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Maximising Decentralization Opportunities for Improved Health

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and

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Abstract

The devastating genocide in Rwanda generated strong support for a political system which will ensure that power never again resides in the arms of a few. A radical decentralization program has been launched, under which a comprehensive system of Administrative Districts, and below them the smaller units of Secteurs and Cells has been created. Elections were held at the Administrative District level in 2001, and at the lower levels in 2002.

This fledgling system has much potential, but a lack of experience and resources is impeding progress. The government has adopted legislation which will allocate the Administrative Districts 11.5% of the previous year's budget (the Community Development Fund (CDF)), to be shared on a formula basis, thus ensuring that they have reliable sources of funds, but this has yet to be implemented. At the same time, with USAID support, measures are being taken to strengthen the financial position of local government by the introduction of new local taxes and charges, combined with improved management and accounting.

This study aims to examine potential synergy between the decentralization of the administration, and the delivery of improved health services. Although the scope of work did not refer to the financing of health provision, it became apparent during the mission that finance matters could not be ignored. Accordingly the report addresses the current financial problems being experienced by the health centers, and proposes means to improve the delivery of health services, the local economy and infrastructure in so doing.

There are four principal mechanisms proposed:

1. Strengthening the support of Local Government to Health, by providing matching grants to District administrations in respect of funds which they budget from the CDF for health purposes; strengthening the finances of health centers, through developing a public works program to permit people to gain health credits through their labor; supporting the construction of latrines by matching grants to the health centers and donations of consumer products; and providing training and technical assistance in the management of the health centers.
2. Developing the current mutual benefit society system, by investigating the potential for individual accounts, allowing members to assess their own contribution, monthly payments, withdrawal of any "surplus" accrued after a certain period, and use of the fund as a guarantee for small short-term loans to members. This will assure the health centers of payment for services.
3. Engaging the community in health activities, by building health posts at the secteur level, training animateurs (community health workers) to manage health posts, developing a career structure for animateurs, and giving them the opportunity for continuing professional development; and expanding the number and role of animateurs to support the Cell and Secteur health committees.

4. Strengthening local government, by supporting the establishment of a local government association which will act as an umbrella body for all interests in local government, such as Mayors and elected officials, Managerial Staff and Accounting staff, and act as a focal point for training and capacity building in local government, representing its interests in respect of national government.

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A note on the language

This report was written in a multi-lingual environment:

- The language of Rwanda, Kinyarwanda
- French which is the most widely used international language, and is normally used for official communications within Rwanda
- English, the language of the principal consultant in the study and the client, and also quite often used in Rwanda.

A few words which are widely used in Rwanda have not been translated in the text, and should be discussed:

Akarere: (Uturere in the plural) the Kinyarwanda word for the Administrative District, which was previously known as a commune. We have chosen to use this word, in preference to Administrative District, so as to avoid confusion with the Health District.

Secteur: this is the level of administrative district below the Akarere. We have preferred to use the French term rather than the English one, Sector, which can be confused with the developmental sense of the word (the education sector, the health sector, etc).

Animateurs: this French word, widely used in French speaking countries in Africa, has no direct equivalent in English. The equivalent term in British Administrative parlance is Community Health Worker, but this lacks the advocacy overtones that the word animateur carries. We have therefore chosen to use the term animateur through the report.

One has been semi-translated,

Mutuelles: This word is widely used and understood in Rwanda, and translates to mutual aid (or benefit) society created for the prepayment of health expenses. The word *mutual* is used adjectively in English in the same context, but we have chosen to use it as a noun as it bears a resemblance to the word Mutuelle and avoids the otherwise wordy translation.

Acronyms and glossary

CDF	Community Development Fund
DED	Deutsche Entwicklungsdienst
GTZ	German Technical Cooperation Agency
MINALOC	Ministry of Local Government and Social Affairs
MINISANTE	Ministry of Health
MINICOFIN	Ministry of Finance and Economic Planning
MTEF	Medium Term Expenditure Framework
ORT	Oral rehydration therapy
PHC	Primary Health Care
RUDO	Regional Urban Development Office of USAID

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Chapter 1

The system in Rwanda

1.1 Local Government

The Ministry of Local Government and Social Affairs published the National Decentralization Policy in May 2000. The system has been operating since the elections in 2001.

Central government is divided between the National Ministries and the Provinces, which are de-concentrated arms of national government and conduits for funds to be spent in the Province (Intara).

Beneath this is the main arm of local government, the legally independent Administrative District, the Akarere (*pl* Uterere), which has a population of between 60,000 – 100,000 persons. Beneath this are sectors of about 5,000 persons each, known as Umurenge (*pl* Imirenge), which are further divided into cells, known as Akagari (*pl* Utugari) of about 1000 persons. The Imirenge and Utugari at present have no staff capacity, so are basically consultative mechanisms, but it is foreseen that eventually the Imirenge will have a role in the provision of local services and the collection of charges and taxes.

This policy has been supported by legislation to establish a Community Development Fund (CDF) which allocates 11.5% of the national budget to local government, (10% for capital projects and 1.5% for recurrent expenditure). This is the first financial year in which the CDF has come into effect, and although payments have been delayed, at least some of the funds are expected to be paid shortly.

In addition the Uterere have incomes from the following sources:

- Rent from municipal buildings (in the urban areas)
- General taxes: primarily the head tax (contribution personnelle minimum (CPM))
- Communal taxes, such as the market tax
- Other miscellaneous taxes and fees

A property tax system is about to be introduced for the first time. This should give local government (especially in the urban areas) a strong financial base from which to operate.

These moves are a solid base on which a new system of local government is being constructed. However no one claims that the process has been or will be an easy one. The proposed changes are dramatic and require new skills, new attitudes, and new systems.

The system is illustrated in the following diagram:

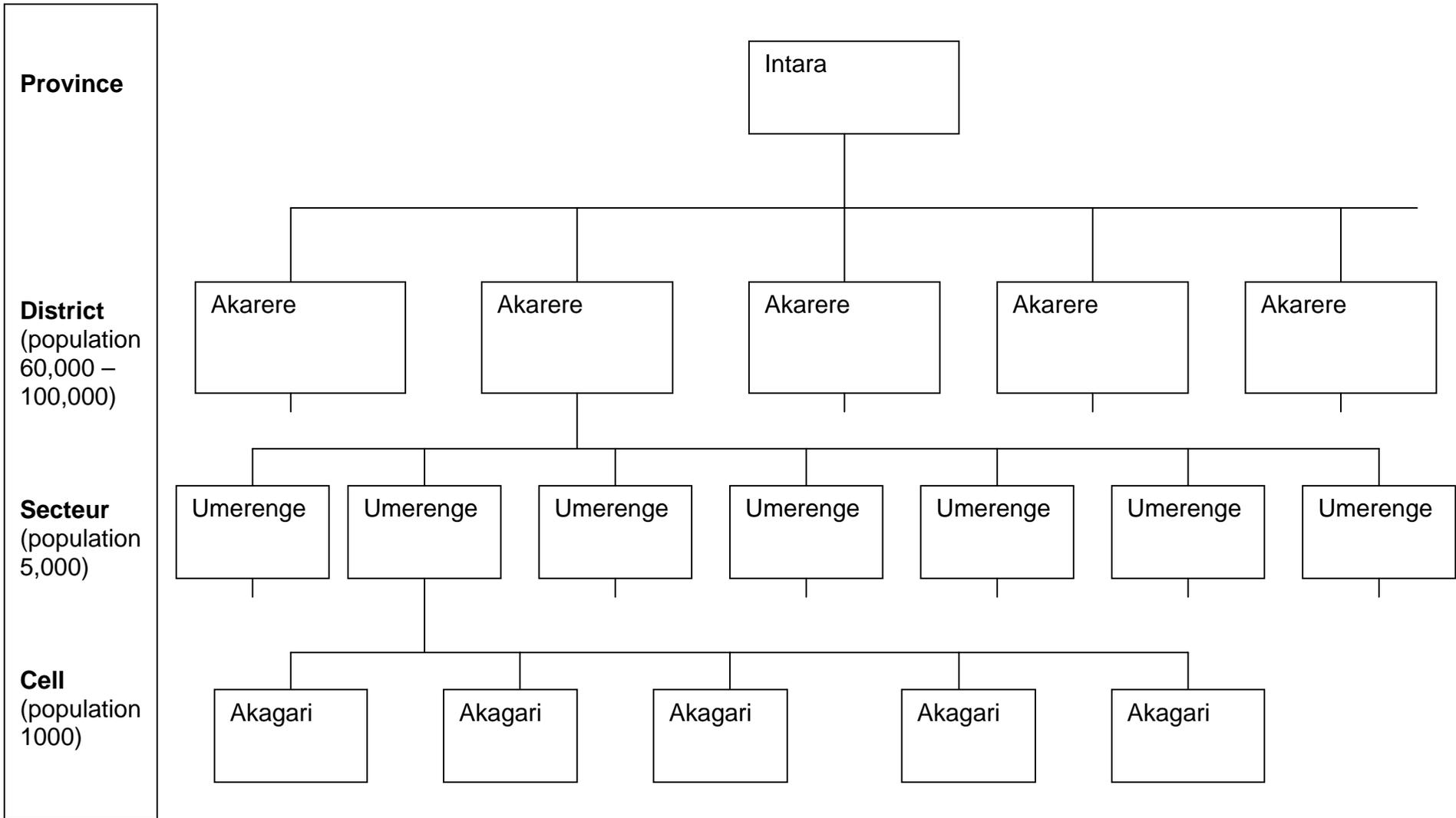


Diagram of Local Government Structure

1.2 Health

The delivery of health services is currently managed exclusively by the Ministry of Health (MINISANTE). For administrative purposes the country is divided into health districts. These are about twice as large as the administrative districts, the Uterere. Each Health District has one hospital, with its own administration and a number of supporting health centers. Medicines, laboratory supplies etc are supplied through the District, which in turn gets them from the central supplies. Technical supervision of the staff is undertaken by the staff of the Health Districts. There are two types of health center: those operated entirely by the government, and those operated by NGOs, e.g. a church) known as “agrées” . We shall, in general, not have to draw a distinction between the different types in what follows, but it should be noted that the ones wholly operated by NGOs tend to be better resourced.

Some members of staff of the health centers are paid by the MINISANTE, others by the Center itself. Centers charge fees for consultations, and medicines are sold at a small margin over the price they pay for them. Each center has a Health Committee, which meets at least every three months, and consists of health professionals as well as community members.

If the above simplistic outline of the system suggests that a good model already exists, it has succeeded. However, the existence of a good model does not imply that it cannot be improved. There are serious problems in terms of the financial sustainability of the existing system as well as accessibility problems.

Chapter 2

Results of the interviews and workshops

We were able to meet a wide variety of persons at national, provincial and local (i.e. District) levels, both officials and elected persons. At national level these included the Ministries of Finance and Economic Planning (Minecofin), Ministry of Health (MINISANTE) and Ministry of Local Government and Social Affairs (MINALOC). At Provincial (Intara) level we met the Umuyobozi (Prefect) of Byumba Province. At district level we met many people in both health districts and administrative districts.

A detailed account of the meetings held is contained in Dr Théophile Nizeyimana's report which is reproduced in the Appendix. This chapter summarizes these findings.

2.1 Interviews

In our meetings we focused mainly on obtaining the views of the respondents on how well the present system is working, and what problems are being experienced at present.

There was remarkable unanimity in the responses. With regard to the Local Government system, there are three major problems at present:

1. The Akarere are severely under-funded. This should be rectified when funds are received from the national budget, via the CDF, in a month or two.¹ It appears to be likely that the equivalent of only 2% of last year's budget will be made available this year, (partly because half the year has elapsed anyway, partly because structures to disburse and administer the funds have not been finalized, and partly because funds have not been available). Next year the amount may be increased to 5%, and possibly 8% the following year.
2. There are wide degrees of competency with regard to the bookkeeping methods and accounting standards being practiced at the District level. (A training program supported by USAID is addressing this²).
3. People who were used to the old system, under which the titular head of the district, the bourgmestre, had substantial power to decide and implement decisions alone, do not welcome the new style which is based on bottom-up governance. They are impatient with the need to consult and operate through committees etc.

With regard to the health system, there are four major problems:

1. A severe shortage of resources has impacted on the provision of health services at all levels. For example due to mismanagement at the

¹ The financial year is the calendar year. We were informed that delays in paying the funds to the CDF have been due to difficulties in finalising the national budget under IMF guidelines. Under negotiations with the IMF have been satisfactorily concluded, no final date for the release of funds can be given.

² Fiscal Decentralization in Rwanda, being implemented by ARD Inc

Provincial level, a number of hospitals in 2000 were crippled due to lack of funds.³

2. The health centers are similarly affected. They receive funds late, and staff are not paid. There are also indications of financial mismanagement. We did not enquire into the cause of the problem in any depth, but anecdotally we heard that a major cause of these difficulties was the lack of skills and experience in the proper management of the accounts. We also heard examples of corrupt practices.
3. Most health centers face severe difficulties due to non-payment of the fees by poor people.
4. There is a serious shortage of qualified staff. Most health centers only have one qualified nurse: some have no qualified staff.

