



INNOVATIONS FOR SUCCESSFUL SOCIETIES

BUILDING A HEALTHIER RWANDA: LINKING SOCIAL PRIORITIES TO THE NATIONAL BUDGET, 2011 – 2016

SYNOPSIS

Rwanda's public health system was among the many 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 enormous progress in remedying the situation, but much more remained to be done. From 2011 to 2016, officials in the finance ministry and health ministry worked together to develop five-year plans for public health, translate their new priorities into annual budgets, and monitor spending so as to ensure progress toward national goals. They revised the budget calendar to improve the planning process, helped local authorities build medium-term public-health strategies, and refined the tools used for tracking spending in the health sector. They met or surpassed more than half of the top targets they set for 2015, cementing the gains Rwanda had made since 1994.

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INTRODUCTION

In the aftermath of the 1994 genocide, Rwanda's health system unraveled. Most doctors and nurses had fled or been killed during the violence,¹ and the government had little money to rebuild social services, because tax revenues had fallen to roughly 60% of the amount collected in 1990.² In 1995, one in four children in Rwanda was expected to die before turning five years old. Life expectancy at birth was 32 years—the world's lowest.³

In the years after 2000, as the new government gained capacity, officials stepped up their responses to the situation. Vision 2020 (text box 1), the foundation for the government's long-term planning, included a series of pledges to improve public health, from halving the infant

mortality rate to increasing average life expectancy by six years,⁴ and the Ministry of Finance and Economic Planning embedded these in its 2002 Poverty Reduction Strategy. The health ministry and local authorities trained and deployed community health workers, expanded resources for family planning, and intensified efforts to deal with HIV/AIDS and other communicable diseases. They also experimented with innovative programs such as community-based health insurance and performance-based financing (text box 2). The government hosted retreats with its international development partners to help direct aid to official priorities, emphasizing the need for general budget support instead of projects that might distract from official priorities.⁵ By 2010, some 58% of donor

Box 1. Vision 2020

Developed from 1997 to 2000, Vision 2020 was the Rwandan government's foundational long-term strategy. Its topline goal was to more than triple Rwanda's per-capita GDP—from US\$290 to US\$900. The plan proposed to halve the infant mortality rate, increase average life expectancy by six years, and cut the proportion of women who died in childbirth by around 80%. It also proposed reducing the population growth rate, cutting the malaria-related death rate in half, reducing the percentage of the population with HIV/AIDS from 13% to 8%, and boosting the number of nurses, doctors, and laboratory workers in the country. In 2012, the government adjusted the plan. Officials aligned its targets with the World Bank's new threshold for lower-middle-income status (Rwanda's GDP per-capita target was adjusted from US\$900 to US\$1,240); included indicators for information technology, regional integration, governance, and climate change, and redefined the targets that the country had already achieved.

Source: *Vision 2020*, Government of Rwanda, Kigali: Ministry of Finance and Economic Planning, and Government of Rwanda, *Vision 2020, Revised 2012*, http://www.minecofin.gov.rw/fileadmin/templates/documents/NDPR/Vision_2020_.pdf

assistance was moving through government systems—nearly triple the average in postconflict settings.⁶

Thanks to such steps, by 2011 Rwanda had reached or surpassed some of its initial targets a year ahead of its 2012 deadline: 91% of the population had enrolled in community-based health insurance plans; more than 90% of the country's children were fully immunized; and there was roughly one nurse for every 1,294 Rwandans.

In other areas, the going was tougher. Although the infant mortality rate had fallen to 50 per 1,000 live births in 2011 from 86 in 2005, to reach the country's targets under the United Nations Millennium Development Goals, the rate would have to drop by another 44%—to 28 per 1,000 live births by 2015.⁷ Increasing the number of doctors and nurses per capita and improving Rwandans' access to health facilities were also difficult objectives. At the time, roughly 23% of patients had to walk either more than an hour or more than five kilometers to reach a health facility.⁸

By 2011, it was time to think about a new strategy that would run from 2013 to 2018. The country's most recent medium-term plan for the health sector was set to expire in 2012, which meant there was a year to evaluate results from the previous plan and decide how to move the country forward. In addition to setting priorities,

officials would have to translate new goals and targets into annual budgets, direct government money toward high-impact activities, and improve the government's ability to track spending and eliminate waste, with the aim of using limited resources as efficiently as possible.

Few in government felt those challenges as heavily as the health ministry's Directorate General of Planning and Monitoring & Evaluation, which in 2011 comprised only around a dozen people, according to Dr. Parfait Uwaliraye, who became its director general the following year. In February 2012, the health ministry's planning specialist, Regis Hitimana, gathered with his colleagues at a retreat in Musanze, a district in Rwanda's north, to map out the health sector's future and determine how to achieve the goals they set. Despite the country's progress since the 1990s, including in many of the areas the health sector had prioritized, there was much more ground to cover.

THE CHALLENGE

To sustain improvement, officials had to address a number of 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

Box 2. *Mutuelles de Santé*, Performance-Based Financing, and *Imihigo*

There were several innovative aspects in Rwanda's health financing and monitoring system. The first was the country's use of performance-based financing, a payment mechanism whereby service delivery units were reimbursed according to the quality and quantity of services they provided. Initially targeting interventions around infectious diseases such as HIV/AIDS, malaria, and tuberculosis, the financing plan ultimately sought to increase the supply of basic health services at district hospitals and health facilities, with the aim of increasing their use by the population. After a series of local, donor-supported pilots, the government made performance-based financing a nationwide policy under a 2005 strategic plan for the health sector.

The second aspect consisted of *mutuelles de santé*, or community-based health insurance systems, first piloted in 1998 and scaled up across the country during the following decade. By 2015, community-based health insurance had been transferred from the health ministry to the Rwanda Social Security Board, whose financing in turn lay under the supervision of the National Bank of Rwanda. (At that time, more than 99% of the fund's expenditures appeared in government budgets; however, the government did not include the fund in its fiscal reports.)

