2005 | 2010 | 2011 | 2012 | 2013 |
|--|------|------|------|-------|------|-------|-------|-------|
| FDI (Balance of Payments, current millions of \$) | 7.6 | 2.2 | 8.3 | 8.0 | 42.3 | 106.2 | 159.8 | 110.8 |
| FDI, net inflows (% of GDP) | 0.3 | 0.2 | 0.5 | 0.3 | 0.7 | 1.7 | 2.2 | 1.5 |
| Commercial bank branches (per 100,000 adults) | .. | .. | .. | 1 | 5 | 5 | 8 | .. |
| Borrowers from commercial banks (per 1,000 adults) | .. | .. | .. | 0.9 | 5.9 | 8.8 | 10.0 | .. |
| Cost of business start-up procedures (% of GNI per capita) | .. | .. | .. | 200.1 | 8.8 | 4.7 | 21.6 | 22.0 |
| Time required to start a business (days) | .. | .. | .. | 18.0 | 7.0 | 7.0 | 8.0 | 7.0 |
| Total tax rate (% of commercial profits) | .. | .. | .. | 41.8 | 35.2 | 35.2 | 35.0 | 33.5 |

Source: World Development Indicators, the World Bank Group

There is no difficulty obtaining foreign exchange in Rwanda or transferring funds associated with an investment into a usable currency and at a legal market-clearing rate. Rwandan law provides permanent residence and access to land to investors who deposit \$500,000 in a commercial bank in the country for

²³ WDI database

²⁴ WDI database (OECD data)

a minimum of six months. There are neither statutory limits on foreign ownership or control, nor any official economic or industrial strategy that discriminates against foreign investors. Rwanda has also established a free trade zone outside the capital, Kigali. Bonded warehouse facilities are now available both in and outside of Kigali for use by businesses importing duty-free goods.

In 2006, the GOR established the Rwanda Development Board (RDB), which serves today as the country’s chief investment promotion agency. RDB offers one of the fastest business registration processes in Africa: new investors can register online at RDB’s website and receive approval to operate in less than 24 hours, and the agency’s “one-stop shop” helps foreign investors secure required approvals, certificates, and work permits.

Historically, the government has encouraged foreign investment through outreach and tax incentives. The only difference in treatment between foreign and domestic companies is the initial capital requirement for official registration, which the GOR sets at \$250,000 for foreign investors, and \$100,000 for domestic investors. Foreign investors can acquire real estate, though there is a general limit on land ownership, and both foreign and local investors can acquire land through leasehold agreements that extend to a maximum of 99 years.

The current investment code provides a variety of general incentives to investors. These same incentives also apply to investors in the health sector. The law on investment and export promotion and facilitation regulates all investments in Rwanda, including in the health sector. The Rwanda legislation (investment and tax policies) provides for:

- Fiscal and nonfiscal inducements to support and encourage investment in any business sector
- Incentives related to investment, employment, and export promotion and facilitation
- Incentives related to taxation of business profits

The current investment law has been revised and a new set of investment codes for all sectors (including health) have been adopted by Parliament and is in the process of being promulgated by the President. A major health related-incentive under the new codes is a seven-year tax holiday given to any investor with a project of at least \$50 million in the health sector – out of reach for many potential investors in this sector. Please see *Annex B* for a set of key general parameters and specific tax and investment incentives.

3.3 THE GOR HEALTH GOALS, STRUCTURE, AND ORGANIZATION

The MOH provides political and technical leadership of the health sector under the framework of the Health Sector Policy (HSP) 2005 that is currently implemented under the HSSP III. The HSSP III provides the focus of all activities in the health sector, led by the GOR and supported by an array of stakeholders including the DPs. The MOH is responsible for coordinating its related institutions, line ministries, the private sector, NGOs, and development partners to improve the country’s health care provision and outcomes. It sets key health policy objectives, identifies the priority health interventions for meeting these objectives, outlines the role of each level in the health

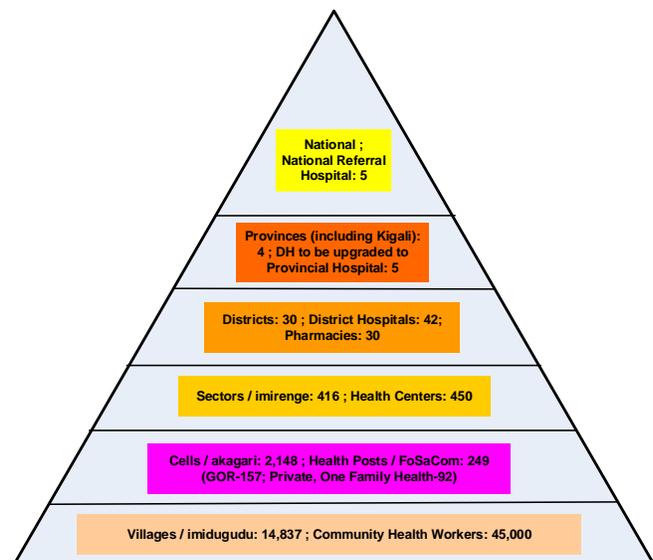


Figure: Rwanda Public Health Care Delivery: Administrative Levels and Facilities

system, and provides guidelines for improved planning and evaluation of activities in the sector. The HSSP III elaborates the strategic directions, activities, and key indicators to achieve sector policy objectives. The overall objective for HSSP III is to **“Ensure universal accessibility (in geographical and financial terms) of quality health services for all Rwandans.”**

Although the MOH has overall stewardship on health issues, 15 other government ministries implement activities that either directly or indirectly impact the health of the Rwandan people. Services are provided at different levels of the health care system (community health, health posts [HPs], health centers [HCs], district hospitals [DHs], and referral hospitals) and by different types of providers (public, FBOs, private-for-profit, and NGO). At all levels, the sector is composed of administrative structures (boards/committees) and implementing agencies. Please see *Annex C* for details on Rwanda’s decentralized health system.

3.4 THE PRIVATE HEALTH SECTOR

It is conventional to define “private” as any entity that falls outside the direct control of the government. In many countries in sub-Saharan Africa, the private health sector is playing an increasing role in serving the needs of the population and offering essential health services. The private health sector is a subset of a country’s health system. It is characterized by nonpublic ownership, including for-profit commercial companies; not-for-profit and faith-based institutions, such as mission hospitals; and social enterprises.

The three major categories are briefly defined below:

- ❖ The commercial for-profit sector is characterized by privately owned companies that have a primary goal of generating a return on investment.
- ❖ Not-for-profit providers, such as NGOs, FBOs, and community-based organizations, rely mainly on donations, grants, and government funding.
- ❖ Social enterprises use a mix of market-rate and below-market financing, including donor funding, with a minimum expectation of financial return.

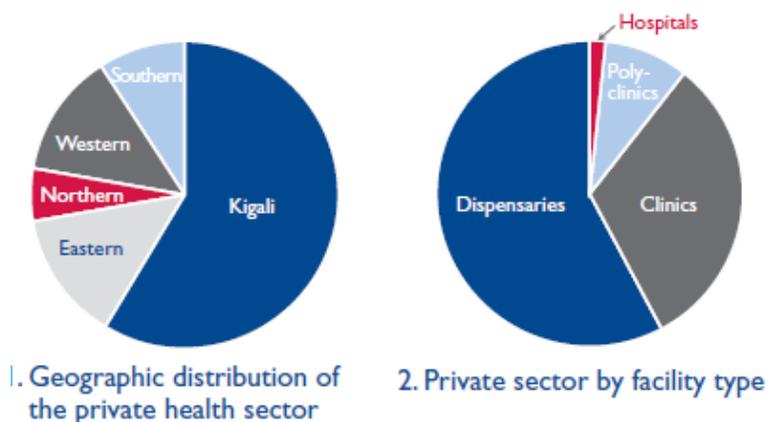
While the assessment reviewed the broad spectrum of the private health sector in Rwanda, the focus was on the commercial sector, which holds the greatest promise of sustainability. The for-profit sector includes medical health professionals who have private clinics; private facilities, such as hospitals, pharmacies, laboratories, diagnostics centers, medical equipment suppliers, insurance companies, private medical training institutions, and medical equipment and product manufacturers.

In many African countries (e.g. Uganda, Mali, Ghana), private health providers account for up to 50 percent or more of health services. In most countries, government resources alone are insufficient to meet the health needs of the population. While the commercial sector is often viewed as primarily serving higher-income segments of society, particularly at the tertiary level, in many countries the private sector serves all income quintiles, including the poor. The private sector (in the form of pharmacies and drug stores) is often the first point of entry for lower-income groups into the health care system. The private sector is typically characterized by varying degrees of quality and regulation. In many countries in sub-Saharan Africa, the public sector has traditionally been the main provider of health services and has been slow to expand its role as a regulator, lacking the capacity to supervise, accredit, dialogue with, and engage the private sector. In addition, in many places the notion still exists that the private sector cannot be trusted as its goal is solely to make profits. The process of creating sustainable public-private partnerships (PPPs) also demands skills that many governments in developing countries may currently lack.

3.5 RWANDAN PRIVATE HEALTH SECTOR AND ITS CURRENT ENGAGEMENTS

The private health sector in Rwanda is relatively small, young, unorganized, fragmented, and based primarily in Kigali. It is comprised of private hospitals, polyclinics, clinics, dispensaries, and a small number of health posts, faith-based hospitals and health centers, pharmacies, pharmaceutical wholesalers, private insurance companies, private professionals associations, private medical training institutions, and NGOs specialized in health. PPPs are limited in scale but evident at most levels. The private health sector in Rwanda is briefly described below with examples of select PPPs. Please refer to the Service Delivery section for additional details.

There are a total of 177 private-for-profit health facilities in Rwanda: three private hospitals, 16 polyclinics, 56 clinics, and 102 dispensaries. Of these, around 60 percent are in Kigali city, where people have a higher purchasing power. The remaining 40 percent is primarily located in the big centers of the provinces, and rural areas remain mostly unserved by the private sector.²⁵ All three of the private hospitals in the country (King Faisal Hospital, *La Croix du Sud* hospital, and Dr. Agarwal's Eye hospital) are in Kigali.



There are several important examples of PPPs in the for-profit service delivery subsector, including the One Family Health social franchise model, which is creating private health posts operated by A2 nurses. Currently, there are 92 health posts throughout the country. Another example is the King Faisal Hospital, a referral hospital, which is in the process of being privatized through a joint venture. Most of the private facilities also have contracts with public insurance, particularly RSSB and Military Medical Insurance (MMI) and with community-based health insurance (CBHI) to a much lesser extent, to serve their members for selected services either under the GOR tariff rate or specially negotiated rates (e.g. Agarwal's Eye Hospital). In addition, select private facilities also participate in PPPs to promote public health, including services for TB, HIV/AIDS, malaria, the Extended Program of Immunization, and blood transfusions. In the many of these programs, participating private providers receive training and access to free or low-cost commodities.

Examples of PSEs and health PPPs in Rwanda:

- ❖ MOH and One Family Health - 92 health posts
- ❖ MOH TB, malaria, HIV and AIDS, EPI programs and private providers
- ❖ MOH and FBOs hospitals and health centers
- ❖ GOR's MPPD and private pharmacies for drug supplies
- ❖ Public insurances and selected private providers

The faith-based health facilities are comprised of both hospitals and HCs. Out of the 42 district hospitals in Rwanda, about 15 (35 percent) are owned and operated by FBOs. These faith-based hospitals are mostly located in rural/remote areas and serve the poor population, a stark contrast to the for-profit providers. When it comes to HCs, FBOs represent about 40 percent of the total 450 around the country. Faith-based service providers are largely subsidized by the GOR due to their

²⁵ Data provided by Rwanda Healthcare Federation

geographic and population coverage and represent a very positive example of some of the first PPPs in the health sector. FBO facilities follow MOH policies and guidelines (including tariff) and in return, the GOR gives them most of the same support as the public facilities.

The private pharmaceutical sector in Rwanda is relatively strong and promising. Legally, anyone is allowed to own a pharmacy or pharmaceutical wholesaler on the condition they hire a pharmacist to manage it. There are 217 pharmacies and pharmaceutical wholesalers in the country. However, 165, or 76 percent, of those are in Kigali.²⁶ Wholesalers make up one-fifth of the total, although most of them are also involved in importation, distribution, and retail sales. Many of the private pharmacies are under contract (through GOR tenders) with the MPPD of RBC and supply select drugs and commodities to the public sector during stock-outs.

The private health insurance industry in Rwanda is relatively new and still developing. There are five insurance companies that offer health coverage, including SORAS, CORAR, Radiant Insurance Company, UAP (formerly known as *Union des Assurances De Paris*), and Britam. Private insurance covers approximately 10 percent of the population. There are no examples of PPPs with private insurance companies, although they do pay one percent to the CBHI but receive no benefits in return.

There is also a large percentage of the population that continues to use traditional healers. The GOR has created a legal framework which guides how traditional medical services operate alongside health services at the district level. Collaboration with the Butare Institute for Scientific and Technological Research ensures the rational development of traditional health care in the country. A census of all traditional healers is now being conducted to record their number, specialties, and locations.

3.6 HEALTH FINANCING AND EXPENDITURES

Over the last few years, Rwanda has developed a comprehensive financing framework for health building on global best practices. This framework has built two main channels for financing: one from the supply side, transfers from the treasury to districts and health facilities; and one from the demand side, the insurance system. These two channels were designed as part of a remarkable post-genocide effort at institution-building, including:

- i. The implementation of fiscal decentralization with increased transfers from the central government to local governments and peripheral health facilities on the basis of needs and performance;
- ii. The construction of a health insurance system including three levels of risk pooling and cross-subsidies from richer to poorer groups.

The main objectives of the Rwanda Health Financing Policy were to:

- Strengthen risk-pooling for improved financial access and household income protection of Rwandan families;
- Improve efficiency in the allocation and use of health resources and coverage of high-impact interventions;
- Increase internal resource mobilization for sustainable funding of the health sector;
- Improve the effectiveness of external assistance in the health sector;
- Strengthen the institutional environment for sustainable financing of the health sector.

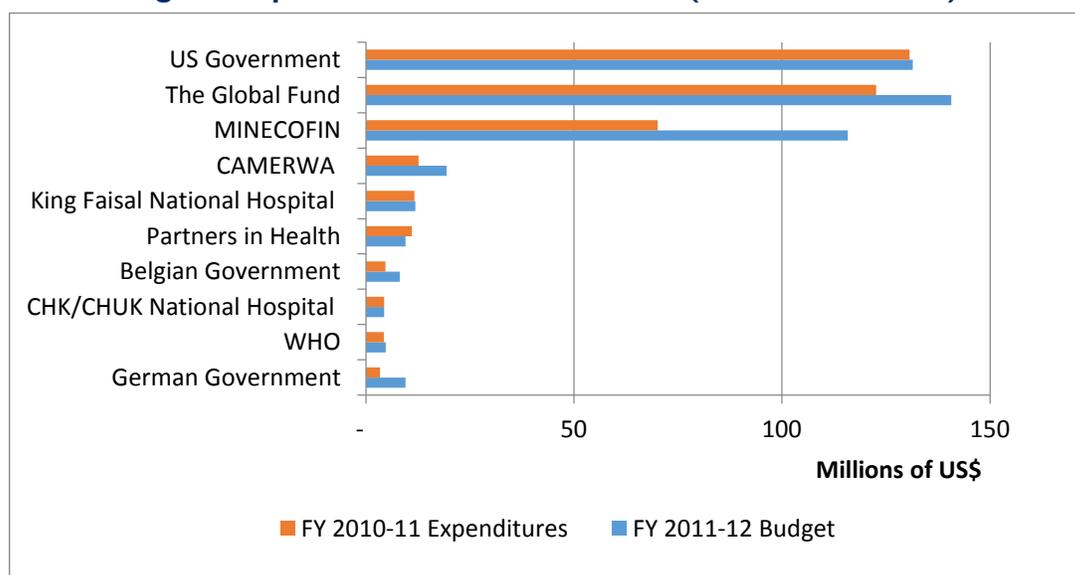
The largest share of THE comes from donor spending. Of Rwanda's annual health budget, the donor share is estimated to be approximately 61 percent. External funding initially steadily increased with funds from global health initiatives such as the President's Emergency Plan for AIDS Relief (PEPFAR), the

²⁶ Ibid

Global Fund (GF), and the President’s Malaria Initiative (PMI). However, the trend is now on a downward swing. In 2013-14, there was a 32 percent decrease in development partner health funding.²⁷ Government spending on health increased absolutely, though its relative share has declined. Rwanda’s health sector has four main funding sources:

1. Government revenues, including revenues generated from loans, grants, taxation, donations, and DP contributions;
2. Health insurance pooled funds (CBHI or *Mutuelle de Santé*) from household expenditures - currently subsidized by the GOR;
3. Private and internationally generated funds from health facilities;
4. Other donor funds.

Figure: Top Funders of Health Activities (Source: HRT 2012)



Under the Maputo agreement, countries agreed to a health allocation of 15 percent of the total government budget. Rwanda was on track with an upward trend in health financing. In 2005, the budget allocation for health was 8.2 percent of the total budget, and by 2010 it had reached 11.5 percent. However, the 2013 budget saw health drop to 9.5 percent of the total budget.²⁸ This decrease was a result of the GOR refocusing resources towards growth and job creation.

Health insurance coverage has been expanded for people employed in the formal sector, as well as informal and rural sectors of the Rwandan economy, since 2000. A medical insurance plan, *Rwandaise d'Assurance Maladie* (RAMA), was established in 2001 for public servants and their dependents, while the military and their dependents are covered through MMI, which is managed within the Ministry of Defense. Under RAMA, employees pay 7.5 percent of their individual gross salary and the employer pays another 7.5 percent. This entitles the employees and their families to an extensive benefits package, which includes tertiary care.

Risk pooling has been greatly improved as a result of the extension of the CBHI scheme, established by Law No. 62/2007 of December 30, 2007. This law allows the majority of the population access to health care services and medicine. Currently, CBHI covers about 72 percent of the population, down from 92 percent just a couple of years ago. *Mutuelles* are primarily financed by households (70 percent), donors

²⁷ World Development Indicators (OECD data)

²⁸ World Development Indicators database

(13 percent), the government (9 percent), and private firms (8 percent), according to 2006 National Health Accounts estimates. Social and private health insurance now covers approximately 93 percent of the population.²⁹

3.7 USAID PSE POLICIES, GOALS AND TOOLS

USAID has a long history partnering with the private sector. USAID believes that collaborating with the private sector can be an effective way to achieve various social and economic development goals, and it seeks to do so across the globe. By fostering well-functioning markets, increasing trade, improving health and education, and enhancing governance and infrastructure, development initiatives create environments for long-term economic growth and social progress. USAID believes that development initiatives also benefit businesses by mitigating risks, creating access to new markets, training workforces, and building relationships with key stakeholders. These initiatives can address sociocultural, economic, and environmental challenges and opportunities to enhance current and future operations.

What USAID Brings to Partnerships

- ❖ Technical development expertise
- ❖ Strong national and local government relationships
- ❖ Long-term country presence
- ❖ Credibility and goodwill
- ❖ Network of local, regional, and global partners
- ❖ Convening power
- ❖ Financial Resources

What Companies Bring to Partnerships

- ❖ Skills, services, and products
- ❖ Access to global supply chains and markets
- ❖ Market-driven approach to initiatives
- ❖ Technology and intellectual property
- ❖ Relationships with local business actors
- ❖ Communication and marketing acumen
- ❖ Financial resources

USAID's first work with the private health sector began more than 20 years ago with centrally funded programs focused on social marketing of health products. Over time, USAID's work with the private health sector has expanded beyond product distribution and social marketing to service delivery and, more recently, private medical education. Today USAID works on a range of issues that impact the private health sector, including policy, regulation and accreditation, access to finance, business training and strengthening, social franchising, health financing, human resources for health, mobile health, and public private partnerships. In order to help support the many health challenges of people in the developing world, USAID uses a number of initiatives, including its flagship private health sector project, Strengthening Health Outcomes through the Private Sector (SHOPS), as well as an array of bilateral projects around the world, including in sub-Saharan Africa (e.g. Uganda Private Health Support Program, Mozambique Night Clinic Initiative, Ghana's Saving Private Maternity Homes project, etc.). Internally, USAID has a wealth of tools to support work with the private health sector, including courses on the Global Health E-Learning Center, such as [Commercial Private Health Sector Basics](#) and [Healthy Businesses](#).

More broadly than health, USAID/Washington (USAID/W) is pursuing a strategy with a strong emphasis on PSE and PPPs. USAID actively engages the private sector and helps companies to find the intersection between critical development issues and their bottom line. The USG has several tools at its disposal to create partnerships that fit in with Rwanda MOH's HSSP III priorities. These include USAID's public-private-partnership hub, the Global Development Alliance (GDA) division. The GDA model seeks to reward partners that share their resources while spreading the risks and responsibilities across the

²⁹ Based on interviews with multiple health financing stakeholders including MOH's Financing Unit

partnerships. Parties to this alliance help to define and address the development issue at hand. The goal is to find a way for the private sector to leverage its ideas, its resources, and its capacity to create developmental impacts. A GDA meets the following key criteria:

- At least 1:1 leverage (in cash and in-kind) of USAID resources;
- Common goal defined for all partners;
- Jointly defined solution to a social or economic development problem;
- Nontraditional resource partners (companies, foundations, etc.);
- Shared resources, risks, and results, with a preference for additionality of impact;
- Innovative, sustainable approaches to development.

USAID regularly issues Annual Program Statements (APS), which is a type of funding mechanism, to encourage local, national, and multinational corporations of any size, both US- and foreign-owned, to propose innovative PPPs that achieve their core business goals, while also enabling USAID to accelerate and exponentially increase the impact of its foreign assistance investments. USAID/R recently issued a call for GDAs through an APS. While this APS does not cover health, with the exception of nutrition, the mission Health Office (HO) is considering amending it to expand its scope.

USAID also has tools at its disposal that aim to address the risk to private sector players. These include USAID's Development Credit Authority (DCA), which provides a 50-percent guarantee to a local bank to encourage it to lend to new or risky sectors. Catalytic first loss capital is also a tool to help to address risk and spur financing. To date, the DCA has leveraged up to \$3.1 billion in private financing available for more than 139,000 entrepreneurs around the world. Under USAID's Banking on Health project, combination of DCAs and/or technical assistance to financial institutions and health care borrowers, stimulated almost \$206 million for the private health sector. Challenge Funds, such as the Development Innovations Fund; the Health Enterprise Fund, which is co-funded through HANSHEP; and the Saving Lives at Birth Challenge Fund are also an important tool for engaging the private sector. Challenge funds provide seed capital to spur innovation and replication (See Investment and Access to Finance section for more details). Another important tool is social impact bonds, which can help raise financing for development.

USAID/R is fully embracing a strategy to increase PSE and PPPs across different sectors, including health.

3.8 USAID/R'S RESPONSE TO RWANDA'S DEVELOPMENT CHALLENGES

Rwanda's extraordinary recovery after the 1994 genocide represents one of Africa's most dramatic and encouraging success stories; yet Rwanda remains among the world's poorest, least-developed, and most overpopulated countries. The GOR has made a decisive commitment to confront its daunting development challenges head-on, and to undertake a fundamental, broad-based economic and social transformation intended to produce sustainable and equitable national development.

Rwanda represents an extraordinary opportunity for the USG to put its foreign policy priorities into practice by supporting a clear, reasoned, and wholly country-owned development vision, in cooperation with a committed and disciplined partner-country government. USAID/R seeks to build on Rwanda's successes in four areas: health, economic growth, education, and democracy and governance. Rwanda also offers an opportunity to work cooperatively with the GOR, civil society, and private sector to increase the accountability and effectiveness of governance. This is vital to Rwanda's ability to maintain its current general consensus on national development direction and vision while sustaining the dramatic recovery it has achieved since 1994.

Since 2003, USAID/R has worked with the GOR to advance the objectives outlined in its Vision 2020 and EDPRS. Annual funding to USAID/R has increased from about \$48 million in 2004 to over \$150

million in 2012. The bulk of the increase was due to the launch of several new US presidential initiatives, including PEPFAR, PMI, and the Feed the Future (FtF) food security initiative. USAID/R continues to support each of the presidential initiatives, as well as the Global Climate Change initiative in its programming. Health budget levels globally have consistently trended downward since 2010, a signal requiring careful prioritization of program activities and increased PSE.

Rwanda no longer receives food assistance, as it was phased out in 2010 and replaced by the FtF initiative. The Mission's education activities focus on improving basic education and promoting youth development through provision of teacher training, creation of new tools and resources to strengthen basic literacy and numeracy skills, and providing work-readiness and entrepreneurship training opportunities for youth. In the area of democracy and governance, USAID/R supports activities which promote reconciliation, peace-building, and civic engagement among diverse segments of the population around issues such as land tenure and human rights.

Health programs constitute about two-thirds of USAID/R's assistance and span a wide variety of issues, including: health systems strengthening, HIV/AIDS and malaria prevention, and family planning and maternal and child health. The USG support also extends to other health system strengthening pillars. For example, the USG underwrites salaries and equipment (e.g., mobile phones, personal digital assistants) for health care workers at the national, facility, and community levels. The GOR vision is to emphasize long-term training for missing specialties in Rwanda.

With regard to health commodities, the USG invests in ensuring the availability of pharmaceuticals, equipment, and supplies for health service delivery. This includes capacity-building of the national medical store to forecast, procure, store, and distribute health commodities; as well as assistance to the coordinated procurement and distribution system for all health commodities; technical assistance for the Pharmacy Department in MOH, and plans to support the establishment of the planned National Medicines Authority and the national pharmacovigilance system; support for an expanded cold chain in support of the introduction of new vaccines; and technical assistance to develop and implement PBF incentives within the supply chain system.

Improving the quality of services provided is another key area of both the GOR and the USG systems support. The USG is providing technical and financial assistance to the MOH to develop a national accreditation system for tertiary and secondary health facilities, as well as the laboratory network. Quality improvement modules are also being incorporated into preservice curricula at institutions receiving USG assistance and a central level cadre of quality improvement supervisors is being developed with technical support from USG partners.

The USG also supports the MOH through private telecommunication companies to implement a mobile phone information support program for CHWs. In addition, the GOR has leveraged private sector resources supporting Rwanda's Health Enterprise Architecture and is benefitting from the USG global Health Informatics Public-Private Partnership, which is co-sponsored by Rockefeller Foundation, Bill & Melinda Gates Foundation, and the International Development Research Centre. Support for PPPs continues to be important under USAID/R's cooperation strategy. Thus, the USG offers TA for M&E, as well as the expansion of the CHW mobile phone program, and the engagement of private pharmacies in providing essential drugs and supplies.

3.9 DONORS AND DEVELOPMENT PARTNERS: COLLABORATION AND SUPPORT FOR PSE

Major support for the Rwandan health sector comes from various donors and DPs. The section below briefly summarizes donor collaboration and identifies DPs (other than USAID) that are currently supporting PSE in the health sector and potential areas of collaboration for future PSE programming.

3.9.1 Donor Environment and Collaboration

DP coordination in Rwanda's health sector is well-organized and inclusive of all partners (bilateral and multilateral donors, international and local NGOs, and the private sector). The MOH plays a strong role in coordinating donor assistance through the Health Sector Working Group (and subgroups) and a Joint Health Sector Review that is conducted twice yearly. As the MOH prioritizes PSE and PPP development it will be very important to coordinate donor support through a technical working group, such as the health financing technical working group, and through DP participation in the proposed Private Health Sector Coordinating Committee, which is discussed in the Leadership and Advocacy section.

3.9.2 Other Donor Support for PSE in Health

The assessment determined that there are a number of DPs that are currently supporting PSE in health in a limited way; there is significant interest in collaborating to support more work in this area; and capacity is currently low.

Belgium Development Agency (BTC): Provides health sector budget support along with contributions to the Capacity Development Pooled Fund, institutional strengthening support to the MOH at the central and district levels. It also collaborates with USAID and the Global Fund on health financing programs. BTC has supported the MOH in some PSE and PPPs aspects, including helping to create a conducive environment for PPPs through supporting the development of the draft PPP policy and supporting the setting up of an annual forum for dialogue with the private health sector to align priorities and activities. BTC will be launching Phase V of its programming in July 2015, which will include a much greater emphasis on PPPs and PSE. The focus areas in this new program include:

- Medical equipment maintenance and asset management, including a partnership with a local university to address the skills gap in this area;
- Development of waste management policies;
- Urban health planning;
- Leadership and governance;
- Support of accreditation activities for public institutions and health professionals.

Under this new program there will be extensive opportunities for USAID and BTC to collaborate with the GOR on PSE and PPPs and coordination will be important.

UNICEF: Provides technical support for preventing mother-to-child transmission of HIV (PMTCT), pediatric treatment, distribution of bed nets, Integrated Management of Childhood Illnesses (IMCI), EPI, and basic emergency obstetric and newborn care (training only) in seven regions. The agency mainly works with the MOH, districts, and civil society organizations/NGOs. UNICEF engages the private sector on several fronts:

- It supports the Rapid SMS platform as a partner with local private sector telecom companies, especially covering SMS and SIM card costs for CHWs. On HIV, it coordinates with UNAIDS to prevent new infections (PMTCT), particularly targeted at adolescents and young children. The agency actively involves PSE, especially in mainstreaming HIV programs by:
 - Fostering the development of HIV workplace programs in all private entities;
 - Planning and service delivery programs in partnership with ILO;
 - Capacity-building programs.

UNICEF is also supporting the RBC to assist private health clinics in setting up accredited HIV-prevention programs (e.g. establish standards, set up reporting structures).

UNAIDS: Primarily works on HIV/AIDS prevention. It is keen to engage the private sector, especially regarding the HIV response and prevention. It supports private entities in improving health outcomes in the workplace regarding HIV/AIDS. With an HIV prevalence of 3 percent in the country – 59 percent of whom are sex workers – one initiative targets private entities that act as “hotspots for sex workers.”

World Bank: Supports community PBF through piloting four community PBF models in collaboration with the National University of Rwanda School of Public Health and scale-up of successful PBF models. USG coordinates closely with the World Bank on the PBF program and the East African regional laboratory capacity-strengthening initiative. It would be useful for the World Bank to be engaged in discussions regarding PBF, particularly in regards to health posts and CHW cooperatives.

Partners in Health (PIH) and CHAI: Provide primary health care services, community health services, and comprehensive HIV services in three districts and collaborate closely with other partners to support HSS in Rwanda. In the past year, CHAI has partnered with several US universities to introduce an HRH program that will improve health care service provision. PIH is currently working with the Ministry of Defense to construct and equip new health posts and could be an important partner in the roll-out of the proposed private health post model, which is described in the Service Delivery section.

World Health Organization (WHO): Provides guidance for disease surveillance and issues guidelines on disease prevention, treatment, and control. WHO receives USAID MCH funds for surveillance of acute flaccid paralysis (polio) and provides technical assistance to the USAID-funded regional Center of Excellence on Programmatic Management of TB. WHO also collaborates with USAID on introduction of new vaccines for children under five years of age in Rwanda. During the discussion with the team, WHO expressed strong interest in partnering with USAID and the GOR to support PSE in the future.

UNFPA: Provides support for reproductive health services and for family planning (FP). UNFPA procures commodities for FP and supports program implementation in a few facilities in Rwanda. It also provides training and tools to support CHW activities. Currently the agency works with local telecom companies to support the Rapid SMS platform. UNFPA sees more opportunities to use mobile platforms to educate and raise awareness on FP and reproductive and maternal health programs and could be a potential collaborating partner in the future to support increased PSE in this area.

4. ASSESSMENT APPROACH

4.1 ASSESSMENT GOAL, PURPOSE, AND OBJECTIVES

4.1.1 Overall Goal

This assessment aims to formulate concepts and recommendations in the identified key strategic areas of the conceptual framework for increased private sector engagement in the Rwandan health sector to help sustain and build on current achievements, especially at the primary and secondary care levels (from community to district level).

4.1.2 Purpose and Objectives

The objectives of this assignment are to:

- Conduct a landscape analysis of the private sector space and actors as it relates to the sustenance and further development of the health sector;
- Identify key opportunities, what works, gaps, challenges, and barriers in the strategic areas that exist for PSE in the Rwandan health sector (especially at the primary and secondary levels);
- Recommend which strategic areas/subsectors show the most promise for public-private collaboration to achieve complementary public-private objectives;

Detailed and careful analysis of the results of this review will ultimately feed into the development of evidence-based, action-oriented, and results-focused recommendations to increase private sector engagement in the health care sector, effectively supporting the realization of:

1. Health objectives stated under the second pillar of the Rwanda Vision 2020, Human Resource Development and a Knowledge Based Economy;
2. Comprehensive privatization objectives stated under the third pillar of the Rwanda Vision 2020, Private Sector-led Development;
3. USAID Country Development Cooperation Strategy Development Objective 3, improved health and well-being is sustained.

4.2 TEAM, METHODOLOGY AND PROCESSES

4.2.1 The Team

ASH enlisted a team of consultants to implement this assessment. The team worked under the overall guidance of USAID/R, GOR, and ASH, and consisted of six members, including five consultants: Tariqul Khan (Team Leader), Meaghan Smith, Nicole Mudenge, Modeste Kabaka, Musabi Muteshi, and Kelly Wolfe, who represented USAID/W's Global Health Bureau. The team (except Ms. Wolfe) worked in Kigali from January 26 to February 21, 2015. It is to be noted that the GOR point of contacts (POCs), Dennis NKUNDA (MOH) and Mr. Edouard NIYONSHUT (RBC) were also instrumental members of the team. They actively participated in and masterfully facilitated the process throughout the whole in-country part of the assessment.

4.2.2 Scope of Work and Strategic Adjustments

Please see *Annex A* for the original scope of work (SOW). It is to be noted that after the inbriefs with both USAID/R and GOR, the original SOW was expanded and strategic approach for the assessment was readjusted to reflect their feedback, including but not limited to assessment goals and objectives (see above), additional ministerial outputs, final report format (to be expanded and structured around the strategic areas), added focus on certain areas, such as resource-generation at the lower levels of the health system, and concept details and key activities for the recommendations.

4.2.3 Methodology

The team used a mixed methods approach for the Health PSE Assessment, including:

- Document review
- Stakeholders analysis
- Key informant interviews (KII);
- FGDs
- Field visits

Using the conceptual framework, this combination of methods enabled the team to better understand various opportunities, weaknesses, gaps, challenges, and barriers that exist for PSE in the health sector.

Document Review: The PSE assessment team began by reviewing relevant documents (both Rwanda-specific and others) provided by USAID/R and GOR. The review provided the team with the necessary background to help shape the approach of the assessment. Specific ways in which the document review

supported subsequent components of the assessment include: conducting stakeholders analysis; drafting of all qualitative guides; getting an initial understanding of the health PS environment; finalizing the assessment implementation work plan; and conducting data collection, analysis, and report writing. A complete list of all documents reviewed is listed in *Annex D* of this report.

Stakeholders Analysis: Based on the document review and additional background research, the team developed a detailed draft stakeholders list. Subsequently, this list was revised and finalized based on the review and input from both USAID/R and GOR (see *Annex E* for a full stakeholders' list).

KIIs and FGDs: Over the course of four weeks, the team held a total of nearly 80 KIIs and FGDs. While the team attended some key discussions together, in most instances it split into two or three teams to meet various organizations, groups, and individuals. In all, the team met and/or spoke to nearly 200 individuals. Information from all group discussions and individual interviews were recorded in notes and later carefully reviewed, examined, and analyzed by the team. A complete list of all individuals met is listed in the *Annex E* to this report.

Field Visits: During the course of the in-country work, the team split into two subgroups for the following district visits: Team 1 visited the Bugesera district (Nyamata hospital) along with a health center and health post (the four-person subteam included the GOR POC from the MOH); and Team 2 visited the Rulindo district (Rutongo hospital) and a health center, health post, and CHW cooperative (the four-person subteam included one person from USAID/R and the GOR POC from the RBC). A subteam consisting of three team members also visited the Nyabikenke health post operated by One Family Health. The core team also visited a medical consumables manufacturing facility that is under construction by PharmaLab, a medical equipment supplier. During these visits, individual members took detailed notes and later discussed and analyzed them for the purposes of assessment and formulation of recommendations.

Please see *Annex F* for the key assessment process steps, phases, and diagram.

4.2.4 Review Questions

Please see *Annex G* for the list of the key review questions.

4.2.5 The Conceptual Framework – Key Strategic Areas

Effective, increased, and sustained PSE will be a key factor in sustaining and building beyond the current gains in the Rwandan health sector in the years to come. In this regard, GOR leadership would be the main driver of sustainability and long-term capacity to plan, implement, manage, and evaluate high-impact PSE activities in health programs. Defining and establishing a country-led PSE approach is a complex process with no single formula or blueprint for success. A complex combination of issues, variables, and players needs to be analyzed in order to develop and execute an effective plan. The process must be flexible, and at the same time be robust enough to capture all the emerging realities in the context of the country, in particular its political, economic, legal, and institutional dynamics. In the case of Rwanda, at the heart of the challenge is fostering an enabling environment to encourage sociopolitical, commercial, policy, and organizational changes and readiness that would support the achievement of increased, broad-based, and sustained PSE under the country-led principles.

PSE Approach and Rwanda:

In the case of Rwanda, the key challenge is the fostering of an enabling environment to encourage sociopolitical, commercial, policy, and organizational changes and readiness that would support increased, broad-based, and sustained PSE under country-led principles.

In developing an approach, the team looked at the following strategic areas (SAs) and their components that are necessary to create an overall environment (including political and institutional) for promoting and sustaining PSE in the health sector. These areas (including the subsectors) are primarily presumed to stand out as pillars of possible recommendations and interventions that would likely have increased and impactful private sector contribution toward improved health outcomes in Rwanda. Under each of



Figure: Conceptual Framework - Strategic Areas Essential for Sustainable PSE

these, the team has formulated some key guiding questions (see Annex H) in order to get a better understanding, including various opportunities, weaknesses, gaps, challenges, and barriers that exist for PSE in the Rwandan health sector. These areas and associated questions will also help effectively answer/discuss the broad research question (RQ) stated above. *Please note that the broad RQs and sub-questions stated above were mapped into the questions for the various key strategic areas, and as such, were answered as part of the discussions for each of these areas.*

Key SAs for Rwanda Health PSE Assessment:

1. Leadership and Advocacy
2. Policy and Planning
3. Investment and Access to Finance
4. Corporate Social Responsibility
5. Health Subsectors
 - a. Service Delivery
 - b. Health Financing
 - c. HRH
 - d. Medical Products (including medicine), Equipment, and Technology
 - e. Health Information System
 - f. Health Promotion and Prevention
 - g. Learning and Knowledge Management

4.2.6 Key Results Areas

The team used the following *two results lenses* to assess, analyze, and formulate recommendations toward and increased and sustained PSE in the Rwandan health sector:

- Enhancement, expansion, and improvement through efficiency gain
- Domestic resource generation/financing and effective mobilization

5. STRATEGIC AREAS: KEY FINDINGS AND RECOMMENDATIONS

Key findings and recommendations are presented below by strategic areas of the conceptual framework. All of the findings and recommendations feed into the following umbrella recommendation:

Foster an enabling environment that promotes the growth of PSE in health over the longer term - while facilitating, developing, and implementing targeted “quick wins/rapid results initiatives,” and broader PPPs that will help sustain and build further on the current gains, especially at the primary and secondary levels of the health system.

OVERALL NATIONAL STRATEGIC STRENGTHS AND OPPORTUNITIES

There are a number of national strategic strengths that have and continue to define, underpin, and spearhead Rwanda’s progress and overall development in different areas. Moving forward, these will continue to be the keys to the future success of Rwanda’s development efforts, including in health and private sector engagement:

- ❖ There is strong, committed, and visionary national leadership.
- ❖ There are bold plans for national development, including in health.
- ❖ There is strong interest in PSE.
- ❖ There are strategic alignments between Vision 2020, EDPRS II, and HSSP III on PSE.
- ❖ There is a strong work ethic and culture of participatory process, compliance, and program implementation.
- ❖ Rwanda has achieved unprecedented results in key health areas.
- ❖ The health decentralization plan is well underway.
- ❖ There is fast-spreading ICT infrastructure, including mobile technology.
- ❖ Rwanda has high security and low corruption indices.
- ❖ New investment codes have been developed (approved but not released) for all sectors, including health.

5.1 LEADERSHIP AND ADVOCACY

5.1.1 Introduction

The most important and fundamental element of an enabling environment that can spark and ignite increased PSE and investment in health is leadership, because it pulls everything else. Leadership, including political will and advocacy, is at the heart of ensuring a country-owned and country-led process to improve the overall health system through effective and increased private sector participation, leading to positively impacting the overall social and health outcomes in the country. Effective leadership and advocacy constitute the primary foundation for all the other strategic areas identified under the conceptual framework of this assessment, and provide ongoing critical support and direction for the overall success. In looking at this strategic area, the team reviewed various documents and asked a key set of probing questions to determine:

- i. The extent of effective leadership at various levels (central, local) for health PSE and its strengthening
- ii. The extent of political support and advocacy for increased PSE in health and how it is demonstrated

As recognized by most in the GOR at various levels, private sector, DPs, and others, there is a clear deficiency of a business-thinking approach and a rallying leadership point for increased PSE at different levels of the health system. The persistence of these challenges at the various leadership levels creates a ripple effect negatively impacting the whole health system. As such, there is a critical need to strengthen leadership and intensify public expression of support, advocacy, and communication from government decision-makers for an integrated, collaborative, and sustainable approach toward health PSE and an overall conducive environment for its implementation. Otherwise, the aspiration of Rwanda’s Vision 2020 and the goals of EDPRS II and HSSP III (including attaining the private sector contribution to five percent of THE) will fall short.