2.2 Workshops

We conducted a small workshop at Kibungo, and a larger one at Byumba to look at these issues. The conclusions, in summary, were:

- There are many advantages in integrating the health system into the Uterere, especially in terms of making them more accountable to the people they serve. The disadvantages concern the administrative and financial capacity of the Districts in their present form, and their lack of specialist knowledge in health.
- The main problems facing the health system today are the poverty of the patients, weak financial and administrative management by the present health committees, difficulties in respect of transport and communication, a lack of medicines and motivated staff. Its strengths concern the fact that it covers preventive and curative health care, and has good vaccination programs.
- The system of mutual-aid societies (Mutuelles) faces problems regarding the low income of many persons, and an inadequate understanding of the system by many. There have been cases of political opposition. People fear losing their money due to maladministration of the funds. The successful mutuels are found where the health center works well, the members already work in a cooperative relationship, and the region is fairly prosperous.

Mutuals seem to succeed where tontines⁴ are common, and where good marketing has taken place, e.g. by PRIME II.

³ As documented in *Le Secteur de la Santé du Rwanda face aux Réformes de Décentralisation*, Cheikh S H Mbengue, a report commissioned by Prime II, with funding from USAID, March 2001.

⁴ Tontines are community-based revolving savings groups, typically involving between 10 and 20 persons. Each person puts a fixed amount into the kitty every week (or month), and each takes turns to receive the whole kitty. Thus in a ten person group, he or she will receive ten times the personal contribution once every ten weeks. This system operates widely throughout Africa, under various names.

- Training is needed for the mayors, secteur co-coordinators, persons with responsibility for health, the health committees, the community health workers (animateurs), and the supervisors of the health districts in subjects such as decentralization, and decentralized management systems.
- Concerning the role of provinces in the management of the health system, one view was that they do not add very much, indeed it was stated that they prevent funds from reaching the District. Another view was that the provinces funded some important aspects such as the costs of furniture, telephones, fuel, electricity etc.
- When asked to propose possible interventions by USAID, the following were suggested:
 - Support for the health centers by payment for the medical costs of the poor.
 - Support for income generating projects such as growing fruit and vegetables or making pineapple juice.
 - Support for the wages of the nurses who have not been paid until such time as the financial strength of the health centers has been restored.
 - Support for the management of the health district and the hospital.
 - Support for the HIV/AIDS Voluntary Counseling and Testing Service
 - Creation of a system of small local hospitals
 - Provide ambulances

With regard to the question of the differences between the Health District and the Akarere, it was clear that the MINISANTE is not convinced that that the integration of the health centers into the local government districts will work. This is an issue which will not be debated at this point in the report, but we looked at it from the perspective of added value – is there value to be added to the health system by working more closely with local government? From there we can look at modalities and the structural implications of integration.

Chapter 3: Norms and Objectives

Overall objectives

3.1 Health and local government

The provision of health is a combination of matters in the public and private spheres. The public sphere concerns the environment, such as good water and sanitation services, housing conditions etc: the private sphere concerns life-style matters such as personal hygiene, care to avoid transmittable diseases etc.

Insofar as both spheres are concerned local government has typically played an essential role in terms of physical services and public health education. With the introduction of a new system of local government in Rwanda, an important opportunity is presented in terms of developing a partnership between the formal health system and local government.

In so doing it is planned to improve the health of the citizens by means of stronger financial systems and better linkages to the communities. How this will be achieved is discussed in detail below, but clearly the paramount issue is one of political will. In the context of present-day Rwanda it can confidently be stated that such will exists, and can be harnessed to good effect.

3.2 Local Government

Within the present decentralization framework, the question is: apart from the urgent needs of meeting the residents' needs of today, what should local government's goals be? This question must be answered in order to prioritize the support that should be given to the transition process.

We have the advantage of extensive work in this regard: distillations of the experience in six countries in Africa which were studied exhaustively over a period of two years. The following is an extract from a report synthesizing the studies, summarizing indicators of good local governance:

1. *Services should be delivered by the agency at the lowest level of government that is able to perform them and as close to the citizens as possible (the principle of subsidiarity).*
2. *There should be a clear demarcation of functions between the different levels.*
3. *Encourage autonomy at lower levels of government while providing overall direction, e.g. in the form of performance measuring and minimum standard of services.*
4. *Avoid detailed and cumbersome central government approvals procedures, and exchange them with performance measurements.*
5. *Where essential, approvals procedures should be transparent, and with clear criteria for approval.*
6. *Infrastructure provision should have a minimum degree of uniformity, but should be administered flexibly at the local level.*
7. *Local government units should duly consider, through the use of a participatory approach to decision-making, their citizens' preferences,*

- affordability and willingness to pay for infrastructure and service provision.*
8. *Local government should cater for local needs, but not at the expense of efficiency or economy.*
 9. *Give the maximum autonomy to local government on the question of land management and use.*
 10. *Responsibilities for hiring and firing staff, as well as remuneration, should be devolved to local government.*
 11. *Service regulations should be developed which are suitable to the needs of local government staff.*
 12. *The law on local government should make a clear distinction between the responsibilities of the politicians and the administration (the top officials).⁵*
 13. *Local government should focus on the development of strategic planning. Clear objectives for the short-, medium- and long-term future should be developed, and the development plans and the budgets should be linked to these plans.*
 14. *Local government should develop decision-making and administration along the lines of the concept of “Good Governance”, by systematic involvement of the citizens, full transparency in decision-making, information sharing, delegation of decision-making power, clear lines of responsibility and strong accountability.⁶*

It will be noted that in many respects the model adopted by Rwanda conforms to the guidelines above. There are obviously some aspects which have not been addressed by the current framework, such as infrastructure provision and staff matters. These are major topics to be noted for future work.

In the present context, however, one point is striking: Rwanda is starting to put into practice the framework for good governance both as between the local government unit and its citizens, and also between central and local government.

In the context of local governance, this report looks at three aspects of the above: the first is the question of decentralization of the powers of one unit of government to another (we refer to the transfer of responsibility for managing health centers from the Ministry of Health (MINISANTE) to District Administration, and whether it is feasible and/or desirable); second to the potential for local government to enhance health standards by participating in the field, and lastly to the potential for the increased involvement of the community in health matters.

3.3 Health

Together with education, health is the sector that touches every person and every family. In spite of this it is widely regarded as being a matter for the

⁵ By this is meant drawing a legal distinction between the policy and governance role of elected officials and the management functions of their staff

⁶ Extracted from “Framework in Sub-national Government Finance and Fiscal Decentralization”, Jesper Steffensen and Svend Trollegaard, paper delivered at the Afri-Cities Conference, Windhoek, May 2000.

very highly qualified and specialized person, and by implication, one which the ordinary person has no part to play. However, the reverse is, in fact, largely true: our approach to the environment and our personal habits can, to a very large extent reduce the risk of sickness and disease. Moreover, as health is such an all-embracing subject, it cannot be ignored.

The following is a list of persons who officially and unofficially have an impact on health matters; persons, one might say, who constitute the “network of health”⁷

- Ministry of Health officials
- District Health officials
- Nurses
- Medical Technicians
- Laboratory staff
- Doctors
- Hospital staff
- Traditional doctors
- Traditional midwives
- Community Health Workers (Animateurs)
- Health committees
- Police
- Local politicians
- Community leaders
- Local Religious leaders
- School teachers
- Local Agricultural advisors
- Department responsible for roads
- Department responsible for water
- Local businessmen

A centralized health delivery system has difficulty in responding to a wide variety of stakeholders such as the above, both because it is too remote to do so, but also because it does not have the systems.

This therefore is a fundamental justification for the very existence of local government: it must provide a system within which the citizens’ needs can be heard and addressed. Such indeed is part of the motivation of the Rwandan policy, which was developed with the specific intent to limit the power of a few in central government to abuse the political system as happened in the genocide.

Although it is hoped that the above has made the case for the involvement of a wide range of interests, it cannot be denied that health is a specialized sector in many ways. The fact that it takes so long to train a doctor is demonstration of that fact.

⁷ This concept is taken from “Management Support for Primary Health Care” by Paul Johnstone and John Ranken, ODA, London 1994.

However, in the context of a developing country such as Rwanda, it is widely recognized that the country cannot afford the standard of medical care made available in developed countries and must develop a system which empowers other levels within the health-care professions, such as nurses, to take more decisions and action.

As with local government, we can use a set of principles against which to evaluate the system, as stated by the World Health Organization:

1. *Primary health care (PHC) should be shaped around the life patterns of the community it serves and should meet the needs of the community.*
2. *PHC should be an integral part of the national health system. Other echelons of service should be designed in SUPPORT of the needs of the peripheral levels, especially as this pertains to technical supply, supervisory and referral support.*
3. *PHC activities should be fully integrated with the activities of other sectors involved in community development (agriculture, education, public works, housing and communication).*
4. *The local population should be actively involved in the formation and implementation of health care activities so that health care can be brought into line with local needs and priorities. Decisions upon what are community needs requiring solution should be based upon a continuing dialogue between the people and the service providers.*
5. *Health care offered should place a maximum reliance on available community resources, especially those which have hitherto remained untapped, and should remain within the stringent cost limitations which are present within each country.*
6. *PHC should use an integrated approach of preventative, promotive, curative and rehabilitative services for the individual, family and community. The balance between these services should vary according to community needs and may well change over time.*
7. *The majority of health interventions should be undertaken at the most peripheral practicable level of the health service by workers most suitably trained for performing these activities.⁸*

Although this statement is now more than twenty-five years old, it remains a very useful guide. As with the case of Local Government, above, we may note with satisfaction that Rwanda has addressed many of these issues in its present policy. The question that must now be answered is whether the system can be improved, and if so what changes are required.

⁸ "Seven essential principles which should be adhered to if primary health care is to be successful" WHO World Health Assembly A28/9, 19 April 1975.

Chapter 4: Proposals

4.1 The importance of the present study

We have tried to illustrate above that there are two well constructed policies in operation in Rwanda relating to the sectors of health and local government respectively. About each one, we have asked the question “What can be done to improve on the existing policy?” We have introduced certain norms or targets which might be considered in answering such a question.

However, the terms of reference for our study look further than this. Given these two parallel systems, they ask, is there a potential for development by looking at them in terms of partnership, so that each may support the other? Expressed another way, will a partnership between health and local government be more than the sum of the parts? We were further asked, among other things, to propose mechanisms by which this could be achieved.⁹

The study comes at a particularly important stage in the evolution of local governance in Rwanda. Because a new system has been introduced, elected officials are now looking to implement programs and policies in a variety of sectors, but to some extent lack the experience and means to do so. While change is always difficult to manage, the climate in present-day Rwanda is overwhelmingly pro-change, thus creating a favorable climate within which to innovate.

On the other hand, in conducting our field studies, it became increasingly clear that there are major threats to the system in terms of the financial vulnerability of the health centers as they are presently constituted.

It also is very clear that there are huge opportunities, at this point in time, to use local government’s systems to support the health sector, both in terms of the potential to involve the community through the secteur and cell committees, but also through specific attention to the environmental aspects of health.