The third were *imihigo*, or performance contracts, which the central government first put into place in 2006 with district mayors in an attempt to ensure their adherence to mutually agreed targets. In 2011, the state rolled out the *imihigo* to central government ministries. The *imihigo* reflected key aspects of the districts' and ministries' annual action plans, which were in turn linked to their yearly budgets.

Source: Louis Rusa, Miriam Schneidman, Gyuri Fritsche, and Laurent Musango, "Rwanda: Performance-Based Financing in the Health Sector." In *Performance Incentives for Global Health: Potential and Pitfalls*, ed. Rena Eichler, Ruth Levine, and the Performance-Based Incentives Working Group, Center for Global Development, 2009; <https://www.cgdev.org/sites/default/files/9781933286297-Levine-performance-incentives.pdf>. The World Bank. "Community Based Health Insurance in Rwanda," Human Development Findings Report 34342, November 2005. *PEFA Assessment Report of Rwanda (2016)*, p. 30. Daniel Scher and Christine MacAulay, *The Promise of Imihigo: Decentralized Service Delivery in Rwanda, 2006-2010*, Innovations for Successful Societies, Princeton University.

in Kigali and with district authorities. That required producing timely and complete financial reports and other evaluations that would stretch the capacity of the health ministry's small staff.

By mobilizing more domestic revenue while continuing to use external assistance, the government was on track to expand its resources. In 2011, *government expenditure* on health was about 2.25% of GDP, and *total health expenditure* was about 9% of GDP—still below the 15% level recommended in the 2001 Abuja Declaration.⁹ Health accounted for 9% of general government expenditures at the time—up from 5% in 2002 and four percentage points above the median for low-income countries.¹⁰

In a country with a rapidly growing population of 10.5 million people, the figures translated into per-capita *government spending* on health of roughly US\$34 in purchasing-power-adjusted international dollars, which was more

than in many African countries—including Nigeria but roughly on a par with Zambia, Zimbabwe, Mauritania, and Senegal—and less than in Ghana (US\$94.7), Kenya (US\$45), and several others.¹¹ By contrast, estimated total per-capita expenditure on health—including external-donor contributions, insurance, and out-of-pocket spending—was US\$134, in purchasing-power adjusted international dollars.¹² Estimates of out-of-pocket spending per capita varied widely depending on the approach used. Some estimates, based on costs of a defined set of items, put out-of-pocket spending at about \$4 per person,¹³ but others put the amount at \$30 in purchasing-power adjusted international dollars in a country whose gross national income per capita was a little more than US\$610 per year (Atlas method).¹⁴

External support accounted for a significant share of spending, but the unpredictability of

such financing, which fluctuated as much as 52% from year to year, made Rwanda's funding situation more challenging.¹⁵ That unpredictability also reinforced the sense among senior officials that it was essential to limit dependence on aid donors, who had left the country at the time of the genocide and would not always be available when needed, noted Daniel Kaberuka, who served as finance minister from 1997 to 2005.

The good news was that since the late 1990s, the Rwandan government had steadily improved the management of its finances.¹⁶ While serving as finance minister, Kaberuka introduced a medium-term-expenditure framework, which required that officials project revenue and expenditure plans on a rolling, three-year basis.¹⁷ The finance ministry reorganized its budget around government programs instead of line items, placing responsibility for developing the recurrent and development budgets under the control of its budget directorate. The finance ministry also established an auditor's office to check actual spending against budget allocations.¹⁸

In 2006, the year after Kaberuka left his post, a new budget law created a clear fiscal calendar and shifted the responsibility for handling the budget's execution—from approving disbursements to tracking spending—from the finance ministry to each of the government's spending agencies, including the health ministry.¹⁹ The latter measure sought to improve accountability and in turn boost civil servants' performance. "The belief at the time was that you cannot hold sectors accountable if they do not have a minimum amount of power and control over their own finances," said Kampeta Sayinzoga, the finance ministry's former permanent secretary, who became director general of Rwanda's National Industrial Research and Development Agency in 2017.

Over the following years, under the leadership of James Musoni and John Rwangombwa, the finance ministry started to roll out a new integrated financial management information system (IFMIS); issued guidelines

that clarified the budget process; and began to host yearly retreats with permanent secretaries to instruct them on their responsibilities as their ministries' top budgetary officials—all of it part of a broad push to reform Rwanda's public financial management practices.²⁰

The ministry also tapped a number of staffers in its planning, budgeting, and accounting departments to serve as counterparts to officials in Rwanda's spending agencies. Under that arrangement, the health ministry's planners, accountants, and budget managers had a contact in the finance ministry, known as a focal person, who provided technical and policy advice throughout the planning and budgeting process. "Our focal persons are always available to sectors for support," said Zachee Iyakaremye, who later served as the health sector's liaison in the finance ministry's budget department. "Any technical support the [health] sector would need in matters related to budgeting, I would be the one to provide it," he said.

Partly as a result of those changes, Rwandan officials were also getting better at using the public's money to achieve the government's long-term goals. From 2006 to 2010, according to an assessment of Rwanda's public financial management conducted through the Public Expenditure and Financial Accountability (PEFA) program, the government ensured that more of the money it spent each year matched the amount allocated by the state budget; deepened the level of detail in budgetary documents; and introduced more order and predictability into the budget process.²¹

There were still obstacles to linking the government's priorities to the budget, however. The 2010 PEFA assessment graded Rwanda poorly on the quality of its financial accounting and reporting, for instance.²² And although districts gathered information on spending at primary health-care facilities, an internal finance ministry report had found no evidence that the health ministry was collecting or acting upon that data.²³ Hospitals and health centers were using an ad hoc mix of accounting tools. And in the

central government, spending agencies were still struggling to make sure their budget allocations aligned with the outer years of the medium-term-expenditure frameworks introduced under Kaberuka.²⁴

What's more, Rwanda had been undergoing a process of decentralization since 2000.²⁵ The health ministry was about to become responsible for supporting planning in the country's 30 district governments and at the Rwanda Biomedical Center, an extension of the health ministry that ran disease control and prevention programs and biomedical services. Gervais Baziga, a staffer in the health ministry, who at the time was supporting such decentralized entities in health planning and monitoring, had to back up district officials as they assumed more responsibility for their own plans.

