RWANDA HEALTH SYSTEM STRENGTHENING DESIGN TEAM SUMMARY REPORT

Kigali, Rwanda
December 2013

This summary report was prepared by Lynn Adrian, Michael Karangwa, and Marina Cardenas from the USAID/Rwanda Mission.

Table of Contents

1. Introduction: 2014-19 Support for Health Systems in Rwanda 3
2. Rwanda's Development Challenge 4
3. Health Systems Strengthening Situation in Rwanda 6
4. Global Imperatives to Scale up Sustainable Health Systems 11
5. Methodology: How was the HSS program design configured? 13
6. Objectives and Outcomes of the Design Team 14
7. Health Systems Strengthening Strategic Directions for Future USAID Investments 16
   SD1. Leadership and Advocacy 18
   SD2. Governance, and Policy & Planning 19
   SD3. Management, Coordination and Implementation 21
   SD4. M&E, Learning, and Knowledge-Based Practices 23
8. Guiding Principles for Future USAID Investments in Health Systems Support to Rwanda's Health Systems 25
Annexes 27
   Annex 1: List of Health Systems Strengthening Design Team Members 27
   Annex 2: Country Ownership 28
   Annex 3 – List of Technical Working Groups and Subgroups 29

1. Introduction: 2014-19 Support for Health Systems in Rwanda

In an effort to address health system strengthening issues, the Government of Rwanda (GOR), its Development Partners (DPs) and key stakeholders, recognize the urgent need to have strong and sustainable health systems for accessible, equitable, efficient, and improved health services that would significantly contribute toward the desired health outcomes. Strong leadership and management are the requisite ingredients for comprehensive policies, efficient planning, better coordination and effective implementation that will result in robust health systems. These systems would, in turn, benefit the whole sector, including service delivery in both public and private arenas. The key challenges for Rwanda now would be to sustain the impressive progress and results it has achieved in the recent years, and to build on this further. To meet these challenges, the robustness and long-term sustainability of the health systems are critical.

Currently, the United States Agency for International Development (USAID) has the largest health program in Rwanda. Continued changes in USAID/Rwanda's assistance approach are driven by several factors, including current forward-leaning agency-wide directives emanating from USAID *Forward*, USAID Global Health Initiative (GHI), USAID's Global Health Strategic Framework FY12-16, the President's Emergency Plan for AIDS Relief (PEPFAR) II: The PEPFAR Five-Year Strategy, extensive USAID/Rwanda reviews and assessments of its health sector assistance to date, and far-reaching changes in Rwanda's governance environment.

Over the years, USAID/Rwanda has been a strong partner of the GOR in helping address various health issues, including Health Systems Strengthening (HSS). In this regard, along with having HSS components in other ongoing initiatives, in 2009, USAID/Rwanda launched the five-year Integrated Health Systems Strengthening Project (IHSSP), which is coming to a close in November 2014. **In its continued effort to support the GOR in its mission to achieve overall health sector goals, USAID/Rwanda is committed to continue supporting key components of HSS.**

2. Rwanda's Development Challenge

Rwanda's extraordinary recovery from complete political, economic and social collapse after the 1994 genocide represents one of Africa's most dramatic and encouraging success stories; yet Rwanda remains among the world's poorest, least-developed, and most overpopulated countries. The Government of Rwanda (GOR) has made a decisive commitment to confront its daunting development challenges head-on, and to undertake a fundamental, broad-based economic and social transformation intended to produce sustainable and equitable national development. This commitment has already yielded highly-visible results in terms of prolonged peace and political stability, as well as major economic and social progress. Annual economic growth rates are among Africa's highest, and huge strides have been made in social indicators such as child and infant mortality, household income, and primary-school enrollment levels.

With the support of USAID and others, Rwanda has made remarkable progress. Between 2006 and 2011, poverty dropped from 56.7% (2006) to 44.9% (2011). Child mortality was reduced by 50%, and free public education was expanded to all students at both the primary and secondary levels. Rwanda represents an extraordinary opportunity for the USG to put its foreign policy priorities into practice by supporting a clear, reasoned and wholly country-owned development vision, in cooperation with a committed and disciplined partner-country government. USAID/Rwanda seeks to build on Rwanda's successes in four areas: health, economic growth, education, and democracy and governance. Rwanda also offers an opportunity to work cooperatively with the GOR and civil society to increase the accountability and effectiveness of governance. This is vital to Rwanda's ability to maintain its current general consensus on national development direction and vision while sustaining the dramatic recovery it has achieved since 1994.

Key Challenges

Rwanda's recovery is even more impressive when considering its natural resource endowment, geographic position, human-resource base and economic infrastructure. Rwanda ranks 166 out of 187 in the UNDP's Human Development Index. While it is the African continent's most densely-populated nation, at 379 people per square kilometer[1], it is also among the least urbanized. Eighty-five percent of the population is rural[2], and 70 percent of the population is employed in agriculture[3]. This low productivity is evidenced by the fact that, despite engaging the bulk of the labor force, agriculture only constitutes 31 percent of GDP[4].

---

[1] *Rwanda. UNdata. Web. 04 May 2012. <http://data.un.org/CountryProfile.aspx?crName=RWANDA>.*

[2] *The Third Integrated Households Living Conditions Survey: Main Indicators Report. Rep. National Institute of Statistics of Rwanda, Feb. 2012. Web. <http://statistics.gov.rw/publications/third-integrated-household-living-conditions-survey-eicv-3-main-indicators-report>.*

[3] *Ibid.*

[4] *Ibid.*

The rural population suffers disproportionately from chronic household food insecurity, due primarily to a combination of low agricultural productivity and poverty. While health indicators have trended in a decidedly positive direction in recent years, chronic malnutrition remains severe, particularly among children under five (44 percent)[5]. Maternal and under-five child mortality continue to be high at 487 and 76 per 1,000 live births[6], respectively. HIV prevalence is estimated at 3.0 percent[7]; this relatively low figure for Africa imposes a heavy burden on the public health system—and the foreign assistance donors that finance.

Rwanda's private sector is small, local and poorly capitalized. As the country has virtually no industrial base, most inputs and finished products must be imported. Given the distance to the nearest port, Dar es Salaam, Tanzania—imported goods carry up to a 40 percent transport-cost premium. Combined with the high cost of energy, Rwandan industry is at a severe cost disadvantage. Given Rwanda's geographic isolation; very small domestic market; low-skilled, low-productivity labor force; and high cost of operation, it is not currently an attractive destination for sufficient foreign direct investment that could leverage broader economic growth.

On the democracy and governance front, Rwanda is among the least corrupt in the developing world but the democratic space for even peaceful, constructive dissent on GOR policy and direction is severely limited. Under the disciplined, visionary leadership of President Paul Kagame since the 1994 genocide, the government has been exemplary in its commitment to broad-based, equitable national development and in its intolerance of corruption.

