



**BUILDING A HEALTHIER RWANDA:  
LINKING SOCIAL PRIORITIES TO THE NATIONAL BUDGET, 2011–2016  
(SHORT VERSION)**

*This summary draws on an ISS case study with the same title can be found on the [ISS website](#). Simon Engler drafted the full case study with the assistance of Louise Umutoni Bower, based on interviews conducted in Kigali, Rwanda in March, April and August 2018. Case published September 2018. Summary published in May 2019.*

## BACKGROUND

Rwanda's public health system was among the casualties of the country's 1994 genocide. In the aftermath of the violence, health workers were in short supply, maternal and child mortality rates spiked, and infectious diseases such as HIV/AIDs and tuberculosis often went untreated. By 2011, Rwanda had made significant gains in remedying the situation.

The country's most-recent medium-term plan for the health sector was set to expire in 2012, and planners had to develop a new strategy that would broaden and deepen progress from 2013 to 2018. They had a year to evaluate the results of past health programs and decide how to move the country forward. Priorities and budgeting topped their to-do list.

## KEY ISSUES

- By 2011, Rwanda's public health system had made enormous progress in recovering from the country's 1994 genocide, but much more remained to be done.
- Resources were limited, with the health system heavily reliant on external donors, whose levels of support could vary from year to year.
- With a medium-term health plan expiring in a year, planners had to develop a new five-year blueprint that would establish goals and set targets that fit into annual budgets, that would direct government money toward high-impact activities, and that would improve the government's ability to track spending and eliminate waste.

## REFORM STRATEGY

Setting new priorities for the health sector and translating them into action required that planners surmount multiple challenges. Rwanda's public resources were still scarce, even though the country's economy and tax revenues had grown since the late 1990s. What's more, health sector officials in the central government had to coordinate with their counterparts across the country, working both with the finance ministry in the capital, Kigali, and with authorities in 30 districts—the political divisions of Rwanda's five provinces that handled public-service delivery.

First, planners had to create a medium-term public health strategy that built on the government's national development goals. Next, officials in the central government had to support the planning and budgeting process at the district level. Finally, the health sector had to translate its priorities into annual budget allocations and track the results of spending.

External support accounted for a significant share of spending, but financing fluctuated as much as 52% from year to year and made Rwanda's funding situation tenuous. Because of the unpredictability of outside aid, senior officials realized it was essential to limit dependence on donors who had left the country at the time of the genocide and would not always be available when needed, noted Donald Kaberuka, who served as finance minister from 1997 to 2005.

## ACTIONS TAKEN

In February 2012, the health ministry's planning specialist, Regis Hitimana, gathered with his colleagues to map out the health sector's future and what had to be done during the coming years. Their final plan set top priority on the achievement of specific United Nations Millennium Development Goals by 2015: to halve the number of people suffering from extreme poverty; to significantly reduce nutritional stunting; to slash child mortality rates; to improve maternal health; to broaden access to contraception; and to limit the spread of HIV/AIDS, malaria, and other infectious diseases. The plan also aimed to expand the accessibility of health-care services and to bolster efforts to train medical support staff. With help from the finance ministry, the health sector planners then developed cost estimates for putting their priorities into practice.

A team of outside consultants used the results to assemble an initial draft of what would become the health sector's strategic plan. Although the health ministry played a part in implementing the plans, so did the districts, which in 2012 had developed medium-term health plans to complement the national program. District planners met with other local officials to create strategies that matched the targets stipulated in the health sector's new five-year plan and in their districts' own general development plans.

Meanwhile, the finance ministry was working on its own agenda for 2013 to 2018, called the second Economic Development and Poverty

Reduction Strategy. The ministry's proposals for public health echoed those that the health sector had laid out: above all, to broaden access to care by investing in more health-care workers, by building more facilities, and by targeting subsidies to help the poorest citizens enroll in the country's community-based health insurance system.