The health ministry's staff was stretched thin. Uwaliraye said the ministry employed just one planning specialist, two monitoring and evaluation specialists, one health system analyst, one e-health specialist, and one information-technology director in 2011. To compensate, the ministry ran a planning process in which the heads of its departments developed their own priorities. "Planning was a core function of all heads of units" in the health ministry, said Uzziel Ndagijimana, who was then its permanent secretary. (Ndagijimana joined the finance ministry in 2014 and became its minister in April 2018.²⁶)

FRAMING A RESPONSE

Officials had to develop ways to coordinate across the government and improve the quality of financial reporting. At the same time, they had to consider how to build a new strategy for the health sector. That required assessing the sector's progress to date.

Since the early 2000s, Rwanda's government had organized its various development plans so that each layer fit into the one above it. The goal was to ensure that each activity served a national purpose. Just as plans for the Rwanda Biomedical Center had to reflect the health sector's medium-

term strategy, for instance, so did the sector's strategy need to build on government-wide priorities. To make plans and then translate them into funding requests, health sector officials had to manage relationships across the civil service—a process that they managed carefully.

Before Hitimana and his colleagues gathered in Musanze in February 2012, they evaluated the progress the health sector had made on its previous medium-term strategy for the health sector. That strategy had laid out three broad objectives: to improve preventive care, to upgrade curative care, and to broaden access to maternal-, child-, reproductive-, and nutrition-related health services.²⁷ Officials had divided those objectives into a narrower series of seven program areas.

Months before the Musanze meeting, health planners spoke with district officials in order to understand the progress the officials had made on their plans and to draw lessons from the ways they had put local health programs into practice. The planners also secured the help of consultants from the International Health Partnership, or IHP+, a global compact organized under the auspices of the World Health Organization and the World Bank, to evaluate their progress on the targets they had set in 2009.²⁸ The evaluation spelled out the distance Rwanda had to cover to reach the targets laid out in the 2009 plan and under the Millennium Development Goals—and it offered a series of recommendations for covering that remaining distance.²⁹

Hitimana said that the consultants also pointed out the need for improvements in the planning process at the district level. "When the team came, they said, 'Oh, you have [a] good planning process, but when you go to the district, it's not coordinated,'" he noted. The consultants also observed that the district health facilities produced valuable data, noting that although the national government effectively used that information to improve its performance, local governments did not.

Meanwhile, the finance ministry was developing a new strategy of its own. The second Economic Development and Poverty Reduction

Strategy, as it was called, would run from 2013 to 2018. Its brief proposals for public health echoed those that the health sector had laid out previously: above all, to broaden access to care by investing in more health-care workers, building more facilities, and targeting subsidies to help the poorest citizens enroll in the country's community-based health insurance system.³⁰ Hitimana said that the finance ministry shared a draft of the five-year Economic Development Strategy with the health ministry's planners around the time that they met in Musanze.

The finance ministry's development strategy also called on the government to improve its ability to account for expenditures, especially at the district level. Amin Miramago, the government's coordinator for public financial management reforms from 2011 until 2016, said the 2010 assessment that PEFA conducted had shown that much more work remained in that area. Improving the quality of reporting could help officials learn whether offices were using budget allocations as intended.

Getting there depended on having a financial management information system suited to the task. Since 2009, Rwanda had been trying to roll out a new IFMIS—a digital tool that officials could use to manage planning, budgeting, and accounting. Led by IFMIS coordinator Jean de Dieu Rurangirwa, a team at the finance ministry ultimately 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.^{31,32} To improve the collection of data on health outputs and outcomes, in 2012, the health ministry also updated a platform known as the Health Management Information System, with support from the US Agency for International Development.³³

Last but not least, 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 each 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.³⁴

GETTING DOWN TO WORK

Choosing new priorities for the health sector and translating them into action required a number of steps. First, the planners at the Musanze retreat had to create a medium-term strategy for public health 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.

Developing a strategy

In February 2012, representatives from the health, finance, and local government ministries gathered with members of the prime minister's office and other social-sector officials for the retreat in Musanze, which lasted for four days. The top priority of the plan that they ultimately created was to reach four of the UN's Millennium Development Goals by 2015: in particular, to halve the number of people suffering from extreme poverty; significantly reduce nutritional stunting; slash child mortality rates; improve maternal health and broaden access to contraception; and limit the spread of HIV/AIDS, malaria, and other infectious diseases. The plan also committed the sector to broaden the accessibility of health care and to train up its medical support staff (text box 3).

The meeting's participants divided themselves into working groups, each of which dealt with a thematic area, such as maternal and child health, and each of which was co-chaired by the head of the relevant department within the government and a staffer from a donor organization. Each group was to assemble a list of challenges in its area of responsibility, propose a series of measures that would meet the challenges, and set specific targets for each goal.

Box 3. The Integrated Financial Management Information System

Building a workable information system to support integrated financial management posed many challenges. Developers hoped to launch the first platform, called SmartFMS, in late 2006, but ineffective coordination between the teams of consultants handling different elements caused problems and it was initially impossible for the new system to ensure that spending matched allocations to government programs and subprograms.