In the years to come, Rwanda will face concurrent challenges and opportunities. While the country's policy environment is neatly pointed in the direction of improved growth and gradual independence from heavy donor funding, the pace of change may come too quickly. Global economic crises and general reductions in external donor support have already led to some donors leaving the country. Pressures to support sustainable change are great. But will Rwanda be able to mobilize domestic resources at the same pace as international investors/donors are leaving? How can USAID, the country's largest bilateral donor, shift its investments to better align with the rapidly changing needs of this high-performing partner government? This context describes key challenges marked a period of downward trends in development assistance, while Rwanda races towards Vision 2020 goals.

[5] *2010 Rwanda Demographic and Health Survey: Key Findings. National Institute of Statistics of Rwanda and ICF International. 2012. Calverton, Maryland, USA: NISR and ICF International.*
[6] *Ibid.*
[7] *Ibid.*

3. Health Systems Strengthening Situation in Rwanda

The Rwandan health sector operates under the core values of a sector-wide approach (SWAp). The three 'ones': one national framework, one national plan and one monitoring and evaluation system are the main principles of the SWAp. The USG is a signatory to the SWAP but does not provide direct funding. In order to carry out its mission, the Ministry of Health have introduced the following major policy objectives for the health sector: (i) to improve the availability of human resources, (ii) to improve the availability of quality drugs, vaccines and consumables, (iii) to expand geographical accessibility to health services, (iv) to improve the financial accessibility to health services, (v) to improve the quality of and demand for services in the control of disease, (vi) to strengthen national referral hospitals and research and treatment institutions, and (vii) to reinforce institutional capacity. Below are brief discussions of some key components of the health system:

Human Resources for Health: In 2010 there were 661 doctors and 7,849 nurses/midwives working in Rwanda. Based on 2010 data from the Human Resources Information System (iHRIS), this corresponds to a ratio of 1 doctor per 15,753 inhabitants, 1 midwife per 92,149 inhabitants and 1 nurse per 1,346 inhabitants. The greatest increases were in the categories of support staff (largely attributed to the inclusion of mutuelle staff and data managers in this category during 2009). The only category that saw a reduction was that of pharmacists, a worrisome trend that could be due to the promise of more lucrative careers in private pharmacies.

Decentralization, Performance Based Financing (PBF), and new initiatives in the Human Resources for Health (HRH) area have all positively impacted health services and outcomes. But there is still work to be done to increase the quantity, quality, and overall management/coordination of HRH. There is a general shortage of health professionals, particularly amongst more highly skilled groups. As geographic distribution favors urban areas, there are still health facilities that are under-staffed. There is a major shortage of midwives, exacerbating the high rate of maternal mortality. The majority (more than 70%) of physicians are working in the public sector. The majority (about 80%) of general practitioners are working in the district hospitals. The remainder of General Practitioners and the majority (about 80%) of public sector specialists are working in the four referral hospitals, which are in the urban locations of Kigali and Butare.

There have been three levels of training for nurses in Rwanda—A2, A1, and A0. A2 level nurses are trained to the secondary school level, A1 nurses possess an advanced certificate in nursing obtained after three years of nursing school, while

A0 nurses possess a bachelor's degree. Rwanda's revised nursing norms call for widespread efforts to upgrade A2 nurses to the A1 level.

To overcome HRH shortages, GOR has recruited about 45,000 community health workers (CHWs). Most villages in Rwanda now have three CHWs each: two called the "binome" (one man and one woman). They provide first line of care, prevention, and treatment and are closely linked with the formal service delivery system. These are volunteers and are remunerated through 415 health cooperatives which they manage. They invest part of the funds they receive through PBF program in income generating activities of the cooperatives. To retain and improve the delivery of services by CHWs, it is important to ensure that (a) cooperatives generate adequate revenue; (b) the CHWs are integrated in the HRH system with clear career track; and (c) their training is regular and integrated.

Medical Product Management: The National Pharmaceutical policy Document and Strategic Plan for Implementation were updated in 2009, with the Pharmacy Task Force (PTF) of the Ministry of Health (MOH) as the implementing agency. There is political will and commitment for establishing the Rwanda Food and Medicines Authority (RFMA). In the meantime, the PTF serves as a transitional alternative to the RFMA and receives financial support from the government and other partners. The PTF licenses importation of medicines and health products, develop quality regulation for medicines, inspects pharmacies and medical stores, monitors adverse drug reactions, and provides pharmaceutical information. The PTF also oversees pharmaceutical management and logistics and coordinates the sector. It coordinates the traditional and complementary medicines institutionalization. Internationally, the PTF has started to collaborate in the process to harmonize medicine registration in the East African Community (EAC) with plans for harmonization standards for EAC labs, medicine regulatory authorities, and inspection procedures. A policy has also been developed within the EAC regarding Trade-Related Aspects of Intellectual Property Rights (TRIPS), with flexibility for pharmaceuticals manufacturing and transfer of technologies.

Services Delivery: The availability, access, coverage, utilization, and outcomes of health services have greatly improved during Health Sector Strategic Plan (HSSP) II. The initiation and implementation of community health services has increased outreach and brought health services closer to the people they serve. The referral system from community to health centers (HCs) and from HCs to hospitals has greatly improved with PBF. In addition, the emergency medical assistance service (SAMU) is now fully operational in all districts with 154 ambulances and a call center managing the flow.

The MOH has produced various protocols, guidelines, and standards for quality health services. Notable examples are the financial management procedures manual for HFs, the Standard Operating Procedures (SOP) for HMIS, and the district health system guidelines that clarify the organizational structure for district health

services. With community participation in Community Based Health Insurance (CBHI), more people have been seeking care, and utilization of health services rose to 95% in 2009 from 75% in 2007. The recent Demographic Health Survey (DHS) demonstrates tremendous achievements in health outcomes that reflect service delivery results.

Implementation of the community health services package has been one of the greatest innovations in integrated decentralization of health services. Linkages have been created between health managers at sub-national units and health facilities; for example there are PBF steering committees at sector level to oversee community PBF activities. Although these committees are not yet very functional, they do represent an important effort to encourage local leaders to participate in health activities.

Health Financing: Over the last few years, Rwanda has developed a comprehensive financing framework for health building on global healthcare financing best practice. This financing framework has built two main channels for financing, one from the supply side, transfers from the treasury to districts and health facilities and one from the demand side, the insurance system. These two channels were designed as part of a remarkable post genocide effort at institution building including: (i) the implementation of fiscal decentralization with increased transfers from the central government to local governments and peripheral health facilities on the basis of needs and performance, and (ii) the construction of a health insurance system including three levels of risk pooling and cross-subsidies from richer to poorer groups.

GOR has placed strong emphasis on reducing dependence on external assistance and attaining sustainability in the HS. In many ways, Rwanda has been successful in improving resource mobilization from both domestic and external sources. It has made progress in revenue collection, revenue pooling, as well as in efficient purchasing of services. In terms of *revenue collection*, there has been increased revenue mobilization from domestic sources, mainly through CBHI, social insurance and other private insurances; from public funds (from tax-based funding); and from external funding channeled through general budget support, sector budget, and project support. The largest share of THE, 63 percent in 2010 came from donor funding, compared to 53 percent of THE in 2006. External funding steadily increased, largely due to the funds flowing from new global health initiatives such as PEPFAR, PMI and Global Fund (GF). THE has increased to $39.10 per capita in 2010 from $34 per capita in 2006, and a reduction in household out-of-pocket spending (15% of THE, down from 28%)[8].