5.1.2 Key Findings/Conclusions

There is strong leadership and political will at senior levels for PSE, which is critical for its success. The overall high-level GOR leadership, including in the health sector, for PSE has been outstanding in recent years. This is clearly visible by the goals, directions, and priorities set in the national policies and plans, including Vision 20/20 and EDPRS II, and particularly in the inclusion of goals for increased PSE in HSSP III, which clearly demonstrate a commitment by the MOH leadership for mobilizing the private sector. There is also increasing recognition by GOR of high-performing private health sector investors. For example, Pharmed received an award from the RDB for being ranked as one of the top 100 companies in Rwanda. Strong political will and leadership are critical for successfully growing the private sector in health.

Under dynamic and visionary national leadership, Rwanda has made phenomenal progress in recent years, including in health outcomes. Its health sector is characterized by vision, leadership, strategic planning, commitment, and a dedicated work force and ethic. However, when it comes to understanding, prioritizing, and lending political support for a business-thinking approach and increased and sustainable PSE in health, there is room for improvement.

The level of understanding and support for PSE, however, varies within the GOR. While there is strong leadership for PSE, there is room to improve the extent of effective leadership at various levels and institutions of GOR when it comes to creating a common understanding and advocating for the importance of increased and sustainable PSE at the national and subnational levels. This becomes even more critical as the existing understanding, prioritization, and political support (both within and outside of the MOH) specifically for PSE is inadequate. A number of interviewees reported that while the senior management seems to say the “right things” and formulated a number of favorable “policies and plans,” the messages do not trickle down the chain, especially at the implementation level.

There is a lack of coordination and clarity of roles and responsibilities between key stakeholders (MOH, RDB, and RBC) that are limiting effective PSE. The assessment found that a strategic, institutional setup involving the MOH, RBC, and RDB is in place to facilitate PSE; however, there is no formal mechanism for these institutions to come together and coordinate their activities regarding private health sector development. Coupled with that, there is a lack of clarity and understanding of the roles and responsibilities of these key stakeholders when it comes to PSE strategy and activities. For example, there is confusion between MOH and RDB as to which institution leads health-specific private sector efforts and inclusion in the budget frameworks. At times, high focus on immediate results adds to the overall confusion and creates a lack of flexibility in the decision-making space among lower-level managers in these institutions. Generally, there is a lack of clarity and understanding of the

complementary roles and associated accountability mechanisms for this critical institutional setup for PSE in health.

There is very limited dialogue and no formal platform and system for regular engagement between the public and private sector. There is a clear lack of confidence, coordination, and communication between the public and private sector. While there was a forum arranged by the Prime Minister’s office last year to hold dialogue with key private sector stakeholders and a plan for an annual investment forum to be held by the Ministry of Trade and Industry (MINICOM) with the private sector to address investment issues, there is no platform in place for regular health-specific dialogue to take place between the public and private sectors. This is indeed a critical barrier to overcome the current “trust deficit” and share the necessary information and concerns between public and private sectors in order to ultimately foster an environment for increased PSE and investment in health. Respondents across the board stated and supported this concern, especially a few private sector business owners who said they are “in the dark” when it comes to dialogue, information, and opportunities regarding the health sector. The lack of communication and information established a misconception among most private businesses that the health sector is not “open for private businesses,” i.e. the private sector is simply not aware of investment opportunities in the health sector.

There is a lack of complete and efficient systems and mechanisms to develop PPPs.

The formal system to efficiently develop and manage PPPs is currently very much underdeveloped and inefficient. As such, effectively conceptualizing, creating, implementing, and monitoring PPPs has been a big challenge. In Rwanda there has been limited experience with health PPPs and no rigorous assessments. As a result, there is a lack of an evidence base to follow and to use in guiding implementation. Ad-hoc and variable standards, norms, rules, and pricing schemes have also made the system unreliable and difficult to follow. This problem has been further exacerbated by limited management and financial/payment systems. One of the largest GOR PPP partners (at the primary health level), reports that certain aspects of the PPP agreement are not effectively monitored and followed through (e.g. rehabilitation of physical infrastructure of HPs), and inefficient verification and payment systems have caused payment delays of over two years with \$500,000 overdue. These payment delays are threatening the viability of this model. Payment delays of several months were also reported by several pharmacies at the central level in Kigali, which supply medicines and other products to GOR facilities when called upon by the MPPD. The assessment determined that the federal system has its challenges as the central government has little control once releasing the money to districts. All these issues have and continue to prevent fostering a genuine relationship and building true interest for new, innovative, and effective PPPs.

Underdeveloped and weak systems and mechanisms creates a barrier for PPPs: One of the largest GOR PPP partners (at the primary health level) reported that certain aspects of the PPP agreement are not effectively monitored and followed through (e.g. rehabilitation of physical infrastructure of the HPs), and inefficient verification and payment systems have caused payment delays of over two years, with \$500,000 overdue. These delays are threatening the viability of this PPP.

There is a lack of adequate capacity within the MOH, RDB, and RBC for effective PSE and PPP development. There is also a capacity deficit within the MOH, RDB, and RBC for effective PSE. They lack capacity for effective PSE and PPPs on two fronts: i) knowledge gap in the private sector, i.e. on what is needed, who should do it and how to leverage good ideas; and ii) technical skills. The MOH currently does not have a PPP focus person. There was a PPP desk with an advisor in the past (supported by a DP); however, the PPP desk position has been vacant for a while due to funding and prioritization issues. As the focus is now on increased PSE, the staff temporarily responsible for this area

(in addition to other duties) does not have the necessary PPP and analytical skills. Designated with the critical task of assessing, analyzing, creating, and supporting the formulation of viable business opportunities for the MOH, and playing a key role in coordination of PSE in health with the MOH and RDB, the RBC's Business Development Unit is relatively new and currently has a very active, informed, and enthusiastic manager in place. However, the overall technical capacity of the unit to fulfil its mandate currently is quite low. The BDU has only two staff: the unit manager and a senior business officer, who mainly perform simple, limited business profit and loss (P&L) analysis. The unit lacks the critical high-end business thinking and analytical skills that are essential for assessing and crafting ideas and formulating PSE strategies and opportunities. Particularly, the absence of a skilled PPP business specialist prevents exploring, organizing, and formulating potential PPP options. At the RDB, there is also limited staff capacity and resources for serving the health sector. Currently, the dedicated position for the health sector at RDB's Services Unit is vacant. RDB staff have a limited understanding of the health sector, citing a need for market information describing opportunities, trends, financing needs, and potential risk.

PSE capacity issues at MOH, RBC, and RDB:

- ❖ MOH's PPP desk currently does not have a PPP focus person/advisor
- ❖ RBC's Business Development Unit does not have a PPP business specialist with high-end business and analytical skills
- ❖ At RDB's Service Unit, the dedicated staff member position for the health sector is currently vacant
- ❖ There is a significant knowledge-gap on the private sector and PPPs across all three institutions

5.1.3 Recommendations

Identify and support key health PSE leadership with critical business thinking and understanding at all levels. This recommendation has the most potential to increase PSE in health. From the leadership perspective, it is recommended that this be addressed both at the central and district levels. At the central level, the most critical recommendation is to set up a PHSCC anchored at the highest levels of the MOH, RBC, and RDB, and chaired by the Minister of Health. The PHSCC should have an official mandate and high-level representation to generate political support, set direction, and provide strategic oversight for a visible and sustainable national health PSE effort. A key function of the PHSCC will be to bring people to consensus and build a common understanding between all key stakeholders, especially the relevant public and private actors. Ultimately, the goal is for it to become a one-stop point for regarding PSE in health, but not an implementation arm. The team also highly recommends that the PHSCC should be effectively and actively supported by a Secretariat, consisting of representatives from all three institutions and other key stakeholders, including the private sector. The principal function of the Secretariat would be to effectively share (internal and external) information, conduct dialogue, formulate PPPs, and facilitate overall PSE in health. Please see *Annex I* for the suggested structure, formulation, and key functions of the PHSCC and the Secretariat.

In addition to the above, it is also recommended that the PHSCC and the Secretariat create and implement a process to identify a point of contact among the existing staff in each key institution at national and district levels who can actively lead and mobilize people and activities at all levels of the agency to help implement a well-coordinated and sustainable PSE awareness campaign and plan. This will help to establish a network of PSE leaders throughout the whole health system and across geographic boundaries. In general, all PSE relevant support, advice, policies, and plans from the central level will also be transmitted to the rest of the system (including the decentralized level) through this network. The assessment team also highly recommends conducting a desk review to identify best practices and successful models of health PSEs for both efficiency gains and resource/income generation activities by the governments, DPs, PSs, or through any combination of partnerships in the East African countries. Also recommended is using the results of this review to develop an evidence base to steer learning,

guide the recommended learning trip(s) for the PHSCC Secretariat task team, and aid the replication/formulation and implementation of Rwanda-specific PSE solutions.

For successful implementation of the above, some of the recommended key next steps would be to launch an immediate dialogue and consultation process among top-level management to evaluate and finalize the proposed models for the PHSCC and the Secretariat - including the structure, membership, and key functions and activities; organize a high-level stakeholders/proposed membership meeting to agree and officially launch the PHSCC and the Secretariat; bring onboard a short-term expert to effectively support and facilitate the above processes, and to guide and support the Secretariat in the short run (3 to 6 months); conduct a comprehensive mapping of all key actors in the private health sector at both national and decentralized levels; carry out an assessment of PSE management leadership and coordination capacity, and build and implement management/leadership programs accordingly at various levels; advocate, support, and launch dialogue among the relevant top-level leadership at RDB, MOH, and RBC to expedite appointment of any key vacant positions (e.g. business specialist at RBC BDU, health focal person in RDB); and strengthen capacity and clarify roles and responsibilities of existing units critical to supporting PSE in health.

Results Area: EG, RG; HSSP III Priority Area: 1, 2, 3, 4, 5; Priority Level: High; Impact: ST, LT

Strengthen overall PPP and business development capacity at MOH and RBC. It is highly recommended that MOH appoints a health PSE (including PPP) expert at its PPP desk who can help support the ministry's PSE and PPP agenda and actively participate as a member of the PHSCC Secretariat. It would be beneficial and preferable to recruit this person from the private sector. This person will ideally bring in the skill set to merge the critical private sector thinking with the technical and policy and planning aspects of the Rwandan health sector, and work closely as the main liaison between the MOH and the PHSCC Secretariat.

It is highly recommended that a long-term/permanent GOR business specialist (PPP) with high-end business development and analytical skills be appointed quickly at RBC's BDU for health. This position will be critical for enabling RBC to fulfill its mission to explore and help formulate PPPs and income-generation activities.

As the recruitment of the long-term/permanent GOR business specialist (PPP) may take some time, it is highly recommended that a short-term (3 to 6 months) technical advisor (PPP) with high-end business development and analytical skills be put in place (possibly through TA) at RBC's BDU until the long-term/permanent GOR business specialist (PPP) comes on board.

Please see Annex J for the Scope of Work (SOW) and some of the key elements of this critical full-time GOR business specialist (PPP) position. Please note that similar objective, SOW, and selection criteria can be used for the short-term technical advisor as well.

Key Next Steps:

1. Launch an immediate dialogue and consultation process to review, evaluate, and finalize the proposed TOR for the long-term PPP business specialist and short-term technical advisor positions
2. Leverage existing or new GOR resources, or solicit TA from DP(s) to bring onboard the short-term (3 to 6 months) technical advisor in an expedited manner in order to keep things moving until the GOR long-term/permanent PPP business specialist comes onboard

Results Area: EG, RG; HSSP III Priority Area: 1, 2, 3, 4, 5; Priority Level: High; Impact: ST, LT

Intensify public expression of support, advocacy, and communication from senior government decision-makers for heightened and sustainable PSE interventions, with corresponding increases in resource allocations. This will play a critical role in transmitting the message down the chain and throughout the system, and to actually provide the ways and means for effective follow-up and implementation of the PSE plan. The starting point would be a common and shared awareness and understanding of the upper management. As such, it is recommended that an advocacy plan and supporting tools be developed to raise the awareness of upper management at all levels regarding the urgency and importance of increased and sustainable PSE and the need to increase the budget allocation for it. Support should also be sought from the upper management to explore, examine, formulate, and implement a more effective strategy and system to realize increased PSE in health.

The actual system and measure of accountability will be critical to make this PSE campaign and implementation effective and real. In this regard, the identified PSE leadership in various entities and levels throughout the system should formally be held accountable for results at the highest level. As such, it is recommended that PHSCC advocates for inclusion of key PSE markers at all levels, particularly at the decentralized (district) levels on high-level performance contracts with the President.

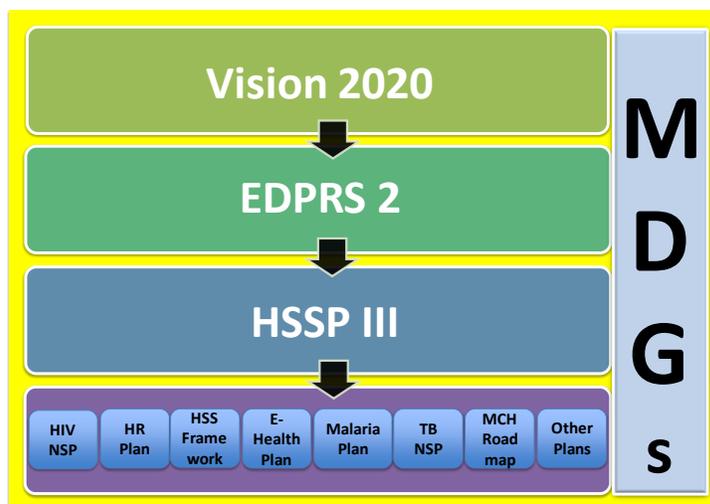


Figure: Rwanda national policies and strategies guiding the health sector

Results Area: EG, RG; HSSP III Priority Area: 1, 2, 3, 4, 5; Priority Level: High; Impact: ST, LT

5.1.4 Broad/Key Recommendations

- Identify and support key health PSE leadership with critical business thinking and understanding at all levels, especially at the national and district levels
- Strengthen overall PPP and business development and management capacity at MOH and RBC
- Intensify public expression of support, advocacy, and communication from senior government decision-makers for heightened and sustainable PSE interventions with corresponding increases in resource allocations

5.2 POLICY AND PLANNING

5.2.1 Introduction

Effective policies and plans are critical elements for achieving increased PSE toward the attainment of broader health objectives. In realizing a well-thought-out, coordinated, integrated, and strengthened PSE effort, effective leadership and broad advocacy have to be supported by an enabling policy and planning environment that clearly sets out not only the strategic objectives and goals, but also a well-defined and prioritized results-oriented operational plan. Together, they formulate the legal and policy base and the critical underpinning toward successful implementation of increased PSE at all levels. Overall, in assessing this strategic area, the team reviewed various documents and asked a key set of probing questions to determine:

- i. To what extent are strategies (if any) in place guide the PSE strengthening efforts;
- ii. Whether the key institutions involved in PSE had the necessary mandate to play their assigned roles;
- iii. In what way the current policy environment was conducive or not conducive for increased PSE.

On the policy and planning side, the MOH and its relevant departments at the national level have the mandate to develop all national health policies and strategies (including for PSE) and to plan for the effective delivery to meet national health goals. The current national policies and strategies guiding the health sector include Vision 2020, EDPRS II, the Rwandan Health Policy of 2004, and HSSP III. Below these are the various subsector and disease program-specific strategic plans.

As such, the capacity of MOH departments and other national-level health institutions (public and private) to formulate relevant, evidence-based, and results-oriented PSE and PPP policies and strategies, and to properly plan for their execution is therefore critical to ensuring increased PSE. Good policies and plans remain just that unless they are done in a participatory manner, owned by all stakeholders, and are adequately distributed and disseminated to all relevant implementers. Therefore, the national-level health departments and agencies must also be able to steer and drive all relevant PSE policies and plans throughout the breadth and levels of the health sector, including the private sector.

5.2.2 Key Findings/Conclusions

PPP mechanisms, legal framework, and PSE/PPP planning processes have either not been finalized or are informal and incomplete. In order to have a smooth and unambiguous system and process to facilitate PSE, there needs to be a clearly laid out legal framework for it. While the legal department within the MOH has created a draft PPP legal framework and law, it has not been approved or made public yet. This continues to create uncertainty and confusion among all, including the private sector, and is limiting its involvement in the health sector. Despite the absence of the PPP law, there are some existing PPPs in the health sector (e.g. One Family Health HPs), which were primarily developed through ad-hoc processes. However, broad inefficiencies in the areas of follow-up, dialogue, monitoring, compliance, and payment show that the necessary and adequate PPP management systems are not in place. This is coupled with lack of technical PPP management capacity among staff and a lack of clear understanding of the roles and responsibilities among the various institutions involved in facilitating health PPPs. The lack of a legal framework for PSE and PPPs also impacts the sustainability of the primary and secondary levels of the health system. For example, in order to become self-sufficient and thrive, the district hospitals could generate additional income by pursuing different income-generating activities, including opening of private wings, consultation services, etc. However, currently there is no clear national guideline on the legality of this, adding further to the confusion and creating indecisiveness – ultimately adversely impacting sustainability.

The overall tax and investment environment in Rwanda is favorable to the private sector but health-specific investment incentives are lacking. As stated earlier, there are a number of general

“The process for obtaining authorization for opening a private facility is very clear, but it can be arbitrary based on personalities, acting out of fear or without adequate training.”

–Stated by a private sector respondent with direct experience in opening a new facility.

investment and tax incentives for new and existing private sector investments. These also apply for health investments as well. There are, however, no additional and/or special incentive(s) specific to health sector investment. One of the key constraints to this is that health is not part of the GOR’s eight priority sectors. There have also been reports of ad-hoc tax policy and investment incentive changes after business set-up and during operation. It is to be noted that the existing investment law has been revised and a new set of investment codes for all sectors, including health, have been adopted by Parliament and are in the process of being

promulgated. Under these new codes, one of the major health-related incentives is a tax holiday of seven years given to any investor with an investment project of at least \$50 million in the health sector. However, this will be out of reach for many potential investors.

Slow implementation of PSE policies and plans. At the policy and planning level, the development and engagement of the private sector has been in the forefront. This is clearly reflected in key documents such as the Vision 20/20, EDPRS II, and HSSP III. For example, the HSSP III states, “The role of the private sector will be essential in the development of the health sector during HSSP III...A major shift is expected in the comparative role of the private sector in health interventions.” According to the HSSP III, the role of the private sector is supposed to be significantly expanded in the areas of service provision; production, promotion, and social marketing of different medical products widely used for disease prevention (e.g., condoms, insecticide-impregnated bednets); treatment (e.g., oral rehydration solution); and production and marketing of generic drugs. In support of this planning, changes have also been introduced in the implementation policies, such as in licensing and the opening of private facilities. However, the assessment team heard a number of reports of delays and bureaucratic complications at the policy implementation levels from private sector respondents. These include but are not limited to a slow and cumbersome process to receive approval to open a facility, including a lengthy administrative process for approvals and authorization by MOH, heavy documentation requirements, multiple reviews and evaluations, lengthy inspection processes, and a lengthy and cumbersome approval process for RSSB insurance on certain services. In other words, at times, the urgency of the plans and policies are not reflected appropriately at the implementation level, which is the key to generate interest for PSE. Also, a number of policies and legal frameworks, such as the health private sector regulatory framework and the new investment codes, have not been finalized and/or approved yet. This also has an impact. At this stage, there is also no health sector-specific coherent strategy for PSE. This has limited flexibility, efficiency, and creativity.

The current GOR tariff structure poses a significant barrier to investment in the health sector.

The single most reported obstacle toward significantly increased PSE and investment is the GOR tariff structure. The last time the tariff rates went through a major overhaul was in 2008, although there have been minor adjustments throughout the years and as recently 2013. As such, the current tariff rates do not adequately reflect inflation and other economic adjustment parameters. This has been a key barrier in both domestic and foreign health business investment in the country, which will be discussed in detail in the Investment and Access to Finance section. Domestically, new clinics and other medical business initiatives are not very encouraging to investors due to low tariff rates (and access to finance issues). Investors simply do not see the profit or even survival aspect most times due to these low tariff rates. Given the lower tariff, it was reported and shown to the team that the rate of return is as low as 2 to 3 percent. This lengthens the break-even period – a major discouraging factor for an enthusiastic entrepreneur. Many of the current private businesses owners, especially the clinics, say they are struggling to stay afloat. When it comes to foreign investors, Several private health service providers indicated that foreign investors had walked away from potential investments in the health services subsector, describing the tariff as a deal-breaker. These investors are looking for double-digit rates of return in line with common practices and expectations. It is, however, important to note that a costing exercise has been completed and a tariff revision is ongoing for the past two years. As expectations are looming within the private sector, rapid finalization of the revision of the tariff structure will be important to spur the growth of the private health sector.

Key Impacts of Current GOR Tariff Structure on PSE and Investment:

- ❖ Low rate of return (lower single digit)
- ❖ Longer break-even period
- ❖ Struggling current investments
- ❖ Nervous potential domestic investors, including doctors
- ❖ Discouraged foreign investors

There are complex regulatory requirements (e.g. procurement, licensing, customs, etc.) that create inefficiencies and can impede the growth of the private sector. Complex regulatory requirements and delays have and continue to impede private sector growth. The centralized public procurement system is extremely complex and long, especially for medicine. Medicine procurement and supply at public facilities is generally inefficient and often results in high costs and frequent stock-outs. The impact is exacerbated by limited procurement management skills. MPPD currently handles drug

Complex Regulatory requirements:

- ❖ Slow and complex drug procurement processes
- ❖ Slow and centralized professional and facility licensing process
- ❖ Provisional license for new facilities has to be cleared at the MOH central level
- ❖ High custom duty (18) and long clearing process for medical equipment spare parts

procurement and supply, with limited private sector involvement. Licensing encompasses professional licensing and facility licensing. Two professional licensing bodies reported that the overall licensing application process is slow and cumbersome. The main registration process is still manual and the actual process is only done in Kigali. This involves lengthy and complex administrative processes, extensive documentation, and a repeated and lengthy inspection process. One key hurdle is MOH clearance requirements for the provisional license. This is particularly discouraging for the private sector as those trying to open clinics/facilities outside of Kigali have long waits just for the provisional license, even though paperwork has been filed with the district authority.

On the customs side, bottlenecks were reported on two fronts for importing spare parts for medical equipment: i) currently such spare parts are treated the same as other types of commodities and carry an 18-percent custom duty, although no duty on new medical equipment; and ii) the clearance process can take weeks or months, although it is unclear if there has been dialogue between the MOH and the customs authority. These issues create significant inefficiencies, and ultimately impede private sector growth and hamper service delivery. Although the newly introduced (early February 2015) electronic single window system (in pilot phase, <http://www.rra.gov.rw/spip.php?article927>) may possibly facilitate international trade by speeding up and simplifying information flows between traders and government institutions – MOH is part of the pilot testing phase. This may significantly improve the delay in the custom clearing phase.

Financial, human, and other resources are not adequately aligned to support effective PSE and PPP development. As discussed throughout other individual components, there is a lack of financial, human, and other technical resources to effectively engage the private sector and formulate PPPs in health. While skills and human resource deficits are limiting effective PSE and PPP strategy and planning, many times the leadership and financial constraints are the underlying reasons for those deficits. While the vision and mission for increased PSE are clear on the part of the leaders at key levels, the actual awareness of the resource needs is inadequate. There is also a lack of policy initiatives, dialogues, and reforms to support and effectively execute the PSE plans and ideas through the effective redistribution of available and new MOH resources.

National- and district-level managers do not have adequate skills and business know-how to implement PSE and PPPs. (This is discussed in the service delivery and HRH sections)

The private sector and other key stakeholders are not adequately engaged in policy dialogue and development and planning. The assessment found that there is limited health and non-health dialogue, coordination, and collaboration for PSE in health among stakeholders. This is particularly true when it comes to the PSE policy and planning of the MOH. Of all the private sector individuals and entities that

the team spoke to, the vast majority never participated in any policy, planning, or dialogue forum with the MOH. Health sector policies and plans, particularly the ones that are directly relevant to the private sector, will fall short in their effectiveness if private sector stakeholders are not adequately engaged and consulted. Currently, there is no formal coordination mechanism and/or consultative forum to have effective dialogue and communication between relevant GOR institutions and the private sector in an inclusive and coordinated manner on health policy and planning.

There are opportunities to increase revenue collections from the importation and registration of new pharmaceutical products.

| Possible revenue collection through registration of new products and GMP Certificates | Current | Planned (future) |
|---|----------------|------------------|
| Number of New Products Evaluated (annual) | 50* | 120* |
| New Product Registration Fee (@US\$1,200 each) | 60,000.00 | 144,000.00 |
| GMP Certificate Service Fee (@US\$2,000, each) | 100,000.00 | 240,000.00 |
| Total (US\$), annual | 160,000.00 | 384,000.00 |
| Total RWF, annual (1 US\$ = 700 RWF) | 112,000,000.00 | 268,800,000.00 |
| * Estimates provided by MOH staff | | |

It is indeed a common global practice for a manufacturer to pay a registration fee (average fee in the EAC region is about \$1,200) when introducing and registering any new drug in a country. In addition to that, it is also a common global practice to collect a retention fee every five years for each

drug. However, Rwanda currently has no such fee structure and does not require a registration fee for new drugs. MOH staff suggest that there are about 50 new drugs registered annually in Rwanda. However, as the new regulatory plan moves ahead, it is estimated that the country could evaluate 30 new products per quarter, for a total of 120 per year. It is also a common practice for a country to charge a fee (average fee in the EAC region is about \$2,000) to send a team and get the manufacturing plant inspected and issue a Good Manufacturing Practices (GMP) certificate. This is also not currently being done in Rwanda. In addition to not having the regulatory structure and institutions in place, lack of skilled personnel to carry out such activities is also a major hurdle. As the table shows, even at present, once the regulatory structure and laws are in place, Rwanda could potentially generate 112 Million RWF annually; and possibly 268 Million RWF in the future once the new regulatory plan is completed and goes into effect. This added revenue could be mobilized to support the health system as needed, especially at the primary and secondary levels, including the CBHI.

Most private sector associations have limited capacity for effectively advocating and representing the interests of their members. It is imperative that the private sector professionals, businesses, and other entities are well organized in associations in order to have a unified representation and voice. Currently there are a number of private sector associations in Rwanda (e.g. Rwanda Health Care Federation [RHF], National Union of Disabilities Organization Rwanda [NUDOR], Private Medical Association, Private Sector Federation [PSF]/ICT Chamber, and Rwanda Medical Association), however they are all relatively new and with limited capacity. Current members of key associations, such as the RHF are non-state actors: doctors, pharmacists, importers of medical equipment, NGOs with health facilities, nurses with private dispensaries, health insurance companies, and physiotherapists. It serves as

an umbrella organization that includes the Association of Private Dispensaries, Association of Private Doctors, Association of Private Pharmacies, Association of Private Dentists, and Association of Private Physiotherapists. Individual hospitals can also be members but they have not joined yet. After talking to these associations, including the RHF, it is abundantly clear that they need significant support to strengthen their capacity in order to effectively carry out their mission of supporting their members, including but not limited to having policy dialogue with the public sector and assisting their members for increased PSE and investment in health. They need to be equipped to serve their members with business thinking, planning, operational, and negotiating skills. These associations are supposed to be the bridges between the private sector and the GOR, so if these bridges are weak, the PSE in health will not reach its potential.

Most hospitals, including the district hospitals, are not autonomous – significantly impacting management effectiveness, accountability, and efficiency. Public hospitals are the most significant component of the health system in Rwanda. Generally they are responsible for 50 percent or more of the recurrent government health sector expenditure. Although there is a draft law for management autonomy of public hospitals, currently only King Faisal has private management. This lack of autonomy slows decision-making processes slow, adversely impacting efficiency, equity, quality of care, public accountability, and resource generation and mobilization.

Lack of autonomy for most **hospitals’ management, including the district hospitals**, is slowing key decision processes, adversely impacting overall efficiency, equity, quality of care, public accountability, and resource generation and mobilization.

5.2.3 Recommendations

Based on the assessment recommendations, prepare a detailed, evidence-based and prioritized implementation action plan for key PSE activities. As the PHSCC and the Secretariat is setup, this would be the first and most important task they should take on. It is recommended that under the guidance of the PHSCC, the Secretariat, working with all other key stakeholders and their representatives, prepare a phased and prioritized action plan through a detailed review and analysis of the assessment recommendations and concepts focusing on key GOR strategic directions (Vision 20/20, EDPRS II), all current health programs and strategies (HSSP III, etc.), all other relevant line ministries activities (e.g. Education, Youth and ICT, Finance, Commerce, Local Government) - keeping close focus on the PSE as a key priority. This action plan could become the MOH’s master work plan document focusing on PSE and can be updated periodically (at least quarterly) as needed. As outlined under the PHSCC functions, close monitoring needs to be done.

This process should also involve putting together and regularly updating a key stakeholders’ map for all PSE activities using two dimensions: i) stakeholders (internal and external); ii) the key strategic areas of the assessment conceptual framework and relevant activities. A third dimension, which would include the resources available and allocated (by areas and specific activities) by all parties, including the GOR, DPs, and private sector stakeholders, should also be considered.

Results Area: EG, RG; HSSP III Priority Area: 1, 2, 3, 4, 5; Priority Level: High; Impact: ST, LT

Based on the above action plan, ensure efficient and equitable allocation of financial, human, and other resources for implementation at all levels. Good strategies and plans will just be those, unless they are implemented properly – and it all starts with the right leadership and advocacy, supported by the right policy and planning actions. As such, the team recommends that the GOR, with support from DPs, design and implement advocacy plans to raise awareness and educate leaders with decision-making powers at all levels. There should be strong support for relevant policy initiatives,

dialogues, or reforms for the effective redistribution of MOH resources to execute the PSE action plan. The actual implementation would also critically depend on the skills and capacity of the implementation level managers, especially at the district levels. To support that, the assessment team recommends creating a structured and modularized health business training program for district- and facility-level managers to educate and sensitize them on PSE concepts and strategies, and improved operational efficiencies. One important element prior to implementation would be to identify the most appropriate income-generation and PSE/PPP opportunities and activities through educated analysis and studies. Please refer to the Health Financing section for more details.

Results Area: EG, RG; HSSP III Priority Area: 1, 2, 3, 4, 5; Priority Level: High; Impact: ST, LT

Strengthen national- and district-level PSE policy and planning capacity. The draft PPP legal framework and a number of associated regulations and specific planning need to be done at both central and district levels. As such, it is recommended that development of evidence-based and results-oriented PSE policies, plans, and strategies at all levels with a clear implementation framework and action plans be promoted and supported, and the necessary policy and planning capacity be developed at both central and district levels. Support should be provided to health care managers at the district levels on PSE planning, policy, and strategy implementation. For better efficiency through effective planning and implementation, it is recommended that general and financial management capacity of relevant current staff be developed at all levels according to the Ministry of Finance and Economic Planning (MINECOFIN) guidelines.

Results Area: EG, RG; HSSP III Priority Area: 4, 5; Priority Level: High; Impact: ST, LT

Promote and increase meaningful participation of all stakeholders (public and private, health and non-health) in formulation of PSE policies, strategies, and plans and ensure ownership and alignment. For the successful formulation, dissemination, adoption, and implementation of the PSE policies and plans, it is imperative that the process be broad and inclusive – alignment and ownership of all key stakeholders (particularly the private sector) need to be built and ensured from the beginning. This will not only help the cause of ownership, but also will be instrumental in building the much needed trust between the public and private sector. One key recommended activity would be to devise and implement advocacy plans and support participation from all key stakeholders from all levels to ensure participatory, meaningful, and effective PSE policy formulation, review, planning, and implementation both at the central and district levels. Having a formal institutionalized platform for regular dialogue and exchange with the stakeholders would be a prerequisite. As such, it is highly recommended to form a new consultative forum (under the guidance of the PHSCC) for broad stakeholders' consultation, finalization, dissemination, and sensitization processes of PSE policies and plans at all levels, especially at the decentralized levels. This will aid the much-needed effective dissemination and actual sensitization of the relevant policies and plans among the key stakeholders, particularly at the decentralized level.

Results Area: RG; HSSP III Priority Area: 2, 3, 4; Priority Level: High; Impact: ST, LT

Review current regulations and amend/introduce new ones in line with international and regional practices to develop PPPs, generate revenue, and gain efficiency. This recommendation is at the heart of not only setting the stage for increased PSE, but also to help gain efficiency and generate resources. Some of these aspects have and will be discussed in other parts of this assessment, but as described above, the key to getting started on them is proper leadership and advocacy. To support this, the assessment team recommends the following activities: finalize the draft PPP legal framework, and disseminate and sensitize at all levels; finalize, approve, and operationalize the revised tariff structure resulting from the latest study; streamline processes for obtaining licenses to open private facilities and

build inspection and supervision capacity at the district level; introduce regulation to mandate that manufacturers pay registration fees for all new products registered in Rwanda; introduce regulation to mandate that manufacturers pay fees toward the process and acquiring a certificate of GMP; and streamline processes and eliminate custom duties on import of already purchased medical equipment spare parts.

Results Area: EG, RG; HSSP III Priority Area: 1, 2, 3; Priority Level: High; Impact: ST, LT

Propose, dialogue, and advocate for possible adaptation of law(s) that will give the hospitals management autonomy with appointed boards of directors. This will expedite decision-making based on better information, for example, about the priorities for spending funds for maintenance, the staff who are performing best, and other local needs; decision-making should be faster since there will be no need to go through long government channels; possibly avoid centralized procurement delays; greater accountability as the board can monitor how funds are used and what is being done to improve services; shift attention to the performance of the hospital, achieving better results than a focus on inputs; would be easier to introduce fees or other financing arrangements to improve the hospital's financial position. These advantages should lead to: i) improved efficiency, with better informed and faster decisions, adapted to local circumstances; ii) better morale and motivation, as staff and managers can settle their own problems rather than being constrained by bureaucracy; and iii) greater institutional accountability. To accomplish this, recommendations include starting a policy dialogue with all relevant stakeholders, including the district hospitals and private sector; formulating and getting draft provisions vetted and agreed by all parties; preparing and proposing draft law(s); and advocating for the passage of the draft law(s).

Results Area: EG, RG; HSSP III Priority Area: 3, 4, 5; Priority Level: Medium; Impact: ST, LT

Strengthen various private sector associations to be self-sustaining and more efficient to serve and represent their members. This recommendation focuses on strengthening the various private sector umbrella associations through institutional and other capacity-building efforts to better serve and represent their members in different aspects, including better advocacy, dialogue, and negotiations; capacity-building; technical assistance; addressing problems and barriers; quality improvement; general facilitation during business start-up periods, etc. Well-managed, developed, and strong associations will be important for having a well-organized, active, and engaged private sector. Recommended activities would include identifying all private sector associations in consultation with key stakeholders, i.e. in addition to the ones mentioned by this assessment, such as RHF, and the Private Medical Association; and to provide TA and other resources to strengthen capacity and follow up on past reviews, completing/updating their business plans, and support in the preparation and implementation of action plans to efficiently support the various private sector members in representing and communicating with the GOR.

Results Area: RG; HSSP III Priority Area: 1, 2, 4; Priority Level: High; Impact: LT

5.2.4 Broad/Key Recommendations

- Based on the PSE assessment recommendations, prepare a detailed, evidence-based and prioritized implementation action plan for key all PSE activities
- Based on the above action plan, ensure efficient and equitable allocation of financial, human, and other resources for implementation at all levels
- Strengthen national- and district-level PSE policy and planning capacity

- Effectively promote and increase meaningful participation of all stakeholders (public and private; health and non-health) in formulation of PSE policies, strategies, and plans and ensure ownership and alignment
- Review current regulations and amend/introduce new ones in line with international and regional practices to develop PPPs, generate revenue, and gain efficiency
- Propose, dialogue, and advocate for possible adaptation of law(s) that will give hospitals management autonomy with appointed boards of directors
- Strengthen various private sector associations toward being self-sustaining and more efficient to serve and represent their members

5.3 INVESTMENT AND ACCESS TO FINANCE

5.3.1 Introduction

Financing is an engine for growth for the private health sector. Without private investment and access to commercial financing, private health care businesses are forced to rely on self-financing through their own savings and by borrowing from friends and family. This limits and slows growth and makes it difficult for health providers to invest in improvements. Along with regulatory and policy changes, expanded access to financing for the private health sector can lead to:

- More reliable operations and better services
- Reduced stock-outs
- Expanded capacity
- New services and products
- More modern facilities and equipment
- Increased clientele

All of these outcomes contribute to improved health and more sustainable and viable businesses that strengthen the overall health system. Key sources of financing are individual and institutional investors (both domestic and foreign), commercial banks and microfinance institutions, and other types of nonbank financial institutions, such as Savings and Credit Cooperatives. The assessment reviewed this SA by conducting interviews with a combination of financial institutions, including commercial banks, microfinance institutions, the Development Bank of Rwanda (BRD), a range of private healthcare businesses, and other key stakeholders, such as the RDB and Ministry of Finance and Economic Planning, and USAID Economic Growth staff. Interviews were supplemented by a literature review on the financial sector and development finance in Rwanda.

5.3.2 Key Findings/Conclusions

There is limited access to affordable financing for the private health sector. While many of the private health care businesses that were interviewed had obtained some financing, they complained that the terms, interest rates (18 percent or higher), collateral requirements (70 to 170 percent loan to value), and mandatory borrower contributions (40 percent of the loan amount), had negatively impacted their ability to finance their businesses. This was corroborated through interviews with financial institutions, which all indicated that health was only one percent or less of their total loan portfolio. None of the financial institutions that were interviewed had a targeted lending product for the health sector and most were unwilling to lend to start-up businesses— a serious constraint.

Bank Terms in Rwanda
 Interest Rates: 18%+
 Borrower Contribution: 40%
 Collateral: 70%-170%
 (avg. 120% loan to value)

There is minimal domestic and foreign investment in health. In addition to the lack of bank financing, there is also very limited domestic and foreign investment in the health sector in Rwanda.

Interviews with private health care businesses indicated that most investment in the sector was coming from personal savings. Overall foreign investment in Rwanda is very low – \$110 million in 2013 – despite scoring number three in sub-Saharan Africa on the World Bank’s Ease of Doing Business Index. While the assessment was not able to determine the percent of total foreign investment in the health sector, interviews indicated that it was minimal. There are, however, several promising trends. The Ministry of Health indicated that the GOR received several bids from foreign investors for King Faisal Hospital, a PPP. In addition, the government is promoting the development of domestic investment groups, comprised of private investors that pool funding for joint investments. If properly harnessed, this could be a potential source of domestic financing for the health sector in the future.

There are a number of constraints to financing the health sector. One of the major constraints is a lack of market information on the private health sector, which makes it difficult to understand the opportunities, risks, and financing needs of this sector. In addition, potential funders expressed concerns about the small market size, concentration of businesses in Kigali, and the dominance of the public health sector. Financial institutions also expressed concerns about risk and the collateral that health service providers can offer, such as facilities and medical equipment. There is political risk for a financial institution to seize a clinic if a loan goes into default and financial institutions questioned if there is a secondary market for medical equipment, if they needed to resell it following a default. Lack of familiarity with a private health sector business model also contributed to perceptions of risk. As health is seen as public good in Rwanda, financial institutions and investors question whether it can be profitable. The low tariff for health services was also identified as a major deterrent to increased financing of the health sector.

Limited business skills in the private health sector are a barrier to financing. Many health care businesses are owned by clinicians who do not have training in business management. Many of these companies are small and are not able to afford professional financial managers or administrators. Interviews of both financial institutions and health care businesses indicated that many of them struggle to develop bankable business plans, produce financial statements, and negotiate appropriate financing terms. Lack of business and financial management capacity increases financial institutions’ concerns about risk for the sector. Lack of business capacity can also directly impact the quality and consistency of services offered in the private sector.

Lack of financing and business skills is a barrier to the development of the private health sector

One private health service provider described his first attempt to open a private clinic as total failure. He applied for financing to construct and equip a facility but did not receive the amount that he requested because of limited personal savings. Instead, he used a loan to start up a rented facility, which he later lost when the landlord did not renew his lease. This experience left him seriously indebted but also encouraged him to get an MBA. He is now in the process of opening a new facility with more appropriate financing.

The RDB is mandated to increase investment in the health sector but currently has limited capacity. The RDB is an important resource to help drive investment in the health sector, working with the RBC and the MOH. However, presently there are several constraints that are limiting its effectiveness, including limited staff capacity and resources for serving the health sector. As mentioned previously, there is no dedicated staff member working on the health sector due to a vacancy. In addition, RDB staff have limited understanding of the health sector, citing a need for market information that would describe opportunities, trends, financing needs, and potential risk. There is also limited coordination with the RBC and MOH and no platform for reaching out to the private health sector and potential investors.

5.3.3 Recommendations

Structure a DCA guarantee supported by technical assistance. It is recommended that USAID consider structuring a DCA portfolio guarantee as a mechanism to share risk with financial institutions and encourage them to lend to the health sector. A DCA could potentially be used to finance:

- Health posts. Additional research and consultation with USAID's Office of Development Credit is needed to determine whether health post nurses would qualify as private and therefore eligible borrowers. If health posts are eligible for the DCA, Urwego Microfinance Bank had appropriate products and terms and was interested in expanding into the health sector.
- CHW cooperatives. Cooperatives raised access to finance as a constraint to increased profitability and expansion of income-generating activities. A DCA to support financing to cooperatives as part of a broader package of assistance to increase income generation would be helpful.
- Private health sector. A DCA structured with a commercial bank to support financing to the private health sector more broadly, including PPPs (where the private sector entity is receiving the loan), private clinics, polyclinics, and hospitals, would be a strategy to help promote the development of the private health sector.

Due to the relatively small market and untested financing need it may be advisable to package a DCA for health with another sector, such as small- and medium-sized enterprises. A DCA should be complemented with a package of technical assistance to financial institutions and borrowers to ensure utilization. Technical assistance to financial institutions may include market research on the private health sector, training to bank management and loan officers in lending to the health sector, loan product development, and referrals of bankable projects. Technical assistance to health borrowers is described below. Next steps in structuring a DCA include identifying and defining eligible borrowers based on USAID and GOR priorities, finalizing the identification of DCA partner banks most appropriate to lend to targeted borrowers, and a risk assessment of the proposed bank by the Office of Development Credit. USAID would lead this activity in collaboration with financial institutions, the private sector, and the GOR.