As a result, until 2010, Rwanda's health ministry handled many of its accounting and reporting tasks by using an off-the-shelf software developed by the British technology firm Sage. In July of that year, the ministry began using a retooled version of the integrated financial information management system, which eventually enabled users to manipulate different segments of the accounting and budgeting process—from planning to payments—within a single, web-enabled system deployed across the central government.

By November 2013, the IFMIS had been installed in more than 200 offices across the Rwandan government—a step that an International Monetary Fund review said had “significantly improved” the country's budget reporting. But health units outside the central government did not log information into the system consistently. Only in 2016–17 did district hospitals begin to report budget execution through the platform. Reflecting on that experience, the African Capacity Building Foundation pointed to the difficulty of embarking on largescale technology projects early in the process of reforming the management of government finances.

Source: International Monetary Fund, “Rwanda: Letter of Intent, Memorandum of Economic and Financial Policies, and Technical Memorandum of Understanding,” November 12, 2013; accessed at <https://www.imf.org/external/np/loi/2013/rwa/111213.pdf>. Mfandaedza Hove and Andy Wynne, *The Experience of Medium-Term Expenditure Framework and Integrated Financial Management Information System Reforms in Sub-Saharan Africa: What Is the Balance Sheet?* Occasional Paper No. 9, African Capacity Building Foundation, 2010 <http://elibrary.acbfpact.org/collect/acbf/index/assoc/HASH01fd.dir/file%20012.pdf>.

Hitimana played a coordinating role, compiling the working groups' proposals and encouraging them to set targets in line with Vision 2020, the finance ministry's five-year economic development and poverty reduction strategy, and the Millennium Development Goals.

With support from the finance ministry, the health sector staffers then estimated how much it would cost to put their priorities into practice. They used two different methods: the input-based costing approach, whereby they projected the expense of each component needed to reach their goals and then added up the figures to calculate a total, and the marginal-budgeting-for-bottlenecks approach, which in theory produced deeper insights by giving officials an understanding of how changes in funding levels could affect performance—especially in the areas of maternal and child health and some infectious diseases.³⁵ The two methods produced overlapping results.

Using the input-based costing process, officials estimated that achieving the strategic plan's targets in the years before 2018 would require a total of US\$3.67 billion—a figure that lay between the plan's low-end and medium-end projections of US\$3.54 billion and US\$3.85 billion, respectively, under the marginal-budgeting-for-bottlenecks method.³⁶ (The finance ministry's own costing model projected a far lower cost, of US\$1.69 billion, for the first five years; officials attributed the divergence to differences in methodology.³⁷)

A team of outside consultants used the results to assemble an initial draft of what would become the health sector's strategic plan. After the working groups revised the results based on comments from others across the government and the donor community, the health ministry sent the draft to the finance ministry's planning department, which requested additional

changes—for instance, that the health sector include operational road maps for its priorities, explaining how it would approach its goals in each year of the strategic plan. That task was time-consuming, Hitimana said, but it proved useful when health officials sought to translate the five-year plan into annual budget requests. (See figure 1 at end of text.)

Supporting planning beyond the central government

Although the health ministry played a part in implementing the plans, so did Rwanda's 30 districts. 2012 marked the first year they released medium-term strategic health plans of their own. Under the guidance of each district's vice mayors of social affairs, district planners convened other local officials to develop strategies that matched the targets spelled out in the health sector's five-year plan and in the districts' own general development plans.³⁸ With support from the local government ministry and others, the health ministry developed guidelines for district health systems. Meanwhile, districts set up management teams comprising local directors of hospitals, pharmacy representatives, community-based health insurance representatives, and health center officials, who in turn oversaw small planning groups that would eventually include planners, policy makers, and monitoring and evaluation workers.

During the early phases, said Gervais Baziga, who was then the health ministry's staffer responsible for decentralization, capacity was a challenge: in most districts, just one official was in charge of district health activities, and only at the end of 2012 did districts add a second staffer to their health units. The health ministry had developed guidelines clarifying the planning activities for which the officials were responsible, but "some of [the health activities] may not even be prioritized by districts in their plans," Baziga said. "They think it's for [the health ministry] to do so."

The strategy-setting process was similar in each district, Baziga said, beginning with an analysis of the state of public health in the area

and moving toward the development of proposed interventions and targets. "It's standardized," he said. "We conduct [a situation analysis] to make sure [that] the interventions that we're going to make are responsive to the issues that we're facing." Once the plans had been finalized, Baziga said, health ministry and district officials met annually to discuss priorities for the year ahead. "We [at the health ministry] identify [and] propose priorities [and] discuss [the priorities] with the districts for inputs and alignment with the national strategies," he noted. "Districts may add interventions, considering their specificity."

But districts did not have complete discretion over how to use their yearly funding. The central government set aside grants for specific purposes, and districts could reallocate funding to new priorities without consulting the central authorities only when they did so with local revenues—which constituted only a small portion of many district budgets.³⁹ Administrative costs, such as salaries for health sector workers, were covered via block grants, the amounts of which the finance and local-government ministries determined at the central level. Earmarked funds for health services, meanwhile, were largely the responsibility of the health ministry, which developed formulas by which to allocate them in each district—with approval by finance ministry officials.⁴⁰

Over time, Baziga said, local officials began to take more interest in the priority-setting process. "[They began] to understand that without health, you can't develop your district," he said. Nonetheless, monitoring and evaluating each district's progress against its targets were tough tasks, Baziga said, partly because of limited capacity for that purpose within each district. In collaboration with districts, the health ministry selected certain key health indicators the districts had to report on each quarter and organized training sessions to help district officials in that process.

The Rwanda Biomedical Center, established in 2011 to combine under a single corporate structure a number of health sector initiatives—

for instance, research and interventions around infectious diseases, mental health, and medical procurement—also had to create medium-term strategies. Jean Pierre Nyemazi joined the center as head of its planning and monitoring division in 2011 and stayed on until 2016, when he became the health ministry’s permanent secretary. His team produced strategic plans for the organization in such areas as infectious disease and developed a monitoring and evaluation plan.