In terms of *revenue pooling*, health insurance coverage has been expanded for people employed in the formal sector, as well as informal and rural sectors of the Rwandan economy since 2000. A medical insurance plan, Rwandaise d'Assurance

[8] *Third Health Sector Strategic Plan (HSSP III), GOR - MOH*

Maladie (RAMA), was established in 2001 for public servants and their dependants, while the military and their dependants are covered through Military Medical Insurance (MMI), which is managed within the Ministry of Defence. Risk pooling has been greatly improved as a result of the extension of community-based health insurance schemes, established by Law No. 62/2007 of 30 December 2007. This law allows the majority of the population access to healthcare services and drugs. Social and private health insurances now cover approximately 92% of the population.

The CBHI database showed 85 percent population coverage in 2011, while the formal sector schemes and private insurance account for about 6 percent of the population, bringing the total health insurance coverage to 91 percent[9].

As for purchasing of services, GOR remains the biggest provider of health services. It provides services through a network of 40 district hospitals and 450 HCs in the country. GOR purchases services by providing direct financial support to these health facilities, PBF, and direct contribution to CBHI. The PBF funding model is being rolled out at all levels of the health system in the entire country. It is the second largest expenditure item and represents 10 percent of the total MTEF for health.

Information System: The vision for the e-Health and monitoring and evaluation units of the MOH is to have reliable infrastructure, applications and information systems supporting effective and efficient delivery of healthcare services, be a foundation of evidence-based decision-making, and oriented towards the achievement and reporting of results. Significant strides are being made to strengthen the information system.

A strategic plan guiding the development and implementation of various independent but interrelated information systems is in place. These efforts have increased the reporting rate, coverage and to some degree quality of data. PBF has facilitated the environment for better reporting by introducing not only incentives for performance and its reporting but also putting penalties for late or incorrect reporting. The selection of the minimum health indicators has been finalized; HMIS forms revised to reduce the transaction cost for health workers; community based information system introduced throughout the country; data quality strategies and structures have been established at central and district levels. Automation of the various subsystems are ongoing, some are functional while others are being developed. The district and headquarters are carrying out data quality audits to each facility every quarter. Improved HRIS and Logistic Management Information System (LMIS) are under development as well as the establishment of a data warehouse and web-enabled dashboard and SOPs for data management and use.

In Rwanda, all hospitals and about half the HCs have access to internet. All CHWs have cell phones that are being used to send SMS messages to get advice or

[9] *Third Health Sector Strategic Plan (HSSP III), GOR - MOH*

ambulances in case of emergencies. CHWs also submit monthly health reports on the phone. Currently the internet connections are not entirely reliable and therefore there is concern in relying totally on the computer based health data.

Rwanda has made many gains during the course of HSSP II in the area of Information management. These have included achievements in the automation of systems that are operational at many levels of the health system (HMIS, SISCom, RapidSMS, LMIS, etc.) and incorporate an innovative mix of paper-based and technological solutions. The sector has improved reporting compliance for the HMIS to nearly 100 percent and addressed issues of data quality by introducing a standardized data quality assessment methodology at national and district levels. Over the past few years, private clinics and dispensaries in the Kigali urban districts have begun to report routinely.

The Ministry's e-Health Department has become a model across Africa through its focus on country ownership and the development of a strategic plan with a clear vision to integrate routine information systems as part of the Rwanda Health Enterprise Architecture initiative, a broad roadmap for ensuring inter-operability between all health sector databases in the interest of improved continuity of care.

DHIS-2 platform is the backbone of the HMIS and has proved to be very manageable. Further investment needs to be made to explore building on it for further systems integration. MOH HMIS technical team and network of data managers at all levels are the backbone of the system, however currently there are significant capacity gap among the staffs. Over all coordination and partnerships between various units in this area need to be strengthened, e.g. HMIS and National Institute of Statistics of Rwanda (NISR).

4. Global Imperatives to Scale up Sustainable Health Systems

The International community has made strong commitment to attain universal health coverage (UHC). It will be a key goal for the decade after 2015 or post MDG era. The UN resolution called "Moving towards Universal Health Coverage" signed in December 2012 has the goal to ensure access to essential services and reducing poverty, and constitutes a decisive step in the fight against health inequality and the drive to improve people's health outcomes. HSS is an imperative to attain this goal and sustain the gains in reduction of child and maternal mortality already achieved. Reduction in maternal mortality is high on the agenda of countries and international community. Several African countries along with multiple donors including US Government and UNICEF have launched the "Every Women Every Child" initiative to end maternal and child mortality.

During the last decade various disease control programs such as HIV/AIDS and malaria recognized that weak health systems are binding constraints on attaining the objectives of these programs. Thus these programs have been strengthening various components of the Health Systems as and when needed including logistics, manpower training and information systems. However, countries and international agencies have recognized that these partial efforts have limited success. Therefore, there is growing emphasis on taking a 'systems approach' and strengthening the whole system in a comprehensive and coordinated manner.

Along with the emphasis on comprehensive HSS, there is a growing concern about funding the health sector, particularly HSS in a sustainable manner. This concern is underscored by the prospect of reduction in foreign assistance. Countries are keen for economic transition of the health sector to sustainable domestic funding for HSS. These resolves were reflected in three landmark events during the last three years as highlighted below:

WHO Report on Health Financing[10]**:** The report highlighted that countries and international community have to address the main financial barriers to health system strengthening. These include:

- Availability of resources;
- Overreliance on direct payments at the time people need care; and
- Inefficient and inequitable use of resources.

The report laid down several actions to address these problems and many of them were reflected in what is called Tunis Declaration.

---

[10] *World Health Organization (2010). The World Health Report: "Health Systems Financing-The Path to Universal Coverage". Switzerland.*

Tunis Declaration on Value for Money, Sustainability and Accountability in the Health Sector[11]: In July 2012 Harmonization for Health in Africa (an organization comprising multilateral and a few bilateral donors) brought together health and finance ministries from over thirty countries in Africa. The main recommendations from this meeting called Tunis Declaration are:

- Intensify dialogue and collaboration between ministries with technical and financial partners;
- Take concrete measures to enhance value for money, sustainability and accountability in the health sector;
- Integrate socio-economic, demographic and health factors into broader development strategies and policies in an effective manner;
- Design effective investments in the health sector, based on evidence-based strategies leading to the prioritization of high impact interventions;
- Promote equitable investment in the health sector; ensure that health financing is pro-poor benefiting disadvantaged areas; strengthen regulatory capacity and the development of a strong African pharmaceutical sector as a growth and job creating sector in Africa;
- Lay out the path to universal health coverage establishing mechanisms to ensure equitable access to essential health services including social health insurance while ensuring effective safety nets to protect vulnerable individuals, households and communities;
- Solidify sustainable health financing systems that build on and coordinate the diversity of sources of finance;
- Strengthen accountability mechanisms that align all relevant partners, build on the growing citizens' voice and ensure the highest possible level of results for the money spent; and
- Increase domestic resources for health through enhanced revenue collection and allocation, re-prioritization where relevant and innovative financing, giving priority to immunizations, non-communicable diseases, AIDS, Tuberculosis and malaria, as well as reproductive, maternal and child health in national budgets.