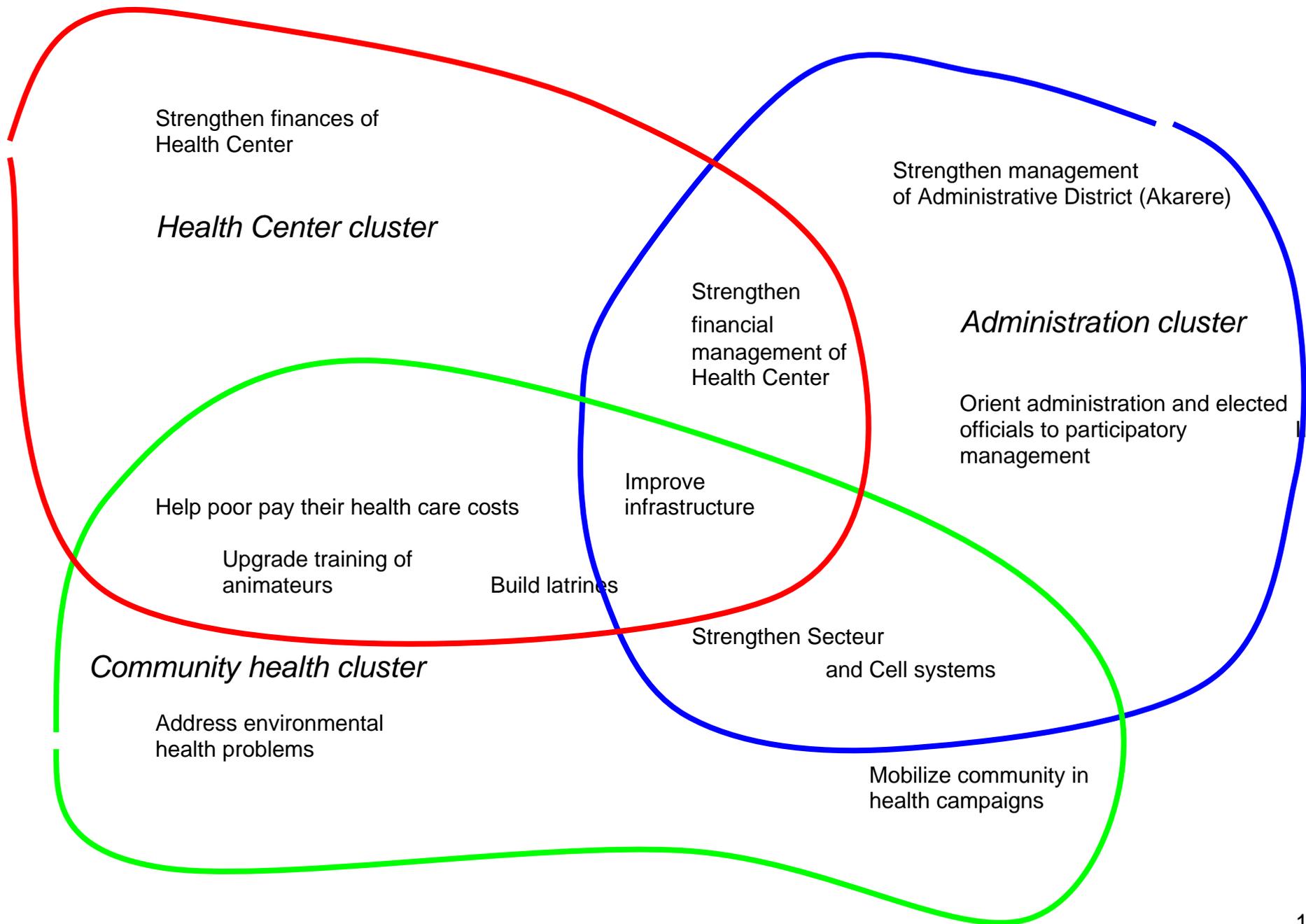
4.2 A needs analysis

We found that, when we looked at the needs as expressed by our many respondents, there were many overlaps, and that it was impossible to fit the needs into self-contained boxes. This is, perhaps, an illustration of the fact

⁹ Additional matters to be covered concerned the role of the Provinces in the system and the needs for training in implementing the proposals. Clearly it is not the intent here to paraphrase the Terms of reference, but rather to highlight our understanding of the key issues.

that health is a sector that affects everyone, and has a wide-ranging significance in terms of many different sectors.

The diagram on the next page is an attempt to capture this complexity. It highlights the degree of overlap and interdependence between the health services, the community and local government.



4.3 Proposals

Below we highlight programmatic interventions that were considered in preparing this report, grouped into the three “clusters” described above.

4.3.1 The Health Cluster

Strengthening the system of Mutuelles, the mutual benefit societies currently being developed to encourage pre-payment of medical expenses.

Use of public works projects to give income to the indigents for health services

Strengthening the management of health centers, especially the financial management.

4.3.2 The Local Government Cluster

A stronger local government at the Akarere level and below. This will use the power of the health lobby at the local level to leverage a wide range of public health benefits and improved governance and administration.

More funds going into the health sector from the Akarere’s CDF funds, and strengthening the Uterere support for the provision of health services and giving them strong links with the communities they serve.

Development of a community based public works program (as referred to above) to provide means for the poor to meet health expenses.

Establishment of a system of regular training and help services for local government and establishment of a local government association to support the local government sector.

Support for the transfer of functions from the Health districts to Uterere, in a logical and convenient way. The option regarding this process are discussed in detail below.

4.3.3 The Community Cluster

Enhancing public health gains through enhanced community involvement, and the establishment of highly motivated public health workers.

Supporting community-based infrastructural improvements through very modest and sustainable finance and training.

The table below amplifies these ideas, and each one is discussed in more detail in the subsequent text.

There is a final point: that of sustainability, which is aim of all development aid: not only should the aid be made available with a framework of sustainability, it should also be a tool in developing additional sustainable systems within the host country. All the interventions have been checked in the light of the need to build a sustainable system.

Table 1: Results and Activities

Result	Activity	Notes
Finances of Health Center Strengthened	1. Mutuelles system made more flexible and expanded	Consideration be given to using fund for loans and/or savings
	2. System of work for payment introduced for poor	Poor persons, or their families, who cannot pay bills be offered guaranteed work to pay off their accounts in health-related activities (see public health infrastructure program and gardening program)
	3. Technical assistance be given to Health Centers in terms of money management and accounting, budgeting, etc	This assistance to be linked with a similar program for District Administration
Local Government Strengthened	4. Developing and strengthening local governance	Support for the establishment of an active Local Government Association and associated technical assistance
	5. Smooth transfer of specific functions from MINISANTE to Uterere	Program prepared which classifies what functions will be undertaken by each party, and when the transfer will be done.
	6. Develop a matching grant system to encourage increased expenditure on health	This would allow the Akarere to finance proposals listed below, such as the proposed health posts at Secteur level
	7. Public health infrastructure program development	Individuals and communities would be supported and encouraged to improve local infrastructure, e.g. by building latrines, improving roads and storm water drainage

Result	Activity	Notes
	8. Public health agriculture program launched	This would be directed primarily at individual families aimed at helping them grow their own food thereby making their children healthier. As part of this initiative, model gardens would be provided at health centers, and saplings/seedlings provided for planting in people's own gardens
	9. Secteur and Cell Health Committees strengthened	Local Government will play a much larger role in fostering the health committees, and giving them a means to make themselves heard. Their powers and functions would be expanded in line with their development
Community involvement in health provision strengthened	10. The status of animateurs increased	Incentives for good performance and a career structure which could result in a permanent job should be instituted
	11. Health posts developed at each Secteur office, and manned by senior animateurs	The Health Center is, in many cases, too far from people's homes for access in all but the most serious cases. This would provide a local level facility for treatment of minor problems
	12. Traditional doctors and birth attendants integrated into the system	The trust between the public and traditional doctors and birth attendants is an important part of the system. In turn they should be trained and/or encouraged to refer difficult cases to the health center.

4.4 Detailed discussion of the proposals

Below we describe in more detail some of the concepts listed above

4.4.1 Mutuelles system made more flexible and expanded

A report on a workshop on the subject of Mutuelles, which we here translate as Mutual Aid (or benefit) Societies, shows that while there have been notable successes, there have been many problems in getting the idea accepted.

The concept is that people join a mutual fund to pool their risk and share costs. An up-front fee is charged based on the expected costs for a certain period (say 6 months or a year), but it may be less or more than the actual costs incurred by the mutual. If they are a member of a mutual they receive treatment and medicines at a very discounted rate, thus discouraging casual or indiscriminate use of the health center. Apart from this charge, the concept is that by virtue of being a member you are entitled to the service for the period of your membership – i.e. the treatment received is not charged to an individual account but to the mutual as a whole, which pays the health center on a per capita basis rather than paying a fee per service.

This concept, widely used by better off sections of society in southern Africa for a very long time, is similar to that of a savings and loan association in which the members are jointly liable for the society's debt. In this it differs from insurance in which a fixed premium is paid, but the risk is carried by an entirely independent body.

Whether it is the risks of bad management, a lack of communication about the benefits of such an arrangement, or other factors that have resulted in a slow take-up of the concept, there are certain obstacles that have been cited regularly.

The first is that there is resistance from “healthy” families to subsidizing “unhealthy” families.

Another has been that finding a lump sum to pay for the agreed period has been difficult for poor families, even though it may be quite small. This situation has been eased by the Banque Populaire agreeing to pay the lump sums in the case of registered societies, who then repay the bank over a period.

Another barrier may be the community's perception of poor quality services at the health center.

We conclude that the mutuals as presently in operation present an excellent base on which to develop, but the problems being faced suggest that alternative models should be explored. There are three elements which, if incorporated into a system could make it more viable.

Savings Bank

One is that the mutual becomes, in effect, a savings bank. As mentioned above, the concept of saving is used in parts of Rwanda, through the tontines system. Under such a system, each family would have identified savings within the mutual, and would pay its contributions at a predetermined rate. This rate would be determined by the family itself in light of its own finances, and would be paid monthly or weekly according to its preferences.

In such a system, if any medical expenses are incurred, the cost is taken off the personal account of the patient's family, thus preventing the concept of subsidy by the healthy of the unhealthy.

However, if a family did not use its savings, it would be free to withdraw them, provided always that it leaves a certain minimum sum in its account (say enough for one year's medical expenses).

This is a concept that has been receiving increasing attention in the South African Medical Aid system. Medical Aid schemes in South Africa are regulated by an Act of Parliament, and most people in formal employment are eligible to join. The schemes finance access to private health care, so are used primarily by middle and upper income groups. Nevertheless, there are elements in their financial management which are of interest in connection with any savings or insurance scheme for any income group. In response to excessive use by many members of the schemes – e.g. going to the doctor for very minor reasons, obtaining drugs at the pharmacy on the medical aid when they have not been prescribed by a doctor, and other fraudulent devices to extract the maximum cash benefit – some schemes have introduced a system whereby unused money at the end of the year is invested in savings accounts.

The important point here is the use of the savings concept to give members a sense of responsibility for how they use the fund, and address the common problem which faces all such schemes of people being reluctant to join because they consider themselves healthy.

Collateral for a loan

In such a system, a family's savings could be used as collateral for a loan, preferably one of the quick revolving type, e.g. repayable within a year. This system then begins to approximate to a tontine system, while also guaranteeing the medical expenses. Loans would not be given to persons simply as individuals. Using the concept developed by the Grameen Bank a borrower would require the support of (say) four sponsors who would guarantee that if the borrower did not pay, they would do so.

For it to operate properly it would have to be supported by an external fund, otherwise it would run out of money – or would run the risk of doing so. However, the rule regarding loan repayment would be very strictly applied so that no one had the feeling that they can get away with not

paying – as so often happened in the past with small business loans to cooperatives etc.

Sliding scales of payment

Another concept which has worked in Bangladesh, (and which used to be the norm in company medical schemes) is that each pays according to his or her means. In a subsistence or semi-assistance economy cash income is clearly not a valid indicator: therefore they used the concept of the number of meals a day each family had. Thus there were three levels of payment: the lowest for those only eating one meal a day, and the highest for those eating three or more. In village society such matters are fairly easily observed and therefore not subject to dispute¹⁰. Whether such a concept is transferable to Rwanda should be investigated.

4.4.2 Public works programs used to allow people to earn credits for health services

We propose three mechanisms by which this will be done, which are described in more detail below under local government programs. To summarize they are:

- Development of labor-intensive programs such as roads upgrading by which people will be able to earn credits to pay medical accounts, and/or develop medical savings in the mutual.
- Development of a individual latrine program which will do the same in terms of labor for the construction
- Provide light work at the health center for those not fit enough for public works programs for the same purpose, e.g. on the garden.

4.4.3 Technical assistance and training to the staff of health centers, especially intended to strengthen their financial management.

We received evidence of widespread mismanagement of funds and a lack of proper systems at the health center. Even at the hospital level it would appear as if problems are being experienced.¹¹

As the turnover of the centers increase, so must the efficiency with which funds are managed. Meanwhile it is essential for public confidence that good financial management should be in place, and should be seen to be so.

4.4.4 Developing and strengthening the system of local governance

This would include support for a proposed local government association as well as technical assistance to it, and/or individual Uterere.

¹⁰ The case referred to here is the Gonoshasthya Kendra (meaning "People's Health Center", an organisation supported by Oxfam and DANIDA). The experience has generally been successful, but they experienced problems in attracting better-off income groups who were expected to pay more. Source: Johnstone, Paul and Ranken John: *Management Support for Primary Health Care*, Overseas Development Administration, London 1994

¹¹ For example, we saw a first and partial draft of findings of a Financial Assessment of Rwamagana Hospital study undertaken by Family Health International's Rwanda Office, which reveals many problems

One of our early conclusions was that a Local Government Association would be an important tool in supporting the development of strong local government. During the mission, we were informed that such an initiative was already taking place – with a meeting to discuss the proposed constitution to be held on 28/29 July. We offer the following recommendations regarding its nature, based on the experience in other countries:

- The Association should be financed by subscriptions from the members, i.e. all the Districts.
- It should represent the interests of elected and non-elected members – e.g. separate chapters can be constituted for Treasurers, Managers, Mayors etc.
- It should see itself as an advocate for the interests of local government to central government, and propose, for example, new legislation which it considers necessary.
- It should play a major role in looking at the creation of a local government service, including matters of salaries and conditions of service (This does not imply that it should or should not impose uniform conditions of service. There is an argument for allowing some autonomy in these matters for each District/City etc). In some countries this includes taking the lead in annual wage negotiations etc.
- It could advise on staffing levels, the preparation of standard organograms, job descriptions, performance contracts etc
- It should be a medium of exchange of good practice, and sharing of implementation experiences.
- Finally, and most importantly, it should take a lead in the matter of training. It is possible that this is a component that could be donor-financed.

Among issues that will confront local government and should be addressed by the local government association together with MINALOC are the long-term merits of transferring responsibility for delivering infrastructure services such as water and roads through the District or a local agency.