Beginning the budget process

If officials could meet the goals they had laid out in the health sector’s strategies, it would seriously improve the lives of ordinary people. But plans require resources, and it was now up to the health sector to secure them.

Rwanda’s fiscal calendar ran from July to June, following a tight schedule overseen by the finance ministry.⁴¹ Each year, three budgets were in play: officials evaluated the budget’s performance in the year before, executed the current year’s budget, and planned the budget for the year ahead. The annual cycle began with updates to the government’s macroeconomic framework. Drawing on exchanges with the tax authorities, the central bank, the national institute of statistics, donor groups, and others, officials in the finance ministry’s macro division assessed Rwanda’s potential for economic growth and government revenues over a three-year period. Around the end of August, the finance ministry released a budget outlook paper—a document that used this macroeconomic framework to build rough, medium-term- spending envelopes for each sector.

The initial signal that the health ministry should start preparing its annual budget had historically arrived in the form of a notice called the first budgeting call circular. The finance ministry released that document late each year to tell all of Rwanda’s spending agencies that they should begin considering their priorities for the next fiscal year and to give them some guidance on what to expect during the budget process. But the line ministries sometimes failed to take the

finance ministry’s first circular seriously, instead waiting to start preparing their budget submissions until the finance ministry had revealed each agency’s spending ceiling later in the year. The delay left officials little time to discuss their annual priorities. “What tended to happen is that we discussed the plan at the same time as the cash, and because there was never enough cash compared to our ambitions, we would end up having a discussion mainly about the cash,” Sayinzoga said. “Once you discuss the budget ceiling first, you’re in a weak position as a Ministry of Finance to influence planning.”

In 2013, the finance ministry retooled the circular to focus on planning. The First Planning and Budgeting Call Circular, as it was known starting in that year, asked each spending agency to submit a list of annual priorities by the end of November—something that planning officials had not previously been required to do. The circular also reminded budget agencies to prepare lists of investments for review by the Public Investment Committee, a group of permanent secretaries that assessed every such proposal for inclusion on the budget submission. “Every investment project has to have a feasibility study and has to be approved by the Public Investment Committee before it gets budget allocation,” Iyakaremye, the health sector’s liaison in the finance ministry budget department, said. “So we always remind them to assemble all the required documents for investment projects before the planning and budgeting process begins.” The investment committee checked whether the conditions for viable investments were in place, Uwaliraye said—for instance, whether a new hospital would be built in a place with electrical connections and roads for easy access by patients.

Health and finance officials negotiated the annual priorities at the finance ministry in January. The main goal of the planning consultations was to discuss the health sector’s priorities so as to ensure that they aligned with national policies and that they left no priority from the year’s other forums behind. “We made sure that the priorities are exhaustive and capture

everything,” said Iyakaremye. Because the finance ministry had already been clued in to the health ministry’s plans since development of the sector’s five-year strategy, Ndagijimana explained, the planning discussions tended not to be contentious. “The challenge is not [the] discussion over priorities,” he said. “It is how to fit in the available resources.”

The latter challenge appeared after the budget department circulated the second budget call circular, in early February. Shaped by the planning consultations and the initial resource envelope that the finance ministry had released in the fall, the circular gave each ministry an initial spending ceiling for the year ahead and a deadline for submitting a budget. “Every year,” Ndagijimana said, the health ministry had “a budget [request] which may [have been] even double what is available.” At an annual retreat for the ministry’s planning staff, the team developed an annual action plan and updated its medium-term-expenditure framework, adjusting the outline presented in the five-year strategic plan to align with expected resources.

Finding the money

Adjusting the health ministry’s budget proposal so that it fit under the spending ceiling fell to the ministry’s finance department. The rules allowed the health ministry to determine the content of its spending categories but not to shift money from one category to another—for instance, by redirecting funds dedicated for clinical services to salaries instead.

The health ministry’s budget officials could meet with their counterparts at the finance ministry to seek technical help and could even work from the finance ministry’s offices when needed, Iyakaremye said.

Using a template provided by the finance ministry, the health ministry’s finance department sent an electronic budget submission to the finance ministry through the IFMIS. Meanwhile, Uwaliraye’s planning team drew up a short document, known as a strategic-issues paper, which laid out the ministry’s goals, explained how

the ministry had reallocated funds in response to the budget ceiling, and pointed out where the ceiling had led to unfunded priorities. “We use[d] the paper] to advocate for more money,” Uwaliraye said.

Iyakaremye said he reviewed the health ministry’s submission to make sure none of the sector’s priorities had been excluded. He had already witnessed much of the priority-setting process, and that earlier exposure helped him identify missing priorities in the ministry’s proposals. Identifying such gaps, Iyakaremye said, helped link the available resources to the sector’s priorities and helped minimize line ministries’ requests for additional funding later in the process, which could happen if they were to elide some of their top priorities in their earlier budget requests. “If you don’t understand [the health ministry’s] priorities,” Iyakaremye said, “you cannot help them with the budget.”

Then it was on to budget consultations, in which the various spending agencies negotiated their initial ceilings with Finance Minister Claver Gatete. Some of the health ministry’s priorities would usually go unfunded, Ndagijimana said. In other cases, health and finance officials would agree to spread the funding for a health sector project over several years, limiting its burden on the fiscal year ahead.

If other agencies failed to make strong cases for their priorities, the finance ministry might lower their budget ceilings, thereby freeing up additional money to spend elsewhere—often, as it turned out, on the health ministry. Since 2012, Iyakaremye said, the finance ministry had never lowered the initial ceiling it assigned to the health ministry.