Results Area: RG; HSSP III Priority Area: 1, 2, 5; Priority Level: High; Impact: ST, LT

Develop additional sources of financing for the private health sector working with the GOR, other international financial institutions, and donors. In addition to the DCA, it is recommended that GOR, USAID, and other DPs explore other mechanisms to expand financing for the private health sector. The GOR has several development finance institutions, which can be leveraged to expand financing for the health sector, including the BRD, which provides debt and equity financing on better terms than commercial banks, as well as the BDF, a subsidiary of the BRD, which provides credit guarantees, lines of credit and matching grants in support of SMEs. As a next step, it is recommended that the GOR initiate an intergovernmental dialogue between the MOH, MINECOFIN, and the Central Bank to designate health as a priority sector to be supported by BDF and BRD.

There are also several international financial institutions and other donors that are active in financing the private health sector, which should be approached to determine potential interest in working in Rwanda. This includes the International Finance Corporation's Health in Africa Initiative, the Medical Credit Fund, and the Investment Fund for Health in Africa. As a next step, it is recommended that relevant international financial institutions/donors be identified and engaged to support increased financing for the health sector.

Finally, the GOR is promoting the growth of investment clubs to pool funds and increase investment in the private sector. Little is currently known about these funds and their potential for financing the health sector. It is recommended that these funds be further explored and potentially leveraged to raise

domestic capital for the health sector. The GOR should lead activities to develop additional sources of financing with support from key stakeholders.

Results Area: RG; HSSP III Priority Area: 1, 2; Priority Level: High; Impact: ST, LT

Create or buy into existing health sector challenge funds to facilitate increased PSE in health. Development challenge funds are a mechanism that has been used by a number of donors, including USAID, the World Bank, the Bill & Melinda Gates Foundation, and the UK Department for International Development to channel public funds in the form of grants or subsidies to the private sector on a competitive basis. Typically, the donor establishes eligibility criteria based on its social objectives and the private sector is required to provide matching funds. Challenge funds have been used to pilot new concepts as well as scale up successful solutions. They have been used to mitigate risk, encourage private sector innovation in businesses with social impact, and help to catalyze private sector development.³⁰

Given the low level of development of the private health sector in Rwanda and the lack of start-up funding, a health challenge fund could be an effective mechanism to help attract private investment, while mitigating risk; encourage start-ups and innovation in areas such as PPPs and m-health; support new types of income generation at CHW cooperatives; and help bridge the financing gap left open by commercial banks and investors. Due to the low level of business management capacity in the health sector, it will be important to complement a challenge fund with technical assistance to awardees to assist them in business plan development and implementation. In addition, assistance should be provided to successful awardees to eventually transition to commercial financing by brokering relationships with investors and commercial banks. The creation of a Rwanda-specific health challenge fund or buying into the HANSHEP-funded Health Enterprise Fund, www.healthenterprisefund.org, should be explored.

The **Health Enterprise Fund** aims to uncover innovative and replicable solutions that address critical health priorities in sub-Saharan Africa—high rates of maternal and child mortality, unmet need for modern FP methods, and lack of access to HIV/AIDS testing, care, and treatment services. The fund provides grants coupled with technical assistance to health enterprises addressing these health priorities in Kenya, Ethiopia, and Nigeria.

Results Area: RG; HSSP III Priority Area: 1, 2; Priority Level: Medium; Impact: ST, LT

Strengthen RDB's capacity to facilitate private health sector investment. The RDB has an important role to play in brokering investment in the private health sector. It will be important to build its capacity to effectively play this role. The RDB should fill its current vacancy and hire someone with knowledge of the health sector. In addition, annual market research on the private health sector (which could be led by the MOH's Research Unit) should be conducted and disseminated to RDB staff. RDB staff should participate in training on health PPPs and PSE (as stated earlier in the report) to strengthen their knowledge and understanding of the sector. Improved coordination between the RDB, MOH, and RBC under the PHSCC and Secretariat will increase the effectiveness of the RDB in promoting investment in the health sector. The RDB should consider additional strategies to advertise and promote private health sector investment. This could include creating an online platform that would feature potential PPPs and other private health sector opportunities. In addition, it is recommended that the RDB should hold an annual health sector trade fair targeted at both domestic and international investors and private health care businesses with panel discussions, and an exhibition hall to improve networking within the health sector, and matchmaking services for potential investors and health care businesses. This activity should be led by the GOR with support from key stakeholders.

³⁰ Challenge Funds in International Development. Anne-Marie O'Riordan, Copestake, Seibold, Smith. December 2013. Triple Line Consulting and University of Bath.

Results Area: RG; HSSP III Priority Area: 1, 2; Priority Level: High; Impact: ST, LT

Devise and support a TA mechanism to assist in the development feasibility studies, analysis, and business plans (BP) for potential private health sector investments. Due to the lack of business and financial management capacity within the private health sector, it will be important to support the private sector in preparing the business case for investment in the health sector. It is recommended that the GOR, with support from its development partners, work with the PHSCC and the Secretariat to select and certify business consulting service providers to administer and manage a technical assistance mechanism that provides assistance to private health care businesses in conducting feasibility studies and analysis, developing financial statements and projections, and preparing business plans. This assistance could be structured on a cost-share basis with the private sector.

Results Area: RG; HSSP III Priority Area: 1, 2, 5; Priority Level: High; Impact: ST, LT

5.3.4 Broad/Key Recommendations

- Structure DCA(s), supported by a TA vehicle, to help grow the private health sector, including possible financing for health posts, CHW cooperatives, and larger PPP and other private health care businesses
- Develop additional sources of financing for the private health sector working with the GOR and other international financial institutions and donors
- Create or buy into existing health sector challenge funds (e.g. Health Enterprise Fund) to facilitate increased PSE in health
- Strengthen the RDB's capacity to facilitate private health sector investment
- Devise and support a TA mechanism to develop feasibility studies, analysis, and business plans for potential private health sector investments

5.4 CORPORATE SOCIAL RESPONSIBILITY (CSR)

5.4.1 Introduction

As Rwanda transitions from donor funding from its traditional development partners to increased resource generation and mobilization for the health sector, it will be important for it to focus on new and alternative sources of funding, including corporate social responsibility (CSR). Corporate social responsibility involves a for-profit company providing funding to support a social or environmental cause, including promoting public health goals, for no immediate financial benefit. Corporations engage in CSR in order to strengthen their image and reputation in a market and/or because CSR contributes to their long-term financial goals. CSR can also be structured to contribute to more immediate business interests and these models typically are the most sustainable. Promotion of CSR in the health sector is one of the goals of the HSSP III.

This assessment sought to identify existing CSR initiatives in the health sector in Rwanda as well as opportunities for future engagement with the corporate sector. It identified the sectors and companies in Rwanda that are most active in CSR efforts and explored opportunities to better integrate CSR in the health sector.

5.4.2 Key Findings/Conclusions

There is limited CSR (including PPPs) for the health sector in Rwanda. One of the key findings was that there is very limited CSR for health in Rwanda. In fact, there is very limited CSR in general in Rwanda with a few notable examples. GlaxoSmithKline (GSK) has invested heavily in the One Family Health social franchise, providing three years of funding to get this model off the ground. With the grant from GSK ending in July 2015, One Family Health is working to overcome difficulties created by the incomplete implementation of the PPP in order to attract funding from new partners. Another important example of CSR for the health sector is General Electric's commitment to assist the GOR to

improve its biomedical engineering capacity, which led to the development of a biomedical technician program under TVET. While this PPP has made some progress, execution of the PPP by the MOH could be improved to ensure full commitment by the corporate partner.

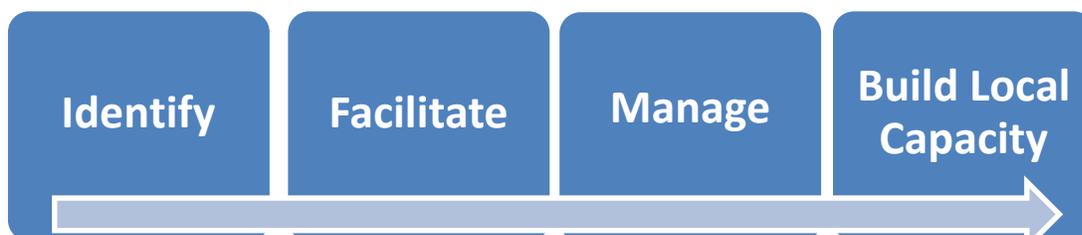
Most CSR funding is in the agricultural and ICT sectors. Most of the CSR activities in the country are geared to the agricultural and ICT sectors. These initiatives are mainly long-term financial commitments to key projects by multinational companies. These initiatives are highly influenced by government- and DP-led investment promotion activities that foster high private sector engagement and public private partnerships. One important example is the \$1 million grant that the WalMart Foundation provided to Global Communities through USAID in support of the Ejo Hazaza program that provides training in improved agricultural techniques and marketing of commodities to rural farmers and aims to reach an additional 50,000 farmers.

There are constraints to the development of CSR for the health sector. There are several factors that are constraining the development of increased CSR for the health sector. One of the most important constraints is a lack of awareness among domestic corporations about CSR and how it can potentially benefit their reputation and bottom line. Outreach and awareness-raising is needed to promote increased CSR in Rwanda. In addition, the lack of familiarity, capacity, and systems within the GOR for developing and implementing PPPs can act as a deterrent to corporations that are not used to dealing with governments, which often act on a very different timeline than the private sector. It will be important for the GOR to fulfill its PPP commitments with the corporate sector to ensure that funding is sustained in the future.

5.4.3 Recommendations

Strengthen CSR to support private sector engagement, PPPs, and increased funding for the health sector in Rwanda. The GOR, with the support from key stakeholders, should take immediate steps to increase CSR for the health sector in Rwanda. The following framework for developing CSR is recommended.

Figure: Proposed CSR framework



Identify

There are a number of steps that can be taken to identify options for CSR. These include:

Identify priority areas for CSR activities in the health sector. Based on the findings from this assessment, the GOR should prioritize areas for potential CSR activities as part of the action plan process recommended in the policy and planning section. Following the prioritization of potential CSR activities, the GOR should work with key stakeholders to reach out the corporate sector and begin discussions. The assessment identified a number of potential CSR opportunities that should be explored in more detail. These include:

- Explore potential CSR for health promotion and prevention. Outreach should be conducted with telecommunications firms to examine the potential to increase SMS and other forms of communication to contribute to HPP.
- Explore potential for CSR to facilitate CBHI/PBF payments to health posts and CHW cooperatives through PPPs. Currently, there is a barrier to using mobile money to make payments to CHWs and health posts due to the high transaction costs for small transfers. One of the financial institutions that was interviewed expressed interest in reducing the individual transaction costs, if the overall volume of payments can be assured.³¹ This is a potential opportunity that should be explored further with mobile money operators.
- Identify potential CSR partners to provide seed capital for the health post roll out and to support improved financing terms. It is estimated that approximately \$5,400,000 to \$9,000,000 in seed capital will be needed for 1,800 health posts. The corporate sector may be tapped to provide some of this funding. It is recommended that the GOR with the support of DPs engage corporations that have a business interest in rural areas, such as beverage and other types of product distributors and telecommunications companies and financial institutions that may be looking to develop agent relationships in rural areas. A health post could potentially serve as an agent for a financial institution or telecommunications company as an additional income-generation activity. In addition, CSR may be important in helping financial institutions reduce interest rates so that loans to health posts are more affordable. One of the financial institutions that was interviewed mentioned that a cash deposit (which could potentially come from a CSR partner) along with a more traditional credit guarantee could help reduce interests rate from 18 percent to as low as 10 percent.

Conduct a workshop and networking event on GDAs/PPPs for the corporate sector. USAID should consider conducting a short workshop followed by an informal networking event for interested corporate partners on GDAs and other types of PPPs in the health sector. This workshop would outline the process, roles, and responsibilities and discuss potential opportunities.

Explore CSR within investment promotion. With the RDB taking the lead, the GOR should explore CSR within the context of investment promotion activities as done in the agriculture and ICT sectors. A CSR dialogue can be structured into investment forums and investment promotion discussions with individual investors.

Conduct a rapid appraisal and vetting process. Additional steps to identify potential partnerships should include a rapid appraisal to determine where corporate interests align with GOR/DP interests and what potential partnerships have the greatest chance of sustainability and impact. Potential partners should be shortlisted and follow-up due diligence should be conducted to ensure success.

Facilitate. Following this identification process, the GOR/DPs should work with selected partners to define the relationship, roles, responsibilities, and resources, which should be agreed upon in a memorandum of understanding (MoU). MoUs should include key indicators that will allow the GOR to monitor the performance and social impact of the partnership as it is rolled out.

Manage and monitor. Once a partnership is developed, the GOR, with support from DPs, should maintain an ongoing relationship with the corporate partner to troubleshoot potential obstacles, monitor implementation, and coordinate with broader health objectives.

Build Capacity. The GOR needs additional capacity development in order to build and manage CSR opportunities with the corporate sector. The MOH, RBC, and RDB staff need training in dealing with the corporate sector and knowledge about PSE and PPPs in the health sector. It is also important to put in place systems that will help facilitate and expedite PPPs so that the corporate sector continues to

³¹ This was expressed in a confidential interview and should be vetted further

provide CSR over the long run. Please refer to recommendations in the Leadership and Advocacy, Policy and Planning and Service Delivery sections for recommendations on building staff capacity and creating systems to engage the private sector.

Results Area: EG, RG; HSSP III Priority Area: 1, 2; Priority Level: High; Impact: ST,LT

5.4.4 Broad/Key Recommendations

- Strengthen CSR to support private sector engagement, PPPs, and increased funding for the health sector in Rwanda

5.5 HEALTH SUBSECTORS: SERVICE DELIVERY

5.5.1 Introduction

Service delivery lies at the heart of any health care system. In Rwanda, the public sector plays the dominant role in health service delivery at the tertiary level (referral hospitals), secondary level (district hospitals), and primary level (HCs, health posts, and CHWs). The private sector plays a much smaller role at all of these levels and is currently comprised of a public tertiary hospital under private management (King Faisal) that is expected to be privatized through a joint venture, several other hospitals, polyclinics, clinics, dispensaries, and some health posts. Increasingly, the GOR is interested in improved income generation and financial sustainability within the health system, and is exploring PPPs and private sector engagement at all levels as strategies to achieve this. In addition to conducting a literature review, the team interviewed the full range of private health care business owners or managers, including clinics, hospitals, pharmacies, wholesalers, medical equipment suppliers, health product manufacturers, and private insurers. The team also conducted field visits to two districts to meet with district hospital managers, HCs, health posts, and CHW cooperatives as well as a site visit to a One Family Health HP. The team also conducted KII and FGDs with USAID HO staff, MOH, RBC, DPs, and USAID IPs, among others.

5.5.2 Key Findings/Conclusions

The private service delivery subsector is small, fragmented, and highly concentrated in Kigali. It is estimated that there are only 177 private facilities in Rwanda, of which approximately 58 percent are small dispensaries owned by nurses (many of which are A2 nurses and there are policy concerns about whether they are legally allowed to operate). The vast majority of facilities are located in Kigali (59 percent) with 100 percent of private hospitals, 94 percent of polyclinics, and 64 percent of clinics based in the capital. In contrast, the rest of the country has very limited access to private health care. Please refer to the chart and graphs below for more information on the location and distribution of private health facilities in Rwanda. With the exception of One Family Health, the assessment did not identify any other examples of health service delivery networks or franchises. There is, however, a small but growing trend in group practice and medical plazas, which can be built on to encourage economies of scale in the development of the private health sector.

Table: Estimate of Private Service Delivery Providers in Rwanda³²

| Location | Hospitals | Polyclinics | Clinics | Dispensaries | Total |
|-------------------|-----------|-------------|-----------|--------------|------------|
| Kigali | 3 | 15 | 36 | 51 | 104 |
| Eastern Province | 0 | 0 | 4 | 20 | 24 |
| Northern Province | 0 | 1 | 3 | 6 | 10 |
| Western Province | 0 | 0 | 8 | 15 | 23 |
| Southern Province | 0 | 0 | 5 | 11 | 16 |
| Total | 3 | 16 | 56 | 102 | 177 |

There is an opportunity to develop a sustainable, private health post model. A private health post model could lower costs to the district health system by keeping patients out of HCs and district hospitals, thereby reducing stress on the whole system and increasing access to care. The assessment found that there is political will to develop the model with the full support of the MOH at the highest levels. There also appears to be support at the district and community level with several initiatives, such as Partners in Health’s collaboration with the Ministry of Defense, already underway with active participation and contributions at the local level. One Family Health has developed a sustainable business plan. While this model has been struggling due to a lack of CBHI payments in some districts, One Family Health believes it would be able to break even when it has 200 to 300 health posts, assuming that they can resolve the payment issues. If CBHI payments are not consistent and timely, a private health post model (One Family Health or any other) will not be sustainable.

There is significant interest in PPPs and other income-generation strategies within district hospitals. Another important finding was that there is broad support and interest in developing PPPs and other income-generation strategies at the district hospital level. This support was conveyed by key informants within the MOH, RBC, and district hospitals. District hospitals are being actively encouraged to manage their facilities “like a business” and increase income and cost efficiencies in order to reduce the overall burden to the health system. Strategies that are under consideration include private wings, private consultations/services, contracting-in private management, and outsourcing services, such as laboratory, pharmacy, waste management, and ambulances. In fact, the RBC is currently assisting two district hospitals to develop private wings and has done a preliminary financial analysis of outsourcing ambulances.

There is no clear process and legal framework, and limited capacity to develop and implement PPPs and other income-generating activities at the facility level. Despite the evident interest in PPPs and income-generating activities for district hospitals, there are several barriers to implementation. As discussed in the Policy and Planning section of this report, the legal framework for health PPPs has been drafted but not finalized. Without this framework in place, district hospitals are reluctant to move forward with PPPs or are not implementing them fully. For example, one district hospital has informally created a private wing which only operates after hours due to concerns about legality, thereby reducing its income generation potential. In addition, while there are a lot of untested ideas for PPPs and other income-generating activities, there is not a clear process or guidance on how to implement them. The RBC, which is mandated to work with district hospitals to develop PPPs, currently only has two staff members to assist district hospitals and needs more capacity and higher-level business and financial analytical skills to support this effort.

³² This information was obtained through document review and interviews and should be validated through private sector mapping

There are limited business skills and a lack of “business culture” at the facility level.

Compounding the capacity issue at the central level, district hospital managers are clinicians that do not have a business background, orientation, or skillset. Hospital administrators have stronger financial skills but typically do not have the higher-level strategy and business background that is needed to develop feasibility studies and business plans and to manage the hospital like a business. Overall, district hospital managers have a limited business mindset, which inhibits the development of PPPs and income generation.

There is an opportunity to strengthen and promote specialized services and tertiary care in the private sector. The assessment determined that there is significant interest in the private sector to develop specialized services and tertiary care. This is also widely supported by the MOH. Lack of skills in Rwanda (please refer to the Human Resources for Health section), difficulty in obtaining investment and financing, and concerns about the tariff were all cited as obstacles to increasing the private sector’s role in this area.

5.5.3 Recommendations

Develop and implement an innovative PPCP model to encourage private sector participation in the establishment and management of HPs. Based on the assessment and discussion with the MOH and other partners, a model is proposed below, which should be vetted and adjusted following more detailed financial analysis and business planning. In this model, the GOR regulates and ensures quality and standards, provides supervision, and procures drugs through the nearest HC; and the district, cell, or community provides the “ready” physical infrastructure. The business is owned and run by a private nurse. The model receives support from a private organization, which serves as a business incubator for the private HPs, offering technical assistance (including training), monitoring and reporting support, and facilitating access to finance to strengthen prospects for viability and additional income-generation activities.

Initial Investment: Initial seed capital of \$3,000 to \$5,000 per health post is needed, depending on the condition of the facility.³³ In addition, the nurse makes a personal investment of \$2,000 from savings and a loan. The initial investment covers the costs to open and equip the health post and to provide an initial stock of drugs and other consumables.

Financing: A financial institution should be identified to finance loans to the private nurses. It will be important to explore options to incentivize lending, reduce the risk to the lender, and lower the interest rate. Options may include a credit guarantee, government guarantee, or credit line. In addition to loans for start-up costs, a factoring product may be an option to help smooth cash flow for nurses.

Business Training: It will be important to provide nurses with business training and capacity-building. It is recommended to work with TVET to develop and roll out training for private nurses in entrepreneurship, business and financial management, claims management, and monitoring and evaluation. The incubator should provide follow-up business counselling and mentorship support to assist the nurses to operate viably.

Role of the Health Center: The HC will provide supervision support, collect monitoring data, process claims (this role could also be done by the business incubator to achieve efficiencies), and procure drugs.

³³ This excludes the cost of the health post, which is provided by the district/cell/community. Initial seed capital can be provided through CSR, a development partner or the GOR.

Role of the Business Incubator: The business incubator will assist nurses with start-up; provide on-going technical support in business and financial management; facilitate access to financing; support strategies for additional income-generation activities; monitor and work with nurses to troubleshoot problems; and assist the GOR in improving efficiencies, such as mobile drug procurement and claims management.

Business Model

- The health post provides a monthly fee to the business incubator as reimbursement for its services. The fee should be a nationally agreed upon percentage of gross sales.
- The health post keeps the copy and remainder of the CBHI reimbursement.
- The business incubator assists health posts to develop other revenue-generation streams, including sales of additional products at the post, and agent relationships with telecoms and financial institutions.

Other Strategies to Improve the Model

- The GOR should explore and institute electronic/mobile bill submission, drug procurement, and effective payment processing for both HPs and HCs.
- HPs should be allowed and encouraged to sell additional products/services to diversify income generation.

Next Steps: As an immediate next step, a full financial analysis and feasibility study should be conducted to fully vet start-up costs and estimates. Based on this analysis, a full business plan should be developed.

Critical Success Factors: The success of this model hinges on several key variables. Districts and communities must provide appropriate, “service-ready” facilities that are located in a commercially viable area. CBHI payments must be timely and consistent, otherwise the model will fail. This activity will be led by the GOR in collaboration with the private sector and DPs. Please see *Annex L* for more details on the proposed model.

Results Area: EG, RG HSSP III Priority Area: 1,2, 3; Priority Level: High; Impact: ST, LT

Create a risk pooling fund, which can be used to supplement the income of less commercially viable HPs. Initial analysis has determined that a HP needs 20 to 25 clients per day to break even. Due to the GOR’s goal of expanding HPs throughout the country to increase access and reduce pressure on the district health system, it is likely that some HPs will be located in more rural and less densely populated areas and will see less than 20 clients per day. It is recommended that the GOR consider establishing a risk pooling fund that will enable it to subsidize HPs that see fewer than 20 clients or others that struggle to be viable for reasons beyond their control. Subsidies should be offered on a prorated basis and carefully evaluated. Assuming 25 percent of the HPs need a 45,000 RWF subsidy per month, the MOH will need a risk pool of 243 million RWF per year. After the first year, the MOH should conduct a study on the profitability of HPs and adjust the budget for the subsidy. The GOR should explore viable options for funding the risk pooling fund, including the reallocation of part of the current PBF supported by the GOR annual national budget. This activity should be led by the GOR with support from key stakeholders.

Results Area: RG; HSSP III Priority Area: 1, 2; Priority Level: High; Impact: ST, LT

Develop and institutionalize a business and financial management capacity-building program for district hospital managers and administrators. This program should be designed to address the capacity gaps at the district level that prevent the implementation of PPPs and other income-generation

strategies. This program should consist of a competency-based, modularized, training program in entrepreneurship, PPPs, and business administration and financial management. At the end of the training, participants will understand the basics of entrepreneurship; how to conceptualize, develop, and implement PPPs and other income-generation strategies; and have acquired key competencies in business and financial management. It is recommended that the basic course be facilitator-led and delivered in a classroom. More advanced and supplemental materials should be available online for further study. The complete course will cover topics, such as:

- Entrepreneurship;
- PPPs and other income-generating strategies;
- Key business and financial management topics that are necessary for running a successful health business. These include:
 - Health as a business;
 - Operations management (human resources, procurement and inventory, medical records, facility management, and risk management);
 - Quality assurance and improvement from a business perspective;
 - Financial management (financial statements, understanding costs and profitability, payments and collections, cash flow management, budgeting, and funding the facility);
 - Marketing and promoting the health care business.

Actual topics should be finalized following a rapid needs assessment. In addition to classroom training, it is strongly recommended that follow-on mentoring and business counselling be provided on an ongoing basis to select hospitals to provide assistance in implementing business changes, developing PPPs, and cementing learning.

It is recommended that the basic course be delivered by the RBC as a first step in assisting district hospitals to initiate PPPs and income-generating strategies. The remaining modules should be housed online or within a local training partner and be offered as part of a certificate program. The implementation process for adapting and delivering the training includes:

- A rapid training needs assessment and finalization of topics;
- Curriculum adaptation;
- A training of trainers (TOT) for RBC Business Development Unit staff and local training partner(s) so that they can deliver the full training in the future;
- Roll-out of the training

The conceptualization, planning, and implementation of all training modules and processes should be coordinated by the PHSCC Secretariat and possibly supported by DPs and local or international training partners. Please refer to *Annex K* for more details on the proposed training.

Results Area: EG, RG; HSSP III Priority Area: 4, 5; Priority Level: High; Impact: ST, LT

Develop and institutionalize a PSE, business, and management capacity-building program for central-level managers. In order to address the capacity gaps at the central level, a three-day training program should be developed that will provide central-level managers with a clear understanding of the basics of entrepreneurship, health business management, and private sector engagement and PPPs. It is recommended that key personnel from the MOH and the RBC attend all three days. Personnel from the RDB's Services Unit and PPP Unit should attend the third day for the PSE module.

The implementation process for adapting and delivering the training includes:

- A rapid training needs assessment and finalization of topics;
- Curriculum adaptation;

- A TOT for RBC’s BDU staff so that they can deliver the training in the future;
- Roll-out of the training.

The conceptualization, planning, and implementation of all training modules and processes should be coordinated by the PHSCC Secretariat with support from the DPs. Please refer to *Annex K* for more details on the proposed training.

Results Area: EG; RG; HSSP III Priority Area: 4, 5; Priority Level: High; Impact: ST, LT

Support and incentivize the establishment of specialized services and tertiary care in the private sector. Given the overlap of interest between the public and private sectors, there is an opportunity to promote the development of specialized services and tertiary care in the private sector. The GOR should carefully explore and support current and new initiatives and investment opportunities for specialized health services and tertiary care (oncology, diabetes, cardiology, etc.) facilities by improving the policy environment through the creation of new incentives and revision of the tariff to encourage investment. (Refer to the Policy and Planning section for more details). Efforts to expand access to finance and strengthen business and financial management capacity in the private sector will also be important. (Refer to Investment and Access to Finance section for more details). This should be led by the GOR in collaboration with the private sector and with the support of other key stakeholders.

Results Area: EG, RG; HSSP III Priority Area: 2, 3; Priority Level: High; Impact: ST, LT

5.5.4 Broad/Key Recommendations

- Develop and implement an innovative PPCP model to encourage private sector participation in the establishment and management of HPs
- Create a risk pooling fund, which can be used to supplement the incomes of less commercially viable HPs on a prorated basis
- Develop and institutionalize a business and financial management capacity-building program for the district hospital managers and administrators
- Develop and institutionalize a PSE, business, and management capacity-building program for central-level managers
- Support and incentivize the establishment of specialized services and tertiary care in the private sector

5.6 HEALTH SUBSECTORS: HEALTH FINANCING

5.6.1 Introduction

According to the WHO, health financing “is concerned with how financial resources are generated, allocated and used in health systems. Health financing policy focuses on how to move closer to universal coverage with issues related to: (i) how and from where to raise sufficient funds for health; (ii) how to overcome financial barriers that exclude many poor from accessing health services; or (iii) how to provide an equitable and efficient mix of health services.”³⁴ Over the past 10 years, Rwanda has made substantial progress towards universal coverage, overcoming financial barriers and improving equity. It is estimated that approximately 93 percent of the population has access to health care through CBHI or *mutuelle* (72 percent); the RSSB (10 percent), which covers civil servants; the military (about 2 percent) and private insurance companies (10 percent). Approximately 7 percent of the population is currently not covered by insurance. A new law has just been finalized (March 2015) for CBHI to be merged under RSSB management starting in July 2015 in an effort gain efficiencies and to address some financial concerns and irregularities. In assessing this strategic subsector, the team conducted a literature review and held KII with private insurers, the RSSB, MOH, medical counsels, and provider association, and

³⁴ www.who.int, March 3, 2015

conducted field visits to examine health financing issues at the district hospital, HP, and CHW cooperative in more detail. Key findings and recommendations from the assessment are provided below.

5.6.2 Key Findings/Conclusions

The health financing system in Rwanda is under stress. Despite the remarkable achievement of near universal coverage, the assessment revealed that the system is coming under stress. Rwanda has a high dependency on donor funding, which currently represents more than 60 percent of health sector funding. In recent years, donor funding has been declining with a reduction in funding from both the USG as well as the Global Fund. Net official development assistance dropped by 32 percent from 2012 to 2011 alone. This has resulted in cuts in personnel at the MOH, a decline in funds available for PBF, and other reductions. Coupled with the low purchasing power of the population, Rwanda's health care system is increasingly under stress and must find alternatives to address the funding gap by mobilizing resources and improving efficiencies in order to sustain the gain in health outcomes.

The integration of CBHI under the RSSB poses an opportunity for improved efficiencies and financial management. The impending merger of the CBHI under the RSSB in July could help to improve economies of scale and efficiencies in managing a more coordinated health financing system.

The tariff is low and has not kept up with inflation. As has been discussed elsewhere in this report, almost every key informant in the private health sector and several district hospital managers expressed concern about the low tariffs for service provision, which are under review but not approved.

Inefficiencies within the CBHI claim processing and payment system creates payment delays. There are a number of inefficiencies with the CBHI claims processing and payment system which can have a negative impact on the provision of health care. While district hospitals typically have some reserves that they can use to cover payment delays, smaller facilities such as health posts do not have this cushion. If this problem is not addressed, the viability of the proposed health post model is questionable. Additional revenue generation by health posts will help mitigate some risk of late payments, but will not address the broader problem.

Private health insurance is limited but there are opportunities for expansion and better integration with the public system. While private insurance currently covers only 10 percent of the population, there are opportunities to better integrate it with the broader health financing system and create complementary and new products for the uninsured and underinsured segment of the population. Several stakeholders identified an opportunity to create a lower cost, private insurance package that would be attractive to the seven percent of the population that is currently opting out of insurance. There is a new law that will require all people resident in Rwanda to have insurance coverage, which could help spur demand for such a product. In addition, while 72 percent of the population is covered under the CBHI, this population is underinsured as they effectively do not have access to tertiary care. There may be an opportunity for the private sector to create a complementary insurance package that provides access to tertiary care for CHBI enrollees.

The majority of CHW cooperatives are operating income-generation activities, which helps strengthen the sustainability of this model, although profit is low and financial issues persist. CHWs are an important factor in Rwanda's success in achieving significant health gains in recent years. In an attempt to increase the sustainability of the CHW program and ensure that CHWs are remunerated and motivated, the MOH initiated a CHW cooperative program in 2009. The cooperatives are currently being financed through 70 percent of the PBF earned by CHWs, which is then invested in various income-generation activities in order to have a multiplier effect on their remuneration. According to the MOH, there are 45,000 CHWs grouped under 474 cooperatives throughout the country, which manage total assets of 11.3 billion RWF. The cooperative program was initially rolled out

with limited technical assistance. As a result, there was inadequate financial and business management and wide variability in income generation and profitability across the cooperatives. In 2013, the MOH hired Square Entrepreneurship Development Consult Ltd. (SEDC), a local management consulting firm, to provide TA to the cooperatives to improve their operations, management, and overall viability. Following this assistance, there appears to be measurable improvements. By November 2014, approximately 81 percent of the cooperatives were involved in income-generating activities. Profitable cooperatives are yielding on an average 7,000 RWF per CHW per month. Additional inputs are needed to continue strengthening cooperatives, scale up income generation and increase profitability.

PPPs and income generation at the district hospital level are limited. Increasingly, the MOH is looking to district hospitals to increase income generation, improve cost recovery and efficiencies, and operate like an independent cost unit. To date, however, there has been very limited implementation of PPPs and income-generation strategies. As discussed in the Service Delivery section, while there is interest in expanding income generation and improving efficiencies, most district hospital managers lack the skills and business mindset.

5.6.3 Recommendations

Establish an integrated system of health insurance combining CBHI and other social insurance schemes under the RSSB, and review the functioning of the system for its impact on quality of services, payments and equity, and sustainability. The GOR's planned merger of the CBHI under the RSSB presents an opportunity to increase efficiencies and improve operations and sustainability. There are several recommendations to strengthen the system. Firstly, the RSSB should review and modify the cost of the benefits packages and associated premiums paid by clients in different income categories every two years to ensure that they keep up with inflation. Improvements are needed within the CBHI system. Data should be computerized and more training is needed for the better management of clients and fee collection. The copayment system should be reevaluated, examining affordability, and adjusted accordingly. In addition the payment system should be reviewed and strengthened to ensure timely CBHI payments to the private sector.

Result Area: EG, RG; HSSP III Priority Area: 1, 2; Priority Level: High; Impact: ST, LT

Strengthen RSSB structural and institutional processes for a successful and smooth integration of CBHI. As a first step, it is recommended that the RSSB conduct a study of how to effectively implement the merger with the CBHI and develop concrete action and change management plans. Technical assistance should be provided to strengthen financial management within the CBHI. In addition, training should be provided to RSSB and CBHI staff to prepare them for the merger and integration. It will also be important to develop and implement an advocacy plan to raise awareness both at the leadership, private sector, and community levels on the impact of the integration. The RSSB should lead this process with technical assistance from development partners.

Results Area: EG; HSSP III Priority Area: 4; Priority Level: High; Impact: ST, LT

Explore partnerships with the private health insurance industry to increase coverage and their contribution to the CBHI. Feasibility studies should be conducted in collaboration with private insurance companies, examining the potential to increase private sector engagement in the insurance system without adversely affecting lower-income groups. Specifically, the potential for new, lower-cost products targeted to the seven percent of the market that is uninsured should be explored. Feasibility studies should also examine the potential for private insurers to develop complementary products (in conjunction with CBHI) for the underinsured. There may be an opportunity to incentivize private insurers to increase their contribution to the CBHI (which is currently only one percent) by coverage of select services by the CBHI to privately insured individuals at primary and secondary level facilities. This

process should be led by the GOR in collaboration with the private insurance industry and development partners.

Results Area: EG, RG; HSSP III Priority Area: 1, 2; Priority Level: Medium; Impact: LT

Continue efforts to strengthen CHW cooperatives by assessing current experiences with revenue generation and developing an effective model for wider replication. Going forward, it will be important to continue to build on the positive momentum initiated by SEDC to strengthen CHW cooperatives. Important goals will be to scale up successful models of income-generating activities across all cooperatives, improve operations and financial management, and increase profitability so that cooperatives are better able to sustain CHWs, especially in light of declining PBF.

Market Study: A market study should be conducted to identify best practices and business models from existing income-generation experiences by the CHW cooperatives. This study should identify opportunities to leverage economies of scale, including unions, which are currently being introduced by SEDC, as well as other forms of consolidation. The market study should also explore options and opportunities to increase the bargaining power of cooperatives, improve market linkages to both domestic and export markets as well as other strategies for increasing profitability.

Technical Assistance: Based on the findings from this study, assistance should be provided to scale up and implement an effective support model for CHW cooperatives. This will require strengthening and intensifying TA and capacity-building to cooperatives with a focus on growth and turnaround for the nonperforming ones. To support increased growth and profitability, it will be important to strengthen linkages to access finance and promote investment groups with technical support. A challenge fund that provides seed capital to select cooperatives could be a useful strategy to promote innovation and incentivize growth.

Quality Standards: A small number of cooperatives are currently in the process of obtaining quality certificates from the Rwanda Standards Board (RSB) as a strategy to increase sales and potential for export. This initiative should be encouraged and supported on a broader scale.

Tax Incentives: CHWs and cooperatives are currently required to pay taxes on income over the standard income threshold set by the Rwanda Revenue Authority (RRA). In order to promote the viability of this model, the GOR should consider giving CHWs and cooperatives a tax holiday for eight to ten years. This will be important given the declining PBF. In this regard, the MOH should prepare a business case for submission to MINECOFIN showing the critical impact and role that CHWs and cooperatives play, and justify why this tax holiday (as part of a consorted approach with other measures) will actually strengthen the backbone of the system, supporting national prosperity.

ICT: Overall, the GOR should explore opportunities to increase the use of ICT (such as mobile money) for payments, reporting, and overall management of the CHW model in order to achieve efficiency gains. Work with the CHW cooperatives should be led by the GOR with support from key stakeholders.

Results Area: RG; HSSP III Priority Area: 1, 2, 4; Priority Level: High; Impact: ST, LT

Conduct a study and evaluate the impact of possibly ending PBF from the GOR national budget for CHWs and cooperatives. There is currently discussion of ending PBF from the GOR national budget for CHWs and cooperatives. While some cooperatives have struggled, the majority are now engaged in income-generating activities that will need continued support in the near term. Loss of the PBF at this time may potentially have negative consequences that should be carefully evaluated before implementing this change. These include:

- Possible loss of motivation on the part of the CHWs

- Limited ability to increase growth and improve the profitability of cooperatives
- Reduced chances for the turnaround of nonperforming cooperatives
- Potential financial losses for cooperatives that depend on the PBF to cover operating expenses

While important improvements have been made to the CHW cooperative model, additional time is needed to strengthen cooperatives. It is recommended that the GOR conduct a study that analyzes the current and future profitability of cooperatives and examines the full financial impact of losing PBF, considering different scenarios, including a total reduction and phased reduction. Based on this analysis, the MOH should seek to replace the PBF or phase the reduction rather than terminating it at once. The MOH could consider using at least 50 percent of the overall profit of all CHW cooperatives across the country as a possible means to cover up for the loss of the PBF under the GOR's national budget. The GOR should lead this study with possible assistance from DPs.

Results Area: RG; HSSP III Priority Area: 1, 2; Priority Level: High; Impact: ST, LT

Establish a national association of HP workers and support increased income generation. In order to strengthen the HP model, a national association of HP nurses should be established. This association would serve as a platform for disseminating best practices and strategies for improving income generation. Support should be provided to the organizational development of the association and to strengthen efforts to assist HPs to develop additional income generation to diversify revenue. Potential partnerships with telecommunications companies, financial institutions, and other corporate entities should be explored. Please see the Service Delivery section and *Annex L* for more details. This activity should be led by the GOR with possible support from DPs.

Results Area: RG; HSSP III Priority Area: 1, 2; Priority Level: Medium; Impact: LT

Explore, plan, implement, and monitor new strategies for income generation and efficiency gain at the DHs. The MOH, RBC, and district hospitals are actively considering PPPs and other income-generation strategies, including setting up private wings, private consultation schemes, outsourcing of key support services, and contracting-in management services. These strategies will require detailed exploration, including conducting feasibility studies and financial analysis, identification and selection of viable opportunities, development of business plans, and formulation of implementation strategies and plans. Potential initiatives will have to be carefully assessed and examined based on the specific hospital, its location, and other business, geographic, and economic parameters - as not all activities will be suitable for every hospital. It will be important to develop RBC's capacity to effectively support, guide, and monitor the various income-generation activities at the district level. The recommended process for exploring, planning, and implementing income-generating activities is described below. In addition, more detailed information is provided on private wings, private consultation schemes, and outsourcing. In the longer term, the MOH should explore full privatization of selected facilities. Please see *Annex M* for more information

Critical General Preparatory and Process Elements

It is recommended to work through the PHSCC Secretariat to:

- Develop and operationalize a formal process to select districts based on agreed-upon criteria
- Conduct a comprehensive review and feasibility study at selected DHs to assess proposed income-generating activities
- Based on the reviews, identify and select the most viable opportunities for the hospitals
- Develop a business plan and support income-generating activities, including the development of PPP models
- Consult and coordinate with RDB to find viable partnerships with financial institutions and private investors
- Provide ongoing technical assistance to ensure the success of the income-generation strategy

- Monitor and share lessons learned and successful models with other district hospitals

Private Wing: A private wing is one possible income-generation strategy for the DHs. The addition of a private wing could generate additional resources and significantly contribute toward self-sufficiency, while becoming a new model for increased, expanded, improved, and diversified services. The recommended implementation process is described below.

Implementation Process and Policy

- Develop and institute a legal framework for the private wing provision at public hospitals
- Conduct a feasibility study and financial analysis to determine viability of private wing at select hospitals
- Develop a business model, which may include revenue sharing, leasing arrangements, and alternate customer services and pricing structure
- Develop an operations manual that can be customized and updated on annually
- Provide specific, targeted technical assistance to the DH managers and administrators to structure, implement, and manage private wings
- Devise and institute effective pricing, payment, resource tracking, and accountability mechanisms
- Conduct ongoing review, evaluation, and update of key policies, including customer services/amenities packages and pricing structure, and enforcement mechanisms
- Ensure same quality of core medical care services for private and public/general patients

Business Model and Case

- Patients pay a higher fee for getting added comfort and amenities, expedited appointments, and better customer service
- The hospital generates additional revenues, which will help improve financial sustainability and eventually lead to increased equity gain through enhanced, expanded, and improved patient care and services

Private Consultation Scheme: Private consultation schemes are another strategy to generate additional revenue at DHs and improve staff retention. Under this concept, doctors would be able to use DH facilities to provide private consultation services (i.e. dual practice) to patients under a set of defined and agreed upon policies and regulations. The private consultation scheme could come with a multitude of benefits for different constituencies; however, the underlying principles and policies need to be carefully crafted, implemented, and enforced to avoid conflict of interest or lapse of services at the hospital. DH management needs to rigorously monitor quality and overall compliance.