- There should be a clear demarcation of functions between the different levels.
- Encourage autonomy at lower levels of government while providing overall direction, e.g. in the form of performance measuring and minimum standard of services.
- Avoid detailed and cumbersome central government approvals procedures, and exchange them with performance measurements.
- Give the maximum autonomy to local government on the question of land management and use.
- Responsibilities for hiring and firing staff, as well as remuneration, should be devolved to local government.
- Service regulations should be developed which are suitable to the needs of local government staff.

- The law on local government should make a clear distinction between the responsibilities of the politicians and the administration (the top officials).

Meanwhile it is considered that there are important short-term technical assistance and training needs in the fields of management, and project planning feasibility studies etc (complementary to the accounting and budgeting being provided under the Fiscal Decentralization (ARD) program).

The training would be aimed at certain general functional targets, as well as giving the staff enhanced skills in specific areas.

The Ministry of Local Government and Social Affairs has already developed excellent and quite detailed frameworks for the project identification and planning process. Under the proposed framework the CDF will have staff who can assist in project identification, feasibility studies and similar matters. However, decentralization brings new duties to staff and elected officials who may not be familiar with planning and management and it is generally considered that an intensive training process will be required in this respect. Among the issues which are often neglected are the costs-in-use and management implications of developments. This is particularly important in health facilities. The capital cost of the facility is a small proportion of the cost of running it.¹² Another skill is the coordination and management of representatives of a wide range of stakeholders, including public participation.

On several occasions respondents referred to the need for a change in attitude from the old “top-down” system, to the new “bottom-up” approach.

Not only does this require a change in the basic philosophy of development, it also requires different techniques which will have to be taught. Under this system, which affects all levels, right from the cell up to the district and even province and central government, government is used to exercise support rather than control. Many of the fears on the subject of decentralization derive from a fear that ill-informed bodies will take control of specialist services – health is the best case in point.

USAID is already funding training and technical assistance in terms of the fiscal decentralization. Suffice it to note here that this is clearly a crucial component, both as far as the revenue generation aspects are concerned, and the accounting and auditing ones. Without these essential instruments in place, effective local government cannot take place.

We may add here that while initially there will be a huge demand for training, local government is a field in which the demand will never cease. This is because there is a regular turnover of elected officials, and newly

¹² This has led to cases in the experience of one of the authors in both Zambia and Kenya where the government has been unable to operate community-developed health facilities as it lacked the funds to staff and operate them.

elected persons will require training after each election; secondly there will be staff turnover, and new staff may well require training; and lastly because central government may assign new responsibilities to local government, and/or introduce new legislation, training in exercising new responsibilities may well be required.

In a country such as Rwanda, with poor communications, attention should be given to the use of Internet as a link and an essential part of any training program. This cannot be done without a full orientation of the participants in the training and properly developed back-up system, but holds great potential. The proposed Local Government Association could be the host for such activities.

Eventually, this training and capacity building will enable local government to achieve increased provision of local services, and make effective use of taxation powers, within a proper framework for government at the local level under the concept of subsidiarity.

4.4.5 Smooth transfer of functions from MINISANTE to Uterere

The Health District is larger than an Akarere. In accordance with the Ministry of Health's document on the subject of decentralization:¹³

The health district is the most distant operational unit. It consists of a district hospital and several health centers, either public, adopted or private, which form an integrated health system. It is responsible for the totality of health needs for the population covered. With the participation of that population it plans, coordinates and executes the health activities in its area.

In respect of the district structures decisions are taken in a collaborative manner between the different committees. The management structures are the district committee, the district management team, the hospital health committee, and the health center committees. The composition, roles and job descriptions of the different committees are defined by ministerial decree.

(Author's translation)

The same document states the responsibilities of the health district as follows:

1. *Implement the Ministry of Health's action plans*
2. *Mobilize the community in respect of health*
3. *Promote the participation of the community*
4. *Collaborate with other sectors*
5. *Promotion of good health*
6. *Planning activities*
7. *Supervision of activities*
8. *Daily management of resources*

¹³ Decentralisation du Ministère de la Santé, Ministère de la Santé, Kigali, January 2002.

9. *Promotion and inspection of public hygiene (latrines, water sources etc) and duly apply health regulations*
 10. *Engage with community health personnel (community health workers (animateurs), traditional practitioners, and traditional midwives)*
 11. *Inspection of pharmacies, and medical clinics*
 12. *Coordination of training in terms of continuing professional development of health professionals*
 13. *Surveillance for epidemics, and implementation of the health information system (SIS (Système D'Information de Santé))*
 14. *Undertake follow-ups to action plans.*
- (Author's translation)*

But what is, in many ways, much more interesting is the Mission of the Health District, from an earlier document:¹⁴

1. *Know the population in the geographical, social and economic sense*
 2. *Plan all activities, and coordinate all health initiatives, public or private, taking account of the national policy, strategies and priorities*
 3. *Manage all health activities in the district (implement, coordinate, monitor and evaluate) and make regular reports to the regional and national levels*
 4. *Manage infrastructure, equipment and material, and financial resources entrusted or allocated to it*
 5. *Manage human resources (while continuing to conduct training in administration) in accordance with the legislation and noting all laws and regulations in effect*
 6. *Manage the information system (information and feed-back) and take appropriate measures in the case of emergencies or critical epidemics*
 7. *Ensure the supervision of all health agencies in the District, and inspect and check private health structures, including dispensaries and pharmacies and the health police.*
 8. *Promote and stimulate community participation*
 9. *Initiate and participate in local inter-sectoral programs (agriculture, education, development etc) in collaboration with local authorities.*
 10. *Participate in medical and paramedical training programs by involving the trainees, and making teachers available*
 11. *Promote operational research, and coordinate all research in the field of health in the district*
 12. *Ensure that health activities in the District are integrated so that resources are used rationally*
- (Author's translation)*

While the above descriptions of the role of the District are prepared from different perspectives, they nevertheless contain little that conflicts with the

¹⁴ Le District de Santé au Rwanda, Ministère de la Santé, January 1995, at p 2

role of the Akarere, as currently in operation. There are clearly specialized activities to be undertaken, but not ones that are more difficult to manage within a decentralized environment than others such as engineering, law or other professions.

This report advocates that the health center should be transferred to the Akarere. This is a bold proposal, and implementation may be difficult, but it is considered an essential step. We recommend that the health center will be independent in the technical sense, but it would receive support from the District in terms of funds and political support as required. It would operate within transparently defined regulations and provided it does so will not be subject to interference. If it needs guidance in terms of health practice, it will receive it from the specialist agency established by Government for the purpose, the Ministry of Health, which takes responsibility for establishing the policy within which health services are delivered.

We recognize that such a proposal will appear to be radical by the MINISANTE, which would prefer to keep direct control of all its facilities. However, the essence of the Decentralization Policy is that provision of services at the local level must be subject to democratically elected leadership. Sectoral ministries (most importantly health and education, but also including public works, agriculture etc) which have responsibilities at the local level typically fear that a loss of control will imply a decline in technical standard of service provision. Our view in this matter is that, in truth, the standard of technical provision is inadequate at the present, and this is partly due to the problems that MINISANTE have in administering their very large Districts. Local control can bring with it more effective and responsive management. The present system has established a system of local control through the health committees, but they lack the resources or the experience in management that a local government unit can provide. We therefore consider that transferring such responsibilities to the Akarere level would result in the provision of improved services, provided always that the MINISANTE is available to supply advice, and any other necessary support when required.

However, it must be recognized that changes in the managerial and reporting structure, which such a move would represent, can be cause for alarm and negativity among the persons affected.

Accordingly it is proposed that the process be conducted in three stages:

Stage 1 would be for the Akarere to add value to the health centers by:

- Using a public works program to pay for the bills of the poor at the health center
- At the cell and secteur level, actively encouraging the formation and growth of mutual-aid societies to increase payment levels.
- Strengthening of community links and mounting public health campaigns, e.g. in relation to latrines, malaria, vaccination etc in support of the health center.

Stage 2 would be for the Akarere to take full responsibility for all public health matters, in co-ordination with each health center. This would include

- After suitable training, strengthening the role of the animateurs in terms of training in dealing with public health matters, e.g. in malaria prevention, HIV/AIDS, nutrition, sanitation and hygiene
- Mounting a self-help latrine construction program

In addition the Akarere, with support from MINISANTE, would support the delivery of curative health services at the local level, by:

- Training the animateurs in additional skills to the level where they can manage a health post (i.e. preliminary diagnosis, first aid, administration of injections and medicine as prescribed by a health center etc).
- Creation of health posts at each Secteur office.

Stage 3 would be to transfer responsibility for the financial management from the Health District to the Akarere.

It should be emphasized that the Ministry of Health will retain its policy role in health matters, but will collaborate with the Akarere in matters of implementation. For example, if a new drug is developed (say a vaccine for AIDS) the Ministry of Health would distribute it directly to the health centers together with instructions for its use. The Akarere would not interfere. However, if a treatment protocol is announced – e.g. on counseling patients who have been diagnosed as HIV positive, which requires skills not available within the existing staffing structure, or accommodation such as a private room – the Ministry of Health, through its regional/provincial office, would discuss with the Akarere how to meet those needs. Such programs could be announced nationally with the clear understanding that Uterere are responsible for implementation. Thus, the responsibilities of the political level of the District would be clear and the electorate could judge accordingly if action were not taken.

The future of the Health Center Committee

The health committees (comités de santé), when first introduced, represented an excellent first step at introducing an element of community involvement in the management of the health centers.

The present structure of the committees is:

- The manager of the health center
 - Representative of the commune (now District) in which the center is situated
 - Representative of every sector (i.e. the *Secteur*) covered by the center
- It is important to note here that the Committees are already, in effect, within the administrative structure of the Akarere, as the District and each Secteur are already represented and in a majority. Presumably the Akarere representative would be the Secretary in charge of Social Affairs.

Thus, while no changes are strictly necessary, consideration should be given to including additional elected representatives from the District level, for example the Secretary in charge of Gender and Women Affairs.

The duties of the Committee, as described in the official regulations¹⁵ (at p 6) and being followed with various degrees of efficiency by the committees are:

1. *Monitor the activities of the center*
2. *Develop regulations for the management of the center and financial systems*
3. *Approve the annual budget, and annual program for the center's activities*
4. *Receive reports submitted by the Chairman regarding the activities and the finances of the center*
5. *Determine the criteria for indigence, and establish and maintain a list of indigents*
6. *Recruit necessary support staff, under prevailing legislation and regulations*
7. *Propose candidates for positions of non-qualified staff to the Ministry of Health through the District Health Committee.*
8. *Propose disciplinary measures to the management team¹⁶ for statutory and contract staff.*

(Author's translation)

It is worth noting that the guidelines specify that the committee is excluded from considering technical matters delegated to the manager of the center.

Items 7 and 8 in the list above pose some difficulty as far as their transfer to the Akarere is concerned. As long as central government staff are employed in the Center, these clauses would be applicable. As soon as the responsibility for all staff matters has been transferred to the Akarere – and we consider that this can be done within three to five years – then these regulations would be changed to refer to the Akarere instead of the District Health Committee and the Management Team.

Health centers would continue to get medicines/ lab supplies etc from the Ministry, provided on an agency basis by the central government or directly from agencies that it appoints (such as the central drug-purchasing agency).

In line with the increasing involvement of the community that decentralization allows, we can expect the role of the committee to expand, and for meetings to be held more frequently.

¹⁵ Le District de Santé au Rwanda, Ministère de la Santé, January 1995

¹⁶ This consists of the Director of the Health District (Chairman), the Director of the District Hospital, the Administrative Manager of the District, two office-bearers from health centre committees, the directors of the Paramedical School and the district supervisors

In particular, we see the involvement of the animateurs in the health center to increase substantially, so that they see themselves as an essential arm of the health system, and gain confidence and knowledge in so doing. Training for the animateurs would, as described elsewhere, be undertaken on a continuous basis.

It would also be essential that it be placed financially under the control of the Akarere. In the interim, this could be done through the Committee making a resolution to that effect, but in the long run more formal measures would be appropriate.

Meanwhile, with the financial supports proposed elsewhere, the finances of the health centers will improve progressively which will allow the standard of service to also rise. We would expect the morale of the staff to increase at the same time.

4.4.6 Matching grant be given to Uterere in respect of CDF Funds allocated for health purposes

At the present time there is evidence that health expenditure does not get the priority that the electorate wishes. Data shown to the authors suggests that there has, indeed, been a relative decline in expenditure for health as against other sectors.

In order to support the obvious local interest in strengthening the health sector, and to encourage greater commitment to health issues at the level of the District Administration, it is proposed that USAID offer matching grants for allocations of CDF funds by Uterere to health. This will help them work with the cell level up to the Akarere itself with confidence that every franc that is spent of theirs will effectively be doubled.