If the budget needed further revisions at this stage, the staff at the national budget directorate would make them. Then, in April, the directorate assembled the budget framework paper, a document that laid out allocations by spending agency and that included an annex that classified those planned expenditures in more detail. After the cabinet’s approval of the budget framework paper and the paper’s subsequent presentation to

the legislature, the parliament's budget committee held hearings with the sector ministries, in which the minister of health appeared to justify the health ministry's priorities and allocations. If the lawmakers asked for further revisions, the government made them in the draft finance law it submitted to the cabinet for approval before presenting it to parliament. Lawmakers voted to approve the budget by the end of June.

The budget's story didn't end there, however. The 2013 budget law allowed spending agencies to request budget revisions in line with the approved macro framework halfway through the fiscal year—for instance, to respond to unexpected changes in the prices of medicines. In such cases, the national budget directorate reviewed the ministry's proposals and made recommendations to the minister of finance as to whether to approve or reject requests. Then the finance ministry's budget department consolidated all of the spending agencies' requests for revisions and passed them on to the legislature for a vote.

In the 2013–14 fiscal year, the first under the sector's new strategic plan, the health ministry budget was 336 billion Rwandan francs, equal at the time to about US\$546 million. Roughly 40% of the money came from domestic sources such as tax revenue and funds from co-payments and insurance premiums; the rest came from donors.⁴²

Tracking results

The health sector had several ways to track and report its spending. One was the integrated financial management information system, the central-government-wide budgeting and accounting tool the finance department had used to submit its budget requests earlier in the fiscal year. The team used the system to send quarterly and annual reports to the finance ministry, which in turn submitted the reports to the cabinet and to the office of the auditor general, led by a career auditor named Obadiah Biraro.^{43,44} Rwanda's constitution and budget law required the auditor general's office to report to parliament on

expenditures across the government, to carry out occasional audits of government bodies as requested by lawmakers, and to report on each agency's progress in implementing its recommendations.⁴⁵

The Health Resources Tracking Tool, which the health ministry introduced in 2012, offered another way to monitor spending. Overseen by economist Ismael Niringiyimana, the tracking tool was a web-based program that let service delivery units link the records of their expenses for the previous fiscal year and their budget for the current fiscal year to the health sector's goals. The tool's purpose was to let officials connect their spending to priorities while uniting expenditure records from various implementing organizations into a single annual report. In that sense, the tracking tool sought to provide officials with a more detailed and strategically useful record of their spending than could the finance ministry's financial management information system.

In theory, the idea was straightforward. At each reporting organization, an accountant or budget officer would log on to the tracking tool, record having spent money on one of the health sector programs that the tool listed, and describe the activity's purpose—for instance, HIV prevention—by choosing from a list of priorities based on the health sector's strategic or annual plans. The goal was to ensure that officials linked every expenditure not just to the budget but also to the government's broader, public-health strategy.

In practice, things were more complicated. For one, users in rural areas were occasionally unable to access the tool because of internet outages. For another, officials sometimes found that the tool did not list the purposes of the activities their organization had spent money on. Fixing that problem required either calling technology specialists to build new activity purposes into the tool or, more conveniently, choosing "Other" from the program's menu. Of course, that selection did not clarify the way an organization had spent money, which was precisely the tracking tool's goal.

In 2014, the ministry rebuilt the tool. After collecting feedback from users, Niringiyimana said, the ministry hired consultants to create a new version of the tracking tool that included an empty form that administrators could fill with custom labels. The new tool provided an off-line option that enabled data reporters could log their expenses or other information without a web connection, then upload their reports once connected. It also had a simpler interface.

Niringiyimana's team began to roll out the system to the subnational level, where district hospitals' chief accountants and administrative districts' budget officers would use it. Starting in 2014, they hosted what became an annual weeklong meeting for subnational officials in Kigali, the capital, where they would review the procedures of the tracking tool and then log their yearly expenditures and budgets, with the health ministry's support. In the months that followed, Niringiyimana's team worked to clean up the data they had collected, corresponding with officials in each implementing agency and checking for accuracy the results they had logged in the system. Then the team compiled its annual report, which it released in the first quarter after the close of the previous fiscal year.

The planning staff tried to use the outputs of these systems, as well as those of the health management information system, to shape their annual plans. "On a quarterly basis, we do priority budget execution meetings using the IFMIS's expenditure information in order to ensure that we are on track," Uwaliraye said. "We propose [new annual] priorities based on the gaps in performance we had in previous years." At events called joint sector reviews, held twice every year, officials from across the sector considered their progress and helped develop priorities for the year ahead—a step that influenced the content of their responses to the budget call circulars. Since 2004, President Paul Kagame had also chaired an annual senior leadership retreat, where officials discussed their ministries' priorities, agreed on a set of national targets for the year ahead, and reflected on their progress so far.⁴⁶

OVERCOMING OBSTACLES

The health sector managed to develop a medium-term plan with a small planning department in its core ministry. Yet by 2014, officials had recognized that this arrangement placed an unsustainable workload for the planning team. "They would work day and night," Iyakaremye said of the ministry's planners. "People were stressed, and they could not always do what you were requesting them to do."

In 2014, the health ministry restructured the existing Directorate General of Planning and combined it with the ministry's health financing unit, which was a stand-alone group reporting to the health ministry's permanent secretary. Uwaliraye became the head of the new group, which was called the Directorate General of Planning, Health Financing and Information System. By nature, Uwaliraye said, "planning and health financing go together. We did [the restructuring] for the purpose of maximizing efficiency, to improve the coordination, [and to] reduce the administrative burden" placed on staffers.

Among the new team's first tasks was to define the roles of its members. At a retreat, the directorate worked out terms of reference for each staff member and considered how they might work together. In the months that followed, "We trained some people in the department of planning in understanding the basic principles of health financing," Uwaliraye said. "We tried as much as we [could to get] people in health financing to be more involved in sector planning and monitoring and evaluation, as well." By 2018, the directorate included about 28 people, most of whom were previously on the health ministry's staff.