Implementation Process and Policy

- Develop and institute legal framework for the provision of private consultation and dual practice at the public hospitals
- Conduct feasibility study and financial analysis to determine viability of private consultation scheme
- Develop a business model, which may include revenue and cost sharing, leasing arrangements, etc.
- Develop an operations manual that can be customized and updated on annually
- Arrange for designated locations for private consultation and/or additional specialized services, such as ultrasound, MRI, advanced optical equipment, etc.
- Provide specific and relevant technical assistance to the DH managers and administrators to structure, implement, and manage private consultation schemes

- Develop and/or revise performance-based policies and effective accountability, monitoring, and enforcement mechanisms for dual practice schemes. The scope and weekly allocation of time for private consultation may take into consideration critical elements such as:
 - Setting a minimum threshold for number of patients seen in public settings per day (or over a week)
 - Quality, standards, and attention to care in public settings, verified by periodic unannounced supervision visits and patients' survey results
- Ongoing review, evaluation, and update of the policies and enforcement mechanisms annually

Business Model: Cost and Revenue Sharing

- Hospital provides private “service ready” consultation room
- Patient pays fees per consultation
- Doctor pays a predetermined percentage (e.g. 20 percent) of the fee (per consultation), which covers cost for using the space, equipment, and other utilities, as well as revenue sharing.
- Alternatively, the hospital charges the doctor a monthly fee to lease or rent the space, equipment and supplies. In this model the doctor keeps the entire consultation fee.

Outsourcing: Outsourcing is a strategy where services, both clinical and nonclinical, are contracted out to the private sector. Possible outsourcing functions include ambulance services, waste management, laundry operations, pharmacy, and lab services. Outsourcing can improve quality of services, reduce operating costs and free up management and staff to focus on core competencies.

Implementation Process and Policy

- Develop models and operations manual that can be customized for selected facilities for various possible outsourcing functions, including ambulance services, waste management, laundry operations, pharmacy, and lab services
- Develop capacity for tender and contract management
- Conduct feasibility studies to select specific functions to be outsourced
- Provide TA to the facility managers to structure, implement, and manage outsourcing
- Develop systems for quality control and implement monitoring

Privatization: In the longer term, the GOR should explore full privatization of selected facilities. Various models can be considered, including options for employee-owned facilities. In the shorter term it is advisable that the GOR initiate other PPP and income-generation strategies as a first step in this direction.

The GOR should lead the development of PPPs and income-generation strategies with support from key stakeholders.

Results Area: RG; HSSP III Priority Area: 1, 2, 4; Priority Level: High; Impact: ST, LT

5.6.4 Broad/Key Recommendations

- Establish an integrated system of health insurance combining CBHI and other social insurance schemes under the RSSB, and review the functioning of the system for its impact on quality of services, payments and equity, and sustainability
- Strengthen RSSB structural and institutional processes for a successful and smooth integration of CBHI
- Explore partnerships with the private health insurance industry to increase coverage and their contribution to the CBHI

- Continue efforts to strengthen CHW cooperatives by assessing current experiences with revenue generation and developing an effective model for wider replication
- Conduct a study and evaluate the impact of possibly ending PBF from the GOR national budget for CHWs and cooperatives
- Establish a national association of HP workers and support increased income generation
- Explore, plan, implement, and monitor new strategies for income generation and efficiency gain at the DHs, including private wings, private consultation schemes, and outsourcing

5.7 HEALTH SUBSECTORS: HUMAN RESOURCES FOR HEALTH

5.7.1 Introduction

The health sector in Rwanda suffers from shortages of health professionals of all levels and specialties as well as an inequitable geographic distribution of staff. After the genocide, the GOR focused its efforts on rebuilding a health system that not only restores the pre-1994 capacity, but also has ambitions to set HRH standards to the level of middle-income economies.

Vision 2020 calls for 10 medical doctors, 20 nurses, and five lab assistants for every 10,000 inhabitants.³⁵ This contrasts sharply with the current situation. The majority of Rwandan physicians are general practitioners, a term indicating that they did not complete a formal, postgraduate training program in a medical specialty. As of February 2011, there were 470 generalist practitioners, 133 Rwandan specialists, and 58 expat specialists working in Rwanda, for a total of 191 specialists (Rwanda Medical Council). With a total of 661 physicians (general practitioners and specialists, public and private, Rwandan and expat), the population ratio is 1 doctor per each 15,306 people (NISR Population Projection, Year 2009).³⁶

The overwhelming majority of nurses in Rwanda have an A2 certification, which means they were trained at the secondary school level. A1-level nurses that have an advanced degree following three years of nursing school, represent less than 10 percent of the total pool of nurses. A2 nurses are relatively evenly spread throughout the country, though there are still disparities between districts, with a number of under-served districts in the South, West, and Northern Provinces. On average there is about 1 nurse per every 1,500 people. The total number of nurses is estimated at 6,629, although the National Council of Nurses and Midwives (NCNM), which is responsible for nurse registration and verification of their qualifications, places this number closer to 9,000.³⁷ The MOH is in the process of phasing out the A2 category and is not currently training new A2 nurses. There are also about 1,300 other health workers (hygienists, lab technicians, physical therapists, etc.).

The most striking gaps in qualified health care workers include specialist physicians, midwives, highly skilled nurses, laboratory technicians, and biomedical engineers. Gaps, however, exist in most specializations.

5.7.2 Key Findings/Conclusions

The lack of skilled health care workers is a constraint to private sector development. While the HRH situation in Rwanda impacts the entire health sector broadly, it will specifically constrain both the speed at which the private health sector is able to develop as well as the types of services it is able to offer. Most strikingly, the lack of specialized doctors and nurses is a barrier to the development of specialized health services in the private sector, which the GOR has flagged as a priority. The gap in trained laboratory technicians will slow the speed of potential lab privatization, and as previously discussed the lack of biomedical engineers and technicians in the country creates a serious obstacle to

³⁵ Human Resources for Health Strategic Plan 2011-2016. Ministry of Health, Republic of Rwanda, March 2011, p. 7.

³⁶ Ibid,

³⁷ DHSST (District Health Strengthening System Tool), 2009

medical equipment maintenance and outsourcing to the private sector. In addition, the private health sector has limited access to training in HPP, which inhibits the delivery of these services in the private sector.

The GOR is acutely aware of the problem and has a long-term vision and plan in place for developing a skilled workforce. While the HRH gaps are daunting, the GOR is actively working to address this weakness in the healthcare system. In partnership with USAID, the MOH launched the HRH Program in 2012 that works through a consortium of top US schools of medicine, nursing, health management, and dentistry to send faculty to help strengthen the University of Rwanda's medical training programs. The program seeks to increase the number of skilled health workers, and improve health worker education, infrastructure and equipment in health facilities, and the management of health facilities. In addition, the GOR has launched a biomedical technician program under TVET and is preparing to launch a bachelors and masters of biomedical engineering program as part of the Center of Excellence. In addition the GOR has initiated Sector Skills Councils in key economic sectors- one of which is the Health Sector Skills Council (HSSC). The Steering Committee of the HSSC is primed to lead discussions and the development of policies for increased PSE engagement in the health sector.

Staff retention is a major issue for all major cadres. Rwanda has suffered a significant brain drain and staff retention is a major concern, especially for doctors in more rural areas. There is a lack of incentives to retain staff, which needs to be addressed. In some countries dual practice, which allows health care workers to operate in both the public and private sector, can be structured as an incentive and improve retention. In Rwanda, only specialists are allowed to operate in dual practice.

5.7.3 Recommendations

Continue to promote the development of specialized health workers (specialized physicians, midwives, biomedical technicians, and engineers). The GOR, with the support of its development partners, should continue to support the development of specialized health workers through TVET programs, such as the biomedical technician program, as well as select priority specialties within the University of Rwanda, including midwifery, biomedical engineering, and specialized medicine.

Results Area: EG, HSSP III Priority Area: 3, 5; Priority: High; Impact: LT

Strengthen internal capacity within the MOH, RBC, and RDB to develop and support PPPs and PSE (discussed in the policy and planning section)

Develop and conduct training and capacity-building at the district facility level (including HPs) in entrepreneurship, PSE, and business and financial management (discussed in the policy and planning section)

Increase the resources and access to HPP relevant training for the private sector. There is untapped potential to expand the private sector's support of HPP, which needs access to training in order to do so. An advocacy effort to increase the resources to support private sector participation in HPP training should be conducted with the GOR and DPs and potential corporate sponsors through CSR. Partnerships with the corporate sector, particularly telecommunications companies, should be explored to increase the use of mobile and other electronic technologies to promote HPP trainings.

Results Area: EG; HSSP III Priority Area: 1, 2; Priority: Medium; Impact: ST, LT

Improve staff retention through incentives, such as revenue-sharing under PPPs and dual practice. The GOR should consider developing incentives that will help retain doctors and other specialized health workers. These include revenue-sharing through PPPs and private consultation schemes at district hospitals. Policy regarding dual practice will need to be revised to allow health

workers to operate legally in the public and private sector. Please refer to Health Financing section for more details. This initiative should be led by the GOR in collaboration with key stakeholders.

Results Area: EG, RG, HSSP III Priority Area: 1, 2, 3, 4, 5; Priority: High; Impact: ST, LT

5.7.4 Broad/Key Recommendations

- Continue to promote the development of specialized health workers (specialized physicians, midwives, biomedical technicians, and engineers)
- Strengthen capacity within the MOH, RBC, and RDB to develop and support PPPs and PSE
- Develop and conduct training and capacity-building at the facility level in entrepreneurship, PSE, and business and financial management
- Create health business training program and follow-on assistance for district- and facility-level managers on PSE strategies and improved operational efficiencies
- Develop entrepreneurship and business training through the TVET program for HPs, and follow-on business counselling and mentoring
- Increase the resources and access to HPP-relevant training for the private sector
- Improve staff retention through incentives, such as revenue-sharing under PPPs and dual practice

5.8 HEALTH SUBSECTORS: MEDICAL PRODUCTS (INCLUDING MEDICINE), EQUIPMENT, AND TECHNOLOGY

5.8.1 Introduction

Access to affordable drugs and other health products and up-to-date and well-maintained medical equipment that utilizes appropriate technology is critical to the functioning of any health system. This section specifically examines health product distribution and retail, medical equipment supply, and maintenance and the manufacturing of products and equipment. According to the WHO, “access to essential medicines and health products is critical for reaching universal health coverage” forming an “indispensable component of health systems in the prevention, diagnosis, and treatment of disease and in alleviating disability and functional deficiency.”³⁸ Improving supply, procurement, distribution, and maintenance (in the case of medical equipment) can help strengthen cost-efficiencies within a health system and is an area that lends itself to PPPs. The HSPP III identifies the maintenance of biomedical equipment and ensuring the availability and quality control of medical commodities, drugs, and consumables and improved supply-chain management as important priorities.³⁹ In reviewing this subsector, the team conducted a literature review and held KII with private pharmacies, wholesalers, medical equipment suppliers, health product and equipment manufacturers (both domestic and international), the MPPD, the RBC, DPs, and others.

5.8.2 Key Findings/Conclusions

Product Distribution and Retail

Rwanda has a relatively active private pharmacy sector, which could play a greater role in the procurement and distribution of drugs. There are a total of 217 pharmacies and pharmaceutical wholesalers in Rwanda. Approximately one-fifth are wholesalers - many of which are also involved in importation, distribution, and retail sales. Approximately 76 percent of pharmacies are located in Kigali, although the government has recently put in place legislation that prohibits the opening of new

³⁸ www.who.int, 3/9/15

³⁹ Third Health Sector Strategic Plan (HSSP III), July 2012 – June 2018, Ministry Of Health, December 2012

pharmacies in the capital to encourage them to go to rural areas. In the past, the issue of low purchasing power of rural communities has acted as a deterrent to private sector investment.

Despite this new policy, most of the pharmacies and wholesalers that were interviewed believe this subsector is a promising one with room for additional expansion. A number of investment opportunities were identified, including the potential to expand regional sales (drugs are less expensive in Rwanda compared to some neighboring countries), chains of pharmacies and new PPPs, which would give the private sector a greater role in public procurement and distribution.

Private sector wholesalers already supply the public sector, including the RBC's MPPD and some district hospitals on a limited basis, primarily through framework agreements, which enable the public sector to purchase specified goods over a period of time on an ad hoc basis when there are stock-outs. The private sector believes that while these agreements are a good first step, they put risk on the private sector to keep drugs in stock that may not be used and could be improved to give the private sector a more consistent role in supply, which could help reduce costs. Wholesalers also expressed concerns about delays in payment from the public sector. On the retail side, private pharmacies currently participate in the RSSB and private insurance coverage and also experience significant payment delays (up to four months) in reimbursement from the public sector.

The RBC is in the process of detaching the MPPD from its current structure and turning it into more of a stand-alone organization, geared toward greater operational and management efficiencies. As it currently is envisioned, it will remain a government agency but will be run autonomously, so that it is able to act more like a private sector entity with streamlined operations, less bureaucratic human resources constraints, and faster procurement processes. The agency will have its own procurement policies, i.e. outside of the current GOR standard policies. In the longer term, there may be opportunities to privatize or partially privatize this entity.

Medical Equipment and Maintenance

The assessment identified a number of important findings, including both constraints and opportunities, in the area of medical equipment and maintenance.

Donor dependency has led to insufficient funding and planning for medical equipment maintenance and management. In the past, donors have played a large role in providing medical equipment to the GOR. While this has had many positive benefits, there have been a number of unintended consequences. As a result of the donations, Rwanda's medical equipment is not harmonized and consists of many different brands, which makes management and maintenance difficult. The RBC does not currently have a complete inventory of medical equipment although it is in the process of undertaking one. Donated equipment does not typically include funding for maintenance and in the past the GOR has not adequately budgeted or planned for this. Several of the KII revealed that many hospitals are operating with essential equipment broken for months (and in some cases years). Donor dependency has led to a culture of replacement rather than repair.

There is a lack of skilled biomedical engineers and technicians in both the public and private sectors, which the GOR is planning to address. Compounding the issues created by donor dependency, Rwanda has a lack of skilled biomedical engineering professionals both at the district and central level. As a result, it does not have the in-house capacity to repair much of its equipment. Rwanda is currently trying to rectify this skills gap through a biomedical technician training program under TVET and plans to develop a bachelor's and master's program through the RBC's planned Center of Excellence, which will serve as an East African regional hub for biomedical engineering. The GOR has

already received seed funding (\$18 million) from the African Development Bank to create the Center of Excellence.

There are complex procurement and customs requirements for medical equipment and spare parts. Procurement issues create inefficiencies, delay medical equipment maintenance and repair, and increase costs. KII revealed that the procurement process is quite lengthy and typically equipment contracts do not include service agreements to maintain and repair broken equipment. In the past, service agreements have not been included in contracts due to a lack of funding. The absence of service agreements, however, is problematic because the RBC and district hospitals do not have the in-house capacity to maintain the equipment. The inclusion of service agreements would be an incentive to the private sector to build its own capacity so that in the future the GOR could consider outsourcing medical equipment maintenance more broadly. In the short run, however, capacity is not adequate in the private sector.

In addition, while the government does not tax medical equipment, it does tax spare parts. The procurement of spare parts is subjected to the same rigorous GOR procurement processes as general goods, which can lead to substantial delays in repairing broken equipment. There is an opportunity to streamline and fast-track the procurement process for medical equipment spare parts.

Manufacturing

There is almost no commercial medical product/equipment manufacturing in Rwanda. The assessment identified one medical equipment supplier (Pharmalab), which is setting up a medical consumables manufacturing facility in the free trade zone. The RBC also has some limited manufacturing capacity. One area that the government is keen to encourage is the local manufacturing of generic drugs. The private sector, however, does not see an immediate market given the cheaper drugs from neighboring countries and India and China. High energy and transport costs and the size of the local market hamper manufacturing overall in Rwanda. There may, however, be some opportunities, such as ITNs, that should be explored further. There is almost no information on potential manufacturing opportunities in the health sector in Rwanda.

5.8.3 Recommendations

Devise and implement a parallel and phased approach on equipment management and maintenance. Addressing Rwanda's equipment management maintenance issues requires long-term planning along with some short-term steps that will result in immediate cost savings. Recommended short- and medium-to-long-term activities are outlined below:

Short Term:

- All procurements should include a service contract for repairing equipment.
- Streamline import and custom requirements for spare parts to reduce time
- Conduct an inventory of the status of medical equipment and populate the Medical Equipment Management and Maintenance System
- Create a policy and harmonize medical equipment to gain economies of scale, reduce maintenance costs, and incentive private sector investment
- Explore framework agreements for the procurement of equipment as part of the harmonization process. These agreements can help speed up procurement and facilitate the purchase of spare parts.

Medium/Long Term:

- Support the training of biomedical technicians by supporting the TVET program and the development and launch of bachelor's and master's biomedical engineering programs

- Provide technical assistance to the RBC in creating a Center of Excellence in Biomedical Engineering. This technical assistance can include support in refining the concept for the Center and developing a business model. Support will also be needed in brokering partnerships with large multinational companies. As currently envisioned, the Center of Excellence will be a public private partnership supported by long-term strategic alliances with large multinational medical equipment and diagnostic companies.

The GOR should lead the implementation of this recommendation with support from key stakeholders.
Results Area: EG, RG, HSSP III Priority Area: 3, 4; Priority Level: High; Impact: ST, LT

Through a broader consultation process with the PS, explore and support production, expansion, and diversification of select medical products and commodities, if financially viable. While manufacturing opportunities in Rwanda will be limited due to transport and energy costs and competition with very low priced products from China and India, there may be select opportunities, such as ITNs. It is recommended that a feasibility study of local production of select medical products/commodities be conducted. If feasible, the results of the study should be used to advocate and promote private sector participation in local production. Support can be given to the private sector to develop a business plan, meeting international quality standards and assistance, and in accessing finance. One area that shows promise is the production of ITNs, which a local textile firm is interested in developing. Support should be provided in examining the feasibility of this opportunity.

This activity should be led by the GOR and the private sector in collaboration with development partners.

Results Area: EG, HSSP III Priority Area: 3; Priority: Medium; Impact: LT

Explore potential for increased privatization of drug procurement and distribution, and improve current planning. Following the separation of the MPPD from the RBC, conduct a feasibility analysis of options to increase private sector engagement in drug procurement and distribution in the short term on a limited basis (as the MPPD does not appear to be interested in a larger role for the private sector over the short term). One possible area to increase private sector participation is in the supply of HPs. Over the longer run, the GOR should explore options for a larger-scale privatization of drug procurement and distribution through a PPP.

Results Area: EG, HSSP III Priority Area: 3, 4; Priority: Medium; Impact: ST, LT

5.8.4 Broad/Key Recommendations

- Devise and implement a parallel and phased approach on equipment management and maintenance
- Through a broader consultation process with the PS, explore and support production of select medical products and commodities, if financially viable
- Explore potential for increased privatization of drug procurement and distribution, and improve current planning

5.9 HEALTH SUBSECTORS: HEALTH INFORMATION SYSTEM

5.9.1 Introduction

Technology is transforming health systems worldwide, impacting service delivery, health promotion, and prevention, supply chain logistics, and health information collection and analysis, monitoring and surveillance. Reliable and up-to-date health information and statistics are vital to identify problems and needs for evidence-based decision-making at all levels, including health sector reviews, planning and optimal resource allocation, and program monitoring and evaluation. If properly harnessed, technology can create significant efficiencies, reducing costs throughout the health care system. Given the relative

importance of the private sector in ICT, there are significant opportunities for public private partnerships and private sector engagement. To assess this subsector the team conducted a literature review and KII and FGDs with the MOH, RBC, Ministry of Youth and ICT, DPs, and implementing partners, private ICT firms and joint ventures, and the Private Sector Federation's Chamber of ICT.

5.9.2 Key Findings/Conclusions

The ICT sector is developing rapidly in Rwanda with significant government support, private sector growth, and examples of successful PPPs. Vision 2020 sets an ambitious goal of transforming Rwanda into a competitive, knowledge-based economy and recognizes the importance that the ICT sector will play in achieving this goal. EDPRS II identifies technology and ICT as the second priority sector after skills and attitudes. Toward this goal, the government has made a significant investment in ICT infrastructure, installing optic fiber cable, which connects all of the districts in the country, linking all 72 government institutions and providing a foundation for private sector growth. To support this investment, the government has developed two PPPs with Korea Telecom, resulting in two joint ventures, Olleh Rwanda Networks (ORN) and Africa Olleh Services (AOS). ORN is adding 4G LTE to the fiber optic infrastructure and serving as a wholesale provider of high-speed mobile broadband. AOS is expanding Rwanda's cloud services capability, enabling business, government, and individuals to conduct a full range of economic and social activities online. In addition to these PPPs, there are a number of private telecommunications companies, expanding networks throughout the country, mobile money platforms now reach rural areas, and there has been a growth in software development firms and other IT companies.

There is a high cost to Internet usage in Rwanda. Despite the significant achievements in ICT infrastructure investment described above, there is a high cost to Internet usage, which acts as a barrier to private sector investment and growth, particularly for SMEs, which make up the majority of health care businesses in Rwanda. High set up and operational costs and unstable electricity make Internet usage costly.

The GOR has made significant strides in e-health but there are more opportunities to improve efficiencies through increased use of technology. The GOR has taken important steps to set up the foundational components of a nationally integrated e-health architecture and has begun implementing a range of health information systems, although not all systems are complete. For example, the MOH is rolling out a community health information system to more efficiently supervise CHWs. While in the past logistics management was done manually, the RBC is in the process of finalizing an electronic system that needs to be tested and rolled out through training. The MPDD of the RBC uses an online system for managing pharmaceutical supplies to district pharmacies, which in turn supply health facilities. One district hospital that was interviewed by the assessment emphasized how this system is preventing stock-outs. Despite these and many other important efforts, more work is needed to ensure that systems that are in development are finalized and rolled out with training and monitoring to ensure uptake. In addition, improved interoperability is needed to reduce duplication and fragmentation. There are significant opportunities to increase the use of technology to improve efficiencies, including using mobile and electronic claims management and payment under the CBHI as well as standardizing an electronic financial management system at the facility level.

There is an increased use of district health information software-2 (DHIS-2) but limited private sector reporting. DHIS-2 is a tool for collection, validation, analysis, and presentation of aggregate statistical data, tailored (but not limited) to integrated health information management activities. The assessment determined there is noticeable progress in the use of the DHIS system, evidenced by high reporting rates with the important exception of the private sector. As PSE increases in Rwanda it will be important to develop strategies to engage the private sector in reporting.

There are low computer and IT skills at various levels. One of the challenges in expanding the use of HIS and ICT for health is the weak level of computer and IT skills and resources throughout the system. Any effort to expand the use of technology needs to ensure that adequate training is developed and that budgets exist to ensure a proper roll-out. For example the CHAI worked with the GOR to develop an electronic Medical Equipment and Management System, which will house a much needed inventory of medical equipment. While this was developed in 2013, it has still not been populated due to a lack of budget for trained data entry workers.

Institutional capacity and systems are inefficient, resulting in a high cost of basic IT and help desk operations. There are inefficient institutional capacity and internal systems, which result in a high cost of basic IT. For example, the help desk function and some software development and maintenance are currently managed internally and are costly to the GOR. There are opportunities to outsource some IT functions to the private sector.

There are limited existing initiatives to engage the private sector in health information and mobile technology. Despite the relatively dynamic private ICT sector in Rwanda there has been limited engagement except in some notable areas, such as the Rapid SMS and Mubuzima project, which provides CHWs with mobile phones for real-time reporting on all community health data to the central level. With the increase of mobile platforms in Rwanda, including mobile money, there are opportunities to engage the private sector to improve efficiencies and streamline operations, such as mobile money payments to CHWs and health posts.

5.9.3 Recommendations

Increase efficiencies through expanded use of e-health. There are a number of recommendations to increase efficiencies through the expanded use of e-health. These are described below.

Increase outsourcing. Increased outsourcing of IT functions to the private sector will reduce costs, streamline efficiencies, and enable the MOH/RBC to focus on areas of core competency. It is recommended the MOH/RBC consult with the private sector and review the MOH/RBC's IT unit to explore options for outsourcing, including basic IT and help desk support. Based on this review, the MOH/RBC should develop a phased and prioritized action plan for increased efficiency gain through strategic outsourcing.

Engage the private sector to support interoperability of HIS. There is an opportunity to increase PSE in software development as well as building interfaces to support interoperability between key health information systems, such as DHIS-2, iHRIS, and others using the DHIS-2 API.

Strengthen operations through mobile platforms. The GOR in collaboration with its DPs should examine opportunities to strengthen operations through mobile platforms. Opportunities include engaging the private sector to develop software and mobile phone interfaces to support CBHI claims management, drug procurement at the HP level, and CHBI/PBF payments at the HP and CHW levels. The GOR should explore the opportunity to work with a telecommunications company to use CSR to reduce the transaction costs of mobile payments to CHWs and HPs.

Address the skills gap. The MOH/RBC should work with the private sector to help strengthen computer and IT skills at various level within the health system. All new (and some existing) HIS systems should be supported by training and appropriate resource allocation. The MOH should explore working through TVET to roll out additional IT training program.

Increase private sector dialogue and collaboration. The MOH/RBC should increase dialogue between the public and private sector (including service providers, insurance companies, and ICT firms) to promote and foster innovative solutions and formulation of PPPs. A key area of discussion should be how to work with insurance companies and private service providers to improve overall data collection. The GOR should lead this recommendation with possible support from the DPs.

Results Area: EG; HSSP III Priority Area: 3, 4, 5; Priority Level: High; Impact: ST, LT

5.9.4 Broad/Key Recommendations

- Increase efficiencies through expanded use of e-health.

5.10 HEALTH SUBSECTORS: HEALTH PROMOTION AND PREVENTION

5.10.1 Introduction

Health promotion and disease prevention is being addressed at all levels (community, district, and national) within Rwanda. Health promotion is the process of enabling people to increase control over their health and its determinants with the aim of improving the health of the population. Disease prevention begins with a threat to health, and seeks to protect as many people as possible from that threat. Education, behaviour change, and screening are key HPP strategies. The Rwanda Health Communication Centre under the Rwanda Biomedical Centre is responsible for HPP with the support of development partners.

Rwanda has made remarkable progress in improving health outcomes through effective HPP in areas such as malaria, TB, HIV/AIDS, neglected tropical diseases, NCDs, and FP. CHWs have been an important component of this success, providing a mechanism to extend HPP to the community level. The PSE assessment examined the potential to expand HPP to include the private sector, and opportunities to develop PPPs to strengthen HPP and improve efficiencies. This strategic area was examined through interviews, a literature review, and an examination of best practices in other countries. Key findings and recommendations are provided below.

5.10.2 Key Findings/Conclusions

Outreach and demand-creation activities are an effective strategy to improve the viability of small-scale private providers. Experience from other countries has shown that HPP strategies can be used to strengthen the client base and viability of small-scale private health providers. In Nigeria, for example, outreach and demand-creation activities significantly increased the viability of small private maternity homes.⁴⁰ This could be an effective strategy to help support the development of HPs and maximize the health benefits to the population.

PPPs related to HPP are working well, but there is room to improve and expand. Several private sector and DP key informants mentioned that there are currently several PPPs with private service providers in areas such as of TB, HIV, and MCH. Please refer to section 3.9 for more details as these PPPs are supported by other DPs. These PPPs are going well and there is significant interest on the part of the private sector to expand and build on them.

The private sector has inadequate access to HPP trainings and resources. Interviews also revealed that the private sector has very limited access to HPP-related trainings and other resources, such as posters, information materials, commodities, and diagnostic equipment/materials (HIV testing kits).

⁴⁰ Strengthening Health Outcomes in the Private Sector, Nigeria Associate Award. 2014.

There are an increased number of registered CHWs with a high commitment to work in HPP.

According to the MOH, there are approximately 45,000 CHWs in Rwanda. These CHWs demonstrate a high commitment and pride in their contributions to HPP. CHWs are an important component of Rwanda's success in achieving health gains over the past five years.

There is a need for refresher trainings and support for CHWs. The assessment determined that ongoing training to CHWs is limited. As a backbone of the GOR's HPP system, CHWs need refresher training and continuous capacity-building in areas such as maternal child health, TB, malaria prevention, and FP.

New Community Health Technicians are being trained to address NCDs and support palliative care. The MOH is in the process of launching a new cadre of CHWs that will have specialized training to deal with NCDs and provide support in palliative care at the village level. This training is being conducted in collaboration with the Workforce Development Authority.

There has been limited corporate engagement related to HPP. The assessment also determined that there has been very limited CSR in the health sector in general and in support of HPP in particular. There is a significant opportunity to create win-win relationships with the corporate sector to strengthen CSR contributions to HPP.

5.10.3 Recommendations

Increase PSE activities with targeted HPP strategies to help strengthen private sector contribution to health outcomes. Key elements of this recommendation are described below.

Develop awareness and outreach campaigns for communities with new HPs to promote use. In coordination with the development and roll-out of the new HP model, it is recommended that a targeted outreach campaign be developed that will raise awareness of HPs and their provision of key essential health services. Targeted demand-creation focused on EPCMD in communities surrounding HPs will contribute to HPP goals and help strengthen the viability of this new business model.

Increase private service provider engagement and PPPs in HPP. HPP should not remain the sole responsibility of public health institutions. The MOH should expand its existing HPP plans to increase private sector engagement, especially related to TB, HIV/AIDS, EPCMD, FP, and NCDs. The private sector should be invited to attend special trainings related to HPP and be provided with access to resources and commodities to support HPP.

Explore mHealth PPPs. While some progress has been made in using mhealth to support HPP in Rwanda, there are more opportunities to be developed in this area. Mobile telecommunications companies should be engaged to identify where corporate interests overlap with health goals. One potential area is an m-health EPCMD campaign.

Explore potential CSR for HPP. Overall, the corporate sector represents an untapped partner to support HPP. The GOR, working with the possible support of DPs, should actively engage the corporate sector to identify opportunities for increased CSR for HPP. Please refer to the CSR section for more details.

The GOR should lead activities to increase PSE in HPP with possible support from DPs.

Results Area: EG, RG; HSSP III Priority Area: 1, 2; Priority Level: Medium; Impact: ST, LT

5.10.4 Broad/Key Recommendations

- Increase PSE activities with targeted HPP strategies to help strengthen private sector contribution to health outcomes.

5.11 HEALTH SUBSECTORS: LEARNING AND KNOWLEDGE MANAGEMENT

5.11.1 Introduction

Learning and knowledge management is critical to a well-functioning health system. Production of timely, accurate, and reliable data leading to useful health information and knowledge products, their access, analysis, and usage are at the heart of evidence-based planning, policy formulation, decision-making, and action. With the ultimate goal of improving health outcomes, the HIS is the principal entry point to provide that crucial information and knowledge that can be used in planning and decision-making. The whole culture of information generation, knowledge capturing, learning, and use at all levels of the health system, from the community to facilities to decision-makers at both central and decentralized levels, is critical to improve program efficiencies and health outcomes. The assessment examined the evidence base and available data on the private health sector in Rwanda and reviewed various strategies and tools to foster learning and knowledge transfer, which could potentially be adapted to support private sector engagement. The assessment looked at three key elements:

- *Research*- including basic scientific research, experimental research, and surveys or general purpose data collection. The assessment identified the scale of existing research activities in the health sector, as well as the opportunities and challenges faced by stakeholders.
- *Knowledge Transfer*- the tools and platforms currently used to collect data and share information with stakeholders across all levels
- *Monitoring and Evaluation*- the process and approach used by public entities in supervision or monitoring activities

Promotion of learning and knowledge management through building human resource capacity and strengthening institutional research and collaboration is one of the key goals of HSSP III. As such, high priority has been placed on increasing institutional capacity in research activities, development of new research initiatives, increasing collaboration amongst learning and research institutions, and increased efficiency in monitoring and evaluation processes to enable immediate and sustainable knowledge transfer through increased access to information by all stakeholders. The Rwanda PSE assessment sought to analyze the current status of the health sector regarding these initiatives and the impact on private sector engagement as a whole.

5.11.2 Key Findings/Conclusions

Due to the crossing-cutting nature of the Learning and Knowledge Management subsector, findings and recommendations related to training (management, business, etc.) and HIS that have already been captured in other parts of this report are not repeated here.

There is limited knowledge within the GOR about health PPPs and PSE. As previously mentioned, the assessment determined that there is limited knowledge and information within the GOR about health PPPs and PSE at all levels and across multiple entities, including the MOH, RBC, and RDB. In addition, there is very limited data on the private health sector. Such data is not being collected in any systematic way and there is no central location for data on the private health sector. As a result, there is no evidence base to support decision-making on PSE and PPPs. Throughout the assessment, the team was asked by multiple stakeholders, such as financial institutions and the RDB, for market research on the private health sector.

There are a limited number of high-level research activities on the private health sector currently. Existing research is mainly focused on national health statistics and community-based health systems and carried out primarily by the MOH and DPs, chief among them USAID. The assessment identified several recent or ongoing efforts to conduct research on the private health sector, including the Rwanda Healthcare Federation's *Health Private Sector Services Performance Analysis*, which is in draft form, and Swecare Foundation's *Report on the Health Care Sector and Business Opportunities in Rwanda*, which was published in September 2014 and focused on investment opportunities for Swedish businesses. While each of these reports provides valuable information on the private health sector, none provides a comprehensive mapping and full analysis of the private health sector, including opportunities for PSE, PPPs, and constraints to growth.

There is limited clinical and operational research capacity (public and private), and inadequate PS involvement. Current clinical research activities are mainly carried out by DPs in partnership with the MOH through key implementation projects and are limited to a few areas; (i) HIV prevention and care, such as the clinical trials carried out by Project San-Francisco in partnership with Kigali University Teaching Hospital, CHUK; and (ii) specialized medical care such as oncology as exemplified by the US-based Twinning program that allows highly specialized medical physicians to train and work with local medical professionals on pediatric oncology research cases.⁴¹ ⁴² To date the private sector has played only a limited role in conducting clinical and operational research.

Most of the existing PPPs in the learning and knowledge management subsector are geared toward training and education. The GOR has extensive experience partnering with the private sector, including for-profit firms, private academic institutions, NGOs, and FBOs to provide training, capacity-building, and knowledge transfer. These partnerships include training facilitation, education, and knowledge transfer of best practices that are provided through training workshops, training of trainers (TOT), twinning programs, and short- and long-term learning programs/courses as well as in-house facilitation. One such key initiative focusing on training and capacity-building is the MOH's partnership with a consortium of US medical, nursing, and other health care colleges through the HRH Program. This program is pairing faculty from US institutions to train and build the capacity of their counterparts within the University of Rwanda's School of Public Health, College of Medical and Health Sciences, and other public learning institutions. The Ministry of Education's TVET program partners with 180 private training organizations to offer a broad range of vocational and skills-building programs. Other examples of partnerships include the MOH's contract with SEDC to provide technical assistance, training, and capacity-building to CHW cooperatives; contracts the private sector IT firms to conduct training and the development of HMIS platforms; and the Private Sector Federation-led ICT discussion forums between local IT companies and medical students on communication and reporting tools applied in medicine and the health sector that has fostered an exchange of ideas and knowledge on health information systems and tools.

5.1.1.3 Recommendations

Test different PPP models and develop operations to monitor and disseminate findings. As there currently is no evidence base on PPPs, it will be important for the MOH/RBC to develop a monitoring and evaluation system to support the planned development of PPPs. Operations research should be conducted and findings disseminated for each new type of PPP and income-generation activity. This will enable the MOH/RBC to make evidenced-based decisions in the future for rolling out and replicating

⁴¹ Rwanda Zambia HIV Research Group. (2012). Project San-Francisco. Rwanda Zambia HIV Research Group website. Retrieved from <http://www.rzhrg.org/Kigali.html>

⁴² Dana-Farber Cancer Institute. (2011 December 11). Twinning' U.S.-based and Rwandan physicians improves lymphoma outcomes in children. dana-farber cancer institute. retrieved from <http://www.dana-farber.org/newsroom/news-releases/twinning-us-based-and-rwandan-physicians-improves-lymphoma-outcomes-in-children.aspx>

successful models across other district- and community-based facilities. This activity should be led by the MOH/RBC with possible support from DPs and collaboration with district hospitals and the private sector.

Results Area: EG, RG; HSSP III Priority Area: 2; Priority: Medium; Impact: LT

Strengthen operational and clinical research. As the private sector is a new area, it will be important to strengthen the capacity of the MOH research unit to manage and conduct research on PPPs and the private health sector. The MOH should actively explore potential partnerships with the private sector to conduct operational and clinical research activities.

Results Area: EG; HSSP III Priority Area: 2, 3; Priority Level: Medium; Impact: LT

Develop, support, and disseminate knowledge, information, and evidence to facilitate PSE and income-generation. The MOH should consider a number of strategies to help develop and disseminate knowledge and lessons learned as it increases private sector engagement, public private partnerships, and income-generation strategies. The MOH should develop analytical tools that can be shared with partners to facilitate knowledge development. It will be important to knowledge-management products to provide up-to-date information that is readily and easily accessible for decision-making. The MOH in collaboration with a DP, should consider a small grants program for researchers in academia, the MOH, and private institutions to develop a body of evidence to monitor and support the overall development of PS in health. It is also recommended that the MOH encourage intra district/sector/community “learning missions” to facilitate hands-on experience and sharing of best practices. This model could be used to transfer knowledge and best practices from CHW cooperatives, HPs and district hospitals that have significantly increased income-generation. It enables to peers to interact, network, and assist each other in replicating success. Please refer to the health information systems section for a recommendation regarding the creation of a knowledge bank on the private sector.

Results Area: EG, RG; HSSP III Priority Area: 1, 2, 3, 4, 5; Priority Level: High; Impact: ST,LT

5.1.1.4 Broad/Key Recommendations

- Test different PPP models and develop operations to monitor and disseminate findings
- Develop internal capacity within the MOH, Rwanda Biomedical Center, and Rwanda Development Board to develop and support PPPs and PSE
- Develop and conduct training and capacity-building at the facility level in business and financial management
- Strengthen operational and clinical research
- Develop, support, and disseminate knowledge, information and evidence to facilitate PSE and income generation

6. KEY STRATEGIC PRIORITIES AND IMMEDIATE NEXT STEPS

The key strategic priority should be to create an improved overall enabling environment (including political and institutional) for effectively promoting, supporting, and sustaining PSE in the health sector for sustainability and to build beyond. All plans and activities should focus on the two key results areas defined by the assessment: “improvement and expansion through efficiency gain” and “resource-generation and effective mobilization.” All recommendations in the assessment report are categorized in these two results areas; priority (high, medium, low) and impact horizon (short and long term), and aligned with the five HSSP III priority areas. While many of these will take time to materialize and bear

fruit, a number of them will require rapid action, investment, and implementation to achieve relevant and useful “quick results” to create a spark and help prepare the ground for intermediate and longer-term successes. Key immediate focus should be on the following next steps, recommendations, and activities:

- ❖ Continue to build on the current momentum and interest generated by the assessment process, keep the dialogue, planning, and activities going, especially at the intra-GOR and DP level.
- ❖ Set up the PHSCC (and the Secretariat) with an official mandate and high-level representation to generate political support, set direction, and provide strategic oversight for a visible and sustainable national health PSE effort, and to bring people to consensus and build a common understanding and bridge between all key stakeholders, especially the relevant public and private actors.
- ❖ Bring onboard a short-term (three to six months) technical advisor (PPP) with strategic, coordination and organizational skills in an expedited manner to support/guide the set-up and implementation of the PHSCC and Secretariat; leveraging existing or new GOR resources, or by soliciting TA from DP(s).
- ❖ Create a platform and facilitate an environment for regular public-private dialogue to build trust and close the current knowledge and information gap regarding the health sector businesses.
- ❖ Through dialogue, consensus, and in a fully inclusive manner, use the assessment report and recommendations to prepare an approach/strategy accompanied by a prioritized and phased action plan with a clear time-line, responsibilities, and resource allocation for all PSE activities.
- ❖ Strengthen overall PPP and business development capacity at MOH and RBC by starting the process of appointing: i) a health PSE (including PPP) expert at the MOH’s PPP desk, who can help support the ministry’s PSE and PPP agenda and actively participate as a member of the PHSCC Secretariat; and ii) a long-term/permanent GOR business specialist (PPP) with high-end business development and analytical skills at the RBC’s BDU to effectively fulfill its mission to explore and help formulate PPPs and income-generation activities in the health sector.
- ❖ Conduct rapid training needs assessments and develop and institutionalize a business and financial management capacity-building program for DH managers and administrators; and PSE, business, and management capacity-building program for central level (MOH, RBC, and RDB) managers.
- ❖ Start the process of exploration and conducting feasibility studies to select, plan, and implement new strategies for income-generation and efficiency gain (private wing, private consultation scheme, outsourcing, etc.) at select DHs and CHW cooperatives.
- ❖ Conduct a feasibility study, finalize a business plan, and implement the suggested PPCP model for HP establishment and management, with a focus on sustainability.
- ❖ Evaluate and explore the recommended activities and initiate work to improve access to finance.
- ❖ Conduct a desk review to identify best practices and successful models of health PSEs for both “efficiency gains” and “resource/income-generation” activities by the governments, DPs, PS, or through any combination of partnerships in the East African countries. Use the results of this review to develop an evidence base to steer learning, guide the recommended “learning trip(s)” for the PHSCC secretariat task team, and aid the replication/formulation and implementation of Rwanda-specific PSE solutions.
- ❖ On the policy end, it should be a high priority to finalize and approve the PPP legal framework and the new GOR tariff structure; to define and adopt a legal framework for DH income-generation activities; and to explore, define, and advocate for health-specific tax and investment incentives.