Africa Health Forum - 2013[12]: During the Spring Meeting of the World Bank the Health and Finance Ministers again got together to discuss the implementation of Tunis Declaration. They recommended that foreign assistance be directed and delivered in a manner that makes the health sector sustainable. Thus they suggested that foreign assistance be used for strengthening the capacity of the countries to implement programs in an efficient manner. The key areas that need strengthening are manpower, data for decision making, and improving the efficiency of the system or get more value for the money.

---

[11] *Joint Declaration by Ministers of Finance and Ministers of Health of Africa. Tunis. July, 2012.*

[12] *Event co-hosted by the World Bank and the U.S. State Department Office of Global Health Diplomacy, in collaboration with Harmonization for Health in Africa. Washington, D.C. April, 2013.*

5. Methodology: How was the HSS program design configured?

The purpose of this section is to review USAID's process for engagement regarding planned USG investments in Health Systems Strengthening (HSS) in Rwanda's health sector. While continuing to support key aspects of health service delivery and demand creation, USAID is also firmly committed to providing support for strategic approaches that protect vital health sector gains while simultaneously transforming systems and institutions to become more self-reliant.

USAID/Rwanda's current flagship program, Integrated Health Systems Strengthening Project (IHSSP) implemented by Management Sciences for Health (MSH), is approaching the completion of its current five-year contract agreement. In preparation for future assistance to the HSS sector in Rwanda, USAID/Rwanda (USAID/R) hosted a Design Team aimed at helping inform the scope and scale of the next competitively awarded five-year agreement (2014-2019). The design of a new award must be carefully aligned with Rwanda's development policy framework (Vision 2020, EDRPS II, and HSSP III as well as other seminal documents), and cleverly address key gaps and new opportunities. USAID's objective is to honor our Agency's principle of building host country capacity to enable government, private and not-for-profit partners to successfully assume ownership of quality health in Rwanda.

During September and October 2013, a highly skilled Design Team for the next USAID's iteration of HSS program support (see Annex 1 attached) conducted a series of in-depth stakeholder consultations and field visits in Rwanda. Using a highly participatory methodology, the Design Team was charged with gathering information from a wide range of key stakeholders to help inform the design of the new award. Both individual consultations as well as follow up group sessions were held. This information would be gathered, checked and re-checked to ensure it reflected consensus assumptions and facts.

Each member of the team carried with him/her an area of expertise – in addition to being sound international public health experts. Team members hailed from the US, Kenya, and Rwanda. Some members participated virtually.

6. Objectives and Outcomes of the Design Team

Design Team Objectives

- Develop a clear understanding of the overall USAID investment in Rwandan health systems;
- Develop an understanding of the people, processes, and institutions, both public and private, that are associated and critical for the Rwandan health systems;
- Identify the strengths, opportunities, gaps and weaknesses of existing systems and therefore formulate strategic directions to inform next iteration of USAID's investment in supporting Rwanda's health systems .

What made design process work?

- Minister of State approved the concept and appointed a team to work with the HSS Design Team
- The assigned MOH points of contact (POC)s worked relentlessly and extremely effectively to help drive and support this process, including finalizing and guiding all GOR stakeholders' discussions.
- ALL MOH staff including the top management (central & district), other GOR stakeholders, NGOs, Private Sector, and DPs were engaged.
- USAID/Rwanda strove to support a broadly participative and 'country owned' process.

Interview process/Gathering of information goals

- Help in understanding the complexities and dynamics of the systems and associated institutions, people and processes
- '*What works*' and '*what does not*'
- Key assets/strengths as well as gaps and challenges
- What are the Rwandan priorities for HSS and its sustainability
- Any and all other relevant ideas and/or recommendations

List of Rwanda Stakeholder/Informants

- **Ministry of Health (MOH) – National**

- Health Financing Unit
- Planning ,M & E Unit
- HMIS and E-Health
- Decentralization and integration Unit
- Single Project Implementation Unit
- Directorate of Finance and Budget Unit
- Human Resources and Administration unit
- Clinical services (Quality Assurance and public facility management)
- Community health desk

- Pharmaceutical and commodities regulation unit

- **Rwanda Biomedical Center**
- Corporate division
- Human Resources Unit
- Planning and M&E Division
- Finance and Administration Unit
- Institute of HIV/AIDS and other infectious diseases
- **Ministry of Health (MOH) – District**
- District Health Management Team (DHMT)
- Sampled facility directors and tituilaires (District hospital and 2 health centers)
- Mutueles Section and District Pools
- Planning, M&E unit
- Finance and budget unit
- **Other Line Ministries**
- Ministry of Finance and Economic Planning
- Ministry of Youth and ICT
- Ministry of Local Government

- **Rwanda Development Board**
- **Rwanda social security board**
- **National Institute of statistics**
- **Professional bodies**
  - Nursing and mid-wife council
  - Medical council

- **The Private Sector**
- Private Sector Federation Secretariat
- Private Health Insurance Companies
- NGOs
- CSOs

- **Academia** (Rwanda School of Public health)
- **Development Partners** (BTC, CHAI, IFC, GF, UNAIDS, UNICEF, WHO, DFID, JICA)
- **USAID**: Health, EG/AGR, ED, DG
- **CDC**

7. Health Systems Strengthening Strategic Directions for Future USAID Investments

While the next iteration of HSS support would retain some of the critical principles and build on selected success models of the current IHSSP project, the main goal of the new phase would be to impact the cross cutting and multi-faceted nature of HSS in a coordinated, complementary, and sustainable manner. The Design Team absorbed and reviewed all information gathered during the lengthy and thorough consultative process in country. Based on the information examined, the Design Team produced strategic directions, that are intended to help shape the structure and priorities of future HSS investments.

Support will be provided by establishing appropriate linkages with other national and local level mechanisms, such as, the Family Health Project (FHP), the Supply Chain Management System (SCMS), DELIVER Project, and GOR's Decentralization Strategy and their support structures. To that end, USAID/R in collaboration with the Ministry of Health (MOH) carried out a review of the USG investments in HSS and the current status of the Rwandan Health System in order to make recommendations on the types of support needed in different aspects to more effectively respond to the persisting and rising HSS related challenges at various levels. This review and subsequent discussions have generated the expectation that, in coordination with the GOR, other USG program and projects, and DPs, USAID/R's potential support would help strengthen key health systems, contributing to improve the overall accessibility (both financial and geographical), quality, effectiveness, and efficiency of overall health services. This in turn will positively impact the key overall health sector goals.