Uwaliraye and his team also developed a set of standard operating procedures to streamline the planning and budgeting process. On a quarterly basis, the health ministry's internal auditor checked the staff's compliance with these procedures. Failures to follow official practices were noted in performance reviews, Uwaliraye said. "People know what they are doing," he

added. “It’s just a matter of documenting it and complying with it.”

ASSESSING RESULTS

From 2012 to 2016, the health sector’s yearly budget allocation from domestic resources increased; donor support for health did not. On average, Ndagijimana said, the total budget for the health sector rose by 7% each year from 2011 through 2016. Government spending on health rose from \$18.31 in purchasing-power-adjusted international dollars to between roughly \$34 and \$36. Total health expenditure per capita increased from \$29.35 in purchasing-power-adjusted international dollars to \$143.18 in 2015. External funding continued to vary from year-to-year; however, while it accounted for roughly 50% of Rwanda’s health spending in the years from 2006 to 2010, it dropped to between 37% and 44% for the years 2011–2016.⁴⁷

Overall government expenditures increased more quickly than the health budget—about 19% annually—so the health sector’s share of the annual budget did not grow. From the 2011–12 to the 2013–14 fiscal years, for example, the health sector’s share fell from 6.9 to 6.6% of the government’s budget.⁴⁸

In the three fiscal years that followed release of the health sector’s strategic plan, Rwandan officials managed to spend an average of 90% of the money that the national budget allocated to their priorities, although budget execution across the health sector’s levels was inconsistent. In the 2015–16 fiscal year, for instance, the sector’s overall budget execution rate was 86%, whereas at the district level, it was higher, at 99.6%.⁴⁹ Uwaliraye suggested that the divergence partly reflected the differences in funding sources between the central government level and the district levels: the latter depended less on external funding, which was tougher to predict than domestic revenues were.

The sector’s performance under external audit improved. In 2016, the auditor general’s office granted the health ministry a clean audit for the first time in its history. Nyemazi attributed the

ministry’s progress in part to its introduction of the standard operating procedures.

According to some in the finance ministry, the creation of the new Directorate of Planning, Health Financing and Information Systems delivered results. “Now that they have a team, life is easier,” Iyakaremye said. “You give them a deadline, and you are sure they will respect it.” The workload was still intense, however.

By 2016, the health resources tracking tool had some distance to cover before it could reach its full potential. Part of the problem lay in staff turnover at the subnational level: when chief accountants and district budget officers moved to new positions, the thinly staffed health ministry would have to quickly train their successors to use the tool. More important, Niringiyimana said, the health resource tracking data weren’t fully used to produce more valuable reports or to shape plans. “We need to push further in terms of justifying how we spend,” Nyemazi said. And some features of the tracking tool and the finance ministry’s integrated financial management system were redundant, needlessly increasing budget officers’ and accountants’ workloads. The finance ministry also struggled to introduce the IFMIS at service delivery points: a 2015 evaluation of the progress Rwanda had made on the third Health Sector Strategic Plan found that some facilities were still “sourcing software from wherever they can get it” in attempts to strengthen their financial management practices on their own. “Unfortunately,” the report concluded, “overall performance in financial management [at the service-delivery level] is very low.”⁵⁰ Only in the 2016–17 fiscal year did all district hospitals start using the IFMIS to plan and report on their expenditures. How officials would use the resulting data to improve performance remained to be seen.⁵¹

The Public Expenditure and Financial Accountability program published another assessment of the government’s public financial management practices in 2016. Thanks to a change in the program’s methodology, the assessment could directly track progress related to

only 13 of the indicators it used in 2010. In 3 of the indicators—the clarity of the budget call circulars, the quality of the consolidation of cash balances, and the tendency toward in-year budget adjustments—the government’s performance improved; in the other 10, it remained constant.⁵²

By 2015, the country had achieved a number of the public health goals it had set three years earlier: 91% of births were taking place in health facilities, which exceeded 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 portion of women who were dying from causes related to childbirth or pregnancy had more than halved, surpassing the targets set for 2015 and 2018. The number of doctors, 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 Goal target of 28 set earlier. Rwanda seemed within reach of achieving its goals for 2018 in most areas, except for childhood stunting; in total, it had met or surpassed 15 of the 26 key performance indicators for 2015 for which data were available.⁵³ “We have achieved more with less money than the majority of other countries,” then health minister Agnes Binagwaho said that year.⁵⁴

REFLECTIONS

Rwanda’s success in setting priorities and linking them to the budget process possibly benefited from the nature of the country’s political settlement, which concentrated power in the ruling party—the Rwandan Patriotic Front—and especially in the presidency. At the annual leadership retreats, President Paul Kagame put intense pressure on ministers to meet their commitments.⁵⁵ But there was more to the picture. Strong leaders do not always focus on service delivery. Kagame’s minority-led government took up the “belief that political legitimacy [would] be through performance,” political scientist Benjamin Chemouni said. The

government also invested in recruiting and training technocratic leaders who shared this perspective.

The finance ministry’s designation of health-sector specialists, or “focal persons,” in its own budgeting, planning, and accounting departments was crucial to the success of the system Rwanda established. Iyakaremye said that his close partnership with his 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 of his counterparts in the health sector. “People here in the budget department should understand [health] policies at the same level as—or at an even higher level than—the health sector understands [them]. Good working relationships between staff in the health and finance ministries always generated positive results.”

The dynamic worked both ways. As Sayinzoga put it: “Understanding the ropes of the ministry of finance is very important for the line ministries. You need your director of planning or your permanent secretary to sit with the director of the budget, explain the reforms that you want to do, have formal meetings and coffee and lunch, explain [things] once, twice, three times, and agree on the sequencing of your actions before you bring them to the minister of finance.”