7. CONCLUSION

The Rwanda Health PSE Assessment conducted a broad landscape analysis covering a wide spectrum of strategic areas (11 in total including seven health subsectors) that are necessary to create an overall enabling environment (including political and institutional) for effectively promoting, supporting, and sustaining PSE in the health sector. The report laid out the historic background, current composition, and situation (from both obstacles and opportunities perspectives), and future prospects for Rwanda's private health sector development and engagement. The report also laid out very detailed recommendations by each of the strategic areas with a set of parameters, which once vetted by the GOR and its partners, can essentially be used as the framework and roadmap for PSE activities for years to come. All recommendations are aligned with the HSSP III priorities, aimed to better engage and leverage the private health sector, and are structured using two results lenses: "improvement and expansion through efficiency gain" and "resource-generation and effective mobilization" – geared to sustain the current achievement and build beyond.

This is indeed both a challenging and opportune time for the Rwandan health sector. If the current health gains are to be sustained in light of declining external financing and donor support, the private sector must play a critical role in helping to bridge the financing gap. Rwanda's bold and visionary national leadership recognizes the importance of the private sector and has initiated efforts to support it. However, a great deal of work remains to increase private sector participation to reach the five percent goal set by HSSP III to help close the financing gap. The recommendations in this report are categorized not only by the results areas, but also based on their priority (high, medium, low) and impact horizon (short and long term). While many of these will take time to materialize and bear fruit, a number of them will require priority rapid action, investment, and implementation to achieve some "quick results" and prepare the ground for longer-term successes. For example, a key immediate focus should be to set up the PHSCC and the Secretariat; use the assessment report and recommendations to prepare a prioritized and phased action plan with responsibilities and resource allocation; build business and PPP capacity at the MOH, RBC, and RDB; train both central- and district-level managers on PSE and PPPs; analyze and support income-generation activities in select DHs and CHW cooperatives, and finalize and implement a revised HP model with a focus on sustainability; and initiate work to improve access to finance. On the policy end, it should be a high priority to finalize and approve the PPP legal framework, the new GOR tariff structure, define and adopt a legal framework for DH income-generation activities, and to explore and define health-specific tax and investment incentives. One of the immediate key tasks of the PHSCC should be to create a platform and facilitate an environment for regular public-private dialogue to build the "trust bridge" and close the current knowledge and information gap regarding health sector businesses.

The private sector has a key role to play in both gaining efficiency and generating new resources in the health sector, ultimately contributing to positive public health outcomes. Rwanda has some unique and significant challenges to that end, especially for the expansion of the for-profit health sector. As such, heightened leadership and efforts need to be made by the GOR with help from all stakeholders, particularly DPs, to effectively create an overall improved enabling environment, including a rigorous communication, information, and knowledge agenda. A vibrant and expanded private sector will help not only to reduce demand on the public sector, but more importantly to help sustain and accelerate the gains achieved by the GOR. n

ANNEX A. SCOPE OF WORK

USAID/RWANDA

Health Private Sector engagement (PSE)

ASSESSMENT SCOPE OF WORK

The goal of this assessment is to identify opportunities for USAID/Rwanda's Health Office to support the Government of Rwanda's (GOR) goal to increase private sector investment in the healthcare sector and, among them, to identify the most promising opportunities for USAID/Rwanda's Health Office to engage with private sector partners directly and to broker partnerships with the Government of Rwanda (GOR)

ASSESSMENT BACKGROUND

Rwanda has made tremendous strides in improving the health and well-being of its citizens over the past decade. The country has realized significant progress towards achieving the Millennium development goals, (4) child health, (5) maternal health, and (6) disease control. The improved delivery of public health services, high levels of external financing, and universal health insurance are significant factors for this progress. However, poverty remains high and education levels low for almost 50% of the population making them more vulnerable to poor health and well-being. Despite the level of poverty, Rwanda has utilized innovative health financing to provide almost universal access to health services resulting in a steep decline in out-of-pocket payments for health care and consequently improved access to health services. Strong planning in the GOR and Ministry of Health through the Health Sector Strategic Plans (HSSP) has been essential in these remarkable successes. The third iteration of HSSP was finalized in 2013 and covers the period 2013-2018 (HSSP III).

Based on several financing scenarios, HSSP III is underfunded and this could be exacerbated if external financing declines significantly. The total cost of HSSP III is USD \$3.7 billion over six years, for an average of approximately USD \$600 million per year. Over the course of HSSP III, a joint USAID-GOR gap analysis showed between a USD \$372 - \$697 million gap under pessimistic and mid-level scenarios. While an optimistic scenario showed virtually no gap, after nearly two years of implementation, this scenario appears unlikely. Donor funding to the health sector makes up approximately 61% of the health resource envelope and the largest health sector donors, the USG and Global Fund, are experiencing a declining trend. The GOR may need to assume a greater share of health sector recurrent costs through domestic financing as these funding streams decline. The GOR sees the private sector as an important partner in mobilizing resources to meet HSSP III goals.

Similar to other developing countries, the GDP of Rwanda is dependent on the private sector. Rwandan private sector investment in health is currently 1.7%, while an international benchmark is 5%. If Rwanda could achieve 5% private sector investment in health, it would mobilize approximately \$260 million annually, or about 50% of yearly health expenditures, which would fill the funding gap foreseen under the HSSP III mid-level scenario. Therefore, the Ministry has set a goal to increase private investment in the health sector from 1.7% of private GDP to 5%.

The Ministry of Health has developed a Health Financing Strategic Plan to increase domestic resources for health which includes private sector investment. The HSSP III and the Health Financing Strategic Plan identify several potential areas of focus to increase resources for health. These include: creating an enabling environment for private sector investment in health, including medical tourism; promoting corporate social responsibility among local and international companies; engaging the private sector in construction of new health facilities and the creation of health posts; improving hospital financial performance and the management of existing programs; and increased capacity of community health workers cooperatives in financial management and mobilizing greater district contributions in cash and in kind.

USAID has identified four overarching channels for the private sector to invest in Rwanda's health sector, thereby decreasing the overall gap in funding for HSSP III. These are: 1) Shared value; 2) Corporate social responsibility; 3) individual entrepreneurial activities by health personnel, i.e., opening a small private clinic; and 4) cost recovery of subsidized health services (vaccines, ITNs, malaria and HIV drugs, contraceptives) for public health facilities and private pharmacies, including through social marketing and/or introducing fees for certain services.

PSE ASSESSMENT PURPOSE

The purpose of the assessment is to conduct a broad landscape analysis of the private sector space and actors in health in Rwanda, honing in on priority areas for the GOR identified in HSSP III and the Health Financing Strategic Plan, and to recommend to USAID/Rwanda which sub-sectors show the most promise for public-private collaboration to achieve complementary public-private objectives. Among the criteria the assessment should consider are: impact that can be achieved by partnering with the private sector; the business challenges and/or risks that could be ameliorated by working in partnership; alignment with GOR and USG strategies; and the probability of private actors, especially multinationals, to engage with USAID and/or the GOR.

The assessment will:

- (i) Analyze the interests, challenges, and issues facing the private sector and other potential partnership partners in order to determine areas for collaboration and partnership.
- (ii) Examine:
 - Regulatory space for local and international private health sector to invest and operate in Rwanda, as well as current incentives and tax structures for private sector to engage in health
 - The capacity of the Rwandan health sector employees to understand and work with the private sector
 - Existing private sector industries that are thriving and/or are open to collaboration

- Opportunities for scaling private sector activity through collaboration, for example scaling up effective solar panel maintenance contracts nationwide to ensure off-the-grid health facilities have reliable power available
- Introducing fees for subsidized health services, and complete an actuarial analysis
- Other donor collaboration with the private sector, and the extent to which present USAID interventions overlap. Where synergies exist with other donors and opportunities for collaboration proposed.
- any loan guarantee or insurance schemes that are focused on facilitating access to finance for the health sector (particularly those that are run by the Government of Rwanda, including One Family Health/Ecobank);
- current exposure to the health sector by commercial lenders, general recommendations on what expertise or market information lenders would need to increase their exposure to the sector (e.g. new product development, health sector training for loan officers, etc.)
- Salient gender issues in the private sector (i.e., access to credit, gender breakdown of business ownership) that would affect the gender balance in the health sector

The assessment analysis is intended to inform private sector engagement plans for the Mission.

PSE ASSESSMENT METHODOLOGY

In addition to reviewing relevant documentation provided by the Mission, the Assessment Team is expected to use stakeholder (group and individual) meetings as a means of gathering data. The assessment will be conducted consistent with current USAID assessment guidelines. Rapid Appraisal techniques (e.g. key informant interviews, site observations, mini-surveys) may also be appropriate for conducting the Assessment. However, the Assessment Team will develop an appropriate methodology and work plan/schedule to address the scope of work. USAID/Rwanda has provided a number of assessment tools as annexes to this SOW, which may be used or adapted, as appropriate.

Prior to the field visit, the Mission will provide the Assessment Team with pertinent background documentation. On arrival in country, an initial briefing will be held with USAID staff and a work plan will then be presented for the information collection, assessment analysis, report, briefings, and follow-up. A presentation on findings and preliminary recommendations will be submitted prior to departure from Post. The Assessment Team will work closely with, and receive direction from the relevant IR teams.

Mission Assistance to the PSE Assessment Team

The Mission will provide reports and other background materials appropriate to the PSE Assessment. The Assessment Team shall be required to provide all logistical arrangements such as office space, international and local travel, accommodations in the field, interpreting, and secretarial and other services. The Assessment Team will be responsible for arranging local transportation. Travel may be required within selected regions to review PSE programs, activities and opportunities, and interview stakeholders and beneficiaries.

Detailed schedules for site visits and interviews will be developed by the Assessment Team in consultation with USAID/Rwanda. Logistical issues to be resolved, among others, include the number of sites to be visited, host partner institutions to be interviewed, and timing of visits to regional locations. The Mission and some implementing partners may assist in scheduling meetings and site visits. An initial list of names and locations for key individuals, both internal and external to USAID, to be interviewed will be provided by USAID/Rwanda. Chief among the USAID staff are the Mission Director, Health Office Director, Partnerships Working Group, Program Office Director and selected Health Office staff members.

PSE Assessment Questions

The Assessment Team will address, among others, the following issues and questions:

External (Private Sector) Questions:

- a) What are the major health sectors that show potential for growth and investment in the next 3-5 years? Do any of these sectors face barriers, constraints or challenges? If so, what are they?
- b) What resources (investment, technology, expertise, etc.) might the private sector bring to bear in addressing these health challenges/concerns? What resources could USAID bring to bear?
- c) What are the particular business challenges/concerns that the private sector would like help in addressing, particularly with regard to scale and sustainability? What USAID/private sector shared values issues are important to companies and can USAID help companies address those issues?
- d) What are the key areas of overlap between the key issues and concerns raised in private sector interviews and dialogue and USAID priority and potential programming?

The Assessment Team will also collect information to improve the draft assessment methodology.

PSE Assessment Deliverables

The Assessment Team shall submit a detailed work plan along with the schedule of field work specifying how the information will be collected, organized, and analyzed to meet the information needs specified in the PSE Assessment scope of work not later than two days after arrival in country.

Upon the completion of the field work and one working day before departure, the team will brief the Mission staff and conduct a draft PSE Assessment findings and recommendations presentation. The Mission will provide comments and suggestions verbally at the presentation and in writing within one week after receiving the draft. The assessment team will then produce three distinct documents. A table of deliverables follows:

| Deliverable | Draft Due | Final Due | Format |
|--|---|---|----------------------------------|
| Detailed work plan, schedule of field work | 2 days after arrival in Rwanda | 3 days after arrival in Rwanda | Electronic .doc |
| An internal USAID report (draft due two weeks after the presentation, final report two weeks following USAID feedback) | 2 weeks after the presentation | 2 weeks following USAID feedback on draft | 2 bound copies Electronic PDF |
| A publicly-available report based on the internal report but with sensitive items redacted | 3 days following the final internal report acceptance | 2 days following USAID feedback | 4 bound copies Electronic PDF |
| A publicly-available 2-5 page summary briefer | 3 days following the final internal report acceptance | 2 days following USAID feedback | 10 copies Electronic PDF |

In addition, a copy of the final internal and public reports will be submitted to:

United States Agency for International Development
Global Development Alliances Office of Development Partners
and appropriate USAID Operating Units for reporting
Ronald Reagan Building
Washington, DC 20523

To maximize readability, the body of the Assessment Report should not exceed 15 pages. There is no limit on the page limit for annexes (e.g. bibliography, work plan, expanded key findings and recommendations, tables, list of interviews). To ensure that the assessment findings, conclusions, and recommendations are presented in a way that is useful for the Mission personnel and program implementers, the following outline is recommended:

- Executive summary not to exceed two pages in length composed of findings, a brief methodology statement, conclusions and key recommendations for identified opportunities;
- Assessment introduction and background section;
- Discussion of SOW questions by applying the following format: findings, conclusions and recommendations.

The report will also include findings and recommendations on priorities for further assistance/activities in the PSE areas of opportunity. Improvements and possible synergies that can be achieved in USAID's programs supporting PSE development should be addressed. A discussion of lessons learned and best practices should be captured for consideration in the implementation of future PSE activities. In summary the PSE Assessment Report will include:

- Country context
- USAID Headquarters and Mission/Rwanda PSE policies and goals
- Situation analysis/problem statement (gaps, challenges and opportunities)
- Findings
- Recommendations that can be utilized to make well-informed strategic decisions about future PSE program planning. These recommendations would be organized by short term impact, long term systemic change, time horizon, potential for sustainability or scale, LOE by USAID staff, and would include:
 - Actionable engagement opportunities
 - Critical assumptions
 - Sectoral impact
 - Action Plan for PSE follow-up by USG, including actionable items for GOR

PSE ASSESSMENT TEAM STRUCTURE

The PSE Assessment Team may consist of up to eight persons: Assessment Team Leader, Rwandan and expatriate PSE Specialists (four; including one or two representatives through the Rwanda Health Systems Strengthening Activity), a Tax Specialist, USAID/Washington and/or USAID/Rwanda PSE Specialist or Specialists, and, optionally, a Research Associate (if available). A Mission-designated staff person will serve as the Activity Manager (AM) and prime contact for the Assessment Team. Additionally, and depending upon Mission work requirements, the AM or other Mission staff person may be assigned to the Assessment Team on a potentially full-time basis during the field visit. The Team Leader and PSE Specialist will have the following qualifications and responsibilities:

Assessment Team Leader

The background requirements and the assessment responsibilities for the Team Leader are as follows:

Education: A master's degree or equivalent in business administration, economics, international development, or finance; or a Master's Degree in a health-related field and significant private sector experience.

- Extensive experience in analyzing international health programming.
- Prior experience in leading USAID sector assessment, evaluation, and design teams.
- Interpersonal, leadership, and management skills.
- Excellent presentation and writing skills.

The Team Leader's principal responsibilities:

- Maintain contact with the Program Office, technical offices, and designated CTO and other Mission personnel.
- Guide the Assessment Team on procedures for information collection and analyses for developing assessment findings, conclusions, and recommendations.
- Conduct and Lead interviews with the private sector
- Lead the team or one of the potential two sub-teams
- Prepare draft Rwanda PSE Assessment Report.
- Conduct the briefing to Mission personnel on findings and recommendations.
- Prepare and submit a final report to the Mission.

Rwandan and Expatriate PSE Specialists

The Rwandan and expatriate PSE Specialists' background requirements and principal responsibilities are as follows:

Education: A Master's degree or equivalent in business administration, economics, international development, or finance.

- Experience in developing public-private sector partnerships.
- Experience in conducting trainings and briefings on GDA/PPP development methods and concepts.
- Prior experience in private sector studies and activities regarding GDA/PPP alliance development.
- Interpersonal, leadership, and management skills.
- Excellent presentation and writing skills.

The specialist's principal responsibilities:

- Conduct and Lead interviews with the private sector
- Lead one of potential two sub-teams, if necessary
- Recommend stakeholder and business community interviews for PSE Assessment data collection.
- Apply PSE opportunity mapping and other analyses for assessing and identifying partnership possibilities.
- Participate in Mission Assessment Report preparation, final Mission briefing on findings and recommendations, and Final Assessment Report revision and refinement.

Tax Expert

The Tax Expert's background requirements and principal responsibilities are as follows:

Education: A Master's degree or equivalent in business law, taxation, accounting, economics, or finance.

- Experience in developing economy taxation frameworks, including commercial tax policy and revenue collection
- Experience in negotiating public-private sector partnerships.
- Prior experience in private sector studies and activities regarding GDA/PPP alliance development.
- Interpersonal, leadership, and management skills.
- Excellent presentation and writing skills.

The Tax Expert's principal responsibilities:

- Conduct and Lead interviews with the government and private sector on tax issues
- Identify tax incentives and bottlenecks to private sector engagement in health
- Identify current and planned development partner interventions related to tax policy and revenue collection reform that would impact public-private partnerships

Draft tax-related findings and recommendations regarding USAID and GOR engagement with the private sector in health Participate in Mission Assessment Report preparation, final Mission briefing on findings and recommendations, and Final Assessment Report revision and refinement.

PSE ASSESSMENT SCHEDULE

Team departure for Rwanda is expected on or about mid-January. The duration of the field work is estimated to be approximately four weeks. A full draft PSE Assessment Report is expected in the beginning of March, and a final report is expected mid-late-March. The redacted report and briefer document are expected at the beginning of April, 2015.

ANNEX B. KEY GENERAL PARAMETERS, AND A NUMBER OF SPECIFIC TAX AND INVESTMENT INCENTIVES

Summary of Key General Parameters of Incentives

- a. Facilitation in investment project registration. Foreign investor is treated in the same way as Rwandan investor in matters related to incentives and facilities.
- b. Incentives offered on direct taxes on income: reduced corporate income tax rate; investment allowance deductible from profits during the first year; training and research expenses incurred and which promote activities are considered as deductible from taxable profits; tax discount in relation to profits and people employed (Rwandan); and tax discount in relation to export commodities and services.
- c. Incentives offered to investors importing specific goods: Machinery and raw materials; movable property and equipment; equipment in education field; specialized vehicles; tourist chartered airplanes; building and finishing materials; **Medical equipment, medicinal products**, agricultural equipment, livestock, fishing and inputs; and Equipment for tourism and hotel industry.
- d. Investors are also exempted from payment of value added tax (VAT) that is levied on goods and services in relation to the investment projects.
- e. Depending on the nature of projects and the importance they have to the nation, their location or the capital invested, the Cabinet (council of ministers) may put in place additional incentives and facilities to investors.
- f. Investment enterprise that invests at least a capital of USD100, 000 shall automatically give the owner the right to: recruit three expatriates with the required expertise from EAC or elsewhere; free initial work permit and a free residence visa valid for a period of one year; and right of acquiring permanent residence status in the country after depositing an amount equal to USD 500,000 on an account in one of the commercial banks in Rwanda for a period of not less than six months.
- g. Incentives on building and finishing materials for a construction project worth at least USD 1.8 Million.

Incentives particular to Value Added Tax (VAT)

The following goods and services are exempted from VAT:

Goods and services related to health purposes: *health and medical services; equipment designed for persons with disabilities; and goods and drugs appearing on the list provided for by an Order of the Minister.*

Bodies eligible for exemption are required to be recognized by Rwanda laws on public institutions, social welfare organizations, and any other form of voluntary or charity institutions.

Financial and insurance services: *premium charged on life and medical insurance services; fees charged on the operation of current accounts; transfer of shares; and Capital market transactions for listed securities.*

Goods and services imported with investment certificate: h) [...] *Medical equipment, drugs, [...].*

Other key Tax and Investment Incentives

- A registered investor that exports commodities or services that bring to the country between US\$3 million and US\$5million in a tax period, is entitled to a tax discount of 3%
- A registered investor that exports commodities or services that bring to the country more than US\$5million in a tax period, is entitled to a tax discount of 5%.
- A registered investment company gets tax discount of 2%, 5%, 6%, and 7% if it employs between 100 and 200, 201 and 400, 401 and 900, and more than 900 Rwandans respectively.
- A registered investor that invests the amount of at least 30 million RWF in new or used assets and the business assets are held at the establishment for at least three tax periods, is entitled to an

investment allowance of 40% of the invested amount. That allowance is deductible in the first tax period of purchase and/or of use of such an assets.

- All training and research expenses incurred and declared, which promote activities during a tax period are considered as deductible from taxable profits.
- If a business legally results in a loss in a tax period, the loss may be deducted from the business profit in the next five tax periods, earlier losses being deducted before later losses.
- In case of reorganization of companies, the transferring company is exempt from tax in respect of capital gains and losses realized on reorganization.

ANNEX C. RWANDA'S DECENTRALIZED HEALTH SYSTEM

At the village level, community health workers (CHWs) are supervised administratively by those in charge of social services and technically by those in charge of HCs (generally by the CHW Coordinators). CHWs receive compensation for their work from performance-based financing (PBF) through formally established local cooperatives. At the sector level, HC committees provide oversight of the work of the various units in the HC, its outreach and supervision activities, and general financial control.

The agencies at the district level are DHs, pharmacies, Community-Based Health Insurance (CBHI), and HIV/AIDS committees. For clinical services, they report to the director of the DH. For administrative matters, however, the agencies are under the supervision of the party responsible for social affairs of the district, the District Health Unit (DHU). This is an administrative unit in charge of the provision of health services in the district and responsible for planning, monitoring, and supervision of implementing agencies. It is part of the inter-sectoral collaboration and coordination with DPs and civil society through the Joint Action Development Forum (JADF). The DHU is composed of a district director of health with three technical staff members (planning, health promotion/disease prevention, and monitoring and evaluation [M&E]), and reports to the vice-mayor for social affairs or to the District Council directly, if necessary.

The District Health Management Team (DHMT) is comprised of the district director of health, the hospital director, the director of mutuelles, the director of pharmacy, and a representative of the HC Manager (titulaires). It is chaired by the vice-mayor for social affairs. The role of the DHMT revolves around planning and management, supervision, coordination, financial and resource oversight, regulation, and increasing participation on the part of the local community in the delivery and management of services.

The Rwanda Decentralization Strategic Framework (RDSF), launched in 2000, has now finalized its second phase (reducing the number of districts from 106 to 30) and recently entered its third phase, aiming to increasingly transfer power and authority to the 30 District Councils. According to the Decentralization Implementation Plan, this third phase “needs to improve on the key downward accountability linkages between local government leadership and citizens.”

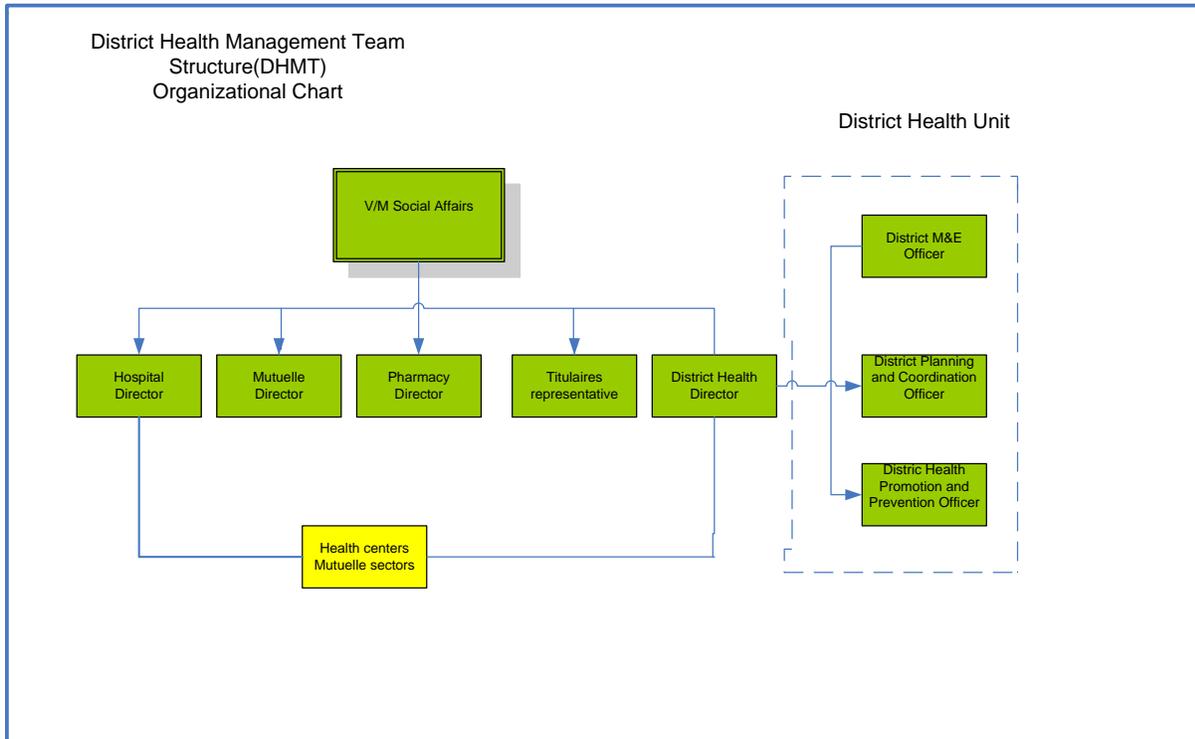


Figure: Structure of the decentralized health system

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ANNEX E. KEY STAKEHOLDERS / PEOPLE INTERVIEWED

| No. | Name | Meeting Type | Organization name | Stakeholder Category |
|-----|----------------------------|-----------------|--|----------------------|
| 1 | Dr. Gunther Faber | FGD | One Family Health, OFH | NGO |
| 2 | Maggie Chirwa | FGD | One Family Health, OFH | NGO |
| 3 | Keith Johnston | FGD | One Family Health, OFH | NGO |
| 4 | Mukunzi Jean Louis | FGD | One Family Health, OFH | NGO |
| 5 | Anne Staple | FGD | MSH | NGO |
| 6 | Michael Karangwa | FGD | USAID/Rwanda | DP |
| 7 | Therese Kunda | FGD | MSH | IP |
| 8 | Spencer Bugingo | FGD | Ministry of Health, MOH | GOR |
| 9 | Dr. Pascal Kayobotsi | FGD | Ministry of Health, MOH | GOR |
| 10 | Dr.Parfait Uwaliraye | FGD | Ministry of Health, MOH | GOR |
| 11 | Nkunda Denis | FGD | Ministry of Health, MOH | GOR |
| 12 | Joy Atwine | FGD | MSH | IP |
| 13 | Randy Wilson | FGD | MSH | IP |
| 14 | Pierre Dongier | FGD | MSH | IP |
| 15 | Appolline Uwayitu | FGD | MSH | IP |
| 16 | Dr. Moses Ahabwe | FGD | MSH | IP |
| 17 | Dennis Akishuri | FGD | MSH | IP |
| 18 | Anne Martin Staple | FGD | MSH | IP |
| 19 | Ingeri Denyse | FGD | Ministry of Health, MOH | GOR |
| 20 | Nyinawunkuri Josephine | FGD | Ministry of Health, MOH | GOR |
| 21 | Nizeyimana Theophile | FGD | Ministry of Health, MOH | GOR |
| 22 | Dr. Kayobotsi Pascal | FGD | Ministry of Health, MOH | GOR |
| 23 | Peter A. Malnak | KII | USAID/Rwanda | DP |
| 24 | Damascene Gasherebuka | KII | RAHPC | PB |
| 25 | Nishimwe Jean Claude | KII | Kibogora Hospital | GOR |
| 26 | Dr. Gerard Ngendahimana | KII | Rwanda Healthcare Federation, RHF | PB |
| 27 | Cyriaque Rugwizangoga | KII, Site Visit | Pharmalab | PS-H |
| 28 | Jean Damascene Nsengiyumva | KII | NUDOR | PB |
| 29 | Sautet Ngarambe | KII | Pharmacie Continentale (Wholesaler) | PS-H |
| 30 | Dr. Desire Ndushabandi | KII | KMISC Lab | PS-H |
| 31 | Pauline Wanjohi | FGD | UAP Insurance Rwanda Ltd | PS-NH |
| 32 | Jackson Koome | FGD | UAP Insurance Rwanda Ltd | PS-NH |
| 33 | Dr. Kanimba Celestin | KII | Polyclinique La Medicale | PS-H |
| 34 | Shema N Fabrice | KII | Pharmacie La Continentale/Africa Med. Supplier | PS-H |
| 35 | Dr. Raymond Muganga | KII | National Pharmacy Council, NPC | PB |

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|----|---------------------------|-----|---|----------|
| 36 | Daniel Nkubito | KII | Rwanda Development Board, RDB | GOR |
| 37 | Eulade Mutembe | KII | Pharmacie Conseil | PS-H |
| 38 | Florence Gatome | KII | Price Waterhouse Cooper,PWC | PS-NH |
| 39 | Sanjay Singh | KII | Sun Enterprises (Pharmaceutical Wholesaler) | PS-H |
| 40 | Dr. Jean de Dieu Gatsinga | KII | Private Medical Association | PB |
| 41 | Dr. Agnes Binagwaho | FGD | Ministry of Health, MOH | GOR |
| 42 | Dr. Patrick Ndimubanzi | FGD | Ministry of Health, MOH | GOR |
| 43 | Dr. Jean Pierre Nyemazi | FGD | Rwanda Biomedical Center, RBC | GOR |
| 44 | Nkunda Denis | FGD | Ministry of Health, MOH | GOR |
| 45 | Edouard Niyonshuti | FGD | Rwanda Biomedical Center, RBC | GOR |
| 46 | Ingeri Denyse | FGD | Ministry of Health, MOH | GOR |
| 47 | Zacharie | FGD | Ministry of Health, MOH | GOR |
| 48 | Emmanuel Rugomboka | KII | Jembi Health Systems, Jembi HS | PS-H |
| 49 | Doris Youngs | KII | Chemonics | NGO |
| 50 | Ritesh Patel | KII | Utextrwa | PS-NH |
| 51 | Jean C. Nyirinkwaya | FGD | Hopital la Croix du Sud | PS-H |
| 52 | Uwimana Liberata | FGD | Hopital la Croix du Sud | PS-H |
| 53 | Amizero Willy | FGD | Hopital la Croix du Sud | PS-H |
| 54 | Dusabe Beata | FGD | Hopital la Croix du Sud | PS-H |
| 55 | Dr. Alphonse Karagirwa | KII | BioMedical Center, BMC | PS-H |
| 56 | Dr John Nkurikiye | FGD | Dr. Agarwal's Eye Hospital | PS-H |
| 57 | S. Raghavendran Rao | FGD | Dr. Agarwal's Eye Hospital | PS-H |
| 58 | Dr. Manasse Nzayirambaho | FGD | UR/School of Public Health | AC |
| 59 | Dr. James Humuza | FGD | UR/School of Public Health | AC |
| 60 | Alex Ntare | KII | Private Sector Federation, PSF | PB |
| 61 | Pansik Shin Ngenzi | FGD | Africa Olleh Services, AOS | PS-NH |
| 62 | Manzi Olivier Rwaka | FGD | Africa Olleh Services, AOS | PS-NH |
| 63 | Maurice Toroitich | KII | Kenya Commercial Bank, KCB | FI |
| 64 | Fabrice Munyakazi | KII | Ecobank | FI |
| 65 | Jean Marie Niyitegeka | KII | Ministry of Youth and ICT | GOR |
| 66 | Dr. Emile Rwamasirabo | KII | King Faisal Hospital, KFH/Medical Council | PS-H/GOR |
| 67 | Dr. Phil Cotton | FGD | UOR, School of Medicine and Health Sciences | AC |
| 68 | Jerome Bushumbusho | FGD | UOR, School of Medicine and Health Sciences | AC |
| 69 | Tineyi Mawocha | KII | Urwego Opportunity Bank, UOB | FI |
| 70 | Didier Nkurikiyimfura | KII | Ministry of Youth and ICT | GOR |
| 71 | Arnout van der Maas | FGD | i+Solutions | PS-NH |
| 72 | Felix Hitayezu | FGD | i+Solutions | PS-NH |
| 73 | Eddy Kayihura | KII | Broadband Systems Corporation, BSC | PS-NH |
| 74 | Dr. Emile Rwamasirabo | KII | King Faisal Hospital, KFH | PS-H/GOR |
| 75 | Jeffrey D. Bowan | FGD | USG (Department of State) | DP |
| 76 | Israel Moya | FGD | USG (Department of State) | DP |
| 77 | Clementine | FGD | USG (Department of State) | DP |

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|-----|------------------------|-----------------|--|------|
| 78 | Daniel Handel | FGD | USAID/Rwanda | DP |
| 79 | Malik Haidara | FGD | USAID/Rwanda | DP |
| 80 | Leon Greg | FGD | USAID/Rwanda | DP |
| 81 | Joseph Lessard | FGD | USAID/Rwanda | DP |
| 82 | Gerald Mugabe | FGD | MINECOFIN | GOR |
| 83 | Emilija Timmis | FGD | MINECOFIN | GOR |
| 84 | Judy Chang | FGD | USAID/Rwanda | DP |
| 85 | Mukashema Lawrence | FGD | USAID/Rwanda | DP |
| 86 | Judith Nyirarukundo | FGD | USAID/Rwanda | DP |
| 87 | Triphine Munganyinka | FGD | USAID/Rwanda | DP |
| 88 | Alphonse Nkusi | FGD | USAID/Rwanda | DP |
| 89 | Elizabeth Rwanyilijira | FGD | USAID/Rwanda | DP |
| 90 | Mbabazi Jennifer | FGD | USAID/Rwanda | DP |
| 91 | Silver Karumba | FGD | USAID/Rwanda | DP |
| 92 | Julie Kimonyo | FGD | National Council for Nurses and Midwives, NCNM | PB |
| 93 | Pandora Hardtman | FGD | National Council for Nurses and Midwives, NCNM | PB |
| 94 | Tabet Tommaso | FGD | Swiss Agency for Development and Cooperation | DP |
| 95 | Bart Lippens | FGD | Belgian Embassy | DP |
| 96 | Charlotte Taylor | FGD | Belgian Development Agency, BTC | DP |
| 97 | Robert Banamwara | FGD | UNFPA | DP |
| 98 | Dr. Denise Ilibagiza | FGD | UNICEF | DP |
| 99 | Grace Muriisa | FGD | UNICEF | DP |
| 100 | Dieudonne Ruturwa | FGD | UNAIDS | DP |
| 101 | Dr. Innocent Gakwaya | FGD | Rwanda Social Security Board, RSSB | GOR |
| 102 | Dr. Diane Ruranganwa | FGD | Rwanda Social Security Board, RSSB | GOR |
| 103 | Alexis Rulisa | FGD | Rwanda Social Security Board, RSSB | GOR |
| 104 | Daan Potgieter | FGD | Abbott Laboratories | PS-H |
| 105 | Laurie Pickard | FGD | USAID/Rwanda | DP |
| 106 | Dr. Rutagengwa Alfred | FGD, Site Visit | Nyamata District Hospital/Bugesera | GOR |
| 107 | Jean Gatabazi | FGD, Site Visit | Nyamata District Hospital/Bugesera | GOR |
| 108 | Ndabereye Theophile | FGD, Site Visit | Nyamata District Hospital/Bugesera | GOR |
| 109 | Karambizi Francois | FGD, Site Visit | Bugesera District Health Unit, DHU | GOR |
| 110 | Rusagara Hortence | FGD, Site Visit | Nyamata District Hospital/Bugesera | GOR |
| 111 | Ndaruhutse Victor | FGD, Site Visit | Nyamata District Hospital/Bugesera | GOR |
| 112 | Bertin Gakomere | FGD, Site Visit | Nyamata District Hospital/Bugesera | GOR |

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|-----|-------------------------------|-----------------|--|-----|
| 113 | Harerimana Gaspard | FGD, Site Visit | Mayange Health Center/Bugesera District | GOR |
| 114 | Rwaburindi Prince | FGD, Site Visit | Rulindo District Health Unit, DHU | GOR |
| 115 | Dr Frederick Fundi Gatere | FGD, Site Visit | Rulindo District Hospital, Rutongo | GOR |
| 116 | Vugayabagabo Martin | FGD, Site Visit | Rulindo District Hospital, Rutongo | GOR |
| 117 | Nigirente Ancille | FGD, Site Visit | Remera Mbogo Health Center/ Rulindo District | GOR |
| 118 | Muneza Theodore | FGD, Site Visit | Remera Mbogo Health Center/ Rulindo District | GOR |
| 119 | Jeanne Mukamushumba | FGD, Site Visit | Remera Mbogo Health Center/ Rulindo District | GOR |
| 120 | Gaspard Harerimana | FGD, Site Visit | Mayange Health Center/Bugesera District | GOR |
| 121 | Umulisa Josette | FGD, Site Visit | Mayange Health Center/Bugesera District | GOR |
| 122 | Jean Marie Viannery Ndaribite | FGD, Site Visit | Mayange Health Center/Bugesera District | GOR |
| 123 | Clarisse Iturinde | KII, Site Visit | Kibenga Health Post | GOR |
| 124 | Rwagasana Jonas | FGD, Site Visit | Baho Remera-Mbogo (CHW) Cooperative | GOR |
| 125 | Kamuhanda Jean De Dieu | FGD, Site Visit | Rulindo District Health Post | GOR |
| 126 | Niwemuiza Familienne | FGD, Site Visit | Rulindo District Health Unit, DHU | GOR |
| 127 | Patrick Uwihanganye | FGD, Site Visit | Rulindo District Health Unit, DHU | GOR |
| 128 | Manirafasha J.D'Amour | FGD, Site Visit | Rulindo District Health Unit, DHU | GOR |
| 129 | Josephine Nyinawankuri | FGD | Ministry of Health, MOH | GOR |
| 130 | Dushime Augustin | FGD | Ministry of Health, MOH | GOR |
| 131 | Umutoni M Claire | FGD | Ministry of Health, MOH | GOR |
| 132 | Alex Gisagara | FGD | Ministry of Health, MOH | GOR |
| 133 | Frederic Muhoza | FGD | Ministry of Health, MOH | GOR |
| 134 | Gillaume Rugira | FGD | Ministry of Health, MOH | GOR |
| 135 | Nkanika L Nnette | FGD | Ministry of Health, MOH | GOR |
| 136 | Venuste Nsanzumuhire | FGD | Ministry of Health, MOH | GOR |
| 137 | Olivier Mukulira | KII | Workforce Development Authority, WDA | GOR |
| 138 | Jean Louis | KII | MINECOFIN | GOR |
| 139 | Dr. Diane Ruranganwa | KII | Rwanda Social Security Board, RSSB | GOR |
| 140 | Jeanne d'Arc Mukagatayija | KII | Rwanda Development Board, RDB | GOR |
| 141 | Benjamin Manzi | KII | Rwanda Development Bank, BRD | GOR |
| 142 | Caleb Rwamuganza | FGD | MINECOFIN | GOR |
| 143 | Jonathan Nzayikorera | FGD | MINECOFIN | GOR |

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|-----|----------------------------|-----|--|----------|
| 144 | Jeanette Rwigamba | FGD | MINECOFIN | GOR |
| 145 | JMW Birasa | KII | Rwanda Biomedical Center, RBC | GOR |
| 146 | Dr. Theophile Dushime | KII | Ministry of Health, MOH | GOR |
| 147 | Spencer Busingo | KII | Ministry of Health, MOH | GOR |
| 148 | Dr. Jean Baptiste Mazarati | FGD | Rwanda Biomedical Center, RBC | GOR |
| 149 | Dr. Gatare Ignace | FGD | NCST | GOR |
| 150 | Maggie Chirwa | FGD | One Family Health, OFH Rwanda | PS-H |
| 151 | Mukanturo Euphrasie | FGD | Nyabikenke Health Post | GOR |
| 152 | Hassan Lumumba | KII | DASH-S Technologies Inc | PS-H |
| 153 | Dr.Parfait Uwaliraye | KII | Ministry of Health, MOH | GOR |
| 154 | Nkanika L Nnette | KII | Ministry of Health, MOH | GOR |
| 155 | Chantal | KII | SEDC | PS-NH |
| 156 | Charles Kagame | KII | Rwanda Revenue Authority, RRA | GOR |
| 157 | Hubert Ruzibiza | FGD | Rwanda Development Board, RDB | GOR |
| 158 | Diane Sayinzonga | FGD | Rwanda Development Board, RDB | GOR |
| 159 | Sankaran Narayanan | KII | Belgian Development Agency, BTC | DP |
| 160 | Ngendahimana Gerard | FGD | Rwanda Healthcare Federation, RHF | PB |
| 161 | Charlotte Taylor | FGD | Belgian Development Agency, BTC | DP |
| 162 | Theoneste Turahirwa | FGD | SEDC | DP |
| 163 | Michael Karangwa | FGD | USAID/Rwanda | DP |
| 164 | Jesse Joseph | FGD | USAID/Rwanda | DP |
| 165 | Nkunda Denis | FGD | Ministry of Health, MOH | GOR |
| 166 | Manzi Olivier Rwaka | FGD | Africa Olleh Services, AOS | PS-NH |
| 167 | Hardtman Pandora | FGD | National Council for Midwives and Nurses, NCNM | PB |
| 168 | Martin Ovberedjo | FGD | WHO | DP |
| 169 | Pierre Dongier | FGD | MSH | IP |
| 170 | Musonera Francoise | FGD | Pharmacie Conseil | PS-H |
| 171 | Mutembe Danny | FGD | Pharmacie Conseil | PS-H |
| 172 | Akishuri Dennis | FGD | MSH | IP |
| 173 | Laurie Pickard | FGD | USAID/Rwanda | DP |
| 174 | Kalinda Sam | FGD | MINECOFIN | GOR |
| 175 | Diana Murebwayire | FGD | SEDC | PS-NH |
| 176 | Atakiet Berhe | FGD | UNICEF | DP |
| 177 | Judy Chang | FGD | USAID/Rwanda | DP |
| 178 | Ashley Smith | FGD | USAID/Rwanda | DP |
| 179 | Dr. Alphonse Karagirwa | FGD | BioMedical Center, BMC | PS-H |
| 180 | Dr. Emille Rwamasirabo | FGD | King Faisal Hospital | PS-H/GOR |
| 181 | Marie Ahmed | FGD | USAID/Rwanda | DP |
| 182 | Fabienne Shumbusho | FGD | Rwanda Healthcare Federation, RHF | PB |
| 183 | Joy Atwine | FGD | MSH | IP |
| 184 | Uwayitu Apolline | FGD | MSH | IP |

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|-----|---------------------------------|-----|------------------------------------|-------|
| 185 | David Gafishi | FGD | Rwanda Biomedical Center, RBC | GOR |
| 186 | John Wilson | FGD | Rwanda Biomedical Center, RBC | GOR |
| 187 | Therese Kunda | FGD | MSH | IP |
| 188 | Dr. Kayitesi Kayitenkore | FGD | Rwanda Medical Association | PB |
| 189 | S.Raghavendran Rao | FGD | Dr. Agarwal's Eye Hospital | PS-H |
| 190 | Rwemo Innocent | FGD | Polyclinique Du Plateau | PS-H |
| 191 | Sautet Ngarambe Ngora | FGD | Pharmacie Continentale | PS-H |
| 192 | Gilbert N. Kayinamura | FGD | Broadband Systems Corporation, BSC | PS-NH |
| 193 | Nyirinkwaya Jean Chrysostome | FGD | La Croix Du Sud | PS-H |
| 194 | John Wilson | FGD | Rwanda Biomedical Center, RBC | GOR |
| 195 | David Gafishi | FGD | Rwanda Biomedical Center, RBC | GOR |
| 196 | Dr. Agnes Binagwaho | FGD | Ministry of Health, MOH | GOR |
| 197 | Dr.Parfait Uwaliraye | FGD | Ministry of Health, MOH | GOR |
| 198 | Dr. Jean Pierre Nyemazi | FGD | Rwanda Biomedical Center, RBC | GOR |
| 199 | Nkunda Denis | FGD | Ministry of Health, MOH | GOR |
| 200 | Edouard Niyonshuti | FGD | Rwanda Biomedical Center, RBC | GOR |
| 201 | Marie Ahmed | FGD | USAID/Rwanda | DP |
| 202 | Andrew Kyambadde | FGD | USAID/Uganda | DP |
| 203 | Wilberforce Owembabazi | FGD | USAID/Uganda | DP |
| 204 | Eugene Cooper | FGD | USAID/Mozambique | DP |
| 205 | Marta Mabasso | FGD | USAID/Mozambique | DP |
| 206 | Meagan Schronce | FGD | USAID/Mozambique | DP |
| 207 | Ishrat Husain | FGD | USAID/Washington | DP |
| 208 | Kelly Wolfe | FGD | USAID/Washington | DP |
| 209 | Lois A. Schaefer | FGD | USAID/Washington | DP |

ANNEX F. KEY ASSESSMENT PROCESS STEPS AND PHASES

Key Process Steps:

- ❖ *Step 1:* Identified key institutional structures and stakeholders, related plans and policies, and key informants.
- ❖ *Step 2:* Prepared and submitted a work plan, conceptual framework (CF) and key review questions (RQ) and sub-questions, methodology, processes, and data collection tools for USAID's review and approval.
- ❖ *Step 3:* Held inbriefs with USAID/R and the GOR.
- ❖ *Step 4:* Used the data collection tools, RQs/sub-questions, and the CF to collect information from all identified stakeholders at various levels, both public and private (guided by the USAID/R and GOR):
- ❖ *Step 5:* Identified key assets (including 'best practices' and what works'), opportunities, weaknesses, gaps, and challenges. Identified key barriers, underpinning the weaknesses and gaps within the strategic areas.
- ❖ *Step 6:* Identified key findings and conclusions, formulated an initial set of recommendations (along with illustrative activities, priority and impact levels, associated responsible and/or collaborating parties) to address the opportunities and/or barriers.
- ❖ *Step 7:* Held outbriefs to validate and get feedback from USAID/Rwanda and GOR on the initial findings and recommendations.
- ❖ *Step 8:* Held a stakeholders' workshop to present, discuss, validate, and further build on findings and recommendations.
- ❖ *Step 9:* Prepared GOR ministerial outputs, full draft report, and technical briefing.
- ❖ *Step 10:* Revised and finalized report.