Strategic Directions

The information below represents the recommended Strategic Directions (SD) for support, implementation strategy and arrangements, and the intended outcomes. It is recommended that support be provided under the following four broad Strategic Directions (SDs):

SD 1: Leadership and Advocacy
SD 2: Governance, and Policy & Planning
SD 3: Management, Coordination and Implementation
SD 4: M&E, Learning, and Knowledge-Based Practices

Note that these areas are interdependent and interrelated, and that for holistic impact, attention will need to be paid to ensure that activities under any one of the areas are consistent with the plans and activities in the others.

One of the key common strategic goals of both the USAID/R Health Strategy and the GHI is to institutionalize country-owned processes and management of key

operations critical to health systems strengthening, including the increased participation from the private sector (including CSOs). This is also consistent with GOR's overall policies and strategies. USAID/R will provide its support under the 'country-led' and 'country-owned' principles, in alignment with the Rwandan, USG, and DP strategies. As such, to the maximum extent possible, USAID/R will provide this support through existing and new relevant GOR systems to ensure that the support has full GOR ownership and leadership, while ensuring that USAID/R retains fiduciary responsibility for the resources. This system strengthening integral approach will ensure that USAID/R support will not create parallel structures that could weaken existing and/or new national systems, providing support to the GOR to strengthen the Rwandan health system and related services, coordinated with Ministry of Health (MOH) entities including the Technical Working Groups (TWGs listed in Annex 3), Health Sector Working Group (HSWG), and District Health Management Teams (DHMTs).

Health System (HS) of a country refers to the people, institutions and resources, arranged together in accordance with established policies, to improve the health of the population they serve, while responding to people's legitimate expectations and protecting them against the cost of ill health through a variety of activities whose primary intent is to improve health. A strong HS ensures that all relevant people and institutions, both public and private, effectively undertake and implement core functions to improve health outcomes. This includes all the activities whose overall purpose is to promote, restore, and/or maintain health. On the other hand, Health Systems Strengthening (HSS) is the process of identifying and implementing the changes in policy and practice in a country's health system, so that the country can respond better to its health and health system challenges. As such, HSS is typically identified by any array of initiatives and strategies that improves one or more of the functions of the HS leading to better health through improvements in access, coverage, quality, or efficiency[13].

The exact configuration of the HSS components and associated services vary from country to country, but in most cases, especially for Rwanda, the most critical elements that are required to come together and interact and work effectively: effective leadership, political will and advocacy, and policy; a robust financing mechanism; a well-trained and adequately paid workforce; reliable information on which to base decisions and policies; well-maintained facilities and logistics to deliver quality medicines and technologies; results-based Monitoring and Evaluation (M&E) and a culture of knowledge-based learning. The core principle for improving all these components and associated services toward a strengthened and effective HS, ultimately leading to better health outcomes, is 'sustainability' – both financial and institutional, which would also lead to programmatic sustainability.

---

[13] *The World Health Report 2000: Health Systems: Improving Performance. Geneva, World Health Organization, 2000. Available at: http://www.who.int/whr/2000/en/whr00_en.pdf*

Country ownership (see *Annex 2* for a more detailed definition) and leadership are the main drivers of sustainability and long-term capacity to plan, implement, manage and evaluate high impact development programs. Defining and establishing a country owned and country led approach is a complex process with no single formula for success. A complex combination of issues, variables and players needs to be analyzed in order to develop and execute an effective plan. The process must be flexible, and at the same time be robust enough to capture all the emerging realities in the context of the country, in particular its political and institutional dynamics. At the heart of the challenge is the fostering of an enabling environment to encourage sociopolitical, policy and organizational change that would support the achievement of development goals under country owned and country led principles.

Taking these important factors into consideration and given the above discussions on HS and HSS, in developing an approach for Rwanda HSS review, the USAID/R HSS Design Team looked at the following four thematic areas that are necessary to create an overall environment (including political and institutional) for planning, promoting, implementing, and sustaining a country owned and led process to strengthen the HS in Rwanda:

SD1. Leadership and Advocacy: Leadership, including 'political will' and advocacy, is at the heart of ensuring a 'country owned' process to strengthen HSS in Rwanda. Rwanda's amazing recent success clearly and convincingly testifies for it. Effective leadership and advocacy constitute the primary foundation for all the other thematic areas and provide ongoing critical support and direction for the overall success of the HSS. In looking at this thematic area, the team reviewed various documents and asked a key set of overarching questions to determine: i) the extent of effective leadership at various levels (national and district) for HSS strengthening, and ii) the extent of political support for strengthening the HSS and how it is demonstrated.

While the overall leadership of the health sector has been outstanding in recent years, there is room to improve the extent of effective leadership at various levels when it comes to understanding and advocating for the importance of the sustainable HSS as a critical underpinning of key socio-economic issues, both at the national and sub-national levels. This becomes more critical as the existing understanding, prioritization, and political support (both within and outside of the MOH) specifically for sustainable HSS is inadequate. As recognized by most in the GOR at various levels, there is still a deficiency of a 'systems thinking' approach and a rallying leadership point for an integrated HSS almost at all levels. As these weaknesses for sustainable HSS persists at the leaderships at various levels, the adverse impact resonates throughout the whole health system. As such, there is a critical need to strengthen leadership and intensify public expression of support, advocacy and communication from senior government decision makers, especially for an integrated sustainable approach toward HSS and overall budget allocation and increase for its implementation.

SD2. Governance, and Policy & Planning: In realizing a well-integrated, strengthened, and sustainable HS, effective leadership and broad advocacy have to be supported by both effective health system governance and an enabling policy and planning environment that clearly sets out not only the strategic objectives and goals, but also a well-defined and prioritized results-oriented operational plan. Together, they formulate the legal and policy base and the critical underpinning toward successful implementation of the HSS at all levels. Overall, in evaluating this thematic area, the team reviewed various documents and asked a key set of questions to determine: i) how effective has the decentralization process been, especially for HSS at the district level, ii) to what extent the strategies in place are used to guide the HSS efforts, iii) whether the key institutions involved in strengthening the HSS had the necessary mandate to play their assigned roles, and iv) in what way the current policy and planning environment was conducive or not conducive to HSS.

Governance generally addresses the capacity of the government and other actors to formulate policies and provide oversight for the overall health system, stakeholder participation, and health system responsiveness, accountability, and regulation. USAID has described effective health governance as the process of "competently directing health system resources, performance, and stakeholder participation toward the goal of saving lives and doing so in ways that are open, transparent, accountable, equitable, and responsive to the needs of the people".

There are five different sets of actors in the Rwandan health sector. Together they are the stakeholders involved in the governance of the health sector:

1. State actors in the public sector (MOH, other ministries, and local governments);
2. Health providers (public sector, private sector, and NGOs, CSOs, FBOs);
3. Civil society and professional bodies;
4. Beneficiaries and clients; and
5. Development partners (bilateral and multilateral) and international NGOs.