4.4.7 Finances of health centers improved by use of infrastructure program

A major financial problem for health centers in the rural areas – if not all of them – is the problem of indigents: those who are too poor to pay for the services and medicines they receive. It is also widely recognized that this becomes a health problem in that poor people are reluctant to get into debt and therefore avoid presenting at a health facility, and/or fear bad treatment if they do so. Many people have referred to the incidence of abuse of patients by health workers.

Before looking at the matter in more detail, we considered the affordability of the costs in a comparative sense as a way of assessing whether, instead of trying to find ways and means of helping the poor pay for their charges, increased direct price subsidies might be preferable. Our comparison is with two other countries¹⁷:

¹⁷ The data for columns 3 and 4 are taken from "Management Support for Primary Health Care, Paul Johnstone and John Ranken, ODA, London 1994.

Comparison between costs, incomes and charges in selected countries

	Rwanda	Congo	Bangladesh
1 egg	50	125	3
1 kg staple food	100	750	11
1 bar soap	100		6
1 chicken	1000		65
1 coca cola	120	375	
Watchman's salary/month	10,000	12,500	1,100
Consultation	100 + Medicine = +/- 500	750	40
Bed/night	250		
Consultation as % of watchman's salary	0.05	0.06	0.03
Consultation in terms of price of one egg	10	6	13

Notes

Rwanda: currency Rwanda Franc, data 2002, collected by authors

Congo: currency Zaire, 1990

Bangladesh: currency Taka, 1990

From the above it will be seen that there is an interesting level of comparability between living costs, wages and charges in the three countries. The ratios in the two bottom rows on the above Table suggest that the costs are in line with those prevailing in other poor communities, and that therefore we should rather look at helping the patients pay for their care than subsidize the costs.¹⁸

Clearly, the patients in all the cases cited above face the same problem, especially in the rural areas: many families have no or very little cash, and a medical emergency can be devastating to their whole financial situation.

Another difficulty in the health situation is the environment. One which is dirty and polluted, and has conditions in which insects and rodents flourish will cause disease. Infrastructure is clearly a major contributor to improved health by, for example providing clean water and sanitation, draining stagnant water, and providing access to and from health facilities.

Under the new decentralized system, Districts will be able to improve the environment and infrastructure in their area. At the moment, water and roads are managed by central government, but this need not be an impediment.

¹⁸ Rather than attempt to enter into the debate about subsidies, we preferred to take the comparative examples as a form of reassurance that systems exist in other countries to help the very poor pay charges at comparable levels. This does not imply that subsidies should never be considered, but, in light of the nervousness in respect of increasing subsidies in an economy already fully stretched, we chose to look for other ways of addressing the problem.

What is proposed here is that the people of the District use their own labor to improve the infrastructure, especially that related to health, and that by so doing they earn credits with the health center, as well as improving the environment.

There are two ways in which this could be done.

In the case of communal projects, such as road repair, construction of culverts and other storm-water control measures, laying water pipes etc:

The District would provide the tools (if any special ones are required) and materials (if required). People would volunteer to work on the project, by providing their labor. The easiest and more transparent system would be to use task work, i.e. payment on the basis of production, not time spent. This be recorded by the supervisor and signed for by the worker. However, the term payment is not strictly accurate, because the work would be used to obtain credits for the health center. In other words, they would not be paid, but their effort would be recognized by crediting their account with the health center (or mutuelle, if they belong to one) with funds of a level approximating to the equivalent wage for an unskilled person.¹⁹

The management of such projects is not always easy, but there have been spectacular successes, for example on a long-running rural roads program in Kenya. The projects should be carefully chosen so as not to require to high a level of technical expertise in the management.

By working on such a project, the very poor could regain their dignity by using their credits to pay off their bills at the center. Likewise they could build up a credit with the mutuelle and/or health center. In some cases, e.g. the elderly, heavy work may not be possible or desirable. In such cases a family member may do the work on behalf of a person, or the person can be offered easier work at the health center, such as in the laundry or garden (see below for more on the garden).

The second is a totally different approach: it is the building of a latrine for use by a specific family.

In this instance, a person who has been trained in such matters (it could be an animateur) will agree with the householder where his latrine should be built, and will give him guidance on what to do. This will include showing him the size of the pit to be dug, the depth, how to

¹⁹ Our attention has been drawn to a similar proposal outlined in a paper entitled "Productivity increasing rural public works – an interim approach to poverty reduction in Rwanda", by John W Mellor, Abt Associates, January 2002. This proposes works programs such as roads as a means of decreasing poverty while also enhancing productivity through improved infrastructure. Payment in this case would be in the form of food, some of which would be expected to be sold to result in a small cash income.

building the walls and door, etc. Once the householder has done the work, the District will supply the parts which require cash, namely the floor slab, the ventilation pipe, and the roof sheets. Once the latrine has been completed, the cell in which the householder lives will have a celebration. Latrine construction can be used to incentivize Cells for additional funds for infrastructure improvement, and/or credits to the mutuelles.

4.4.8 Public health agriculture program launched

Fresh fruit and vegetables are important in all diets. Since the Akarere has responsibility for agriculture it is proposed that these skills be used to enhance the skills and practices of good fruit and vegetable husbandry in connection with the health centers.

There are two reasons for this. The first is that the health center is a focal point for a large number of people, especially those most in need of good diets.

The second is that the health center is always staffed, therefore people to attend to the garden will always be available.

Thirdly, the produce can be used to feed the patients – some of whom have no family members to do so, and others whose family can scarcely afford to feed themselves, or who live very far away.

The garden would be used to demonstrate good practice in terms of cultivation, and would also be used to produce vegetable seedlings which people could buy at reduced price to grow at home.

Similarly, the garden would grow fruit trees for planting at people's homes, e.g. avocados, guavas, papayas etc. They too would be sold at a nominal price, so they would be sure to be looked after, and the amateurs would help to explain to the buyer how to plant and look after the tree.

4.4.9 Secteur and Cell Health Committees strengthened

The government has placed emphasis on strengthening the role of the Secteur and cell committees in terms of project planning and administration. In the long run, service delivery is expected to take place at the Secteur level. We have already referred to the proposal to place health posts at the Secteur level.

Cell and Secteur committee members would be invited to brief their representative on the health center committee regarding its performance – a type of peer performance assessment. It is well known that such community pressures are far more effective than attempting to impose administrative rules on the staff. Well used, such monitoring can boost morale due to the enhancement of public support for the center.

It does not need to be emphasized that in line with additional responsibilities the members of secteur committees would benefit from training.

Three aspects are likely to be particularly useful:

- The approach to co-operative governance in which elected bodies use their power to support rather than control the activities within their boundaries.
- Secondly training in project selection, planning and implementation activities.
- Financial management

In the context of health, in addition, the role of the animateurs would be enhanced: they will be acting as the arms, eyes and ears of the committees at both levels. The Cell and Secteur Committee would also be trained in the use of health data, which would be collected by the animateurs. These data would be a very useful indicator of the degree of success being achieved in each cell in health matters. The data would also constitute a basic census tool for use in future planning.

This is expected to lead to a reduction in the incidence of environmentally linked diseases, and an improvement in indicators such as the number of vaccinations, child welfare etc.

Furthermore, the committees would act as links with other secteurs, especially education and agriculture, and gain from the potential synergies of the secteurs.

Education is particularly important both in terms of educating the population in health matters in a systematic way, and also by using the children to influence the behavior of their parents.

The importance of the agricultural staff in the District does not need to be emphasized, but they can give useful support to the center in terms of running demonstration vegetable and fruit gardens at the health centers. This is described in more detail above.

4.4.10 The status of animateurs increased

Animateurs are voluntary workers. They are one of the most important elements in the whole public health system.

It is considered that their role can be expanded to great effect, and their status correspondingly increased. This will have the effect of motivating them, and will attract good people to that position. We have been told that consideration is being given to increasing the number of animateurs to three per cell. This would be of value, provided that appropriate training is made available.

Among ideas mentioned elsewhere are training them to play a bigger role in curative health, e.g. by manning a health post, and giving them additional responsibilities at the cell level. To motivate them, consideration should be given to increasing their training, giving it certification, and making training events something of a special event, for example giving them a traveling and subsistence allowance, and using the opportunity to create group bonding and morale building.

Another concept which has been canvassed and should be considered carefully is introducing a salary or small allowance. It might be wise to limit this to senior animateurs, (e.g. the one who runs the Secteur Health Post) thus making it something of a career path. A balance must be drawn between the concept of working as a community volunteer and a full time worker. Voluntary work is not sustainable if a certain time threshold is exceeded, because the volunteer will have to choose between survival and voluntary work. In subsistence economies, the seasons will impose their own limits on people's time: at some time of the year they may have more than enough: at others they may have none. Our view is that remuneration, however, should not be done in such a way as to make the person feel that he or she is working "for the government". The community link between compensation and output must be maintained.

4.4.11 Health posts built at Secteur level

Many people have to travel long distances to reach their health center. There is a therefore strong grass-roots demand for a more convenient and appropriate service. The concept is that at least at each Secteur level there should be a health post. This would be operated by a specially trained animateurs, supported by visits on a part-time basis by a nurse for the health center, who could, e.g. conduct mother and child clinics and undertake vaccinations.

The Akarere would take responsibility for building the structures, which would be part of, or close to, the Secteur offices. The health posts would have two functions:

A curative function, e.g.

- Basis diagnosis and treatment
- First aid
- ORT therapy
- Dispensary for drugs such as malaria prophylactics, pain killers, and drugs required for certain chronic diseases as prescribed by the health center.

A preventative role

- Coordinating the animateurs in the cells
- Acting as a center for materials required in preventive campaigns
- Stocking subsidized items such as mosquito nets and gauze.

The construction of a health post could be an excellent starting point for the mobilization of the community around health issues, and could be done through community self help.

Its costs would be met by the Akarere.

4.4.12 Traditional doctors and traditional midwives should be actively encouraged to participate in the affairs of the health center, and the cell committees

This is already official policy, but we have been told that there tends to be resistance from both sides to the arrangement.

It is important that both traditions in medicine cooperate. On the one side traditional doctors (clearly not doctors in the technical sense of their qualifications, but seen as such by the people they serve) often have a better personal knowledge of the patient than their counterpart in the health center. He should therefore be encouraged and trained if necessary to refer a patient when something out of the ordinary is suspected. It is well known that when they feel sick, the first choice of many patients is to go to a traditional doctor because they have confidence in them.

Similar factors apply to the use of traditional midwives, (traditional birth attendants). These people are often highly experienced and can be used for the good.

The context for this recommendation is that traditional doctors and midwives are very much part of the community, and the community should use their experience and skills in the most appropriate way possible.

Chapter 5

The administrative issues

5.1 The role of the Province

In governance terms, the provinces are seen in two senses. The first is as a layer of control, and/or a financial intermediary.

If the government is serious about decentralization – and there are many cases where the letter of the law and the spirit of its implementation are different – then the Provinces should not play such a role. A paper prepared for USAID has documented the mismanagement of funds by Provinces in the 2000 financial year²⁰, which led to massive problems being experienced by hospitals whose funds had been diverted for other purposes.

We were advised that this would not be allowed to happen again, but it is symptomatic of the type of problem which an intermediary can cause.

When we asked the questions about the role of Provinces, however, it was stressed that they can act as important coordinators, and that in the present system there is no alternative system.

Furthermore, some people at senior levels of government express the view that Provinces, as they presently exist, will not exist in ten or fifteen years' time, and we should expect them to be replaced by the more streamlined concept of a region, and reduced from ten to about four. This allows the government to keep some links to the local level, while not imposing an intermediate level of bureaucracy.

Reverting to the role of the Province as it exists today, we recognize that it continues to play an important role in the structure of health administration, with the linkage to the hospital and its management committee etc. We do not, however, consider that this system is truly linked to a Province in the political sense. Rather it is that the hospital is the nexus of an administrative arrangement and whether it happens to serve one province or more or less than that is, administratively, of no significance.

In such a framework, we have not received much support for, or much objection to working through or with the Provinces. As with many administrative systems, it would appear that where the Provincial administration is good, there is merit in using its influence and enthusiasm to drive a process. If this is not the case, then the situation speaks for itself.

5.2 The Health District

In chapter four we analyzed the functions being performed by the health district and noted that some may be transferred easily to the Akarere –

²⁰ As documented in *Le Secteur de la Santé du Rwanda face aux Réformes de Décentralisation*, Cheikh S H Mbengue, a report commissioned by Prime II, with funding from USAID, March 2001.

indeed are *de facto* under the Akarere already. However, there are also specialist functions which the Akarere may not wish to take responsibility for, or if it does, would not want to do so until a later stage.

The question now is, how will the system operate by which specialists from the center support activities at the Akarere level, when they are not politically or administratively responsible to it?

We believe that the role of the higher authorities in the health system should be divided into two.

Clearly the MINISANTE will continue to represent the interests of the health sector at the national level, and will determine health policy. As such, in collaboration with the Minister of Local Government and Social Affaires, it will have the power to direct and/or advise Uterere regarding the implementation of the policy.