The finance ministry's development strategy also called on the government to improve its ability to account for expenditures. Achieving that goal required effective financial management and support of other arms of government. Since 2009, Rwanda had been trying to roll out a new, integrated financial management information system, or IFMIS—a digital tool that officials could use in the management of planning, budgeting, and accounting. A team at the finance ministry aimed to have every public organization that spent government money in the health sector—from the health ministry in Kigali to health facilities in the countryside—tracking budget execution on the program.

To foster coordination, the finance ministry tapped staffers from its planning, budgeting, and accounting departments to serve as counterparts to officials in government spending agencies. Those focal persons provided important technical and policy advice for health ministry planners, accountants, and budget managers while they built mutual understanding of shared problems.

Focusing on the collection of data on health outputs and outcomes, the health ministry in 2012 also updated a platform known as the Health Management Information System, with support from the US Agency for International Development. And in 2013, the ministry revised its budgeting procedures so as to require that districts focus their attention on planning at a much earlier stage in the process.

In May 2011, Rwanda's cabinet approved new policies that called on line ministries, including the health ministry, to meet with representatives of local governments every year to discuss budget allocations. The cabinet also mandated that the finance and local government ministries train local authorities in fundamental financial management tasks such as budget preparation and execution.

The Health Resources Tracking Tool, which the health ministry introduced in 2012, offered another way to monitor spending. A web-based program, it enabled service-delivery units to link expense records for the previous fiscal year and their budgets for the current fiscal year to the health sector's goals. The tool's purpose was to enable officials to connect their spending to priorities while uniting expenditure records from various implementing organizations into a single annual report. The ministry in 2014 rebuilt the tool to increase its flexibility and accuracy and to make it simpler to use.

Also in 2014, the health ministry restructured the existing Directorate General of Planning by combining it with the ministry's health-financing unit

to increase budget-planning capacity, which had been stretched by the new requirements. In addition, the restructuring streamlined certain budget procedures and made compliance with them a part of the performance review process for employees.

## RESULTS

By 2015, Rwanda had achieved a number of the public health goals it had set three years earlier: 91% of births were taking place in health facilities, exceeding the target that planners had set for 2018; and life expectancy had reached 65.7 years, which far exceeded the 2015 target of 58 years. The proportion of women who were dying from causes related to childbirth or pregnancy had declined by more than half, surpassing the targets set for 2015 and 2018. The number of physicians, nurses, and midwives per capita had reached the standard that planners had set for 2015. And the infant mortality rate had fallen to 32 per 1,000 live births from 50 per 1,000 live births in 2011—just shy of the Millennium Development Goals target of 28.

In late 2018, Rwanda seemed within reach of achieving most of its goals for the year; it had met or surpassed 15 of the 26 key performance indicators for 2015 for which data were available.

The health sector's performance under external audit also improved. In 2016, the auditor general's office granted the health ministry a clean audit for the first time in its history. Jean Pierre Nyemazi, the health ministry's permanent secretary, attributed the ministry's progress in part to its introduction of standard operating procedures. Still, problems remained, attributable largely to thin staffing and lack of training, which caused difficulties in rolling out technical solutions such as IFMIS—particularly at the local level.

## LESSONS LEARNED

- Rwanda's success in setting priorities and linking them to the budget process had benefited from the nature of the country's postgenocide political arrangement, which concentrated power in the ruling party—the Rwandan Patriotic Front—and especially in the presidency. At annual leadership retreats, President Paul Kagame put intense pressure on ministers to meet their commitments to deliver services.
- The finance ministry's designation of health-sector focal persons in its own budgeting, planning, and accounting departments was crucial to the success of the system Rwanda established. Zachee Iyakaremye, the health sector's liaison in the finance ministry's budget office, said his close partnership with counterparts at the health ministry gave him inside knowledge of health sector priorities. "If you don't speak the same language as the one they speak, they will never take your advice," Iyakaremye said.

- Rwanda's experience illuminated the challenge of effectively collecting and using data at the local level for planning and service delivery—something both the finance and health ministries struggled with from 2011 to 2016. "What we need is to just keep building the capacity of the users of the system [to] make sure everything is captured in the system, and the system is used effectively and efficiently," said Gervais Baziga, the health ministry's staff member formerly in charge of decentralization.

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