Rwanda Health PSE Assessment: An Evidence Based Drive



ANNEX G. REVIEW QUESTIONS

RQ1. What is the status of the private health sector (by sub-sector) in Rwanda and what are the opportunities for growth and investment (by subsector) in the next 3-5 years?

a. What is the current status and size of the private health sector in Rwanda by subsector (Service Delivery, Health Financing, Human Resource for Health, Medical Products, Equipment and Technology, Health Information System, Health Promotion and Prevention, Learning and Knowledge Management)

i. What are the major opportunities by sub-sector?

ii. What are the major barriers/constraints or challenges by sub-sector?

b. What are the major health subsectors that show potential for growth and investment in the next 3-5 years?

RQ2. What is the status of public private partnerships in health and what are the opportunities in the next 3-5 years and constraints?

RQ3. Does the enabling environment support private health sector development?

a. What is the overall policy environment for the private health sector?

b. Does the GOR support private health sector development and what are the GOR's priorities vis-à-vis the private sector

c. Is there an adequate legal/regulatory framework for PPPs?

d. How do tax policies impact the private health sector?

e. How do investment policies impact investment in the health sector?

f. What is the capacity of the GOR to regulate, engage and dialogue with the private health sector?

RQ4. What resources exist to support health sector development?

a. What is the status of access of to finance and investment in the health sector? Can access to finance be increased?

b. What are the prospects that private providers will be able to participate in national health insurance?

c. What is the status of corporate social responsibility for the health sector? Are corporations interested in providing CSR funding? What are the opportunities to increase CSR?

d. Does the private health sector have adequate advocacy bodies to dialogue with the government?

e. What resources could USAID bring to bear? What resources do other donors bring to bear?

RQ5. What are the business challenges/concerns that the private sector would like help in addressing, particularly with regard to scale and sustainability? What USAID/private sector shared values issues are important to companies and can USAID help companies address those issues?

ANNEX H: CONCEPTUAL FRAMEWORK QUESTIONS KEY STRATEGIC AREAS AND SUB-SECTORS

The following table provides questions for the key strategic areas/sub-sectors of the assessment conceptual framework mapped against the broad Review Questions (RQ) and sub-questions. Please refer to the beginning of the document for a complete list of the RQs.

| Key Strategic Areas | Questions |
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| All Stakeholders | <p>Key General Broad Interview Questions for All Stakeholders</p> <ul style="list-style-type: none"> • In your opinion, what are some of the key strengths of PSE in health and efforts to further expand and strengthen it (i.e., what is working well?) • In your opinion, what are some of the key weaknesses or challenges of PSE in health and efforts to strengthen it (i.e., what is not working so well?) • How would you describe the GOR's leadership of and advocacy for increased PSE in health? • How is the policy environment conducive or not conducive to PSE in health? • Recognizing the remarkable progress the GOR has achieved in the health sector, what are 2 or 3 HSS priorities that the government should pursue in regards to PSE in health to help sustain its achievements? • How or in what areas do you think future USG/USAID investment in PSE can do the most good? • How or in what areas do you think other future DPs investment in PSE can do the most good? • How or in what areas do you think the various commercial sector companies' (with explicit example/ideas) any future investment in PSE can do the most good in the health arena? |
| Leadership and Advocacy | <p>Government of Rwanda (refer to Policy and Planning for additional questions)</p> <p><i>Overarching Questions</i></p> <ol style="list-style-type: none"> 1. To what extent is there effective leadership at various levels (national, district, local) for PSE in health? (RQ3) 2. To what extent is there political support for PSE in health and how is it demonstrated? (RQ3) <p><i>Key Probing Questions</i></p> <ul style="list-style-type: none"> • Is there a single national 'champion' who can mobilize people at all levels of the health system to support and implement increased PSE? (RQ3) • Who are the potential champions in each key agency and what are their roles, understandings, and leadership skills related to PSE? (RQ3) • Are there public recognition and expressions of support for PSE from the senior leadership/decision makers? (RQ3) • Does failure impose loss of reputation, position or income for the senior officials/decision makers? (RQ3) |

- Do the senior officials/decision makers encourage innovation and risk taking? (RQ3)
- Do the senior officials/decision makers actively participate in high level stakeholders' discussions about PSE and lead/follow-up/avail/facilitate necessary regulations/incentives/resources to achieve them? (RQ3)
- Are the senior officials/decision makers aware of any existing and/or future internal/external resistance to change in regards to greater PSE in health and have a plan to deal with it? (RQ3)
- Does the GOR support PSE and what are their priorities and concerns? (to be examined within and across ministries and other entities)? (RQ3)
- What is the capacity of Rwandan health sector employees to understand and work with the private sector? (RQ3)

Provider Associations

- Does the private health sector have adequate advocacy bodies to dialogue with the government?(RQ4)
- Are there associations that exclusively represent private health care businesses? (RQ4)
- What services do they provide their members? (RQ4)
- How many members do the associations have and how many are women? (RQ1)
- What is the total number of private health care businesses in their sector and how many are owned by women? (RQ1)
- What are their challenges as an organization? (RQ4)
- How many women do they have in leadership positions within the association? (RQ4)
- What are the major opportunities and barriers/constraints facing association members, particularly with regard to scale and sustainability? (RQ1,RQ5)
- How can they best assist members to leverage opportunities and address business challenges and what assistance do they need from USAID or others to do so? (RQ4)
- What assistance do they currently receive from donors or others to support the private health sector? (RQ4)
- What are their biggest challenges in representing members' interests and what assistance do they need to better represent members to promote private sector growth and investment? (RQ4)
- What changes could be made or mechanisms put in place to improve dialogue and facilitate advocacy with the government? (RQ3)
- What are the opportunities for public private partnerships in the subsector and what role could the association play in helping to facilitate them? (RQ2,4)
- Is access to finance/investment a constraint for members and what role could the association play in helping to facilitate it? (RQ4)

Other Donors

- Do other donors currently support PSE and PPPs in the health sector or have plans to do so? (RQ4)
- Do other donors have resources that could be used to support PSE? (RQ4)
- Do other donors have an interest in collaborating with USAID on a PSE agenda? (RQ4)
- What do other donors consider to be the biggest challenges and opportunities for private sector growth and investment and what is needed to address them? (RQ1)

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| Policy and Planning | <p>Overarching Questions</p> <ul style="list-style-type: none"> • How are the GOR strategies (including health) in place used to guide PSE strengthening efforts? (RQ3) • Do the key institutions involved in PSE have the necessary mandate to play their assigned roles? (RQ3) • How is the policy environment conducive or not conducive to improved and expanded PSE in health? (RQ3) <p>Key Probing Questions:</p> <ul style="list-style-type: none"> • Are there formal and accepted national evidence-based PSE strategic plan and policies? (RQ3) • Does PSE plan/strategy have a corresponding prioritized and budgeted operational/implementation plan? (RQ3) • Are the PSE policies and strategies fully aligned with the sectoral and national development plans? If not, how specifically they obstruct or contradict each other? (RQ3) • Do the current policies provide the necessary support to help fully implement the PSE plan (if there is one)? (RQ3) • Is there a formal and effective mechanism in place to regularly review PSE related policies, strategy, and associated implementation plan at annual intervals to ensure that they remain relevant to both overall national and health sector development plan/goals and are followed and updated? (RQ3) • What is the overall policy environment for the private health sector and specific subsectors? (RQ3) • How does the GOR’s HSSP III and Health Financing Strategic plan address the private sector and PSE? (RQ3) • Is there a legal/regulatory framework for PPPs and PSE and how is it being applied and implemented? (RQ3) • How do investment policies impact private investment in the health sector (by subsector) and what changes could be made to incentivize private sector investment in health? (RQ3, RQ4) • Is there a willingness by the government to concede investment incentives in the health sector? (RQ3, RQ4) • Are there specific subsectors that the government considers strategic for private investment and PPPs? (RQ3, RQ1) • What is the level of support within the GOR for introducing fees for certain services at public facilities? (RQ3) |

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| | <ul style="list-style-type: none"> • What percent of the population receives subsidized health services and products and what is the GOR’s view on market segmentation vis-à-vis the private health sector? (RQ3) • What is the capacity of the GOR to regulate, engage and dialogue with the private health sector? (RQ3) • Are there formal forums/mechanisms that facilitate public private dialogue? (RQ3) • Which entities are responsible for PSE and does the GOR have or plan to develop a PPP unit within the MOH? (RQ3) • Is there a mechanism for intersectoral coordination within the GOR to support PSE and PPPs in the health sector? (RQ3) • What is the prospect for including the private sector in national health financing? (RQ1, RQ3, RQ4) • How do tax policies impact the private health sector and what changes could be made to tax policy to incentivize PPPs and private sector growth?(RQ3) • Is there support within the GOR for modifying tax policies and eliminate barriers? (RQ3) • How does the policy and regulatory environment impact the importation and sale of health products and equipment in the private sector? (RQ3, RQ1) • Are there government imposed restrictions on prices of health services and products in the private sector? (RQ3, RQ1) • Does the government have any programs to incentivize financing to the health sector or other priority sectors, which could be adapted to health? (RQ3, RQ4) • Does the government currently contract with the private sector and are there contracting out policies, procedures and capacity in place? (RQ3) • Is there a registry of private facilities and is it current (RQ3, RQ1)? • What are the requirements and process for establishing and operating a private facility/pharmacy? (RQ3) • Is dual practice (work in both public and private sector) legal in Rwanda? (RQ3) • Is advertising of health services or brands or products legal in Rwanda? (RQ3) • How does the GOR ensure quality of services in the private sector? (RQ3) • What does the GOR do to prevent the importation/sale of counterfeit/expired medicines in the private sector (RQ3)? • What assistance could be provided to the GOR to support PSE policy and planning and are there existing resources (USAID/other donors) to provide this support? (RQ3, RQ4) |
| Health Sub-Sectors | |
| Service Delivery | <ul style="list-style-type: none"> • What is the current status, size and location of the private health service businesses (solo practitioners, clinics, hospitals, laboratory and diagnostic facilities)? What number is owned by women? (RQ1) • Does the private sector currently provide essential health services, such as family planning, HIV and AIDS services, malaria prevention and treatment, and what are the prospects for increasing this? (RQ1), (RQ8) • What is the number/value of medical referrals (medical evacuations) outside of Rwanda and the type of diseases? (RQ1) |

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| | <ul style="list-style-type: none"> • What is the potential for medical tourism in Rwanda? (RQ1) • What are the opportunities in the health services subsector and prospects for growth in the next 3-5 years? (RQ1, RQ8) • Are there opportunities for scaling private sector activity in this subsector? (RQ1) • What PPPs currently exist in this subsector and what are the opportunities for PPPs? (RQ2) • What are the major barriers/constraints or challenges in this subsector? (RQ1, 8) • How does competition with the public sector impact prospects for growth? (RQ1,RQ3) • How is the demand and ability to pay for services in the private sector? Is it growing? (RQ1) • What is the willingness and ability of public sector customers to pay for certain services at public facilities? (RQ1) • What is the capacity at the facility level to implement fee-for-service or other income generation activities? (RQ1) • What are the opportunities to work with other private sector companies (catering, laundry, solar panels, etc.) to contribute to improved service delivery in the public sector? (RQ1) • What market segment does the private sector serve? (RQ1) • Are there specific tax, regulatory or policy issues that impact this subsector? (RQ3) • What is the status of access to finance and investment in this subsector? (RQ4) • Are there quality issues in the private health sector? (RQ1) • What assistance does this subsector require to address constraints to spur growth and improved sustainability and is it open to collaboration? (RQ1, RQ4, RQ5, RQ9) • What USAID/private sector shared values/issues are important to companies in this subsector and can USAID help companies address those issues? (RQ5) • What types of PSE activities in this subsector have the best chance to achieve sustainability and would potential partnerships result in the necessary local capacity to carry out the work in the future? (RQ10) |
| Health Financing | <ul style="list-style-type: none"> • What is the current status, size and location of the commercial health insurance companies and how many lives are covered? What number is owned by women? (RQ1) • What were the total value of premiums collected last year by commercial insurance providers? (RQ1) • Do private insurers have contractual relationships with private/public/NGO health facilities? (RQ1) • Are there other non-government health financing schemes? (RQ1) • What are the opportunities in this subsector and prospects for growth in the next 3-5 years? (RQ1, RQ8) • Are there opportunities for scaling private sector activity in this subsector (RQ1) • What PPPs currently exist in this subsector and what are the opportunities for PPPs? (RQ2) • Are there opportunities for private insurance to participate in the national health |

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| | <p>insurance system? (RQ1)</p> <ul style="list-style-type: none"> • What are the major barriers/constraints or challenges in this subsector? (RQ1, 8) • How does competition with the public sector impact prospects for growth? (RQ1,RQ3) • What is the demand and ability to pay for private health insurance? Is it growing? (RQ1) • What market segment does it serve and is there opportunity to move into other market segments? (RQ1) • Are there specific tax, regulatory or policy issues that impact this sector? (RQ3) • What is the status of access to finance and investment in this subsector? (RQ4) • What assistance does this subsector require to address constraints to spur growth and improved sustainability and is it open to collaboration? (RQ1, RQ4, RQ5, RQ9) • What USAD/private sector shared values/issues are important to companies in this subsector and can USAID help companies address those issues (RQ5) • What types of PSE activities in this sub-sector have the best chance to achieve sustainability and would potential partnerships result in the necessary local capacity to carry out the work in the future? (RQ10) |
| <p>Human Resources for Health</p> | <ul style="list-style-type: none"> • What are the estimates of health personnel in the public and private sectors by cadre? (RQ1) • Is the remuneration in the private sector attractive for health personnel locally and regionally? (RQ1) • Are there shortages in health care workers in Rwanda and how does this impact the private sector (by subsector)? (RQ1) • What is the status of private medical education in Rwanda? How many private medical/nursing schools exist, where and how many are owned by women? (RQ1) • How many students (by cadre) are enrolled in private training institutions? (RQ1) • What are the continuing medical education requirements for private service providers? (RQ1) • What are the private sector opportunities in the subsector and prospects for growth in the next 3-5 years? (RQ1, RQ8) • Are there opportunities for scaling private sector activity in this subsector? (RQ1) • What PPPs currently exist in this subsector and what are the opportunities for PPPs? (RQ2) • What are the major barriers/constraints or challenges in this subsector? (RQ1, 8) • How does competition with the public sector impact prospects for growth? (RQ1,RQ3) • What is the demand and ability to pay for private medical education? Is it growing? (RQ1) • Are there specific tax, regulatory or policy issues that impact this sector? (RQ3) • What is the status of access to finance and investment in this subsector? (RQ4) • Are there quality issues in private medical education? (RQ1) • What assistance does this subsector require to address constraints to spur growth and improved sustainability and is it open to collaboration? (RQ1, RQ4, RQ5, RQ9) |

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| | <ul style="list-style-type: none"> • What USAD/private sector shared values/issues are important to companies in this subsector and can USAID help companies address those issues (RQ5) • What types of PSE activities in this sub-sector have the best chance to achieve sustainability and would potential partnerships result in the necessary local capacity to carry out the work in the future? (RQ10) |
| Medical Products, Equipment, Technology | <ul style="list-style-type: none"> • What is the current status, size and location of the subsector (broken down by private pharmacies, pharmaceutical distributors, medical equipment suppliers and manufacturers)? What number is owned by women? (RQ1) • Does the private sector currently provide essential health products, such as family planning, HIV and AIDS, malaria prevention and treatment, and what are the prospects for increasing this? (RQ1), (RQ8) • What are the opportunities in this subsector and prospects for growth in the next 3-5 years? (RQ1, RQ8) • Are there opportunities for scaling private sector activity in this subsector (RQ1) • What PPPs currently exist in this subsector and what are the opportunities for PPPs? (RQ2) • What are the major barriers/constraints or challenges in this subsector? (RQ1, 8) • How does competition with the public sector impact prospects for growth? (RQ1,RQ3) • What is the demand and ability to pay for products, equipment and technology in the private sector? Is it growing? (RQ1) • What market segment does the private sector serve? (RQ1) • Is there an opportunity to increase private sector share through social marketing? (RQ1) • Are there importation issues that impact this subsector? (RQ1, RQ3) • Are stock-outs of essential health products (contraceptives, antiretroviral, etc.) a problem in the private sector? (RQ1, RQ3) • What percent of manufacturing serves the local market vs. export? (RQ1) • What incentives exist to stimulate manufacturing? (RQ3) • Are there specific tax, regulatory or policy issues that impact this subsector? (RQ3) • What is the status of access to finance and investment in this subsector? What is the status of supplier credit? (RQ4) • Are there quality issues in this subsector? (RQ1) • What assistance does this subsector require to address constraints to spur growth and improved sustainability and is it open to collaboration? (RQ1, RQ4, RQ5, RQ9) • What USAD/private sector shared values/issues are important to companies in this subsector and can USAID help companies address those issues (RQ5) • What types of PSE activities in this sub-sector have the best chance to achieve sustainability and would potential partnerships result in the necessary local capacity to carry out the work in the future? (RQ10) |
| Health Information Systems | <ul style="list-style-type: none"> • Does telemedicine currently exist in Rwanda? What are the opportunities and constraints? (RQ1) • What is the current status and size of the private IT sector (mobile operators, software companies, other IT platforms)? What number is owned by women? (RQ1) |

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| | <ul style="list-style-type: none"> • How does the private IT sector currently serve the health sector (health financing, insurance, ICT, health systems strengthening, data management, etc.)? (RQ1) • What are the opportunities to expand private IT services to the health sector and prospects for growth in the next 3-5 years? (RQ1, RQ8) • Are there opportunities for scaling existing private sector activity in this subsector? (RQ1) • What PPPs currently exist in this subsector and what are the opportunities for PPPs? (RQ2) • What are the major barriers/constraints or challenges in this subsector? (RQ1, 8) • How does competition with the public sector impact prospects for growth? (RQ1,RQ3) • What is the demand and ability to pay for services in the private sector? Is it growing? (RQ1) • Are there specific tax, regulatory or policy issues that impact this sector? (RQ3) • What is the status of access to finance and investment in this subsector? (RQ4) • What assistance does this subsector require to address constraints to spur growth and improved sustainability and is it open to collaboration? (RQ1, RQ4, RQ5, RQ9) • What USAD/private sector shared values/issues are important to companies in this subsector and can USAID help companies address those issues (RQ5) • What types of PSE activities in this sub-sector have the best chance to achieve sustainability and would potential partnerships result in the necessary local capacity to carry out the work in the future? (RQ10) |
| Health Promotion and Prevention | <ul style="list-style-type: none"> • Is the private sector involved in health promotion and prevention? (RQ1) • Are these private companies or NGOs and what number are owned/run by women? (RQ1) • What are the opportunities in this subsector and prospects for growth in the next 3-5 years? (RQ1, RQ8) • Are there opportunities for scaling private sector activity in this subsector (RQ1) • What PPPs currently exist in this subsector and what are the opportunities for PPPs? (RQ2) • What are the major barriers/constraints or challenges in this subsector? (RQ1, 8) • How does competition with the public sector impact prospects for growth? (RQ1,RQ3) • What is the demand for and ability to pay for health promotion and prevention in the private sector? Is it growing? (RQ1) • Are there specific tax, regulatory or policy issues that impact this sector? (RQ3) • What is the status of access to finance and investment in this subsector? (RQ4) • What assistance does this subsector require to address constraints to spur growth and improved sustainability and is it open to collaboration? (RQ1, RQ4, RQ5, RQ9) • What USAD/private sector shared values/issues are important to companies in this subsector and can USAID help companies address those issues (RQ5) • What types of PSE activities in this sub-sector have the best chance to achieve sustainability and would potential partnerships result in the necessary local capacity to carry out the work in the future? (RQ10) |
| Learning and | <ul style="list-style-type: none"> • What kinds of private and civil society organizations are involved in learning and KM |

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| Knowledge Management (KM) | <p>(media, research organizations, NGOs)? What is the size of this subsector?</p> <ul style="list-style-type: none"> • Does the health sector engage with the media and are there opportunities to increase the media’s role in learning and KM? (RQ1) • What are the opportunities in this subsector and prospects for growth in the next 3-5 years? (RQ1, RQ8) • Are there opportunities for scaling private sector activity in this subsector (RQ1) • What PPPs currently exist in this subsector and what are the opportunities for PPPs? (RQ2) • What are the major barriers/constraints or challenges in this subsector? (RQ1, 8) • How does competition with the public sector impact prospects for growth? (RQ1,RQ3) • Are there specific tax, regulatory or policy issues that impact this sector? (RQ3) • What is the status of access to finance and investment in this subsector? (RQ4) • What assistance does this subsector require to address constraints to spur growth and improved sustainability and is it open to collaboration? (RQ1, RQ4, RQ5, RQ9) • What USAID/private sector shared values/issues are important to companies in this subsector and can USAID help companies address those issues (RQ5) • What types of PSE activities in this sub-sector have the best chance to achieve sustainability and would potential partnerships result in the necessary local capacity to carry out the work in the future? (RQ10) |
| Investment and Access to Finance | <ul style="list-style-type: none"> • Are financial institutions lending/investing in the health sector and what is the overall portfolio size? (RQ4) • Are there any guarantee or other programs that are facilitating access to finance for the health sector? (RQ4) • What types of financial products are offered to the private health sector? (RQ4) • Are there local, regional or global private equity firms willing to invest in the health sector in Rwanda? What would incentivize investment? (RQ4) • What are the major risks and constraints of financing the private health sector? (RQ4) • What are the gender concerns related to access to finance? (RQ4) • Are there any legal, policy or tax issues that constrain local and foreign financing to the sector? • What role do remittances play in supporting investment in the health sector? Are there opportunities to incentivize diaspora investment (RQ3, RQ4) • What would help incentivize local and international financial institutions and investors to expand into the health sector? (RQ4, RQ8) • What do financial institutions/investors think are the major opportunities in the health sector over the next 3 to 5 years (RQ1) • What do financial institutions/investors think are the major challenges to the private health sector (RQ1) |
| Corporate Social Responsibility (CSR) | <ul style="list-style-type: none"> • What sectors/companies are most active in CSR efforts? (RQ4) • What are the opportunities to expand CSR for health? (RQ4) • Are there PPPs between the government/donor sector and corporations to support health outcomes? Could this be expanded? (RQ4) • Do corporations provide healthcare to employees/catchment areas? Could this be |

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| | <p>expanded? (RQ4)</p> <ul style="list-style-type: none">• Do the company's interests and challenges intersect with USAID's development goals? (RQ8)• What types of CSR partnerships have the best chance to achieve sustainability and result in the necessary local capacity to carry on the work (RQ10) |
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ANNEX I: CONCEPTS FOR PRIVATE HEALTH SECTOR COORDINATION COMMITTEE (PHSCC) AND SECRETARIAT

Overview:

An immediate key strategic step and success factor toward better facilitation and coordination of private sector engagement (PSE) in health would be to launch an urgent process to establish a *Private Health Sector Coordination Committee (PHSCC)* actively supported by a *Secretariat*. The PHSCC should have an official mandate and high level representations to generate political support, set direction, and provide strategic oversight for a visible and sustainable national health PSE effort. A key function of the PHSCC will be to bring people to consensus and build a common understanding and bridge between all key stakeholders, especially the relevant public and private actors. Ultimately, the goal is for it to become a *one stop point* for all ‘who’, ‘what’, and ‘where’ in relevance to PSE in health, but *not* an implementation arm.

Structure, Formulation, and Key Functions:

| Private Health Sector Coordination Committee (PHSCC) | |
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| Structure and Formulation | Key Functions/Activities |
| <p>Chair: Honorable Minister, Ministry of Health (MOH)</p> <p>Co-Chair: Permanent Secretary (MOH)</p> <p>Secretary: Director General - Policy, Planning and Health Financing (MOH)</p> <p>Members:</p> <ol style="list-style-type: none"> 1. CEO or COO, Rwanda Development Board (RDB) 2. Head, Services Development Department (RDB) 3. Head, PPP Unit (RDB) 4. Director General, Rwanda Biomedical Center (RBC) 5. Head, Division of Planning, M&E, and Business Strategy (RBC) 6. Director General – Clinical and Public Health Services (MOH) 7. Division Manager, Corporate Service Division (MOH) 8. Representative (MINECOFIN) 9. Representative (MINEDUC) 10. Representative (MINICOM) 11. Representative (MINIY&ICT) 12. Two Representatives (District Health Directors) 13. Representative (Development Partner Coordination Group, DPCG) 14. Representative (Key Private Sector Association) | <ul style="list-style-type: none"> ▪ Generate the necessary political support, set direction, facilitate, and provide strategic oversight for a visible and sustainable national health PSE effort at all levels ▪ Ensure regular, effective, and inclusive dialog among all stakeholders to foster consensus building, especially building common understanding and trust between the public and private actors toward further fostering a conducive environment for increased PSE ▪ Regularly review all relevant regulatory and policy issues, advocate for and initiate the necessary dialogs for legislative support/change(s) at both public and private levels to facilitate, foster, and further incentivize increased PSE in health ▪ Develop and steer long-term sustainability strategies for effective PSE in health ▪ Using the PSE assessment results - guide, oversee, and ensure the preparation of a prioritized and phased draft Action Plan with an associated implementation plan and strategy; seek feedback on the draft Action Plan and commitments from all stakeholders to support it; and use this input to finalize the Action Plan ▪ Present the proposed Action Plan to all key stakeholders including the Development Partners (DPs) and private sector actors to solicit expressions of interest in supporting specific action areas ▪ Provide approval/clearance for all PSE programs and activities, deliverables, milestones and any changes in preset/agreed scope(s) and results |

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| | <ul style="list-style-type: none"> ▪ Effectively analyze and devise plan to strategically align key PSE initiatives and activities with the overall national goals and strategies such as, Vision 20/20, EDPRS II, and HSSP III ▪ To the maximum extent possible, ensure that all PSE activities are part of the GOR planning and support the overall health sector goals and priorities at both national and local levels ▪ Ensure that any activities supported outside the GOR workplan are relevant, demand driven, and fully aligned with overall GOR plans and priorities ▪ Define, verify, and track progress on agreed timelines, roles and responsibilities for all players ▪ Ensure appropriate and effective accountability mechanisms are in place for all parties ▪ Monitor and ensure reporting on progress toward goals, targets, results, and expenditures in a timely and transparent manner ▪ Based on recommendations, initiate process and advise relevant parties/entities on measures for efficiency gain and performance improvement ▪ Review, build, strengthen and sustain current and new strategic partnerships for sustainable PSE ▪ Review, approve and mobilize technical assistance (TA) requests for potential PS initiatives ▪ Provide an avenue through which major PSE related conflicts and disagreements can be resolved ▪ Meet at least once every 3 months, or as frequently as it deems necessary to fulfill its mandate |
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PHSCC Secretariat

| Structure and Formulation | Key Functions/Activities |
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| <p>Headed By: Director General - Policy, Planning and Health Financing (MOH)</p> <p>Members:</p> <ol style="list-style-type: none"> 1. Manager, Services Development Division (RDB) 2. Line Manager, PPP Unit (RDB) 3. Manager, Business Development Unit (RBC) 4. Business Specialist (Technical Advisor), Business Development Unit (RBC) 5. Representative (Policy & Planning) – Directorate of Policy, Planning and Health Financing Unit (MOH) 6. Representative (Health Financing) – Directorate of Policy, Planning and Health Financing Unit (MOH) 7. PPP Desk Representative (MOH) 8. Director, Health Policy & Regulation Unit | <ul style="list-style-type: none"> ▪ Facilitate the PHSCC in all decision making ▪ Regularly scan the environment, research, review, dialog, and analyze to identify opportunities and formulate briefings, plans and options to be reviewed and considered by the PHSCC for increased PSE in health at all levels ▪ Engage in regular and effective dialog with all stakeholders, particularly the private sector players (such as quarterly meetings) to share and solicit ideas and feedback on existing environment, setting priorities, identifying opportunities, and formulation of strategies, plans and options for increased PSE at all levels. ▪ Constantly and consistently research and review all relevant regulatory and policy aspects and formulate expert opinions and propositions for regulatory support/changes(s) to facilitate, foster, and further incentivize increased PSE in health ▪ Using the PSE assessment outcomes, under the |

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| <p>(MOH)</p> <p>9. Director, Health Services Quality Assurance Unit (MOH)</p> <p>10. Two Representatives (District Hospital Directors)</p> <p>11. Representative (Development Partner Coordination Group, DPCG)</p> <p>12. Two Representatives (Key Private Sector Association)</p> | <p>overall guidance of the PHSCC, prepare the draft prioritized and phased Action Plan (including visible and high impact ‘quick wins’) with associated implementation strategy in a fully participatory and inclusive manner</p> <ul style="list-style-type: none"> ▪ Prepare all follow-up draft work plans and activities through ensuring active and effective dialog and coordination with all key stakeholders including the private sector to validate and agree on all activities and strategic directions in a complementary manner both at the national and local levels. ▪ Develop a strategy and plan to monitor implementation progress and alignment of implementation resources and programs with the strategic plan ▪ Ensure that all initiatives and supported activities are fully complementary to all other ongoing or planned PSE activities supported by either GOR, private sector or DPs ▪ Identify current and propose new partnerships and alliances as needed and on an ongoing basis for increased and effective health PSE ▪ Track, verify and report on progress to the PHSCC toward targets, results, and expenditures in a timely manner ▪ Review the roles, responsibilities and performance of relevant parties/entities and recommend measures for efficiency, performance improvements and increased coordination ▪ Assess data and information demand/needs focusing on health PS facilitation and development, and coordinate with others to design analytical tools and responsive information and knowledge management products, including a ‘knowledge bank’ with up to date data/information that is readily and easily accessible ▪ Review and analyze technical assistance (TA) requests for PS initiatives, and recommend funding ▪ Identify and review unexpected obstacles, and formulate and recommend solutions ▪ Document and share lessons learnt (i.e., ‘what works’ and ‘what doesn’t’) with broader national constituencies ▪ Meet at least once a month, or as frequently as it deems necessary to fulfill its mandate |
|---|--|

Key Next Steps:

- 1.** Launch an immediate dialog and consultation process at the top level management to evaluate and finalize the proposed models for the PHSCC and the Secretariat - including the structure, membership and key functions and activities.
- 2.** Organize a high level stakeholders/proposed membership meeting to agree and officially launch the PHSCC and the Secretariat.
- 3.** Bring onboard a short term expert to effectively support and facilitate Nos. 1 and 2 above, and to guide and support the Secretariat in the short run (3-6 months). The expert should have strong:
 - a.** Background in strategic thinking, planning, and communication;
 - b.** Organizational development and management skills;
 - c.** Stakeholders' and alliance development and management skills; an
 - d.** Understanding of PSE in health.

ANNEX J. BUSINESS SPECIALIST (PPPS) IN RBC'S BUSINESS DEVELOPMENT UNIT

Overview and Background:

Created by the law no54/2010 of 25th January 2011, Rwanda Biomedical Center (RBC) is the implementation arm of the Ministry of Health (MOH). Its mission is *to promote quality affordable and sustainable health care services to the population through innovative and evidence based interventions and practices guided by ethics and professionalism*. One of RBC's fourteen divisions, *The planning, Monitoring and Evaluation Division* is a cross-cutting division under the direct supervision of RBC Director General's Office and has four units: i) Planning Unit, ii) M&E Unit, iii) Health Information System Unit, and iv) Business Development Unit. It is the Business Development Unit (BDU) that is tasked to assess, analyze, create and support formulation of viable business opportunities for the MOH. In this regard, BDU is actively looking into opportunities for viable businesses through private sector engagement (PSE) and other means to create income generating activities at public facilities within the health system.

Current Capacity and Key Recommendation:

Designated with the critical task of assessing, analyzing, creating and supporting the formulation of viable business opportunities for the MOH, and playing a key role in coordination of PSE in health in consortium with the MOH and Rwanda Development Board (RDB), the RBC's BDU is relatively new and currently has a very active, informed, and enthusiastic Manager in place. However, the overall technical capacity of the unit to fulfil its mandate is inadequate at the moment. Currently BDU has only two personnel: the unit Manager and a Senior Business Officer, mainly performing simple, limited business profit and loss (P&L) analysis. The unit lacks the critical high end business thinking and analytical skills that are essential for assessing and crafting ideas, and formulating PSE strategies and opportunities. It is understood that a third fulltime staff, a *Business Specialist* position has been approved by GOR for the BDU, and a search process is currently underway. As such, in this regard, two key recommendations of the assessment are to:

- i) Prioritize and expedite filling the Business Specialist (PPP focused) position at the BDU, and
- ii) Immediately recruit a short-term technical advisor with high end business development (including PPPs) and analytical skills until the Business Specialist is fully on board.

Some of the key elements of this critical fulltime GOR Business Specialist (PPP) position are outlined below (similar objective, scope of work, and selection criteria can be used for the short-term technical advisor as well):

Position Title

Business Specialist (PPPs)

Administrative Unit

Business Development Unit
The Planning, Monitoring and Evaluation Division
Rwanda Biomedical Center

Duration

Long-term/permanent contract with a six month probationary period

Objective

Working within the RBC's BDU and through the Private Health Sector Coordination Committee (PHSCC) Secretariat, the objective of this position is to provide the required Advisory Services to RBC on key aspects of PPP Strategy and action plan development; business opportunities and plans exploration, analysis and specific project preparation; stakeholder engagement and management; Support for and oversee capacity building of the RBC, MOH, RDB, and selected district hospitals (DHs) to enable and equip them to carry out successful PPP transactions.

Scope of Work: Key Roles and Responsibilities

The Scope of Work of this position will include, but not be limited to the following provision of a range of advisory services:

1. **Development of a PPP strategy and Action Plan:** Provide overall guidance and technical input to assist RBC and MOH to develop and implement a PPP strategy along with an Action Plan for the health sector.
2. **Capacity Building:**
 - a. Build project identification, analysis, and preparation capacity of relevant staff at the RBC, MOH, and selected district hospitals (DHs).
 - b. Facilitate the transfer of lessons learned regarding practices in other countries.
3. **PPP Project Identification, Pre-feasibility and Feasibility:**
 - a. Assist in the identification of potential health sector PPP projects.
 - b. Prepare pre-feasibility and feasibility studies assessment framework and standard form TORs, which can be applied for future reference.
 - c. Actively participate in preparing and reviewing pre-feasibility and feasibility studies for health sector PPPs.
 - d. Actively participate in supporting the private sector in business plan preparation, review and analysis.
4. **Development of Transaction Advisor TORs, Contract Negotiation and Management:**
 - a. Provide necessary advice on the preparation of Terms of References (TORs) for selection of Transaction Advisors specific to project(s).
 - b. Advise and provide necessary support in evaluation of PPP contracts and supervision of Transaction Advisors assigned to various projects.
 - c. Advise on setting up successful framework and structure for negotiations to reach commercial close.
 - d. Assist relevant staff in RDB, RBC, MOH, and selected DHs in the development of capacity in negotiation skills, strategy and tactics, including risk mitigation strategies and techniques.
 - e. Assist relevant project teams to set up a framework for monitoring compliance and performance of various PPP Projects.
5. **Stakeholder Engagement Strategy and Implementation:**
 - a. Carry out a wide and in-depth study of various categories of potential private sector investors and institutions in the health and financial sectors. Analyze and recommend strategies to draw investor interest, while applying other strategies as a means for stakeholder engagement.
 - b. Assisting in the design and implementation of a suitable strategy for stakeholders' communication.

- c. Assist RDB, RBC, and MOH in developing and designing project information documents (prospectus), market testing, and organizing/scheduling of PPP investor conferences and health business trade fairs.
 - d. Advise on stakeholder consultation for specific projects, including where appropriate, media relations and portfolio as part of outreach strategies.
6. **Management Support:**
- a. Review and analyze BDU's operational model and procedures, and advise on ways for efficiency gain and higher impact.
 - b. Provide technical supervision to other relevant staff working on business development efforts, including PPPs.

Key Selection Criteria:

1. MBA and/or advanced (masters) degree in health arena (e.g. MPH), public policy, or fields relevant to international development;
2. Have at least 10 years relevant experience with at least 5 years specific experience working on health;
3. Experience working with governments, particularly on health projects;
4. Ability to assess a project's financial and fiscal viability, and potential attractiveness to investors/providers;
5. Strong financial modeling skills;
6. Knowledge and experience of processes and systems for PPP project and PPP contract management;
7. Development and implementation of income generation and PPP transactions;
8. PPP and private sector engagement capacity building for government officials; and
9. At least 5 years work experience in Sub-Saharan Africa.

Key Next Steps:

3. Launch an immediate dialog and consultation process to review, evaluate and finalize the proposed TOR for the long-term PPP Business Specialist and short-term technical advisor positions.
4. Leverage existing or new GOR resources OR solicit TA from DP(s) to bring onboard the short-term technical advisor in an expedited manner.

ANNEX K. CONCEPTS FOR BUSINESS AND ENTREPRENEURSHIP TRAINING PROGRAMS

Central Level

Entrepreneurship, Health Business Management, and the Essentials of Private Sector Engagement (PSE) Training Program

Description: This will be an intense three day training course covering three modules i) the basics of entrepreneurship, ii) basic business management for health, and iii) the essentials of PSE and public private partnerships (PPPs).

The basics of entrepreneurship module will cover topics including:

- Key basic entrepreneurial skills,
- Creativity and innovation, and
- Risk-taking and management.

The business management for health module will cover:

- Key basic business skills,
- Income generation concepts, and
- Cost recovery and management (cost savings and efficiency).

The PSE module will cover:

- The essentials of private sector engagement,
- An overview of major types of income generating activities through PPPs, including contracting in private management, private wings and consultation rooms, and outsourcing. This module will include practical case studies from other countries and an overview of the process for developing PPPs.

All topics will be finalized following a rapid needs assessment.

Audience: It is recommended that key personnel from the Ministry of Health (MOH) and the Rwanda Biomedical Center (RBC) attend all three days. Personnel from the Rwanda Development Board's (RDB) Services Development Unit and PPP Unit should attend the third day for the PSE Module.

Learning Objective: At the end of the training, participants will have a clear understanding of the basics of entrepreneurship, health business management, and PSE and PPPs.