Governance structures in the health sector distinguish between (1) central and local administrative structures with constituency representative functions and (2) implementing agencies, responsible for providing health services to the population. The various levels of the health care pyramid are thus governed by the formal structures shown below:

LEVELS	ADMINISTRATIVE STRUCTURES	IMPLEMENTING AGENCIES
National	Parliament / Government	Ministry of Health
Province	Governors	Provincial Hospital (not yet in place)
District	District Councils / Executive Committee / District Health Unit	District Hospital / Hospital Board
Sector / *Umurenge*	Elected councils / Executive secretary and staff	Health Center / Health Center Committee
Cell / *Akagari*	Elected councils / Executive secretary and staff	Health Post / Community Health Worker
Village / *Umudugudu*	Village council / Village coordinator and staff	CHW

Table 1: Governance Structures in the Rwandan Health Sector[14]

On the policy and planning side, the MOH and its relevant departments at the national level have the mandate to develop national health policies and strategies and to plan for the effective delivery of priority health services to meet national health goals. The current national polices and strategies guiding the health sector include Vision 2020 and the health strategies arising from it, EDPRS 2, the Rwandan Health Policy of 2004, and the third strategic plan of the MOH, HSSP III. Below these are the various subsector and disease program specific strategic plans. The HSSP III is aligned with sub-sector strategic plans, e.g. the HIV Strategic Plan, the National Strategic Plan for the Control and Prevention of Malaria, E-Health Plan, HSS Framework, and the Human Resources Strategic Plan.

The capacity of MOH departments and other national level health institutions (public and private) to formulate relevant, evidence based and results oriented policies and strategies and to properly plan for the execution of the strategies is therefore a critical pillar of ensuring effective service delivery to all. Good policies remain just that unless they are owned by all stakeholders and are adequately distributed and disseminated to all relevant implementers. Therefore, the national level health departments and agencies must also be able to steer and drive policy throughout the breadth and levels of the health sector. This responsibility is made even more critical by the devolution of health service under the ongoing decentralization processes.

[14] *Third Health Sector Strategic Plan July 2012 – June 2018*

SD3. Management, Coordination and Implementation: Generally, the development community is far better at developing strategies and plans than actually successfully implementing them. The aspect of overcoming the political and organizational obstacles needed for effective implementation has generally not been adequately addressed across the development community. The plans and goals have to be connected to the actual implementation with effective management and coordination among all stakeholders. While many times the necessary policies and strategies may seem to be in place, the actual implementation of them is largely absent due to weak and inefficient management, coordination and institutional effectiveness. As such, the team looked into this thematic area in the following key functional and organizational sub-components for HSS, which are fully in line with the conceptual framework contained in the GOR's Third Health Sector Strategic Plan July 2012 – June 2018 (HSSP III):

- Health Financing
- Human Resources for Health (HRH)
- Medicines, Products & Technology
- Quality Assurance (QA), Standards, and Accreditation
- Health Information System (HIS)
- Health Promotion & Prevention
- Private Sector
- Coordination, Collaboration & Stakeholder Engagement.

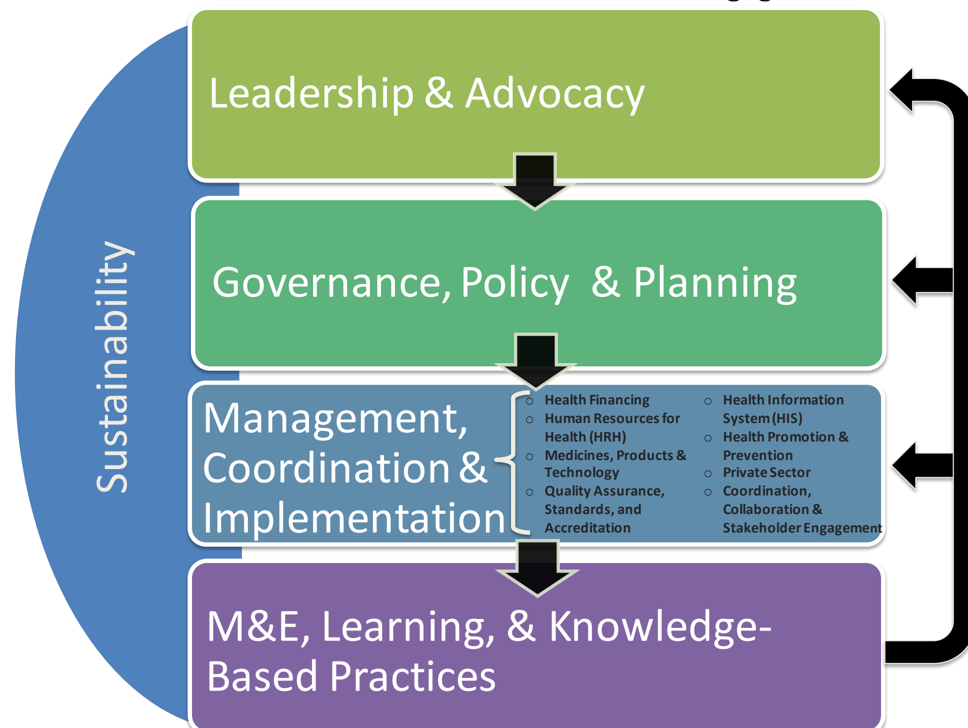

Figure 1: Strategic Components Essential for Sustainable HSS – effectively interacting together under the core principle of 'sustainability'

The team reviewed various documents and asked a key set questions to determine: i) whether there were sufficient human and financial resources to implement the HSS plans, ii) if the various institutional roles and responsibilities for HSS were clearly assigned, iii) if there are well-maintained facilities and logistics to deliver quality medicines and technologies, iv) if there exists an effective HIS for reliable information on which to base decisions and policies, v) the extent to which the private sector for HSS with the right incentives is in place, vi) if there was effective interagency coordination to guide and implement the HSS strategy and corresponding operational plan, and vii) overall, how effective is the generation and mobilization of resources for HSS, and the efficiency of the current resources uses.

MOH national level departments and divisions have the responsibility of managing and implementing the various relevant HSS strategies and plans in a coordinated approach to support effective overall service delivery. These roles require the national departments and agencies to have commensurate institutional effectiveness in executing HSS related plans and strategies. The local (including district and community) level institutions are then responsible for the actual smooth and effective delivery and management of these services to their constituencies at various levels. Thus all these institutions require sufficient organizational, human, technical and technological capacities to manage and coordinate resources (human, financial and material), operations and projects. Their effectiveness as national and local level health institutions will also require genuine and adequate stakeholder engagement and coordination to support implementation of an integrated approach and strategy for HSS.

Although, Rwanda has made great progress in many of the above mentioned areas, significant challenges as mostly recognized by GOR remain. These challenges are exacerbated by the changes in epidemiological pattern. While reducing communicable diseases remain a challenge, the non-communicable diseases (NCDs) are emerging particularly as Rwanda is experiencing rapid urbanization and life style changes due to rapid economic growth. Thus, the health system has to be developed in a dynamic, flexible, and sustainable manner to be able to respond to changing situations.