However, at the present the MINISANTE, through its central agencies, the Provinces and the Districts is also providing a service. There is no impediment, we believe, to it continuing to do so, even after the present health district system no longer operates. This would be achieved by using a concept that is familiar to the private sector, and is getting increasing support in public administration. It is simply that one agency contracts with another to undertake specific services. Thus, for example, one body could provide technical services for another that lacks the skills.

The situation in the case of health services is exactly the same. The Akarere would enter into an agency agreement, under which the MINISANTE would provide specific services to it, and its health centers and health posts.

This is a similar concept to the one that is already in use in terms of the procurement of drugs. The MINISANTE has established a central drug-buying agency, from which hospitals and Health Districts buy. A similar relationship could be established in respect of other services, including staff.

Meanwhile, the question will be asked about the relationship between the health center and the hospital. Under the present arrangement there is an administrative link between the hospital management and that of the health center. We do not consider that this *administrative* relationship is a pre-condition to the hospital treating the patients from the health centers within its hinterland (i.e. the previous health district). The transfer of responsibility from the Health District to the Akarere would not change the hospital to which each health center refers its cases. In the medical sense, matters would continue as before.

The proposed transitional process is outlined under section 4.4.5 above, but in summary it will consist of three phases:

Stage 1 would be for the Akarere to add value to the health centers by:

- Using a public works program to pay for the bills of the poor at the health center
- At the cell and secteur level, actively encouraging formation and growth of mutual-aid societies to increase payment levels.
- Strengthening of community links, mounting public health campaigns, e.g. in relation to latrines, malaria, vaccination etc in support of the health center.

Stage 2 would be for the Akarere to take full responsibility for all public health matters, in co-ordination with each health center. This would include

- After suitable training, strengthening the role of the animateurs in terms of training in dealing with public health matters, e.g. in malaria prevention, HIV/AIDS, nutrition, sanitation and hygiene
- Mounting a self-help latrine construction program

In addition the Akarere would support the delivery of curative health services at the local level, by:

- With support from MINISANTE train the animateurs in additional skills to the level where they can manage a health post (i.e. preliminary diagnosis, first aid, administration of injections and medicine as prescribed by a health center etc).
- Creation of health posts at each Secteur office.

Stage 3 would be to transfer responsibility for the financial management from the Health District to the Akarere.

Chapter 6 Summary

6.1 Summary of our response to the Terms of Reference

The terms of reference stated four tasks, as summarized below:

1. *Determine the level of interest and commitment among key partners to improve health.*

We found that there is a very substantial level of interest among the partners. There is widespread recognition of the value of bringing local government and health closer, and that the possibilities offered by the new system of local government are very substantial. The fact that this report is as long as it is, is testimony to the many possibilities that exist. We therefore have no hesitation in confirming that the interest in the health sector is high.

2. *Propose 2 –3 complementary funding mechanisms by which USAID could stimulate resource mobilization at the local level*

Above we have sketched a global picture of needs and proposed methods of addressing the needs, and described a number of possible initiatives in some detail.

This has been done in Chapter 4, summarized below.

3. *Identify key needs for capacity building . . . to increase understanding of this new partnership process.*

It is believed that at this stage in the evolution of governance in Rwanda, capacity building and training are vital if the full potential of the system is to be realized. We have proposed two major initiatives in this respect:

- a. Financial management at the Health Centers in relation to health
- b. Strengthening the local government system in project identification, planning and implementation
- c. Support for the local government association
- d. Training of animateurs to increase their skills and status

4. *Explore existing and potential role of the provincial staff in financing and managing local health activities*

Our response to this, as described in more detail in Chapter 5, is that if there is a choice it is broadly preferable to concentrate support at the Akarere level. Furthermore, the German donor, GTZ, has just announced a program to support Kibungo Province.

6.2 Summary of recommendations

In conclusion we summarize the situation and place it into a strategic framework.

Four main initiatives are proposed:

6.2.1 Strengthening the support of local government for health

We propose five mechanisms to achieve this purpose:

- 6.2.1.1 Provide matching grants to District administrations in respect of funds which they budget from the CDF for health purposes.
- 6.2.1.2 Develop a public works program to permit people to gain health credits through contributions to public works programs.
- 6.2.1.3 Support the construction of latrines by matching grants to the health centers and donations of consumer products.
- 6.2.1.4 Review existing management and accounting practices in health centers, and provide training and support to rectify deficiencies and ensure that centers are properly managed.
- 6.2.1.5 Develop the prepayment system (as described in 6.2.2 below)

6.2.2 Developing the mutual system

6.2.2.1 Develop alternatives to the present mutual system, with regard to including the following options:

- Individual accounts, allowing members to assess their own contribution
- Payment monthly
- Withdrawal of any “surplus” accrued after a certain period
- Use of the fund as a guarantee for small short-term loans to members of the mutual

6.2.3 Engaging the community in health activities

- 6.2.3.1 Build health posts at the secteur level
- 6.2.3.2 Train animateurs to manage health posts
- 6.2.3.3 Develop a career structure for animateurs, and involve them in regular training
- 6.2.3.4 Expand the number and role of animateurs to support the Cell and Secteur health committees
- 6.2.3.5 See also 6.2.1.1 above
- 6.2.3.6 See 6.2.1.2 above

6.2.4 Strengthening local government

- 6.2.4.1 Support the establishment of a local government association which will:
 - Act as an umbrella body for all interests in local government, e.g.
 - Mayors and elected officials
 - Managerial staff
 - Accounting staff
 - Technical staff
 - Act as a focal point for training and capacity building in local government
 - Advise central government on matters concerning legislation, taxation and charges etc.

- Act as a lobby group for the interests of local government
 - Create opportunities for the exchange of information and research
 - Be financed from the contributions of local government, not annual subventions from central government
- 6.2.4.2 See 6.2.1.1 above
- 6.2.4.3 See 6.2.1.2 above
- 6.2.4.4 See 6.2.1.3 above

6.3 Transitional phase

While these initiatives are being developed and implemented, there will be a transitional phase during which functions will be transferred on an incremental basis from the Health District to the Akarere. Initially, this will be done on the basis of the Akarere adding value to the Health Centers in the form of improved finances and community support as described in items 1 and 3 above. With 3 – 5 years it is expected that full responsibility will be transferred to the Akarere.

Meanwhile, the Provinces will concentrate on the activities of coordination and oversight, identifying gaps in the delivery of health services and remedying them to the extent possible.

It is understood that over time the present boundaries of the Uterere may be reviewed, and a possible reduction in the number may result. If so there could be increasing coincidence between the present District Health System and the future Uterere. However, this future possibility need not inhibit the process outlined above by which the District Administration will use its funds and links with the community to strengthen health delivery at the local level.

Appendix

Site visits and conclusions

Report by

Dr Théophile Nizeyimana

Chapitre I Introduction

En Afrique, les systèmes de santé ont été marqués ces dernières décennies par des réformes importantes qui dérivent essentiellement de la mise en œuvre par les différents gouvernements de la stratégie des soins de santé primaires adoptée à la conférence d'Alma Ata (1978). C'est ainsi que les conférences de Lusaka (1985) et de Harare (1989) ont formalisé l'émergence du système de district en tant que cadre opérationnel de mise en œuvre intégré des soins de santé primaires, dans une perspective résolument orientée vers la décentralisation des services de santé. Dans le même esprit, l'adoption de l'initiative de Bamako (1987) a, entre autre, donnée un cadre d'expression appropriée à la participation des communautés à l'effort de la santé.

L'option du Rwanda pour un système de santé décentralisée apparaissait déjà à travers la création des secteurs de santé qui deviendront plus tard les régions sanitaires. Ces entités disposaient d'une relative autonomie de gestion des ressources matérielles et financières destinées à leur géographie.

Cependant, le système était caractérisée par une centralisation excessive de la gestion des programmes qui s'ajoutait au fait que la taille des régions sanitaires ne permettait pas une coordination de proximité.

La formation de l'autonomie de gestion des centres de santé en 1992 et l'adoption du système de santé de district en 1992 et l'adoption du système de santé de district en 1996 ont considérablement modifié le paysage de santé au Rwanda, en participant toutes deux de la même logique, même si l'une est antérieure à la guerre et au génocide et que l'autre est ultérieure à ces deux événements tragiques.

A l'instar de ceux de la plupart des pays africains, le processus de reorganisation interne du système de santé du Rwanda a été rattrapée par des réformes de décentralisation administrative et politique qui bouleversent l'environnement institutionnel, entraînent de nouvelles relations avec les autorités administratives et les acteurs politiques, et obligent le secteur de la santé à procéder à des ajustements considérables.

Après la guerre et le génocide, le gouvernement rwandais a initié un processus de consultations populaires qui a culminé avec les débats organisés par le président de la République de mai 1998 à mars 1999. Ces réflexions ont abouti, entre autres, à un consensus sur la nécessité de mettre en œuvre des réformes de décentralisation susceptibles de renforcer les efforts de réconciliation nationale et les politiques de développement économique et social. La politique Nationale de décentralisation, adoptée en mai 2000, prévoit une première phase caractérisée par la déconcentration au niveau de la préfecture et la dévolution au niveau de la commune.

Cette reorganisation va affecter les services déconcentrés du secteur de la santé, du fait notamment de la suppression du poste de MEDIRESA et de la création d'une Direction santé, genre et affaires sociales et avec, en son sein, une Division de la santé chargée de la coordination des districts.

En prelude à l'application de la politique de décentralisation, le Gouvernement Rwandais s'est engagée dans la mise en oeuvre, à partir de l'année 2000, de mesures de déconcentration des budgets des services peripheriques. Ainsi, les crédits des services déconcentrés sont gérés par la province qui, en collaboration avec les responsables desdits services, doit être en mesure d'en assurer l'utilisation correcte. Si l'on sait que les services déconcentrés du MINISANTE, contrairement à ceux des autres ministères, disposaient déjà d'une large autonomie de gestion dans le cadre du système de district de santé, on comprend tout l'interet que revet l'examen de la mise en oeuvre de cette mesure. Il s'agit de s'assurer de l'effectivité de l'utilisation par les services de santé de la totalité des ressources qui leur sont destinées, d'identifier les raisons des écarts eventuels et d'étudier les consequences de ces mesures sur le fonctionnement des services.

L'interêt que le MINISANTE et les différents partenaires accordent à la question des reformes de décentralisation se trouve ainsi justifiée par un besoin legitime de mettre le secteur de la santé dans une situation confortable qui lui permet d'accueillir les differentes reformes dans une posture favorable à la preservation de ses acquis et à l'atteinte de ses objectifs.

C'est ainsi que l'USAID a recruté deux experts, l'un de la décentralisation et l'autre de la santé, en vue d'étudier le système actuellement en cours et de proposer comment maximiser les opportunités de la décentralisation en vue d'enrichir la santé.

Chapitre II

Les tâches spécifiques

L'objectif stratégique de la bonne gouvernance (SO1) à l'USAID/RWANDA a déjà introduit quelques approches innovatrices pour maximiser le potentiel de la décentralisation. Premièrement, avec son partenaire ARD, il supporte le niveau central dans ses capacités et système de développement pour la décentralisation fiscale. Après avoir implémenté le système au niveau central, ils vont l'expérimenter au niveau de quatre districts que sont Mirenge, Kicukiro, Byumba town et Bugarama.

Deuxièmement, avec leur partenaire IRC, ils supportent les communautés avec les districts administratifs dans l'implémentation des activités de santé, d'éducation, et de l'eau.

Les activités de SO2 sont focalisées premièrement dans le domaine de la santé pour augmenter la capacité et la qualité des services dans les domaines de santé reproductive et du VIH/SIDA. SO2 est en train d'expérimenter dans la province où travaille IRC les facteurs qui compromettent la gestion efficace des hôpitaux de districts.

L'objectif de cette consultance est d'aider SO1 et SO2 d'établir un lien entre les techniciens du secteur social, les autorités élues, et la population comme des moyens de pérenniser les capacités à mieux identifier les priorités au niveau local. Dans cet exercice, le point sera porté sur les techniciens de la santé. Alors les assignés à la mission sont les suivantes:

Déterminer le niveau d'intérêt et de commitment dans un échantillon de partenaires clés aux niveaux du district de santé et du district administratif au niveau de deux provinces afin de développer un mécanisme de partenariat pour augmenter l'adhésion à la santé.

Proposer deux ou trois mécanismes complémentaires de financement par lesquels l'USAID pourrait stimuler la mobilisation de ressources au niveau local pour supporter les activités de santé. Par exemple, un type de matching grant pour augmenter les fonds alloués à la santé à partir des nouvelles ressources des secteurs sociaux au niveau du district administratif.

Identifier les besoins clés de formation ainsi que les groupes cibles à travers tous les partenaires au niveau du district administratif, les techniciens du district de santé, et la population générale pour augmenter la compréhension et l'implication dans cette nouvelle approche.

Explorer le rôle existant et potentiel de l'équipe provinciale dans le financement et la gestion des activités locales de santé, en relation avec le niveau du district de santé et le niveau du district administratif.

Chapitre III

Méthodologie

La consultance a duré deux semaines. Vue la courte durée de la mission, elle n'a pas pu entrer en profondeur mais a neamoins pu visiter le Ministère de la santé, le Ministère de l'administration locale, les projets americains tels que IRC et ARD, les provinces de Kibungo et de Byumba.