Process: The implementation process for adapting and delivering the training includes:

- A rapid training needs assessment and finalization of topics;
- Curriculum adaption;
- A training of trainers (TOT) for RBC's Business Development Unit staff so that they can deliver the training in the future; and
- Roll-out of the training.

Important Note: The conceptualization, planning, and implementation of all training modules and processes will be coordinated by the Private Health Sector Coordination Committee (PHSCC) Secretariat in partnership with other relevant stakeholders including international and/or local training partners.

District Level

Managing a Healthy Business: Entrepreneurship, Health Business Management, and Public Private Partnerships (PPPs) for District Hospital Managers

Description: *Managing a Healthy Business* is a competency-based modularized training program in entrepreneurship, PPPs, and business administration and financial management. The program will be adapted to assist district hospital managers and administrators to understand the key concepts of entrepreneurship, and acquire the competencies to improve income generation, management and efficiencies at district hospitals. It is recommended that the basic course will be facilitator-led to be delivered in a class room setting as many of the topics will be new for participants. More advanced and supplemental materials will be available online for further study. The complete course will cover topics, topics, such as:

- Entrepreneurship;
- PPPs; and
- Key business and financial management topics that are necessary for running a successful health business, including:
 - Health as a business;
 - Operations management (human resources, procurement and inventory, medical records, facility management, risk management);
 - Quality assurance and improvement from a business perspective;
 - Financial management (financial statements, understanding costs and profitability, payments and collections, cashflow management, budgeting, and funding the facility); and
 - Marketing and promoting the healthcare business.

Actual topics will be finalized following a rapid needs assessment. In addition to class room training, it is strongly recommended that follow-on mentoring and business counselling be provided on an on-going basis to select hospitals to provide assistance in implementing business changes, develop PPPs, and to cement learning.

Audience: It is recommended that all district hospital managers and administrators take the basic course.

Learning Objective: At the end of the training, participants will understand the basics of entrepreneurship; how to conceptualize, develop, and implement PPPs; and have acquired key competencies in business and financial management.

Process: It is recommended that the basic course be delivered by the RBC as a first step in assisting district hospitals to initiate PPPs and income generating strategies. The remaining modules should be housed online or within a local training partner and be offered as part of a certificate program. The implementation process for adapting and delivering the training includes:

- A rapid training needs assessment and finalization of topics;
- Curriculum adaptation;
- A training of trainers (TOT) for RBC Business Development Unit staff and local training partner(s) so that they can deliver the full training in the future; and
- Roll-out of the training

Important Note: The conceptualization, planning, and implementation of all training modules and processes will be coordinated by the Private Health Sector Coordination Committee (PHSCC) Secretariat in partnership with other relevant stakeholders including international and/or local training partners.

ANNEX L. HEALTH POST MODEL

Overview

The public private community partnership (PPCP) health post (HP) model seeks to strengthen care at the community level through an innovative public private partnership (PPP) between the Government of Rwanda (GOR) and private nurses. In this model, the GOR regulates and ensures quality, standards, provides supervision and procures drugs through the nearest Health Center (HC); and the district, cell, or the community provides the 'ready' physical infrastructure. The business is owned and run by a private nurse. The model receives support from a private organization, which serves as an incubator for the private HPs, offering technical assistance (including training), monitoring and reporting support, and facilitating access to finance to strengthen prospects for viability and additional income generation activities.

Initial Investment

- The district/cell provides a building that is fully renovated to serve as a clinic. The location of the HP should be carefully selected to ensure that it attracts the largest number of potential clients so that is commercially viable.
- Initial seed capital: \$3,000-5,000 per post=\$5,400,000 - \$9,000,000 for 1,800 health posts⁴³
- Nurse invests \$500 from personal savings and takes a loan for \$1,500 for a total personal investment of \$2,000. A total of \$3,600,000 is leveraged from private nurses.

The initial investment will cover the costs to open and equip the health post and to provide an initial stock of drugs and other consumables.

Financing

- A financial institution should be identified to finance loans to the private nurses. It will be important to explore options to incentivize lending, reduce the risk to the lender and lower the interest rate. Options may include a credit guarantee, government guarantee, or credit line.
- In addition to loans for start-up costs, a factoring product may be an option to help smooth cashflow for nurses if there are payment delays from the CBHI. Factoring would involve the health post selling their accounts receivables (CBHI payment) to a bank for a fee (which is the equivalent of interest). This product would help bridge the gap between service delivery and payment so that operations are not negatively impacted if there is a delay in payment.

Business Training and Capacity Building

- Work with TVET to develop and roll-out training for private nurses in entrepreneurship, business and financial management, claims management and monitoring and evaluation.
- The incubator will provide follow-up business counselling and mentorship support to assist the nurses to operate viably.

Role of the Health Center

The health center will be responsible for the following:

- Provide supervision support
- Collect monitoring data
- Process claims (this role could also be done by the business incubator to achieve efficiencies)
- Procure drugs

⁴³ If the health post is delivered fully renovated the lower end of the range applies. If additional renovations are needed, a higher level of seed capital will be necessary.

Role of the Business Incubator

The business incubator will be responsible for:

- Assist nurses with start-up;
- Provide on-going technical support in business and financial management;
- Facilitate access to financing;
- Support strategies for additional income generation activities;
- Monitor and work with nurses to trouble shoot problems; and
- Assist the GOR in improving efficiencies, such as mobile drug procurement and claims management.

Business Model

- The health post provides a monthly fee to the business incubator as reimbursement for its services. The fee should be nationally agreed upon percentage of gross sales
- The health post keeps the co-pay and remainder of the CBHI reimbursement
- The business incubator assists health posts to develop other revenue generation streams, including but not limited to sales of additional products at the post, agent relationships with telecoms and financial institutions.

Recommended Changes to Strengthen Viability and Efficiency

There are several changes that can be made to strengthen viability and efficiency. These include:

- Improve payment mechanisms and processes to ensure timely CBHI payments. Explore potential for electronic and mobile payments;
- Roll-out online/mobile claims submission and processing for both HPs and HCs;
- Enable health posts to place drug orders using mobile technology; and
- Approval for health posts to sell additional products/services.

Risk Pool

Due to the location of some health posts in more rural areas, not all will be commercially viable. It is estimated that a health post will need 20-25 clients per day to breakeven. It is recommended that the Ministry of Health create a risk pooling fund, which can be used to supplement the incomes of nurses that see fewer than 20 clients per day on a prorated basis. Assuming 25% of the HPs need a 45,000 RWF subsidy per month, the Ministry of Health (MOH) will need a risk pool of 243 Million RWF per annum. After the first year, the MOH should conduct a study on the profitability of HPs and adjust the budget for the subsidy. A possible start up source of the risk pooling fund could be the reallocation of part of the current PBF supported by GOR annual national budget.

Comparison of Public and Private Health Posts

Below is a comparison of public and private HPs. The revenue and expenses for the public HP were based on estimates provided by a HC and have been adjusted to assume only one nurse. The private HP costs are based observation and an interview with a private health post owner. Neither of these cost estimates factor in the costs of transport for drugs and monitoring or other support services to the HPs. The public sector model is more costly due to a number of factors, including higher salaries for the nurse as well as more staff (security guard and day staff) than the private model. Drug cost estimates in the public model are also higher. *Both models should be carefully fact checked through a broader analysis of costs and revenues earned at public and private HPs.*

Public Sector Health Post: 20 clients per day

| | |
|------------------|------------------|
| Monthly Revenue | 668,820 (\$962) |
| Monthly Expenses | |
| Salaries | 313,557 (\$447) |
| Drugs | 400,000 (\$571) |
| Other | 112,000 (\$60) |
| Total Expenses | 825,557(\$1,179) |
| Profit | -156,737(-224) |

*Estimates provided by Rulindo District HC.

Adjusted for assumption of one nurse.

Private Sector Health Post (Estimated):20 clients per day

| | |
|-----------------------|-----------------|
| Start-Up Costs | |
| Seed Capital | \$3,000 |
| Loan | \$2,000 |
| Total Start-Up Costs | \$5,000 |
| | |
| Monthly Revenue* | 600,000 (\$857) |
| Monthly Expenses | 450,000 (\$642) |
| Profit | 150,000 (\$214) |
| Monthly Interest** | |
| | 34,085(\$51) |
| Net Profit | |
| | 115,915 (\$166) |

* Based on a 200 RWF flat fee and an average of 800 RWF CBHI claim per patient, per visit.

**Assumes a 5 year loan term at 18%. Estimated based on team's observation and discussion with HP staff.

Critical Success Factors

There are several factors that must be in place for this model to be successful. These include:

- The districts/cells/community must provide appropriate facilities in a good, commercially viable location.
- Nurses must receive CBHI payments in a timely manner. If this does not happen, the model will fail as the nurse will not be able to maintain a livelihood, make loan and drug payments, and subsequently quality will be negatively impacted.

Next Steps

- A full financial analysis should be conducted to cross check the estimates provided. This analysis should, examine:
 - Initial start-up costs and investment
 - Develop monthly revenue and expense projections for a private HP through more detailed examination of client flow, average price per client visit, and average operating costs for running a HP
 - Verify breakeven projections for the HP
 - Identify the cost to the district of providing supervision, drug procurement and claims management so that these costs are factored into the HC budgets
 - Identify the cost of running the private business incubator and possible contribution amount from HP nurses
- Based on the analysis and a rapid feasibility study, develop a generic business plan (BP) model for HPs

ANNEX M. INCOME GENERATION AT DHs: CONCEPTS FOR PRIVATE WING AND PRIVATE CONSULTATION SCHEMES

Overview

The Ministry of Health (MOH) in Rwanda is actively exploring and pursuing ideas and opportunities for ways for the district hospitals (DHs) to be operated and managed with a private sector mindset. The concept of developing new strategies for additional income generation at the DHs toward their self-sustenance and profitability is one such measure, which requires detail exploration including conducting feasibility studies and financial analysis, identification and selection of the viable opportunities, development of business plans (BP), and formulation of implementation strategies and plans. Under this concept, potentially viable activities include but are not limited to setting up private wings, private consultation schemes, outsourcing of key support services, and contracting in of management services. Potential initiatives will have to be carefully assessed and examined based on the specific hospital, its location, and other business, geographic and economic parameters - as not all activities will be suitable for every hospital. It will be important to develop the Rwanda Biomedical Center's (RBC) capacity to effectively support, guide, and monitor the various income generation activities at the district level, such as private wing development, private consultation scheme, outsourcing of services, contracting in private management etc.

Critical General Preparatory and Process Elements

For any such activities to be properly vetted and to be successful, it is recommended to work through the PHSCC Secretariat to:

- Develop and institutionalize structured and modularized health business training programs for DH managers and administrators in order to educate and sensitize them on basic skills for entrepreneurship, income generation, private sector engagement (PSE) concepts and strategies, and improved operational efficiencies and business management (See Output Three)
- Devise and operationalize a formalized process to select a key set of districts (pilot) based on a set of carefully thought out and evidence based criteria
- Conduct a comprehensive review and feasibility study at those district hospitals to assess potential facility specific income generating activities including PSE opportunities (private wing, private consultation, outsourcing of key support services, contracting in of management services)
- Based on the reviews, identify and select the most viable opportunity(s) for each of the DHs under the pilot program
- Develop business plan (BP) and support potential income generating activities including the development of PPP models
- Consult and coordinate with Rwanda Development Board (RDB) to find viable partnerships with financial institutions and private investors

Concept: Private Wing

Overview

A private wing is one possible income generation strategy for the DHs. Currently, most of the public hospitals (including the DHs) are about 60% dependent on external resources. The addition of a private wing could generate additional resources and significantly contribute toward self-sufficiency of the DHs, while becoming a new model for increased, expanded, improved, and diversified services. In principal, the private wing can provide with both medical and non-medical services, however the quality of the *core medical care services for private and public/general patients must be the same*. As described above, a careful assessment needs to be conducted to determine the feasibility of a private wing on a case by case basis. Possible benefits of a private wing are outlined below.

Key benefits for the patient may include:

- A higher level of amenities, comfort (private room, meals, internet service, waiting room, reservation service etc.), and customer service
- A more private environment
- Less waiting time and more convenient appointment times
- Variety in package selection and associated prices

Key benefits for the staff may include:

- Caring for people with an increased level of patient satisfaction
- For eligible employees, a potential to increase earnings
- Increased learning and new skill sets, especially under a private sector mindset

Key benefits for the hospital may include:

- Retention of qualified staff
- Possible expansion of patient base
- Increased revenue for institutional improvement and system strengthening
- Overall equity gain
- Higher standard of customer services throughout the hospital
- Improved patient satisfaction
- Improved reputation

Implementation Process and Policy

- Develop and institute a legal framework for the private wing provision at the public hospitals
- Conduct feasibility study and financial analysis to determine viability of private wing at select hospitals
- Develop business model, which may include but not be limited to revenue sharing, leasing arrangements, alternate customer services and pricing structure
- Develop operations manual that can be customized and updated on an annual basis
- Provide specific targeted technical assistance (TA) to the DH managers and administrators to structure, implement, and manage private wings
- Devise and institute effective pricing, payment, resource tracking, and accountability mechanisms
- Ongoing review, evaluation, and update of key policies including customer services/amenities packages and pricing structure, and enforcement mechanisms on an annual basis
- Ensure same quality of core medical care services for private and public/general patients

Business Model and Case

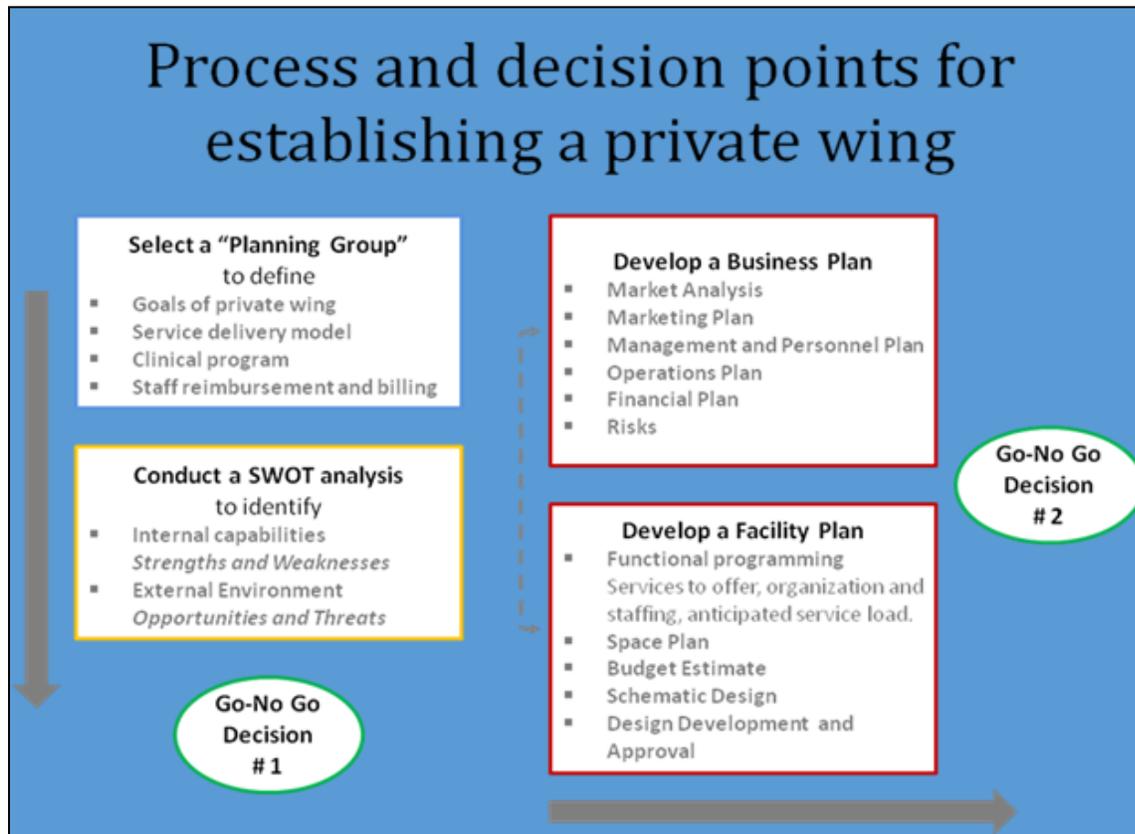
- ❖ Patients pay a higher fee (at different level based on the chosen package) for getting added comfort and amenities, expedited appointments, and better customer service
- ❖ Hospital generates additional revenues, which will help improve financial sustainability and eventually lead to increased equity gain through enhanced, expanded and improved patient care and services
- ❖ Based on the RBC's profit and loss (P&L) model for a potential private wing at the Gihundwe DH, all three scenarios shows a net monthly profit:

| <i>ALOS: 5 Days</i> | Scenario 1 (OP/Day: 14) OR: 40% | Scenario 2 (OP/Day: 18) OR: 60% (likely scenario) | Scenario 3 (OP/Day: 25) OR: 80% |
|---------------------|------------------------------------|--|------------------------------------|
| Net profit | 795,588 RWF (~US\$ 1,136) | 2,330,677 RWF (~US\$ 3,329) | 4,983,843 RWF (~US\$ 7,120) |

ALOS: Average length of stay

OP: Out patient
OR: Occupancy rate

Important note: as stated earlier, appropriate feasibility study and financial analysis will have to be carried out at each DH site to assess viability.



Concept: Private Consultation Scheme

Overview

Private consultation schemes are another strategy to generate additional revenue at DHs and improve staff retention. Under this concept, doctors would be able to use DH facilities to provide private consultation services (i.e. dual practice mode) to patients under a set of defined and agreed upon policies and regulations. The private consultation scheme could come with a multitude of benefits for different constituencies (as outlined below), however, the underlying principles and policies need to be carefully crafted, implemented, and enforced to avoid conflict of interest or lapse of services at the hospital. DH management needs to rigorously monitor quality and overall compliance. Careful assessment needs to take place on a case by case basis for the actual viability of this scheme in each of the selected DHs.

Key benefits for the patient may include:

- More convenience and options for doctor's appointment
- A higher sense of privacy
- A more heightened, frequent, and quicker access to doctor
- More flexibility in choosing particular doctor

Key benefits for the doctor may include:

- Possible added financial and career incentives
- Possible increased level of patient satisfaction
- More frequent access to patient for regular and systematic follow-ups

Key benefit for the hospital may include:

- Attract and retain qualified doctors
- Increase revenue for institutional improvement and systems strengthening
- Possible cost sharing with dual practitioners
- Possible increase in patient base
- Improve patient satisfaction
- Improve overall reputation
- In case of emergencies, availability of more doctors on the premise during the private consultation periods, especially during after-hours

Implementation Process and Policy

- Develop and institute legal framework for the provision of private consultation and dual practice at the public hospitals
- Conduct feasibility study and financial analysis to determine viability of private consultation scheme
- Develop a business model, which may include but not be limited to revenue and cost sharing, leasing arrangements etc.
- Develop operations manual that can be customized and updated on an annual basis
- Arrange for designated locations for private consultation and/or additional specialized services, such as ultrasound, MRI, advanced optical equipment etc.
- Provide specific and relevant technical assistance (TA) to the DH managers and administrators to structure, implement, and manage private consultation schemes
- Develop and/or revise *performance based* policies and effective accountability, monitoring and enforcement mechanisms for dual practice schemes. The scope and weekly allocation of time for private consultation may take into consideration critical elements like:
 - Setting a minimum threshold for number of patients seen in public settings per day (or over a week)
 - Quality, standards, and attention to care in public settings, verified by periodic unannounced supervision visits and patients' survey results
- Ongoing review, evaluation, and update of the policies and enforcement mechanisms on an annual basis

Business Model: Cost and Revenue Sharing

- ❖ Hospital provides private 'service ready' consultation room
- ❖ Patient pays fees for per consultation
- ❖ Doctor pays a predetermined percentage (e.g. 20%) of the fee (per consultation), which covers cost for using the space, equipment and other utilities as well as revenue sharing.
- ❖ Alternatively, the hospital charges the doctor a monthly fee to lease or rent the space, equipment and supplies. In this model the doctor keeps the entire consultation fee.

Key Next Steps:

1. Ensure institution of legal framework(s) for dual practice/private consultation model

2. Launch an immediate consultation process to fine tune and detail out the concepts
3. Select a set of DHs and devise and launch a program to test the concept
4. Conduct rapid assessments/feasibility studies at the pilot DH locations and determine actual viability for specific activity(s)
5. Develop business plan and models, including risk assessment and mitigation strategy and costing exercise to determine appropriate revenue share/leasing arrangement
6. Formulate an implementation plan, monitoring and compliance systems, and rollout

ANNEX N. RECOMMENDATIONS FOR COMMUNITY HEALTH WORKER (CHW) COOPERATIVES

Background and Current Status

Community health workers are an important factor in Rwanda's success in achieving significant health gains in recent years. In an attempt to increase the sustainability of the community health worker (CHW) program and ensure that CHWs were remunerated and motivated, the Ministry of Health (MOH) initiated a CHW cooperative program in 2009. The cooperatives are currently being financed through 70 percent of the performance-based financing (PBF) earned by CHWs, which is then invested in various income generation activities. The CHWs receive the remaining 30% from the total amount transferred by the MOH. CHWs also share a portion of the profits earned by the cooperative, which is meant to have a multiplier effect on their remuneration. According to the Ministry of Health, currently there are 45,000 CHWs grouped under 474 cooperatives throughout the country, which manage total assets of 11.3 billion RWF. As of November, 2014, 153 cooperatives were still not yet registered. Membership of these cooperatives range from between 40-250 CHWs depending on the number of villages in a health center's catchment area. The cooperative program was initially rolled out with very limited technical assistance (TA). As a result, there was inadequate financial and business management and wide variability in income generation and profitability across the cooperatives. In 2013, the Ministry of Health hired Square Entrepreneurship Development Consult Ltd. (S.E.D.C), a local management consulting firm, to provide TA to the cooperatives to improve their operations, management, and overall viability. Following this, there appears to be measurable improvements, although additional inputs are needed to strengthen this further. By November 2014, approximately 81 percent of the cooperatives were involved in income generating activities (the remainder invested in fixed assets, which do not yield income, or have not invested funds). Profitable cooperatives are yielding on an average 7,000 RWF per CHW per month.

Recommendations

Going forward, it will be important to continue to build on the positive momentum initiated by S.E.D.C to strengthen CHW cooperatives. Important goals will be to scale-up successful models of income generating activities across all cooperatives, improve operations and financial management, and increase profitability so that cooperatives are better able to sustain CHWs, especially in light of declining PBF. Specific recommendations include:

- Conduct a market study to identify best practices and business models from existing income generating experiences by the CHW cooperatives. This study should identify opportunities to leverage economies of scale, including unions, which are currently being introduced by S.E.D.C, (16 unions are at different stages of formation) as well as other forms of consolidation. The market study will also explore options and opportunities to increase the bargaining power of cooperatives, improve market linkages to both domestic and export markets as well as other strategies for increasing profitability.
- Based on the findings from this study, assistance should be provided to scale up and implement an effective support model for CHW cooperatives. This will require strengthening and intensifying TA and capacity building to cooperatives with a focus on growth and turnaround for the non-performing ones.
- To support increased growth and profitability, it will be important to strengthen linkages to access to finance and promote investment groups with technical support.
- A challenge fund that provides seed capital to select cooperatives could be a useful strategy to promote innovation and incentivize growth.

- A small number of cooperatives are currently in the process of obtaining quality certificates from the Rwanda Standards Board (RSB) as a strategy to increase sales and potential for export. This initiative should be encouraged and supported on a broader scale.
- CHWs and cooperatives are currently required to pay taxes on income over the standard income threshold set by the Rwanda Revenue Authority (RRA). In order to promote the viability of this model, the GOR should consider giving CHWs and cooperatives a tax holiday for an eight to ten year period. This will be important given the declining PBF. In this regard, the MOH should prepare a business case for submission to MINECOFIN showing the critical impact and role that the CHWs and the cooperatives play, and justify why this tax holiday (as part of a consorted approach with other measures) will actually strengthen the backbone of the system, supporting national prosperity.
- Overall, there are opportunities for efficiency gains within the CHW model by increasing the use of ICT (such as ‘mobile money’) for payments, reporting and overall management.

Possible Effect of Loss of Performance Based Financing

There is currently discussion of ending PBF from the GOR national budget for CHWs and cooperatives. While some cooperatives have struggled, the majority are now engaged in income generating activities that will need continued support in the near term. Loss of the PBF at this time may potentially have some negative consequences that should be carefully evaluated before implementing this change. These include:

- Possible loss of motivation on the part of the CHWs
- Limited ability to increase growth and improved profitability of cooperatives
- Reduced chances for the turnaround of non-performing cooperatives
- Potential financial losses for cooperatives that depend on the PBF to cover operating expenses

While important improvements have been made to the CHW cooperative model, additional time is needed to strengthen cooperatives. PBF currently plays an important role in financing the cooperatives, which will need more time to transition to a fully self-financing model. As such, current and future profitability should be analyzed carefully and additional resources should be sought to cover the loss of PBF, or the MOH may consider reducing PBF in a phased approach rather than terminating it all together at once. In this regard, it is recommended that the MOH conduct a full financial/impact analysis of the loss of PBF that considers alternate scenarios with other possible sources of financing, including using at least 50% of the overall profit of all CHW cooperatives across the country as a possible means to cover up for the loss of the PBF under the GOR’s national budget.

ANNEX O. RESULTS AREAS, OVERALL RECOMMENDATION, AND DETAILED RECOMMENDATIONS MATRIX BY STRATEGIC AREAS AND COMPONENTS

1. Assessment Results Areas:

- *Enhancement, expansion, and improvement through efficiency gain (EG)*
- *Domestic resource generation/financing and effective mobilization (RG)*

2. Overall Umbrella Recommendation:

Foster an enabling environment that promotes the growth of the private sector engagement (PSE) in health over the longer term - while facilitating, developing and implementing targeted ‘quick wins’/‘rapid results initiatives’, and broader Public Private partnerships (PPPs) that will help sustain and build further on the current gains, especially at the primary and secondary levels of the health system

3. Detailed Recommendations Matrix by Strategic Areas and Components

| Strategic Area 1: Leadership and Advocacy | | | | | | | |
|---|--|---|------------------------------------|--|---|---|---|
| <i>Key Findings/Conclusions</i> | <i>Key Broad Recommendation</i> | <i>Key Sub-Elements/ Illustrative Activities</i> | <i>Results Area (EG and/or RG)</i> | <i>Impacting and/or Supporting HSSP III Priority Area(s)</i> | <i>Suggested Priority Level (high, medium, low)</i> | <i>Impact (short/long term – LT/ST)</i> | <i>Responsible and/or Collaborating Parties</i> |
| <ul style="list-style-type: none"> ▪ There is strong leadership and political will at senior levels, which is a critical success factor for PSE. ▪ The level of understanding and support for PSE, however, varies within the GOR | <i>Identify and support key health PSE leadership with critical ‘business’ thinking and understanding at all levels</i> | <ul style="list-style-type: none"> ▪ Launch dialog and consultation among the relevant top level management group(s) and carry on an immediate process to <i>formally</i> seek a national leader, taking charge <i>for increased and sustainable PSE in health at the highest level of government</i> who can master the necessary political will and mobilize people at all levels of the health system ▪ Through high level strategic dialog between MOH, RBC, and RDB, setup a <i>Private Health Sector Coordination Committee</i> | EG, RG | 1,2,3,4,5 | High | ST, LT | GOR (MOH, RBC, RDB); Collaborators: PS, DPs, IPs, USAID/R (Possible TA) |

Strategic Area 1: Leadership and Advocacy

| Key Findings/Conclusions | Key Broad Recommendation | Key Sub-Elements/ Illustrative Activities | Results Area (EG and/or RG) | Impacting and/or Supporting HSSP III Priority Area(s) | Suggested Priority Level (high, medium, low) | Impact (short/long term – LT/ST) | Responsible and/or Collaborating Parties |
|---|--------------------------|--|-----------------------------|---|--|----------------------------------|--|
| <ul style="list-style-type: none"> ▪ There is a lack of systems and knowledge about how to engage the private sector, especially to develop PPPs ▪ There is a lack of coordination and clarity of roles and responsibilities between key stakeholders (MOH, RDB, RBC) that is limiting effective PSE ▪ There is a lack of adequate capacity within the MOH, RDB, and RBC for effective PSE and PPP development ▪ There is very limited dialogue and no formal platforms and systems for | | <p>(PHSCC) chaired by the Minister of Health and effectively supported by a <i>Secretariat</i> (consisting of representatives from all three institutions and other key stakeholders including PS), as outlined in the PSE assessment report for effective (internal and external) information sharing, dialog, PPP formulation, and overall facilitation of PSE in health</p> <ul style="list-style-type: none"> ▪ Arrange a study/learning trip for the <i>Secretariat</i> members to a regional country(s), such as Uganda and/or Kenya, to meet with counterparts and explore different successful models for PSE, i.e. ‘what works’. <p>Key Next Steps:</p> <ol style="list-style-type: none"> 1. Launch an immediate dialog and consultation process at the top level management to evaluate and finalize the proposed models for the PHSCC and the Secretariat - including the structure, membership, and key functions and activities; 2. Organize a high level stakeholders/proposed memberships’ meeting to agree and officially launch the PHSCC and the Secretariat; and 3. Bring onboard a short term expert to effectively support and facilitate Nos. 1 and 2 above, and to guide and support the Secretariat in the short run (3-6 months) <ul style="list-style-type: none"> ▪ Conduct a comprehensive mapping of all key | | | | | |

Strategic Area 1: Leadership and Advocacy

| <i>Key Findings/Conclusions</i> | <i>Key Broad Recommendation</i> | <i>Key Sub-Elements/ Illustrative Activities</i> | <i>Results Area (EG and/or RG)</i> | <i>Impacting and/or Supporting HSSP III Priority Area(s)</i> | <i>Suggested Priority Level (high, medium, low)</i> | <i>Impact (short/long term – LT/ST)</i> | <i>Responsible and/or Collaborating Parties</i> |
|---|---------------------------------|--|------------------------------------|--|---|---|---|
| engagement between the public and private sectors | | <p>actors in health PS at both national and decentralized levels</p> <ul style="list-style-type: none"> ▪ Identify a lead person (point of contact) among the existing staff in each key institution (at national and district levels) who can actively lead and mobilize people and activities at all levels of the agency to help implement a well-integrated and sustainable PSE awareness campaign and plan ▪ Carry out an assessment of PSE management leadership, and coordination capacity, and build and implement management/leadership programs accordingly at various levels ▪ Advocate, support and launch dialog among the relevant top level leaderships at RDB, MOH and RBC to expedite appointment of any key vacant positions (e.g. Business Specialist at RBC’s BDU, health focal person in RDB), and strengthen capacity and clarify roles and responsibilities of existing units critical to supporting PSE in health ▪ Conduct a desk review to identify best practices and successful models of health PSEs for both ‘efficiency gains’ and ‘resource/income generation’ activities by the governments, DPs, PS, or through any combination of partnerships in the East African countries. Use the results of this | | | | | |

Strategic Area 1: Leadership and Advocacy

| <i>Key Findings/Conclusions</i> | <i>Key Broad Recommendation</i> | <i>Key Sub-Elements/ Illustrative Activities</i> | <i>Results Area (EG and/or RG)</i> | <i>Impacting and/or Supporting HSSP III Priority Area(s)</i> | <i>Suggested Priority Level (high, medium, low)</i> | <i>Impact (short/long term – LT/ST)</i> | <i>Responsible and/or Collaborating Parties</i> |
|---------------------------------|--|---|------------------------------------|--|---|---|---|
| | | review to develop an evidence base to steer learning, guide the recommended ‘learning trip(s)’ for the PHSCC Secretariat task team, and aid the replication/formulation and implement of Rwanda specific PSE solutions. | | | | | |
| | Strengthen overall PPP and business development capacity at MOH and RBC | <ul style="list-style-type: none"> ▪ Appoint a health PSE (including PPP) expert at the MOH PPP desk (preferably from the private sector) ▪ Add a long-term/permanent GOR <i>Business Specialist (PPP)</i> with high end business development and analytical skills at RBC’s Business Development Unit (BDU) for health in an expedited manner <p>Objective: the objective of this position is to provide the required advisory services to RBC on key aspects of PPP strategy and action plan development; business opportunities and plans exploration, analysis and specific project preparation; stakeholder engagement and management; Support for and oversee capacity building of the RBC, MOH, RDB, and selected district hospitals (DHs) to enable and equip them to carry out successful PPP transactions</p> <ul style="list-style-type: none"> ▪ Add a short-term technical advisor (PPP) with high end business development and analytical skills at RBC’s BDU in an expedited manner, until the long- | EG, RG | 1,2,3,4,5 | High | ST, LT | GOR (MOH, RBC, RDB); Collaborators: PS, DPs, IPs, USAID/R (Possible TA) |

Strategic Area 1: Leadership and Advocacy

| <i>Key Findings/Conclusions</i> | <i>Key Broad Recommendation</i> | <i>Key Sub-Elements/ Illustrative Activities</i> | <i>Results Area (EG and/or RG)</i> | <i>Impacting and/or Supporting HSSP III Priority Area(s)</i> | <i>Suggested Priority Level (high, medium, low)</i> | <i>Impact (short/long term – LT/ST)</i> | <i>Responsible and/or Collaborating Parties</i> |
|---------------------------------|--|--|------------------------------------|--|---|---|---|
| | | <p>term/permanent GOR <i>Business Specialist (PPP)</i> is on board</p> <p>Key Next Steps:</p> <ol style="list-style-type: none"> 1. Launch an immediate dialog and consultation process to review, evaluate and finalize the proposed TOR (see assessment report) for the long-term PPP Business Specialist and short-term technical advisor positions. 2. Leverage existing or new GOR resources or solicit TA from DP(s) to bring onboard the short-term technical advisor ASAP <ul style="list-style-type: none"> ▪ Create a framework and opportunities for private sector investments in health ▪ Involve representative of the for profit sector in the planning process to obtain their views and priorities at all levels of the system ▪ Identify potential areas of private-public sector collaboration and create conducive conditions for investments ▪ Provide adequate information, guidance, and technical assistance to potential PS investors | | | | | |
| | <i>Intensify public expression of support, advocacy and communication from senior government decision makers for the importance of and</i> | <ul style="list-style-type: none"> ▪ Develop an advocacy plan and supporting tools to raise the awareness of upper management at all levels regarding the urgency and importance of increased and sustainable PSE and the need to increase budget allocation for it ▪ Raise upper management awareness and seek support to examine and implement a more | EG, RG | 1,2,3,4,5 | High | ST, LT | GOR (MOH, RBC, RDB); Collaborators: PS, DPs, IPs, USAID/R (Possible TA) |

Strategic Area 1: Leadership and Advocacy

| <i>Key Findings/Conclusions</i> | <i>Key Broad Recommendation</i> | <i>Key Sub-Elements/ Illustrative Activities</i> | <i>Results Area (EG and/or RG)</i> | <i>Impacting and/or Supporting HSSP III Priority Area(s)</i> | <i>Suggested Priority Level (high, medium, low)</i> | <i>Impact (short/long term – LT/ST)</i> | <i>Responsible and/or Collaborating Parties</i> |
|---------------------------------|---|---|------------------------------------|--|---|---|---|
| | <i>to increase resource allocation for heightened and sustainable PSE interventions</i> | <p>effective strategy and system to realize increased PSE in health</p> <ul style="list-style-type: none"> ▪ Under the guidance of the PHSCC, plan and create a formal platform for regular dialog (on a quarterly basis), information exchange, and active follow-ups with the relevant PS stakeholders, particularly focusing on key issues of policy & planning, collaboration and partnerships ▪ Under the guidance of the PHSCC, plan and launch an intense nationwide campaign (e.g. media, online platforms, trade fairs, etc.) to highlight the health PSE, its importance, and opportunities ▪ Advocate for inclusion of key PSE markers at the decentralized (community to District) levels on high level performance contracts with the president | | | | | |

Strategic Area 2: Policy and Planning

| <i>Key Findings/Conclusions</i> | <i>Key Broad Recommendation</i> | <i>Key Sub-Elements/ Illustrative Activities</i> | <i>Results Area (EG and/or RG)</i> | <i>Impacting and/or Supporting HSSP III Priority Area(s)</i> | <i>Suggested Priority Level (high, medium, low)</i> | <i>Impact (short/long term – LT/ST)</i> | <i>Responsible and/or Collaborating Parties</i> |
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Strategic Area 2: Policy and Planning

| <i>Key Findings/Conclusions</i> | <i>Key Broad Recommendation</i> | <i>Key Sub-Elements/ Illustrative Activities</i> | <i>Results Area (EG and/or RG)</i> | <i>Impacting and/or Supporting HSSP III Priority Area(s)</i> | <i>Suggested Priority Level (high, medium, low)</i> | <i>Impact (short/long term – LT/ST)</i> | <i>Responsible and/or Collaborating Parties</i> |
|---|--|---|------------------------------------|--|---|---|--|
| <ul style="list-style-type: none"> ▪ The overall tax and investment environment in Rwanda is favorable for private sector development. ▪ There is a new PPP framework that has been approved but not disseminated. ▪ The MOH, RBC and RDB all have units or positions designed to engage the private health sector. ▪ Specific health incentives are lacking in the investment and tax codes. ▪ There is a slow implementation of PSE policies and plans ▪ PPP mechanisms and PSE/PPP | <p><i>Based on the PSE assessment recommendations, prepare a detailed, evidence based and prioritized Implementation Action Plan for key PSE activities</i></p> | <ul style="list-style-type: none"> ▪ Under the guidance of the PHSCC, conduct GOR internal review, analysis, and prioritization process of the assessment recommendations and concepts focusing on key GOR strategic directions (e.g. Vision 20/20, EDPRS II), all current health programs and strategies (e.g. , HSSP III etc.), and all other relevant line ministries activities (e.g. Education, Youth & ICT, Finance, Commerce, Local Government) ▪ Put together and regularly update a key stakeholders’ map for PSE activities using two dimensions: i) stakeholders (internal & external), ii) the key strategic areas of the assessment conceptual framework and relevant activities ▪ Include representatives from all key stakeholders for discussion and finalization of the Action Plan | EG, RG | 1,2,3,4,5 | High | ST & LT | GOR (MOH, RBC, RDB); Collaborators: Other line Ministries, PS, DPs, IPs, USAID/R (Possible TA) |
| | <p><i>Based on the above Action Plan, ensure efficient and equitable allocation of financial, human, and other resources for implementation at all levels</i></p> | <ul style="list-style-type: none"> ▪ Design and implement advocacy plans to raise awareness and educate leaders with decision making powers at all levels ▪ Support relevant policy initiatives, dialogs, or reforms to execute the plan and for the effective redistribution of MOH resources ▪ Create a structured and modularized health business training program for district and facility level managers to educate and sensitize them on PSE concepts and | EG, RG | 1,2,3,4,5 | High | ST & LT | GOR (MOH, RBC, RDB); Collaborators: PS, DPs, IPs, USAID/R (Possible TA) |

Strategic Area 2: Policy and Planning

| <i>Key Findings/Conclusions</i> | <i>Key Broad Recommendation</i> | <i>Key Sub-Elements/ Illustrative Activities</i> | <i>Results Area (EG and/or RG)</i> | <i>Impacting and/or Supporting HSSP III Priority Area(s)</i> | <i>Suggested Priority Level (high, medium, low)</i> | <i>Impact (short/long term – LT/ST)</i> | <i>Responsible and/or Collaborating Parties</i> |
|--|---|---|------------------------------------|--|---|---|--|
| <p>planning process have not been finalized</p> <ul style="list-style-type: none"> Financial, human and other resources are not adequately aligned to support effective PSE and PPP development National and district level managers do not have adequate skills and business know-hows to implement PSE and PPPs The private sector and other key stakeholders are not adequately engaged in policy dialog and development, and planning Limited communication and confidence | | <p>strategies, and improved operational efficiencies (see SD sub-sector for details)</p> <ul style="list-style-type: none"> Conduct a comprehensive review and feasibility study (from community to district) for selected (through a formalized process) facilities to assess potential facility specific income generating PSE opportunities Based on the reviews, identify, select, and support potential income generating & PPP models | | | | | |
| | <i>Strengthen national and district level PSE policy and planning capacity</i> | <ul style="list-style-type: none"> Promote and support development of evidence based and results oriented PSE policies, plans, and strategies at all levels with clear implementation framework and action plans Support healthcare managers at the district levels on PSE planning, policy and strategy implementation Build general and financial management capacity of current staff at all levels according to MINECOFIN guidelines | EG, RG | 4,5 | High | ST & LT | GOR (MOH, RBC, RDB); Collaborators: Other line Ministries (e.g. MINEDUC, Academia, PS, DPs, IPs, USAID/R (Possible TA) |
| | <i>Promote and increase meaningful participation of all stakeholders (public & private; health and non-health) in formulation of PSE</i> | <ul style="list-style-type: none"> Devise and implement advocacy plan and support participation from all key stakeholders from all levels to ensure participatory, meaningful, and effective PSE policy formulation, review, planning, and implementation both at the central and district levels | RG | 2,3,4 | High | ST & LT | GOR (MOH, RBC, RDB); Collaborators: PS, DPs, IPs, USAID/R (Possible TA) |