That the finance ministry’s staffers worked with the health ministry at so many steps in the fiscal calendar reduced the conflict between the two ministries during budget negotiations. It also safeguarded finance officials’ control over the planning and budget process by packing the budget calendar with points at which the finance ministry could shape the health sector’s proposals. So did the nested structure of medium-term planning, which embedded the health sector’s plans in the long-term strategies that the finance ministry had developed.

Rwanda’s story also pointed to 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. For districts to build effective strategies, said Frank Terwindt, a Dutch consultant who advised the Rwandan government on its sectorwide approach in the mid 2000s, “you need [an adequate] assessment of resources and requirements by district.” As Parfait Uwaliraye put it, “you can’t plan without information from data as evidence.”

But channeling the right information to decision-makers depended, in turn, on building the skills of district staff members and proving an easy-to-use platform. Amin Miramago, the government’s former coordinator for public financial management reforms, noted the importance of training staffers at service delivery units to use the integrated financial management information system (IFMIS). Success required more than installing good software, he argued: “You need *people* to implement IFMIS.” Gervais Baziga, the health ministry’s staff member formerly in charge of decentralization, agreed.

“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,” he said. “[Otherwise], knowing how much you get or how much you spend may not be that easy.”

Rwanda’s success depended on constant adaptation. As public health improved, citizens’ demands for services could change, demanding further reforms. Longer life expectancies could increase the burden of noncommunicable diseases, and as ordinary people’s standards of living rose, they might seek more frequent or more expensive care. “How do you provide more in the context of rising incomes and rising expectations but a constrained budget?” Sayinzoga asked. “You need to be able to report back to citizens and say, ‘This is what we’ve done with your money.’”

Figure 1: The Third Health Sector Strategic Plan

Table 1. Trends 2000–2010 (baseline) and targets for MDG (2015) and HSSP III (2018)

INDICATORS	Baseline VISION 2020	HSSP I 2005	MTR June 2008	MTR Aug 2011	TARGET CY 2014	TARGET June 2018
Source of Information	2000	DHS 2005	I-DHS	DHS 2010 HMIS 2011	MDG	HSSP III
IMPACT INDICATORS						
Population (in millions)	7.7	8.6	9.31	10.5	11.3	11.5
Life Expectancy	49			55	58	68
Infant Mortality Rate / 1,000	107	86	62	50	28	22
Under Five Mortality Rate / 1,000		152	103	76	30	42
Maternal Mortality Ratio / 100,000	1,070	750	590	487	287	220
Total Fertility Rate (TFR)	6.5	6.1	5.5	4.6	4.5	3.4
Contraceptive Prevalence Rate (CPR)		17	36	49	62	72
HIV Prevalence Rate among 15–49 yrs	1.3	1.0	NA	3.0	3.0	3.0
OUTCOME / OUTPUT INDICATORS						
Prevalence of Underweight (Wt/Age) among children 6–59 months	30	18	NA	11	8	4
Prevalence of Stunting (Ht/Age) among children 6–59 months		51	NA	44	24.5	18
Prevalence of Wasting (Ht/Wt)		5	NA	3	2	2
% Births Attended in Health Facilities		39	45	69	78	90
% PW Receiving 4 ANC Visits		13	24	35	50	65
% Children <1 yr. immunized for measles		75	80	95	97	97
# Districts with One-Stop Center (GBV)				4	19	42
% Contraceptive Utilization Rate				31	36	40
% HIV Prevalence among PW Attending ANC	NA	NA		1.5	1	0.6
% HF with VCT / PMTCT Services				94	96	96
% Malaria Prevalence Women / Children		NA	1.4 / 2.6	0.7 / 1.4	<1 / 1.2	<1 / 1
% HHs with at Least One LLIN		18	60	82	85	>85
% TB Treatment Success Rate / DOTS		58	86	87.6	88	90
% TB/HIV Patients Receiving ART				67	85	90
Diarrhea prevalence among the under five (% of U5 with diarrhea in last 2 weeks before survey)				13	11	9

Figure 1, Continued

INDICATORS	Baseline VISION 2020	HSSP I 2005	MTR June 2008	MTR Aug 2011	TARGET CY 2014	TARGET June 2018
Source of Information	2000	DHS 2005	I-DHS	DHS 2010 HMIS 2011	MDG	HSSP III
INPUT INDICATORS						
% GOR Budget Allocated to Health		8.2	9.1	11	12	15
Per Capita Total Annual Health Expend (USD)		NA	NHA	\$39.10	\$ 42.00	\$ 45.00
% Population Covered by CBHI		12	75	91	91	91
Doctor / population ratio	1 / 75,000	1 / 50,000	1 / 33,000	1 / 16,001	1 / 13,748	1 / 11,993
Nurse / population ratio	1 / 6,250	1 / 3,900	1 / 1,700	1 / 1,291	1 / 1,291	1 / 1,000
Midwives / population ratio	NA	NA	1 / 100,000	1 / 66,749	1 / 45,000	1 / 25,000

Note: Where available, HMIS figures have been used for the outcome / output indicators here and in the various sections of the document, as HMIS will allow for annual monitoring of figures.

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⁵² *PEFA Assessment Report of Rwanda (2016)*, p. 10.

⁵³ *Mid Term Review of the Rwanda Third Health Sector Strategic Plan*, October 2015.

⁵⁴ “Rwandan Minister of Health Dr Agnes Binagwaho discusses country’s health advances,” *Global Health Matters*, September/October 2015; <https://www.fic.nih.gov/News/GlobalHealthMatters/september-october-2015/Pages/barnes-lecture-2015-agnes-binagwaho-health-minister-rwanda.aspx>.

⁵⁵ Benjamin Chemouni, “The Politics of Core Public Sector Reform in Rwanda.”



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