La mission a eu deux petits seminaires, l'un à Kibungo et l'autre à Byumba, qui ont pu donner des informations supplementaires à la mission.

Chapitre IV

Décentralisation des Services de Santé, dans le Contexte de la Décentralisation Administrative

Dans le cadre de la décentralisation adoptée par le gouvernement, l'organisation du système de santé de district de santé qui est l'unité opérationnelle décentralisée de planification, d'exécution et de gestion du système. Le District de santé se définit comme une entité plus ou moins autonome desservant une population bien définie vivant dans une zone urbaine ou rurale. Le district de santé englobe tous les établissements et individus qui procurent des soins dans cette zone que ce soit à l'échelon du gouvernement ou des institutions non gouvernementales dans le secteur privé ou le secteur traditionnel. Il consiste par conséquent en une large gamme d'éléments interdépendants qui contribuent à la santé. Il incorpore tous le personnel et établissements de soins de santé et est coordonnée de manière à ce que la gamme d'activités de santé définies - promotion, prévention, soins, réhabilitation - soit aussi complète que possible.

1. Découpage des zones de rayonnement des structures de santé.

Le découpage est essentiellement dictée par des critères d'accessibilité aux soins, de disponibilité de structures et de rationalisation des ressources, ce qui implique que le réseau de santé d'avant 2000 présentait une structure pyramidale dont les niveaux ne correspondaient pas nécessairement au découpage administratif.

Cependant, aujourd'hui des mécanismes de coordination entre les structures de décentralisation de l'administration générale et de l'administration sanitaire sont définies à différents niveaux. Le Ministère de la Santé est en élaboration de la carte de santé qui est basée sur l'accessibilité géographique de la population aux services de santé. La carte de Santé répond aux directives de la politique de santé qui prévoit: Des hôpitaux de référence nationale, la région sanitaire et le district de santé qui comprend un hôpital de district, et plusieurs centres de santé.

2. Relations fonctionnelles.

Il s'agit des relations administratives et des relations techniques entre les différentes structures.

Administrativement, la région sanitaire ainsi que le district de santé et l'hôpital de district dépendent de la province administrative conformément à l'organigramme de la province. Le centre de santé dépend du district administratif où il est basé.

Sur le plan technique, la région sanitaire dépend du Ministère de la santé. Le district de santé dépend de la région sanitaire alors que l'hôpital de district est sous la supervision du district de santé. Le centre de santé est sous la supervision directe du district de santé.

Les hôpitaux de référence nationale sont des entités à part qui dépendent techniquement du Ministère de la santé.

3. Role des différents niveaux du système de santé.

3.1. Niveau central.

Le niveau central doit élaborer la politique nationale de santé ainsi que les stratégies et les plans de sa mise en œuvre. Il organise, coordonne et appuie les niveaux intermédiaires et périphériques du système national de santé dans les domaines technique et logistique.

Par ailleurs au niveau des formations sanitaires, le pays compte trois hôpitaux de référence, l'hôpital de Butare et le centre hospitalier de Kigali(CHK) regroupés en centre hospitalier universitaire(CHU) ainsi que l'hôpital neuro-psychiatrique de Ndera et le service de consultations psycho-sociales servant d'entité de référence nationale pour la santé mentale.

L'hôpital Militaire de Kanombe dépend de services de santé de l'armée mais rend un certain nombre de services à la population locale et accueille occasionnellement des cas référés par les structures publiques.

L'hôpital Roi Fayçal est une formation de santé de statut privé. Il a été conçu pour proposer un plateau technique supérieur à celui des hôpitaux de référence nationale pouvant permettre la référence ultime tant du secteur privé que public. Il devrait également permettre la réduction du nombre de transferts à l'étranger. Néanmoins, au stade actuel, ses modalités de fonctionnement sont encore à l'étude de sorte qu'il ne peut encore occuper sa place dans la pyramide de santé.

3.2. Niveau Intermédiaire.

La direction de santé, genre et affaires sociales de la province est garante de la mise en œuvre de la politique nationale de la santé dans sa province. Elle coordonne les activités menées au niveau des districts et assure leur encadrement technique et logistique.

Elle veille à une répartition équitable des ressources et à leur utilisation rationnelle. Le Directeur santé, genre et affaires sociales, qui est d'office médecin, est le conseiller du préfet en matière de santé et assure le lien entre le Ministère de la santé et la province.

3.3. Niveau périphérique.

Le district de santé est l'unité opérationnelle la plus périphérique du système de santé. Il se compose d'un hôpital de district et de plusieurs centres de santé tant publics qu'agréés ou privés qui doivent former un système de santé intégré. Il prend en charge l'ensemble des problèmes de santé d'une population bien définie. Avec la participation de cette dernière, il planifie, coordonne, et exécute les activités de santé de son aire géographique.

Au niveau des structures du district, la prise de décisions se fait de manière collégiale à travers différents comités. Les structures de gestion du district sont le comité de santé de district, l'équipe cadre de district, le comité de gestion de l'hôpital, les comités de santé des centres de santé. Les

compositions, rôles et attributions des responsabilités de ces différents comités sont définis par arrêté ministériel.

Afin d'assurer au client la meilleure prise en charge possible, un système de référence contre - référence est étagé en 3 niveaux en fonction des compétences techniques requises et de l'utilisation rationnelle des ressources, c'est à dire que le centre de santé référé au niveau de l'hôpital de district et ce dernier va référer au niveau de l'hôpital de district.

4. Les tâches à chaque niveau.

4.1. Niveau central.

1. Elaboration des politiques et des plans de développement nationaux;
2. Définition des normes et des standards;
3. Conception et développement des outils, des mécanismes, directives et instructions pour la mise en œuvre et le suivi des normes et des standards;
4. Elaboration, Suivi, et Evaluation du plan de développement des ressources humaines;
5. Enregistrement des professionnels médicaux;
6. Déclaration des épidémies et la coordination des catastrophes médicales;
7. Coordination des programmes de santé.
8. Elaboration et gestion de la carte de santé;
9. Coordination de la mobilisation des ressources et des intervenants en matière de santé;
10. Servir de coordination à la police de santé;
11. Politique et enregistrement des médicaments;
12. Inspection des usines pharmaceutiques;
13. Autorisations définitives d'ouverture des cliniques privées, des pharmacies, et des comptoirs pharmaceutiques;
14. Supervision intégrée;
15. Formation/recyclage continue du personnel de santé.

4.2. Région sanitaire.

1. Encadrement des districts sanitaires et des hôpitaux de districts;
2. Coordination multi-sectorielle en matière de santé;
3. La surveillance épidémiologique et gestion du SIS;
4. Elaboration du plan de développement de la province;
5. Mobilisation des ressources pour les services de santé;
6. Faire le suivi de l'exécution des plans d'action;
7. Coordination des activités de santé au niveau de la province;
8. Autorisations provisoires d'ouverture des cliniques privées, des pharmacies et des comptoirs pharmaceutiques;
9. Planification, monitoring et évaluation des programmes de santé;

4.3. District de santé.

1. Octroyer des soins à la population de 1er et de 2ème niveau (PMA et PCA);
2. Mise en œuvre des plans d'action du Ministère de la santé;
3. Mobilisation de la communauté en faveur de la santé;

4. Promotion de la participation de la communauté dans la prise en charge de ses problèmes de santé;
5. Collaboration intersectorielle en matière de santé;
6. Execution, suivi et evaluation des activités de santé du district;
7. Supervision des activités;
8. Gestion quotidienne de toutes les ressources;
9. Promotion et inspection de l'hygiène publique et assurer la mise en oeuvre correcte de la réglementation de la santé;
10. Encadrement des agents de santé de la communauté;
11. Inspection des pharmacies et des cliniques médicales;
12. Coordination de la formation continue et recyclage du personnel de santé;
13. Surveillance épidémiologique et du SIS;
14. Faire le suivi de l'exécution des plans d'action.

Chapitre V

Grands principes de la décentralisation du système de santé

5.1 Généralités.

1. Aucun district de santé ne pourra déborder les limites géographiques des provinces.
2. Des districts à cheval font l'objet d'un nouveau découpage.
3. L'hôpital de district et le district de santé dépendent de la province.
4. L'équipe cadre du district est défini par le document régissant le district de santé et est composé par le médecin chef de district, les médecins de l'hôpital, l'administrateur du district de santé, le maire, le responsable de la pharmacie, le chargé des programmes de santé publique et l'inspecteur d'hygiène publique.
5. L'équipe de la région de santé est définie par le cadre organique de la province.
6. Administrativement, le centre de santé dépend du district administratif.
7. L'hôpital de référence dépend du niveau central du MINISANTE.
8. Le Médecin chef de district et le Directeur médical de l'hôpital ont les avantages du chef de division (logements et déplacements).
9. L'hôpital a une autonomie de gestion.

5.2. Niveau central du MINISANTE.

1. Maintien de la direction des ressources humaines et des services d'appui.
2. Maintien de la direction planification.
3. Création de la direction de lutte contre les maladies transmissibles.
4. Création de la Direction de gestion des hôpitaux.
5. Création d'une agence autonome de gestion des médicaments.
6. Renforcement de l'unité d'audit interne du secrétariat général.

5.3. Au niveau de la province.

1. Administrativement, la correspondance entre le niveau central du MINISANTE et la direction chargée de la santé au niveau de la province se fait via le préfet de la province et techniquement, le préfet est informé de ce qui se fait des deux côtés.
2. Des comptes bancaires pharmacie et fonctionnement des districts sont maintenus mais les signataires devraient être conformés aux nouvelles directives de la décentralisation administrative.
3. Un sous-compte santé-province est ouvert pour les activités de la santé de la province.
4. La Direction Santé, Genre et Affaires Sociales est assurée par un médecin.

5.4. Direction Santé, Genre et Affaires Sociales.

1. Cette direction respecte le cadre organique du MINALOC.
2. Cette direction doit avoir deux chauffeurs, un pour le directeur, et un autre pour les deux divisions.
3. Elle doit avoir un agent chargé de la saisie, un agent chargé de la pharmacie et un agent chargé de l'hygiène publique et assainissement.

5.5. Division Coordination des District de Santé.

En plus du coordinateur du district de Santé, cette division doit avoir:

1. Un personnel de soutien: un chauffeur pour la supervision, un chauffeur pour l'ambulance, un chauffeur pour la division et un planton.
2. Un secrétaire comptable.
3. Un agent chargé de l'inspection de la santé.
4. Un agent chargé de la santé publique et du SIS.

Entretien avec Hertilan Inyarubuga

La décentralisation dans le secteur de la santé est caractérisée par une gestion périphérique du personnel et de fonds avec une décentralisation accrue des bailleurs. Les réformes actuelles sont caractérisées par une mise en place de la Direction santé, genre et affaires sociales qui devrait remplacer la région sanitaire. L'avantage est que les districts administratifs sont conscients que la santé est sous leur responsabilité; c'est le cas de Ngarama où le maire a demandé avec insistance un appareil de radiographie qui devait servir sa population.

L'aspect négatif est que la décentralisation ne tient pas en compte le district de santé, ainsi par exemple le budget ne tient pas compte de la réparation des véhicules du district qui doivent absorber un gros budget.

La formation doit donc impliquer les cadres de la province au sujet par exemple de la maintenance des équipements et de la description de poste au niveau d'un hôpital et d'un centre de santé.

Le Ministère de la santé avait des moyens pour former et encadrer des comités de santé et pour le moment la situation a changé .

Tout le pays compte 44 mutuelles dont le nombre d'adhérents change .

Entretien avec Dr Nizeyimana Vianney

Directeur de la planification au sein du Ministère de la Santé.

La budgétisation se fait au niveau de la province qui est responsable des finances et a des modèles de gestion avec des lignes directrices et du personnel.

Les problèmes les plus importants sont les suivants:

- Le fait qu'on est au début de l'exercice de décentralisation .
- La gestion des fonds est au début du phénomène.
- La province compte beaucoup de postes vides et même au niveau de la coordination des districts et des hôpitaux de districts plusieurs postes sont vacants.

Concernant les tarifs de prestations; ils sont fixés pour les médicaments, la tarification est souvent par acte et l'affichage est exigé.

Parmi les grands problèmes, celui des indigents est à noter et celui-ci fait tomber en faillite les hôpitaux et les centres de santé.

Le succes dépend du taux d'adhesion et le secteur santé ne suffit pas à lui seul.

District de santé Kibungo

Le district de Kibungo comprend 10 c.s actuellement fonctionnels. Il comprend aussi deux postes de santé et 2 c.s en construction: Sangaza et Gashongora. Les postes de santé sont situés à Kibungo ville et Gasetza. Il compte aussi un hôpital de district ce qui n'est pas le cas des autres districts de la région de Kibungo que sont Rwinkwavu et Kirehe.

Cet hôpital de district compte 3 médecins rwandais et 9 médecins chinois. Le District de Kibungo comprend les districts administratifs de Mirenge, Kigarama, Kibungo ville et une partie des districts administratifs de Rukira et de Rusumo.