Strategic Area 2: Policy and Planning

| Key Findings/Conclusions | Key Broad Recommendation | Key Sub-Elements/ Illustrative Activities | Results Area (EG and/or RG) | Impacting and/or Supporting HSSP III Priority Area(s) | Suggested Priority Level (high, medium, low) | Impact (short/long term – LT/ST) | Responsible and/or Collaborating Parties |
|--|---|---|------------------------------------|--|---|---|---|
| <p>between the public and private sectors</p> <ul style="list-style-type: none"> The current GOR tariff structure poses a significant barrier to investment in the health sector - finalization and approval of the revision of the tariff structure will be important to spur the growth of the private health sector There are complex regulatory requirements (e.g. procurement, licensing, customs etc.) that create inefficiencies and can impede the growth of the private sector The newly new introduced (early February, 2015) | <p>policies, strategies and plans and ensure ownership and alignment</p> | <ul style="list-style-type: none"> Under the guidance of PHSCC, strengthen existing or form a new consultative forum for broad stakeholders' consultation, finalization, dissemination and sensitization processes of PSE policies and plans at all levels, especially at the decentralized levels | | | | | |
| | <p>Review current regulations and amend/introduce new ones in line with international and regional practices to develop PPPs, generate revenue and gain efficiency</p> | <ul style="list-style-type: none"> Finalize the draft PPP legal framework, and disseminate and sensitize at all levels Finalize, approve, and operationalize the revised tariff structure resulting from the latest study to encourage increased PSE Streamline processes for obtaining license to open private facilities and build inspection and supervision capacity at the district level Introduce regulation to mandate that manufacturers pay registration fees for all new products registered in Rwanda Introduce regulation to mandate that manufacturers pay fees toward the process and acquiring a certificate of <i>Good Manufacturing Practices (GMP)</i> Streamline processes and eliminate custom duties on import of already purchased medical equipment spare parts | EG, RG | 1,2,3 | High | ST & LT | GOR (MOH, RBC, RDB); Collaborators: Customs, RRA, PS, DPs (Possible TA) |
| | <p>Propose, dialog, and advocate for possible adaptation of law(s) that will</p> | <ul style="list-style-type: none"> Start a policy dialog with all relevant stakeholders including the DHs and PS Formulate and get draft provisions vetted and agreed by all parties | | | | | |

Strategic Area 2: Policy and Planning

| Key Findings/Conclusions | Key Broad Recommendation | Key Sub-Elements/ Illustrative Activities | Results Area (EG and/or RG) | Impacting and/or Supporting HSSP III Priority Area(s) | Suggested Priority Level (high, medium, low) | Impact (short/long term – LT/ST) | Responsible and/or Collaborating Parties |
|--|--|--|-----------------------------|---|--|----------------------------------|--|
| <p>electronic single window system (in pilot phase, http://www.rra.gov.rw/spip.php?article927), may possibly facilitate international trade by speeding up and simplifying information flows between traders and government institutions – MOH is part of the pilot testing</p> <ul style="list-style-type: none"> ▪ There are opportunities to increase revenue collections from the importation and registration of new pharmaceutical products ▪ Most private sector associations have limited capacity for | <p><i>give the hospitals management autonomy with appointed Board of Directors</i></p> <p><i>Strengthen various private sector associations toward making themselves self-sustaining and more efficient to serve and represent their members</i></p> | <ul style="list-style-type: none"> ▪ Prepare and propose draft law (s) ▪ Advocate for the passage of the draft law(s) <ul style="list-style-type: none"> ▪ In addition to the ones mentioned by this assessment (RHF, NUDOR, Private Medical Association, PSF/ICT Chamber, Rwanda Medical Association), identify all critical private sector associations in consultation with key stakeholders ▪ Provide TA and other resources to strengthen capacity and follow-up on past reviews, completing/updating their business plans, and support preparation and implementation of Action Plans to efficiently support the various PS members in representing and dialoging with the GOR | <p>RG</p> | <p>1,2,4</p> | <p>High</p> | <p>LT</p> | <p>PS, DPs, and GOR (MOH, RBC, RDB)</p> |

Strategic Area 2: Policy and Planning

| Key Findings/Conclusions | Key Broad Recommendation | Key Sub-Elements/ Illustrative Activities | Results Area (EG and/or RG) | Impacting and/or Supporting HSSP III Priority Area(s) | Suggested Priority Level (high, medium, low) | Impact (short/long term – LT/ST) | Responsible and/or Collaborating Parties |
|--|---------------------------------|--|------------------------------------|--|---|---|---|
| <p>effectively advocating and representing the interests of their members</p> <ul style="list-style-type: none"> ▪ Most hospitals’ management, including the DHs, are not autonomous – significant management effectiveness, accountability, and efficiency could be attained by making them autonomous and run by a Board of Directors, as PS models | | | | | | | |

Strategic Area 3: Investment and Access to Finance

| Key Findings/Conclusions | Key Broad Recommendation | Key Sub-Elements/ Illustrative Activities | Results Area (EG and/or RG) | Impacting and/or Supporting HSSP III Priority Area(s) | Suggested Priority Level (high, medium, low) | Impact (short/long term – LT/ST) | Responsible and/or Collaborating Parties |
|---|--|--|------------------------------------|--|---|---|---|
| <ul style="list-style-type: none"> ▪ There is currently some financing for the private health sector ▪ Interest rates, collateral requirements, loan terms and borrower contribution requirements restrict borrowing by private health providers and there is a lack of start-up funding ▪ Lack of market information, small market size, and concerns about risk and the health business model limit lending to the health sector ▪ There is minimal domestic and foreign investment in the health sector ▪ The RDB has | <p>Create or buy into existing Health Sector Challenge Funds (e.g. Health Enterprise Fund) to facilitate increased PSE in health</p> | <ul style="list-style-type: none"> ▪ Provide seed capital and ongoing support with TA for private sector innovation (such as ICT4H, m-Health etc.), PPPs and innovative ideas to strengthen CHW cooperatives ▪ Provide TA to awardees on business plans ▪ Select successful models and provide support to transition into commercial financing | RG | 1,2 | Medium | ST, LT | GOR (MOH, RBC, RDB); DPs Collaborators: PS |
| | <p>Structure DCA(s), supported by a TA vehicle to support growth in private health sector, including financing for health posts (HPs), CHW cooperatives, and larger PPP loans</p> | <ul style="list-style-type: none"> ▪ Identify eligible borrowers based on USAID DCA regulations, and both GOR and USAID/R priorities ▪ Finalize identification of DCA partner bank(s) (possibly with good representation in all or most districts) and structure DCA guarantee ▪ Provide TAs to both the borrowers and financial institutions in understanding and lending to the health sector, loan product development, and market research on opportunities | RG | 1,2,5 | High | ST, LT | DPs (USAID); PS Commercial financial institutions; Collaborators: GOR |
| | <p>Develop additional sources of financing for the private health sector working with the GOR, other international financial</p> | <ul style="list-style-type: none"> ▪ Initiate inter-governmental (MOH, MINECOFIN, Central Bank) dialog to designate health as a priority sector to be supported by BDF and BRD in order to support increased debt/equity financing in health ▪ Identify and engage with international financial institutions and/or other donors to | RG | 1,2 | High | ST, LT | GOR (MOH, MINECOFIN, CB), local and international FIs (BDF, BRD), DPs Collaborators: PS |

| | | | | | | | |
|--|--|---|----|-------|------|--------|---|
| <p>limited knowledge of the health sector and institutional capacity to increase investment in this sector</p> <ul style="list-style-type: none"> Limited business skills in the health sector are barriers to increased access to finance and investment | <p><i>institutions, and donors</i></p> | <p>have increased financing for private health sector</p> <ul style="list-style-type: none"> Explore potential to tap into Investment Clubs for increased equity investment in the private health sector | | | | | |
| | <p><i>Strengthen RDB's capacity to facilitate private health sector investment</i></p> | <ul style="list-style-type: none"> Conduct annual market research, staff training, and improve coordination with MOH and RBC through the PHSCC and the Secretariat Create online platform to advertise potential PPPs and private health sector opportunities Hold annual <i>Health Sector Trade Fair</i> targeted at both domestic and international investors with panel discussions, exhibition hall, and matchmaking | RG | 1,2 | High | ST, LT | GOR (MOH, RBC, RDB); Collaborators: PS, DPs (Possible TA) |
| | <p><i>Devise and support a TA mechanism to support feasibility studies, analysis, and Business Plan (BP) development for potential private health sector investments</i></p> | <ul style="list-style-type: none"> Work with PHSCC and its Secretariat to select and certify business consulting service providers to administer and manage the TA mechanism | RG | 1,2,5 | High | ST, LT | GOR (MOH, RBC, RDB); DPs (Possible TA); Collaborators: PS |

Strategic Area 4: Corporate Social Responsibility (CSR)

| Key Findings/Conclusions | Key Broad Recommendation | Key Sub-Elements/ Illustrative Activities | Results Area (EG and/or RG) | Impacting and/or Supporting HSSP III Priority Area(s) | Suggested Priority Level (high, medium, low) | Impact (short/long term – LT/ST) | Responsible and/or Collaborating Parties |
|---|---|---|------------------------------------|--|---|---|--|
| <ul style="list-style-type: none"> ▪ There are some examples of CSR (including PPPs) for the health sector in Rwanda (eg. GlaxoSmithKline’s support of One Family Health, Bralirwa’s support for the local manufacturing of mosquito nets and workplace programming) ▪ Currently most CSR funding is in the agricultural and ICT sectors by foreign investors (e.g. Walmart Foundation) mainly due to GOR, DPs led investment promotion activities ▪ There are constraints to the development of CSR for the health sector | <p><i>Strengthen CSR to support private sector engagement, PPPs, and increased funding for the health sector in Rwanda</i></p> | <ul style="list-style-type: none"> ▪ Explore potential PPP/CSR for Health Promotion and Prevention (HPP), and in training and capacity building in general at the decentralized levels (similar to AG, ICT etc.) ▪ Explore potential for PPP/CSR for CBHI/PBF payments to health posts and CHW cooperatives ▪ Identify potential CSR partners to provide seed capital for health post roll out and to support improved financing terms ▪ Identify priority areas for CSR activities in the health sector ▪ Actively explore investment promotion activities (e.g. CSR dialog & investment forums) in the health sector (similar to AGR, ICT etc.) ▪ Explore inclusion of social impact frameworks in PPP agreements | EG, RG | 1,2,3 | High | ST, LT | Corporations, Private Sector Federation, USAID, IPs Collaborators: GOR (MOH, MINEDUC, MINYICT), DPs |

Strategic Area 5: Health Sub-Sectors

| Key Findings/Conclusions | Key Broad Recommendation | Key Sub-Elements/ Illustrative Activities | Results Area (EG and/or RG) | Impacting and/or Supporting HSSP III Priority Area(s) | Suggested Priority Level (high, medium, low) | Impact (short/long term – LT/ST) | Responsible and/or Collaborating Parties |
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| Service Delivery | | | | | | | |
| <ul style="list-style-type: none"> ▪ The private health sector is interested in expanding and partnering with the public sector and some public facilities are actively exploring PPPs ▪ The private service delivery sector is small and fragmented ▪ There is an opportunity to develop a sustainable private health post model, which may lower costs to the district health system, reduce stress on the whole system, and increase access to care. ▪ There is significant interest within district hospitals and the MOH to increase PPPs and other | <p><i>Develop and implement an innovative Public Private Community Partnership (PPCP) model to encourage private sector participation in health post (HP) establishment and management</i></p> | <ul style="list-style-type: none"> ▪ The district, cell, or the community provides the ‘ready’ physical infrastructure (new or renovated) to serve as the clinic ▪ The GOR regulates and ensures quality, standards, provides supervision, and procures drugs through the nearest Health Center (HC) ▪ The business is owned and run by a private (A2/A1) nurse ▪ The model receives support from a private organization, which serves as an incubator for the private HPs, offering technical assistance (including training), monitoring and reporting support, and facilitating access to finance to strengthen prospects for viability and additional income generation activities ▪ Startup cost of \$3,000 - \$5,000 per HP covered by seed capital (~\$3000), and combination of loan (under a reduced interest rate) and investment (~\$2000) ▪ Nurse invests \$500 from personal savings and takes a loan for \$1,500 for a total personal investment of \$2,000 ▪ Work with TVET to develop and roll-out training for private nurses in entrepreneurship, business and financial | EG, RG | 1,2,3 | High | ST, LT | GOR (MOH-central & local levels, RBC, RDB), A2/A1 Nurses, PS, Collaborators: Financial Institutions, DPs |

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| <p>income generation strategies within facilities</p> <ul style="list-style-type: none"> ▪ There is no clear process and legal framework, and limited capacity to develop and implement PPPs and other income generating activities at the facility level ▪ There are limited business skills and “business culture” at the facility level ▪ There is an interest and opportunity to strengthen and promote specialized services and tertiary care in the private sector | | <p>management, claims management and monitoring and evaluation</p> <ul style="list-style-type: none"> ▪ The incubator provides follow-up business counselling and mentorship support to assist the nurses to operate viably ▪ Nearest HC provides supervision support, collects data, processes CBHI claims (this role could also be done by the business incubator to achieve efficiencies), and procures and delivers drugs ▪ The health post keeps the co-pay and remainder of the CBHI reimbursement ▪ The HP provides a monthly fee to the business incubator as reimbursement for its services. The fee should be nationally agreed upon percentage of gross sales ▪ The business incubator assists health posts to develop other revenue generation streams, including but not limited to sales of additional products at the post, agent relationships with telecoms and financial institutions ▪ Explore and institute electronic bill submission, drug procurement, and effective payment processing system ▪ Explore possible expansion of service portfolio (vaccine, implants, STD etc.) ▪ Institute same service package for GOR and private HPs ▪ Critical success factor: i) timely CBHI payments must be made to the nurses, ii) the districts/cells/community must provide appropriate facilities in a good, commercially viable location, and iii) a rapid feasibility study and business plan | | | | | |
| | <i>Create a risk</i> | <ul style="list-style-type: none"> ▪ Conduct a study on the profitability of the | RG | 1,2 | High | ST, LT | GOR (MOH, |

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| <p><i>pooling fund, which can be used to supplement the incomes of HPs that see fewer than 20 clients per day on a prorated basis or struggle to stay afloat for other reasons beyond their control</i></p> | <p>HPs and adjust the budget for the subsidy</p> <ul style="list-style-type: none"> ▪ Plan to setup a risk pool of 243Million RWF per annum, assuming 25% of the HPs will need a 45,000 RWF subsidy per month ▪ Explore viable options including the reallocation of part of the current PBF supported by GOR annual national budget as a possible start up source of the risk pooling fund | | | | | <p>MINECOFIN) Collaborators: USAID, other DPs</p> |
| <p><i>Develop and institutionalize business and financial management capacity building program for the district and facility level managers and administrators</i></p> | <ul style="list-style-type: none"> ▪ Create a structured and modularized health business training program for district and facility level managers to educate and sensitize them on entrepreneurship, PSE concepts and strategies, and improved business administration and financial management ▪ Mode: combination of facilitator-led (classroom setting) and online ▪ Process: <ul style="list-style-type: none"> ○ A rapid training needs assessment and finalization of topics ○ Curriculum adaptation ○ A training of trainers (TOT) for RBC Business Development Unit staff and local training partner(s) so that they can deliver the full training in the future ○ Roll-out of the training ▪ Provide ongoing refresher training and mentoring support ▪ PHSCC Secretariat to coordinate The conceptualization, planning, and | <p>EG, RG</p> | <p>4,5</p> | <p>High</p> | <p>ST, LT</p> | <p>GOR (MOH, RBC, RDB), PS (local training institutions) Collaborators: USAID, other DPs</p> |

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| | implementation of all training modules and processes | | | | | |
| <i>Develop and institutionalize, PSE, business and management capacity building program for central level managers</i> | <ul style="list-style-type: none"> ▪ Create a structured and modularized health business training program for central level managers to educate and sensitize them on: <ul style="list-style-type: none"> ○ i) the basics of entrepreneurship ○ ii) basic business management for health ○ iii) the essentials of PSE and PPPs ▪ Mode: three day facilitator-led (classroom setting) training course ▪ Process: <ul style="list-style-type: none"> ○ A rapid training needs assessment and finalization of topics ○ Curriculum adaptation ○ A training of trainers (TOT) for RBC Business Development Unit staff and local training partner(s) so that they can deliver the full training in the future ○ Roll-out of the training ▪ PHSCC Secretariat to coordinate The conceptualization, planning, and implementation of all training modules and processes | EG, RG | 4,5 | High | ST, LT | GOR (MOH, RBC, RDB), PS (local training institutions) Collaborators: USAID, other DPs |
| <i>Support and incentivize the establishment of specialized services and tertiary care in the private sector</i> | <ul style="list-style-type: none"> ▪ Carefully explore and support current and new initiatives and investment opportunities for specialized health services and tertiary care (oncology, diabetes, cardiology etc.) facilities by improving the policy environment (creating new incentives, tariff etc.) and expanding access to finance | EG, RG | 2,3 | High | LT | GOR (MOH, RDB, RBC), PS Collaborators: financial institutions, USAID/R, IPs, other DPs |

Health Financing

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| <ul style="list-style-type: none"> ▪ Rwanda has made substantial progress towards universal coverage, overcoming financial barriers and improving equity. ▪ The integration of CBHI under the RSSB poses an opportunity for improved efficiencies and financial management ▪ A high dependency on donor funding, which is declining, and the low purchasing power of the population is creating stress on Rwanda's health financing system | <p><i>Establish an integrated system (as envisaged by GOR) of health insurance combining CBHI, RAMA, and other social insurance schemes, and review the functioning of the system for its impact on quality of services, payments & equity, and sustainability</i></p> | <ul style="list-style-type: none"> ▪ Review and modify every two years the cost of benefit packages and associated premiums paid by clients in different income categories ▪ Computerize the CBHI data and train workers for better management of clients and fee collection ▪ Reevaluate the co-payment system and its affordability, and adjust accordingly ▪ Devise and institute an effective payment systems for timely payment of the CBHI PS bills | EG, RG | 1,2 | High | ST, LT | GOR (MOH, RBC, RDB, RSSB) Collaborators: USAID/R, IPs, and other DPs |
| <ul style="list-style-type: none"> ▪ The tariff is low and has not kept up with inflation - a deterrent to private sector investment in health ▪ A costing exercise has been completed to revise the GOR tariff structure, which is now awaiting approval | <p><i>Strengthen RSSB structural and institutional processes for a successful and smooth integration of CBHI</i></p> | <ul style="list-style-type: none"> ▪ Conduct a study of how to effectively implement the merger, and develop associated concrete action and change management plans ▪ Provide adequate TA toward computerization of the CBHI operation, particularly for financial management ▪ Provide adequate training to RSSB and CBHI staff to get them to a state of readiness for the merger ▪ Develop and implement an advocacy plan to raise awareness both at the leadership, PS and citizen's levels (particularly community level) on the various impact of the integration | EG | 4 | High | ST, LT | GOR (MOH, RBC, RDB, RSSB) Collaborators: USAID/R, IPs, and other DPs |
| | <p><i>Continue efforts to strengthen</i></p> | <ul style="list-style-type: none"> ▪ Conduct market survey to identify best practices and business models from existing | RG | 1,2,4 | High | ST, LT | GOR (MOH, RBC, RDB, |

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| <ul style="list-style-type: none"> ▪ Inefficiencies within the CBHI claim processing and payment system creates payment delays, which can have negative consequences on the viability of private health posts ▪ Additional revenue generation by health posts will help sustain this model and help mitigate dependence on CBHI ▪ Private health insurance in Rwanda is relatively small ▪ There are opportunities to better integrate private insurance into the health financing system and create complementary and new products for the un and underinsured | <p><i>CHW cooperatives by assessing current experiences with revenue generation and developing an effective model for wider replication</i></p> | <p>income generating experiences by the CHWs Coops</p> <ul style="list-style-type: none"> ▪ Identify opportunities to leverage economies of scale, improve market linkages and consolidation and increase profitability ▪ Strengthen and intensify technical assistance and capacity building to CHW cooperatives ▪ Explore possibility of a challenge fund that provides seed capital to select cooperatives could be a useful strategy to promote innovation and incentivize growth ▪ Support the initiative on a broader scale to obtain quality certificates from the Rwanda Standards Board (RSB) as a strategy to increase sales and potential for export for the CHW cooperatives ▪ Scale up and implement an effective support model for wider CHW cooperative ▪ Advocate for a tax holiday for CHW cooperatives: prepare a business case for submission to MINECOFIN showing the critical impact and role that the CHWs and the cooperatives play, and justify why this tax holiday (as part of a consorted approach with other measures) will actually strengthen the backbone of the system, supporting national prosperity | | | | | <p>CHW Coops, MINECOFIN) Collaborators: PS, USAID/R, IPs, and other DPs</p> |
| <ul style="list-style-type: none"> ▪ The majority of CHW cooperatives are operating income generation activities although profit is low and financial issues persist ▪ Technical assistance | <p><i>Conduct a study and carefully evaluate the impact of possibly ending PBF from the GOR national</i></p> | <ul style="list-style-type: none"> ▪ Measure and analyze possible negative consequences of ending PBF, including but not limited to: <ul style="list-style-type: none"> ○ Possible loss of motivation on the part of the CHWs ○ Limited ability to increase growth and improved profitability of | <p>RG</p> | <p>1,2</p> | <p>High</p> | <p>ST, LT</p> | <p>GOR (MOH, RBC, RDB, CHW Coops, MINECOFIN) Collaborators: PS, USAID/R, IPs, and other</p> |

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| <p>to CHW cooperatives over the last few years has improved the viability of this model although additional assistance is needed</p> <ul style="list-style-type: none"> ▪ PPPs and income generation at the district hospital level is limited. There is keen interest in expanding income generation and improving efficiencies, but DH managers lack the skills and business mindset | <p><i>budget for CHWs and cooperatives</i></p> | <ul style="list-style-type: none"> o cooperatives o Reduced chances for the turnaround of non-performing cooperatives o Potential financial losses for cooperatives that depend on the PBF to cover operating expenses ▪ Based on the results of the analysis: <ul style="list-style-type: none"> o Consider reducing PBF in a phased approach rather than terminating it all together at once o Consider alternate scenarios with other possible sources of financing, including using at least 50% of the overall profit of all CHW cooperatives across the country as a possible means to cover up for the loss of the PBF under the GOR's national budget | | | | | DPs |
| | <p><i>Establish a national association (work through Rwanda Cooperative Agency, RCA) of health post workers and support income generation</i></p> | <ul style="list-style-type: none"> ▪ Support additional income generation activities at the HP ▪ Support organizational development of the national association ▪ Explore potential partnership opportunities in both financing and income generation with telecoms, financial institutions, and other corporate entities | RG | 1,2 | Medium | LT | GOR (MOH, RBC, RDB, RCA, CHW Coops) Collaborators: PS, USAID/R, IPs, and other DPs |
| | <p><i>Explore, plan, implement, and monitor new strategies for income generation and efficiency gain at the district</i></p> | <p>Critical General Preparatory and Process Elements:</p> <ul style="list-style-type: none"> ▪ Develop and institutionalize structured and modularized health business training programs for DH managers and administrators in order to educate and sensitize them on basic skills for entrepreneurship, income generation, | RG | 1,2,4 | High | ST, LT | GOR (MOH, RBC, RDB), PS Collaborators: USAID/R, IPs, and other DPs |

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| <i>hospitals</i> | <p>private sector engagement (PSE) concepts and strategies, and improved operational efficiencies and business management</p> <ul style="list-style-type: none"> ▪ Devise and operationalize a formalized process to select a key set of districts (pilot) based on a set of carefully thought out and evidence based criteria ▪ Conduct a comprehensive review and feasibility study at those DHs to assess potential facility specific income generating activities including PSE opportunities (private wing, private consultation, outsourcing of key support services, contracting in of management services etc.) ▪ Based on the reviews, identify and select the most viable opportunity(s) for each of the DHs under the pilot program ▪ Develop business plan (BP) and support potential income generating activities including the development of PPP models ▪ Consult and coordinate with Rwanda Development Board (RDB) to find viable partnerships with financial institutions and private investors <p><u>Concept - Private Wing</u> Implementation Process and Policy:</p> <ul style="list-style-type: none"> ▪ Develop and institute a legal framework for the private wing provision at the public hospitals ▪ Conduct feasibility study and financial analysis to determine viability of private wing at select hospitals ▪ Develop business model, which may include but not be limited to revenue sharing, leasing arrangements, alternate | | | | | |
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| | <p>customer services and pricing structure</p> <ul style="list-style-type: none"> ▪ Develop operations manual that can be customized and updated on an annual basis ▪ Provide specific targeted technical assistance (TA) to the DH managers and administrators to structure, implement, and manage private wings ▪ Devise and institute effective pricing, payment, resource tracking, and accountability mechanisms ▪ Conduct ongoing review, evaluation, and update of key policies including customer services/amenities packages and pricing structure, and enforcement mechanisms on an annual basis ▪ Ensure same quality of core medical care services for private and public/general patients <p>Business Model:</p> <ul style="list-style-type: none"> ▪ Patients pay a higher fee (at different level based on the chosen package) for getting added comfort and amenities, expedited appointments, and better customer service ▪ Hospital generates additional revenues, which will help improve financial sustainability and eventually lead to increased equity gain through enhanced, expanded and improved patient care and services <p><u>Concept: Private Consultation Scheme</u></p> <p>Implementation Process and Policy:</p> <ul style="list-style-type: none"> ▪ Develop and institute legal framework for | | | | | |
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| | <p>the provision of private consultation and dual practice at the public hospitals</p> <ul style="list-style-type: none"> ▪ Conduct feasibility study and financial analysis to determine viability of private consultation scheme ▪ Develop a business model, which may include but not be limited to revenue and cost sharing, leasing arrangements, etc. ▪ Develop operations manual that can be customized and updated on an annual basis ▪ Arrange for designated locations for private consultation and/or additional specialized services, such as ultrasound, MRI, advanced optical equipment, etc. ▪ Provide specific and relevant technical assistance (TA) to the DH managers and administrators to structure, implement, and manage private consultation schemes ▪ Develop and/or revise performance based policies and effective accountability, monitoring and enforcement mechanisms for dual practice schemes. The scope and weekly allocation of time for private consultation may take into consideration critical elements like: <ul style="list-style-type: none"> ○ Setting a minimum threshold for number of patients seen in public settings per day (or over a week) ○ Quality, standards, and attention to care in public settings, verified by periodic unannounced supervision visits and patients' survey results ▪ Conduct ongoing review, evaluation, and update of the policies and enforcement mechanisms on an annual basis | | | | | |
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| | <p>Business Model:</p> <ul style="list-style-type: none"> ▪ Hospital provides private ‘service ready’ consultation room ▪ Patient pays fees for per consultation ▪ Doctor pays a predetermined percentage (e.g. 20%) of the fee (per consultation), which covers cost for using the space, equipment and other utilities as well as revenue sharing. ▪ Alternatively, the hospital charges the doctor a monthly fee to lease or rent the space, equipment and supplies. In this model the doctor keeps the entire consultation fee <p>Key General Next Steps:</p> <ol style="list-style-type: none"> 1. Ensure institution of legal framework(s) for private wing, dual practice/private consultation models 2. Launch an immediate consultation process to fine tune and detail out the concepts 3. Select a set of DHs and devise and launch a program to test the concepts 4. Conduct rapid assessments/feasibility studies at the pilot DH locations and determine actual viability for specific activity(s) 5. Develop business plan and models, including risk assessment and mitigation strategy and costing exercise to determine appropriate revenue share/leasing arrangement 6. Formulate an implementation plan, monitoring and compliance systems, and rollout <p>Concept: Outsourcing</p> | | | | | |
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| | | <ul style="list-style-type: none"> ▪ Develop models and operations manual that can be customized for selected facilities for various possible outsourcing functions including but not limited to ambulance services, waste management, laundry operations, pharmacy, lab services, etc. ▪ Develop capacity for tender and contract management. ▪ Conduct feasibility studies to select specific functions to be outsourced. ▪ Provide TA to the facility managers to structure, implement, and manage outsourcing <p><u>Concept: Full Privatization</u></p> <ul style="list-style-type: none"> ▪ In the longer term, explore full privatization/employee owned facility options at selected facilities | | | | | |
| | <i>Explore partnerships with private health insurance industry to increase coverage and their contribution to the CBHI</i> | <ul style="list-style-type: none"> ▪ Conduct feasibility studies in collaboration with private insurance companies to create lower cost package and complementary coverage package (in conjunction with CBHI) for the 7% of the population who are not covered at all, and those who are not fully covered ▪ Explore the feasibility of increasing private insurance contribution to CBHI (from the current 1% to 3-5%) by incentivizing the industry through coverage of select services by the CBHI to privately insured individuals at the primary and secondary level facilities | EG, RG | 1,2 | Medium | LT | GOR (MOH, RBC, RDB), PS Collaborators: USAID/R, IPs, and other DPs |
| <i>Human Resource for Health (HRH)</i> | | | | | | | |
| <ul style="list-style-type: none"> ▪ The lack of skilled healthcare workers is a constraint to private | <i>Continue to promote the development of</i> | <ul style="list-style-type: none"> ▪ Support TVET programs, such as biomedical technicians, and select priority specialties at the UofR | EG, RG | 3,5 | High | LT | GOR (MOH) Collaborators: USAID/R, PS, |

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| <p>sector development in general, and to the development of specialized health services in the private sector, and the privatization of medical equipment maintenance</p> <ul style="list-style-type: none"> ▪ The GoR is acutely aware of the problem and has a long term vision and plan in place for developing a skilled workforce ▪ There is a lack of knowledge of health PPPs/PSE at all levels within the GOR and a lack of business and financial management skills at the facility level ▪ Staff retention is a major issue for all major cadres - lack of incentives to retain doctors, particularly in rural areas | <p><i>specialized health workers (specialized physicians, midwives, biomedical technicians and engineers)</i></p> | | | | | | Other DPs |
| | <p><i>Strengthen internal capacity within the MOH, RBC, and RDB to develop and support PPPs and PSE</i></p> | <ul style="list-style-type: none"> ▪ Conduct internal dissemination workshops for the MOH, RDB, and RBC to discuss findings of the PSE assessment, establish priorities and create action plans for addressing challenges ▪ Create and conduct a training on health PPPs and PSE for the MOH, RBC, and RDB | | 1,2,3,4,5 | High | ST, LT | GOR (MOH, RBC, RDB) Collaborators: USAID/R, PS, IPs, Other DPs |
| | <p><i>Develop and conduct training and capacity building for the central, district and facility level managers in entrepreneurship, PSE, and business & financial management</i></p> | <ul style="list-style-type: none"> ▪ Create a structured and modularized health business training program and follow-on assistance for district and facility level managers to educate and sensitize them on PSE concepts and strategies, and improved operational efficiencies ▪ Develop entrepreneurship, business, financial, and management capacity through the TVET program for Health Posts, and provide follow-on business counseling and mentoring support ▪ Build general and financial management capacity of current staff at all levels according to MINECOFIN guidelines | EG, RG | 1,2,3,4,5 | High | ST, LT | GOR (MOH, RBC, RDB, Districts) Collaborators: PS, USAID/R, IPs, Other DPs |
| | <p><i>Increase the resources and access to Health Promotion and Prevention (HPP) relevant</i></p> | <ul style="list-style-type: none"> ▪ Advocate for and increase GOR, DPs, and CSR resources for HPP relevant trainings ▪ Explore partnerships with the PS, particularly the communication companies, and increase use of mobile and other electronic technologies to promote HPP | EG | 1,2 | Medium | ST, LT | GOR (MOH, RBC, RDB) Collaborators: PS, USAID/R, IPs, Other DPs |

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| | <i>training for the private sector</i> | trainings | | | | | |
| | <i>Improve staff retention through incentives, such as revenue sharing under PPPs and dual practice</i> | <ul style="list-style-type: none"> ▪ Revise policy enabling dual practice. ▪ Conduct feasibility studies and provide technical assistance to enable doctors to participate in revenue sharing schemes through PPPs private consultation wings. | EG, RG | 1,2,3,4,5 | High | ST, LT | GOR (MOH, RBC,) Collaborators: PS, USAID/R, IPs, Other DPs |
| Medical Products (including medicine), equipment, and Technology | | | | | | | |
| <ul style="list-style-type: none"> ▪ There is insufficient funding and planning for medical equipment maintenance & management ▪ There is a lack of skilled biomedical engineers and technicians in both the public and private sectors ▪ There are programs under development for strengthening biomedical engineering skills and the GOR has received seed funding (US\$18M) from the ADB to create a Center of Excellence ▪ Donor dependency has led to a culture of replacement rather than repair and | <i>Devise and implement a parallel and phased approach on equipment management and maintenance</i> | <p>Short term:</p> <ul style="list-style-type: none"> ▪ All procurements should include a service contract for repairing equipment ▪ Streamline domestic import and custom requirements for spare parts to reduce time (on a broader scale, explore pursuing the East Africa Legislative Assembly (EALA) to amend the EAC Customs External Tariff for duty free spare parts of medical equipment) ▪ Conduct an inventory of the status of medical equipment ▪ Create a policy and harmonize medical equipment ▪ Explore framework agreements for the procurement of equipment as part of the harmonization process <p>Medium/Long Term:</p> <ul style="list-style-type: none"> ▪ Support the training of biomedical technicians and biomedical engineers ▪ Provide technical assistance to RBC in creating a Center of Excellence in Biomedical Engineering, including: <ul style="list-style-type: none"> ○ Assistance in refining the concept of the Center of Excellence and developing a business model | EG, RG | 3,4 | High | ST, LT | GOR (MOH, RBC, RDB) Collaborators: PS, USAID/R, IPs, Other DPs |

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| <p>maintenance of medical equipment</p> <ul style="list-style-type: none"> There are complex procurement and customs requirements for medical equipment and spare parts There is almost no medical product/equipment manufacturing in Rwanda and limited information on potential opportunities Rwanda has a relatively active private pharmacy sector, which could play a greater role in the procurement and distribution of drugs | <p><i>Through a broader consultation process with the PS players, explore and support production, expansion and diversification of medical products and commodities</i></p> | <ul style="list-style-type: none"> Brokering partnerships with large multinational companies (e.g. GE, Phillips, Abbot Labs etc.) Undertake a feasibility study of local production of medical products (including common drugs) and commodities (e.g. ITN) Use the results of the study to advocate and promote private sector participation in local production of medical products (including generic drugs) and commodities, such as ITNs Use the results of the study to actively engage the private sector in a meaningful dialog Assist in the development of business plans and accessing financing for the viable opportunities, as appropriate Develop and finalize an appropriate legal framework and guidelines to govern and support institutionalization of traditional medicine practice | EG, RG | 3 | Medium | LT | GOR (MOH, RBC, RDB) Collaborators: PS, USAID/R, IPs, Other DPs |
| | <p><i>Explore potential for increased privatization of drug procurement and distribution, and improve current planning</i></p> | <ul style="list-style-type: none"> Following spin out of the MPPD, conduct feasibility analysis of options to increase private sector engagement in drug procurement and distribution in the short term on a limited basis, such as supplying private health posts Explore wider scale privatization of system wide drug procurement and distribution in the longer run Improve the supply chain through better planning and communication, and electronic system to avoid drug stock-outs and wastage; explore new electronic and mobile technologies to unblock logistic delivery bottlenecks | EG | 3,4 | Medium | ST, LT | GOR (MOH, RBC, RDB) Collaborators: PS, USAID/R, IPs, Other DPs |

Health Information System (HIS)

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| <ul style="list-style-type: none"> ▪ The ITC sector is developing very fast in Rwanda with significant government support, private sector growth and examples of successful PPPs ▪ The GOR has made significant strides in e-health but there are more opportunities to increase efficiencies through increased use of technology ▪ Increased use of DHIS2 with high reporting rate ▪ Limited existing initiatives of private sector engagement in health information and mobile technology (e.g. RapidSMS) ▪ Weak basic computer and IT skills at various levels ▪ Inefficient institutional capacity and systems, and high cost of basic IT and help desk operation ▪ High cost of internet: High set up and | <p><i>Increase efficiencies through expanded use of e-health</i></p> | <ul style="list-style-type: none"> ▪ Engage in consultation with PS and conduct review of MOH/RBC's IT unit and explore outsourcing (basic IT support, help desk etc.) ▪ Based on the review, develop a phased and prioritized action plan for increased efficiency gain through strategic outsourcing ▪ Increase PSE in building various interfaces to support interoperability between key existing systems, including but not limited to DHIS-2, iHRIS, and others using the DHIS-2 API ▪ Develop software and mobile phone interface for CBHI claims management ▪ Develop software and mobile phone interface for electronic drug procurement at health post level ▪ Use mobile money for health posts and CHW cooperatives payments ▪ Explore potential for PPP/CSR for CBHI/PBF payments to health posts and CHW cooperatives ▪ Strengthen basic computer and IT skills at various levels through increases PSE ▪ Setup discussion forums and Increase dialog between the public and PS (including ICT companies) to promote and foster innovative solutions and formulation of PPPs | EG | 3,4,5 | High | ST, LT | <p>GOR (MOH, RBC, RDB, MINYICT) Collaborators: PS, USAID/R, IPs, Other DPs</p> |
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| operational costs for infrastructure, unstable electricity, lack of resources makes operations quite costly | | | | | | | |
| Health Promotion and Prevention (HPP) | | | | | | | |
| <ul style="list-style-type: none"> ▪ Rwanda has made remarkable progress in improving health outcomes through effective HPP in areas such as malaria, tuberculosis, HIV and AIDS, neglected tropical diseases, NCDs and family planning ▪ Outreach and demand creation activities can improve the viability of small-scale private providers ▪ PPPs related to HPP are working well, but there is room to improve and expand ▪ Increased HPP activities through private partnerships, especially in TB, HIV, and MCH ▪ Increased number of registered CHWs with high commitment to work | <p><i>Increase PSE activities with targeted HPP strategies to help strengthen private sector contribution to health outcomes</i></p> | <ul style="list-style-type: none"> ▪ Develop an awareness campaign for communities with new health posts to promote use ▪ Support new health posts with targeted outreach focused on Ending Preventable Child and maternal Death (EPCMD) ▪ Increase private service provider engagement and PPPs in health promotion and prevention, including TB, HIV and AIDS, family planning, and NCDs ▪ Explore potential to develop m-health EPCMD campaign with mobile telecom partnership ▪ Explore potential CSR for HPP | EG, RG | 1,2,3 | Medium | ST, LT | GOR (MOH, RBC, RDB) Collaborators: PS, USAID/R, IPs, Other DPs |

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| <p>in HPP work</p> <ul style="list-style-type: none"> ▪ Need for refresher trainings for CHWs and continuous capacity building in various areas: maternal, child health, TB, malaria prevention, etc. ▪ There has been limited corporate engagement related HPP/CSR ▪ New training programs being developed for Community Health Technicians on NCDs in collaboration with the Workforce Development Authority (WDA) ▪ Inadequate resources and access to HPP relevant trainings | | | | | | |
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Learning and Knowledge Management (LKM)

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| <ul style="list-style-type: none"> There are a number of existing public private partnerships geared towards training facilitation; education and knowledge transfer of best practices provided through training workshops, training of trainers, (TOT), short and long-term learning programs/courses as well as in-house facilitation There is limited knowledge within the GOR about health PPPs and PSE; no central location for data on the private health sector; and no evidence base. There is limited internal capacity within the MOH, RBC and RDB to develop and support PPPs and PSEs There is lack of business and financial management skills at the facility level There are a few high level market research | <p><i>Test different PPP models, disseminate findings and scale-up successful models</i></p> | <ul style="list-style-type: none"> Develop operations research to monitor and learn from the roll-out of different types of PPPs income generation activities with district hospitals Disseminate findings and replicate successful models | EG, RG | 2 | Medium | LT | GOR (MOH, RBC, RDB) Collaborators: PS, USAID/R, IPs, Other DPs |
| | <p><i>Develop internal capacity within the MOH, RBC and RDB to develop and support PPPs and PSE</i></p> | <ul style="list-style-type: none"> Conduct internal dissemination workshops for the MOH, RDB and RBC to discuss findings of the PSE, establish priorities and create action plans for addressing challenges Create and conduct a training on health PPPs and PSE for the MOH, RBC and RDB | EG, RG | 1,2,3,4,5 | High | ST, LT | GOR (MOH, RBC, RDB) Collaborators: PS, USAID/R, IPs, Other DPs |
| | <p><i>Develop and conduct training and capacity building at the facility level in business and financial management</i></p> | <ul style="list-style-type: none"> Create a structured and modularized health business training program and follow-on assistance for district and facility level managers to educate and sensitize them on PSE concepts and strategies, and improved operational efficiencies Develop entrepreneurship, business, financial, and management capacity through the TVET program for health posts, and provide follow-on business counseling and mentoring support | EG, RG | 1,2,3,4,5 | High | ST, LT | GOR (MOH, RBC, RDB) Collaborators: PS, USAID/R, IPs, Other DPs |
| | <p><i>Strengthen Operational and Clinical Research</i></p> | <ul style="list-style-type: none"> Strengthen capacity of MOH research unit to manage and conduct operational and clinical research Actively explore PSE in operational and clinical research activities | EG | 2,3,5 | Medium | LT | GOR (MOH, RBC, RDB) Collaborators: PS, USAID/R, IPs, Other DPs |
| | <p><i>Develop, support, share, and disseminate knowledge, information and evidence to</i></p> | <ul style="list-style-type: none"> Assess data and information needs focusing on health PS facilitation and development, and design analytical tools and responsive information and knowledge management products, including a ‘knowledge bank’ (with ‘key indicators database’) with up to | EG, RG | 1,2,3,4,5 | High | ST, LT | GOR (MOH, RBC, RDB) Collaborators: PS, USAID/R, IPs, Other DPs |

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| <p>activities in the health sector currently, mainly focused on national health statistics and community based health systems</p> <ul style="list-style-type: none"> ▪ There is low clinical and operational research capacity (public & private), and inadequate PS involvement ▪ | <p><i>facilitate PSE and income generation</i></p> | <p>date data/information that is readily and easily accessible</p> <ul style="list-style-type: none"> ▪ Provide small grants to researchers in academic, GOR, and private institutions to develop a body of evidence to monitor and support the overall development of PS in health ▪ Support intra district/sector/community “learning missions” across geographic and administrative boundaries to facilitate hands-on experience, learning, sharing, and documenting ‘best practices’ and ‘what works’ for successful income generation activities ▪ Arrange a study/learning trip for the <i>PHSCC Secretariat</i> members to a regional country(s), such as Uganda and/or Kenya, to meet with counterparts and explore different successful models for PSE, i.e. ‘what works’. | | | | | |
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