Effective coordination, collaboration and engagement among stakeholders are absolutely critical for the successful planning and implementation of all HSS activities toward the achievement of the overall results of the health sector, under MOH oversight and direction. While the national and international NGOs, CSOs, and FBOs are internally organized and have regular technical dialogue with the MOH, the operational collaboration with the private-for-profit sector, the civil society, and the professional bodies remains to be improved. In order to bring all these actors actively into the sector, HSSP III will need to develop strategies, interventions (including indicators) of private sector, civil society, and professional bodies' engagement.

SD4. M&E, Learning, and Knowledge-Based Practices: Production of timely, accurate, and reliable data leading to useful health information and knowledge products, their access, analysis, and usage are at the heart of evidence based planning, policy formulation, decision making, and action. With the ultimate goal of improving health outcomes in Rwanda, the HIS and overall learning agenda of the HSS are the principal entry point to provide that crucial information and knowledge that can be used in planning and decision-making. The whole culture of information generation, knowledge capturing, learning and use at all levels of the health system from the community to facilities to decision makers at the district and national levels is critical to improve program efficiencies and health outcomes. In order to trigger a culture shift and strengthen the demand for information at all levels, serious efforts need to be made to promote information use and in turn build and strengthen capacity at all levels to respond to this demand. The team reviewed various documents and asked a key set of questions to determine: i) overall, are there effective M&E frameworks and mechanisms to ensure the relevancy, accuracy, and wide dissemination of outputs, ii) are there public data and information access portal that is reliable, relevant and up-to-date, iii) are there on the job training and periodic retraining facilities and programs for staff along with incentives for self-training, iv) is there an incentive system to encourage the usage of knowledge based practices including 'what works' and 'what doesn't work' for implementation support at all level, v) are there forums where people from all levels can exchange experience and perspectives and share tools, practices and concepts for success, and vi) is there effective impact, operations and health system research toward sustainable HSS?

Evidence for healthcare interventions and delivery can be obtained from formal research and from analysis and interpretation of routine program level and service delivery data and practices. So, monitoring an evaluation (M&E), learning, knowledge management, and health systems research is not only cardinal in M&E of health systems performance, but also critical in using evidence based data in informing current and future HSS investments and sustainable sector development. A key challenge is how to balance the need for evaluation with the need for monitoring and using the data to improve programs in real-time. Another challenge is how to define and measure successful and effective M&E in the context of programs focused on care delivery and HSS as well as determining major pitfalls in collecting data. Then how can we overcome them, there by building internal capacity and ownership for carrying out M&E activities by decentralized level activities.

Strategic information which ensures that the concerned people in general have access to information in a manner that allows for making well informed choices on relevant issues is critical. Collaboration with relevant line ministries at all levels (especially at the district level) should allow the facilitation of two-way strategic information sharing that will inform decision making. Strategic community and facility based partnerships are critical to ensuring the continuum of health promotion-prevention-treatment-care and support services for all.

The intersection of knowledge management and health systems strengthening will serve as the bedrock of evidence based planning and decision making to improve the health sector performance. The Rwanda health system research agenda include five dimensions;

- Concepts reflecting the health system, such as policy and financial structures, regulatory functions, processes such as technology evaluation and quality monitoring, and results such satisfaction and health gain.
- The levels of the health system, such as the households and the community primary health care facilities and hospitals.
- The issues or problems pertaining to the health systems, such as priorities, equity, and the public-private mix.
- The population addressed by the system such as maternal and child health.
- The health needs dressed, whether in terms of risks or disease.

Existing and ongoing investments will ensure the availability of complete and reliable communication and information. However, this information will not contribute to improved service delivery unless it can be used to inform management and service delivery.

Rwanda has strong and sound sector and subsector strategies as well as operational frameworks and action plans and effective HMIS. All 30 districts have sector strategies and a well functional District Health Information System (DHIS 2). However, what's lacking is a sector wide M&E system at the central level that informs the decentralized processes and makes use of data for decision making which partly compounded by lack of clarity on data access and sharing both within the sector and subsector levels. It is important to note that Rwanda's health sector decentralization strategy doesn't have an M&E system in place. The core challenge for GOR is to have establish and strengthen one country platform for M&E of HSS based on the Paris Deceleration on Aid Effectiveness and International Health Partnership+. The platform will contribute to better alignment of HSS interventions as well as ensuring joint HSS programming and tracking. Although USG and other DPs have invested heavily in systems strengthening in Rwanda, systems performance and capacity has not been documented well, and this calls for major investments in a coherent country health sector M& E framework that comprises of all major disease programs and health systems.

8. Guiding Principles for Future USAID Investments in Health Systems Support to Rwanda's Health Systems

Incorporating tenets of the USG strategies including the GHI and USAID Forward, GHI-Rwanda, USAID/R Health Sector Strategy, and other international mandates together with social and health needs and priorities in Rwanda, the following set of guiding principles will also serve as the backbone for programming future HSS activities and implementation plans in the next five years:

i) Assure country-led, country-owned, and country-managed. To this end, USAID promotes the tenets of the 2005 Paris Declaration which encourages countries to define and manage their development policies and strategies. Under strong GOR leadership, Rwanda has directed its own health programs in theory and in practice for many years, and country ownership is fundamental to the GOR-USG relationship. With sound national goals, policies and strategic plans for improved health available, the USG has chosen to directly adopted Rwanda's national goals and objectives, thus furthering country ownership and investments in country-led plans. Both the GOR and the USG have recognized, however, that strong government ownership does not alone constitute country ownership. GHI Rwanda strategy provides a solid example of USG's existing commitment to encourage country ownership and invest in country led plans. Working closely with the GOR, other donors, civil society, and its own partners, USAID/R will support country ownership and enable long-term country capacity to plan and manage and evaluate high impact health and social service delivery program. This will involve assuring close alliances with the GOR; fully engaging civil society to assure that health services meet the needs of people; and expanding involvement of private for-profit commercial sector, private institutions and organizations and not-for-profit private sector institutions, including professional associations, Non-governmental organization (NGOs), faith-based organizations (FBOs) and community based organization (CBOs).

ii) Align Rwandan, USG and development partner strategies. In developing the Rwanda GHI, USAID/R Health Sector Strategies, USAID/R considered Rwanda's program strategies and plans and other DP strategies and matched them, as appropriate, with USG foreign assistance strategies, programs and priorities. USAID/R will harmonize its HSS actions with the GOR and development partners in the country to pursue the national objectives set forth in Rwanda Vision 2020, EDPRS 2, and HSSP III.

iii) Build sustainability through health systems strengthening. This activity is all about Systems' strengthening. It is a crosscutting issue that affects implementation and delivery of all other health projects that USAID/R supports and given some of the key challenges in the functioning of key elements of the health system (HRH, supply chain management, capacity building in health planning and management and M&E etc.). Systems strengthening should therefore be an integral

part of implementing any intervention. Efficient and synergistic improvements across the health and social sector will be targeted through efforts to: train and retain health care workers; strengthening community linkages and systems; and build capacity of institutions. USAID/R will also support the strengthening of leadership and management systems at the district levels, including systems for human resources and M&E.