Elle compte 270,000 habitants.

Les pathologies les plus souvent rencontrées sont le paludisme, les parasitoses intestinales, les infections aiguës des voies respiratoires supérieures et inférieures ainsi que les traumatismes physiques. L' hôpital de district compte 204 lits et est séparé de plus de 40 km du centre de santé périphérique.

Il ne compte que 9 phonies et est en dehors de la décentralisation puisqu'il ne reçoit aucun fonds du gouvernement et ne survit que quand l'UNICEF ou GAVI ont donné quelque chose. La région n'a que près de 650l de carburant et la province a promis de n'entretenir qu'un véhicule de la région.

Le District administratif de Mirenge.

Ce district compte 5 c.s. celui de Jarama, Rukoma, Rukumberi, Zaza, et celui de Nyange. Le centre de santé de Sangaza est en construction. La zone compte 21 secteurs et le plus éloigné de Kibungo est à plus de 40km.

L'effort du district administratif voudrait que la population ait la capacité de se faire soigner mais les médicaments manquent et aussi l'argent fait défaut pour se faire soigner correctement. Il a été initié les mutuelles de santé mais les conditions de la population ont fait que celle-ci n'a pas pu participer comme il faut: en effet, la population était dans une pauvreté extrême qui a fait qu'elle n'a pu cotiser.

C'est ainsi que le centre de santé de Jarama fut celui qui a le plus cotisé et n'a eu que 15% du taux de cotisation.

D'autres facteurs ont fait que la population n'a pas pu participer comme il faut entre autres il y eut manque d'un document à la base, la région n'ayant pas de techniciens pour tracer les documents à la base et décrire la vraie situation des mutuelles du moins dans les débuts.

Les comités de santé aussi souffrent d'un manque d'encadrement surtout pour les centres de santé agréés où le propriétaire n'est pas représenté.

Pour ce qui est des pathologies, bien que la population est informée, seul 5% de la population a des moustiquaires.

Tout laisse penser que le VIH/SIDA est arrivé dans la région: ceci se voit par le nombre de décès qui augmente et la symptomatologie douteuse même si les tests n'ont pas encore commencé de ce côté.

1. *Avantages et inconvénients d'avoir les centres de santé sous l'administration des districts administratifs.*

Les avantages sont les suivants:

- L'existence (recrutement) d'un agent de santé dans l'administration du district qui pourrait encadrer les centres de santé ainsi le pouvoir de décision en matière de santé serait rapproché de la population.
- La supervision et l'encadrement des Centres de Santé.
- La capacité d'appuyer les centres de santé en leur prêtant les moyens de transport et sauvegarder la sécurité du centre de santé.
- Le district administratif pourrait être un collaborateur et un coordinateur des activités des centres de santé.

Les inconvénients sont les suivants:

- Au cas où le district administratif n'aurait pas de moyens, le c.s. se verrait vite en faillite.
- Au cas où le district sanitaire et le district administratif n'interviendrait pas dans le fonctionnement des c.s., ceux-ci ne marcheraient pas normalement.
- Les titulaires des centres de santé se verraient sous pression de police, lorsque le district administratif voudrait superviser sans collaborer avec le titulaire du centre de santé.

2. *Examiner les forces et les faiblesses du système de santé actuel.*

Les forces sont les suivantes:

- Les centres nutritionnels essaient d'encadrer et de changer la mentalité des gens.
- La prévention de certaines maladies par la vaccination.
- Les animateurs de santé qui sont très actifs. Ainsi par exemple la vaccination animée par les animateurs de santé et les comités de santé de façon à hausser les taux de vaccination de 90% à 100%.
- Les mêmes résultats sont constatés en cas de consultations prénatales.
- La population est habituée au système de consultation avant de prendre les médicaments.
- Collaboration avec les instances administratives c'est-à-dire entre le district administratif et le district sanitaire.

Les faiblesses sont les suivantes:

- La population ne sait pas que le centre de santé est communautaire.
- Les comités de santé n'entrent pas en profondeur dans la gestion du centre de santé suite à l'ignorance de leur responsabilité.
- Le personnel insuffisant et non qualifié.

- Manque d'appui pour démarrer et rester dans la pauvreté perpétuelle seulement c'est la subsistance.
- La pauvreté de la population ne permet pas le bon fonctionnement des centres de santé.
- Beaucoup de gens ne se font pas soigner à temps.
- Les transports et communication font défaut.
- L'ignorance de la population.

3. *Qu'est qui d'après vous a fait que les mutuelles n'ont pas marche et quelles sont les autres mecanismes de financement actuellement disponibles ?*

- La pauvreté et le faible encadrement de la population.
- L'ignorance de la population.
- La faible supervision des autorités locales.
- Le manque de changement des autorités locales et des autorités de santé.
- Le faible pouvoir d'achat de la population.
- Les mecanismes financiers impossible: Faible rentabilité.

4. *Identifier les besoins de formation ainsi que les groupes cibles qui pourraient etre envisages dans le but d'augmenter la comprehension d'une nouvelle approche.*

a. Les groupes cibles.

- Les maires de districts, les secrétaires chargés des affaires sociales.
- Les coordinateurs de secteurs.
- Les titulaires des centres de santé.
- Les comités de santé.
- Le comité de gestion de l'hôpital de district après l'avoir renouveau avec ajoute.
- Le chef de division chargé des affaires sociales au niveau provincial.
- Les maires des districts administratifs desservis par l'hôpital.

Auquel s'ajoute le comité existant a savoir :

- Le directeur de district sanitaire
- Le directeur de l'hôpital
- L'administrateur gestionnaire de l'hôpital
- Le chef de nursing
- Le représentant des fonctionnaires de l'hôpital
- Un représentant des intervenants
- Les animateurs de santé
- Sensibilisation de la population générale par des affiches, des reunions.
- Les superviseurs de districts sanitaires

b. Les besoins de formation.

- Décentralisation du pays en general;
- Décentralisation des services de santé;
- Formation en gestion des services de santé (hôpital et centres de santé).

5. *Quel est le rôle de la province dans le financement et la gestion des services et activités de santé ?*

La situation actuelle est déplorable: le district sanitaire n'a pas encore reçu le budget de fonctionnement des districts de santé pour l'année 2002.

La province devrait décentraliser le budget pour renforcer le fonctionnement des districts de santé (la base administrative des districts de santé, les hôpitaux et les centres de santé).

La province devrait aussi organiser des formations des agents de santé sur les thèmes clés sans oublier la formation des comités de gestion et des comités de santé.

6. *Proposer au moins trois mécanismes de financement par lesquels l'USAID pourrait stimuler la mobilisation des ressources dans le secteur de la santé au niveau local.*

- Appui aux mutuelles de santé pour le démarrage et contribuer pour les indigents.
- Appui aux projets générateurs de revenus (les centres de santé qui ont l'initiative de cultiver les fruits comme par exemple la production du jus à partir des ananas; ce projet pourrait associer plusieurs centres de santé; les légumes,...)
- La rémunération temporaire des infirmiers dont le district a besoin.
- Appui au fonctionnement du district et de l'hôpital.

District de Santé de Byumba

C'est un grand district de santé qui compte 28 centres de santé. Pour affronter les problèmes de supervision, il a été scindé en quatre zones de santé:

Le premier est celui de Manyagiro qui va superviser deux districts administratifs à savoir Bwisige et Rushaki.

Le deuxième est la zone de Kinyihira qui va superviser les districts administratifs de Kinyihira et Kisaro.

Le troisième est celui de Muhura qui va superviser les districts administratifs de Humure et Rwamiko.

Enfin celui de la ville de Byumba va superviser les districts administratifs de Rebero et la mairie de la ville de Byumba.

Toutes les activités d'un district de santé vont s'accomplir dans ces Zones telles que les activités liées à la formation des animateurs de santé, des comités de santé et des personnels de santé.

Une activité de mobilisation et de sensibilisation pour les mutuelles de santé est en cours et jouit de la participation active des autorités politico-administratives des districts administratifs.

L'exemple le plus parlant est celui de Bungwe qui vient de dépasser 60% de la population.

1. *Avantages et inconvénients d'avoir les centres de santé sous l'administration des districts administratifs.*

Les avantages seraient les suivants:

- Mobilisations sociales faciles lors de la transmission d'un message par l'intermédiaire des autorités politico-administratives locales.
- Suivi et évaluation des activités des centres de santé ainsi par exemple le comptable du district administratif serait impliqué dans le contrôle du centre de santé.
- Décentralisation des superviseurs.

Les inconvénients seraient les suivants:

- Attestation des indigents de soins de santé données par le district administratif mais qui ne sont pas payés à la fin du mois.
- Ingérence du centre de santé sous l'administration du district administratif.

2. *Examiner les forces et les faiblesses du système de santé actuel.*

Les forces seraient les suivantes:

- Le système de santé actuel couvre les besoins de santé préventif et curatif.
- Le système de santé est accessible.

Les faiblesses du système de santé actuel:

- Insuffisance du personnel de santé en général.
- L'accessibilité au médicament est insuffisante.

3. *Qu'est-ce qui d'après vous a fait que les mutuelles ont marché ou n'ont pas marché et quelles sont les autres mécanismes de financement actuellement disponibles ?*

Pour les mutuelles qui marchent bien:

- Il y a implication des titulaires.
- Implication des autorités politico-administratives.
- Potentialité économique de la région.
- Les différentes associations existantes dans la région.
- La qualité des soins offerte au centre de santé.
- Les centres de santé sont à majorité équilibrés.
- Bonne gestion des formations sanitaires.
- Existence d'une certaine forme d'appui aux indigents.

Pour les mutuelles qui ne marchent pas bien:

- Insuffisance des hôpitaux de districts.
- Insuffisance de la sensibilisation par les autorités politico-administratives.
- Ignorance de la population.
- Déception par le paquet complémentaire d'activités.
- Faible implication des agents de santé.
- Mauvaise gestion des fonds cotisés.
- Insuffisance des moyens pour faire la sensibilisation.

Les mécanismes de financement actuellement disponibles sont les suivants:

- Credits bancaires pour les districts administratifs ayant une banque.
- Les tontines
- Appui par prime II (formation et outils de gestion).
- Associations comme ASSOPTHE - COOPTHE.....

4. *Identifier les besoins de formation ainsi que les groupes cibles qui pourraient être envisagés dans le but d'augmenter la compréhension d'une nouvelle approche.*

Formation en gestion:

- Organes des mutuelles
- Conseil d'administration.
- Conseil de surveillance
- Conseil de gestion
- Comités des cellules, secteurs, districts administratifs, et province.

Formation en assurance qualité:

- Agents de santé tant publique que privée.

Formation en plaidoyer:

- Toutes les autorités politico-administratives de la cellule à la province.

5. *Quel est le rôle de la province dans le financement et la gestion des services et activités de santé ?*

La province a payé les factures de réparation des véhicules de Ngarama; elle a donné le carburant pour la supervision; a payé les factures de téléphones, eau et électricité à l'hôpital de Byumba. Elle pris en charge la formation du paludisme à Byumba et a donné quelques fournitures de bureau. Mais toutes ces réalisations ont été faibles et étaient caractérisées par les ruptures fréquentes de stock.

6. *Proposer au moins trois mécanismes de financement par lesquels l'USAID pourrait stimuler la mobilisation des ressources dans le secteur de la santé au niveau local.*

- Création des VCT et PMTCT au niveau de chaque district administratif.
- Création d'un hôpital pour deux districts administratifs.
- Renforcer le système mutualiste existant.
- Fournir des moyens de déplacement.

Chapitre VI

Conclusions et recommandations

Personnel

En effet, les centres de santé visités n'ont pas de personnel qualifié pouvant occuper les postes de médecin chef de district et de médecin directeur d'hôpital.

Dans la plupart des centres de santé ils n'ont qu'un seul infirmier comme personne qualifiée. Ce sont des centres tels que Rukumberi, Rutare, et Manyagiro qui n'ont qu'un agent qualifié alors que les autres sont des auxiliaires ou des travailleurs. Il faudrait affecter le plus rapidement possible dans ces centres de santé au moins un médecin qui serait chef de district et le médecin directeur de l'hôpital.

Le premier serait forme en santé publique à Butare et l'autre pourrait être forme avec la GTZ en médecine interne, Chirurgie, gynéco obstétrique et pédiatrie. Il faudrait aussi prévoir d'autres infirmiers spécialisés comme les anesthésistes, les radiologues, les dentistes, etc....

Equipement

Les centres de santé visités manquent un équipement minimum sauf les centres agréés qui ont un équipement adéquat. C'est ainsi que même les lits et les matelas manquent souvent et que l'équipement des énergies solaires fait défaut.

Communication

Nous avons remarqué qu'un système de radiophonie fait défaut dans plusieurs centres de santé et il faudrait que ce système soit opérationnel afin que les ambulances puissent fonctionner comme il faut.

Transport

Les ambulances manquent et tous les moyens de communication font défaut.

Formation

Formation de base

Formation continue

Internet

Entretien des routes par les indigents.