iv) Maximize a client centered and Women, Girls and Gender Equality Approach. The GOR and other health institutions are committed to a client-centered approach that targets each client's needs and focuses on specific positive social and health outcomes for that client. Women are often the gateway to healthy families. Implementing a women, girls and gender equality approach is critical to sustaining the gains made and for GHI success. The GOR has prioritized mainstreaming of gender issues across all sectors; the GHI guidance provides assistance for USG implementers to ensure a focus on issues such as equitable access, empowerment and inclusion of women and girls, and engagement of men and boys. In program planning, family focus and integrating gender will be important considerations.

v) Leverage key multilateral organizations, global health partnerships. USG actively communicates with key multilateral organizations and coordinates efforts with partners and GOR on the health sector priorities and activities, including the donors group. The USG will continue to be actively engaged with the GOR and the donor network in the development and implementation of all programs.

vi) Ensure strategic collaboration and coordination. USAID/R's health team has strong relationships internally so it works as a highly functioning team, solid relationships within the USAID Mission, which help create "win-win" programming with other sectors, with its other USG partners (e.g. CDC). Strong collaboration between the GOR, donors and DPs is essential to ensure a synergistic approach without duplication of effort and high transaction costs. USAID/R will support the GOR efforts to coordinate a whole country approach by facilitating the organization and effectiveness of its coordinating mechanisms. Central level coordination exists between the GOR, DPs in the health sector, and local and international implementing partners. USG has a recognized history of good interagency collaboration and communication, while at the same time utilizing the flexibility of different operational and funding mechanisms across agencies to increase impact.

vii) Increase involvement of the private sector. The private sector in Rwanda stands out as an area that is poised to play a much larger role. Key past findings and assessment along with the Rwandan leadership points to the urgent need of heightened involvement and use of the private sector as an important source for HSS and citizens to obtain health services.

viii) Manage for results with mutual accountability. As partners, Rwandan institutions and USAID/R must place more focus on the end result: impacting the health and well-being of the people of Rwanda in order to make a tangible difference in their lives. USAID/R and its partners, working together, will develop better tools and systems to measure this impact. Moreover, there must be mutual accountability and more transparency in decision making and effective and efficient use of USAID/R funds. It is imperative that the GOR and other Rwandan institutions jointly plan and be accountable for the strongest, most cost effective and efficient contribution to the targeted end results.

Annexes

Annex 1: List of Health Systems Strengthening Design Team Members

Tariqul Khan - Team Leader (Consultant)

Ishrat Husain - USAID/Washington

Michael Karangwa -USAID/Rwanda

Lynn Adrian - USAID/Rwanda

Caroll Vasquez - USAID/Rwanda

Marie Ahmed - USAID/Rwanda

Marina Cardenas - USAID/Rwanda

Bedan Gichanga - USAID/Kenya

Joseph Naimoli - USAID/Washington

Meredith Pierce - USAID/Washington

Emily Roseman - USAID/Washington

Moses Mukuna - USAID/Eastern Africa

Annex 2: Country Ownership[15]

The whole development world now clearly agrees and embraces ‘country ownership’ as an absolutely critical element of aid effectiveness and for sustainable results driven development. However, working through the various dimensions, layers, and variables, defining and measuring country ownership has been quite a complex process. Currently, there is no international consensus on a unique definition of ‘country ownership’ and what indicates and/or constitutes a successful and effective one. In recent years, various organizations and individuals have defined ‘country ownership’ in different ways. Below is such an effort to define ‘country ownership’ and what constitutes it:

In sum, country is in the driver’s seat to plan, prioritize, implement, and manage their development agenda. More specifically, in constituting effective, functioning, and comprehensive ‘country ownership’, all or most of the following should be clearly visible (although the actual extent, nature, and timeframe may vary based on the different country contexts):

- There is effective national leadership to recognize, analyze and define development goals/results, and to formulate prioritized results-based development plans and supporting policies and strategies through broad stakeholders’ consultation;
- Broad and meaningful participation by all stakeholders is effectively advocated, encouraged, and allowed, especially the civil society and private sector in the development, implementation, and monitoring of national development plans and strategies;
- Strong political commitment and public support to implement the national development strategies;
- Holds itself accountable and reports all relevant information in a timely and transparent manner to all stakeholders about processes and progress; and
- Any donor support is only demand driven, fully aligned with country development priorities and strategies, and targeted to only build and/or strengthen country systems for sustainability.

Ensuring effective ‘country ownership’ is an extremely complex and difficult challenge, and would require the highest commitment, patience, and sincere shift in the mindset and development culture of both the host country and its development partners alike.

---

[15] *Prepared by Tariqul Khan (Tariqul_khan@hotmail.com). Reproduction or use of this is authorized provided the author is acknowledged appropriately. In putting this together, the definitions of ‘country ownership’ by the World Bank, Paris Declaration on Aid Effectiveness of 2005, and the Millennium Challenge Account were consulted.*

Annex 3 – List of Technical Working Groups and Subgroups[16]

Technical working groups (TWGs) are operational entities where technical and policy issues are discussed by staff of the MOH with relevant and interested representatives of development partners, NGOs, and FBOs. In most instances, people participate in their technical capacity and do not normally represent their agencies. The objective of the TWG is to support and advise the MOH in the implementation of sector strategies and policies. All TWGs operate under the authority of the Health Sector Working Group (HSWG), which is constituted of representatives of the MOH, DPs, and civil society.
All TWGs (with their "desks" and sub-desks) are coordinated and guided by a chair (MOH representative) and a co-chair (DP representative). The performance of the TWG varies over time with the capacity of the chair and co-chair to effectively coordinate TWG members.

The MOH distinguishes the following technical working groups

Maternal and Child Health

The MCH Unit of the MOH is composed of several desks and sub-desks, most of which work with partners in technical working groups in which all the required technical expertise is brought together.

- Maternal (including Fistula) and Child Health Units (with sub-desks in ASRH&R and Gender / Gender-Based Violence)
- Family Planning Desk
- Nutrition Desk
- Community Health Desk
- Environmental Desk
- The EPI Desk (This desk has recently been moved to RBC)

Other (operational) TWGs, and related desks and sub-desks, are working in the areas of:

Prevention of Diseases

- HIV and Other Communicable Diseases
- Noncommunicable Disease (NCDs)
- Health Promotion and BCC
- Environmental Health

Treatment and Control of Diseases

- Care and Treatment
- Mental Health
- Laboratory

---

[16] *Source: HSSP III*

- Epidemic Control and Surveillance

Health Systems Strengthening (HSS)

- Planning, Budgeting and M&E
- Human Resources for Health
- Health Commodities
- Health Technology
- Health Financing
- Quality of Service Delivery
- Governance and Decentralization
- Specialized Services

Social Mitigation

- OVC and Other Vulnerable People
- Approbation of Micro-projects

Health Sector Research

- Communicable Diseases
- Noncommunicable Diseases
- Operational Research
- Clinical Research
- Research in Social Sciences

HIS and e-Health / e-Learning