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# RWANDA HEALTH GOVERNANCE ASSESSMENT



December 2010

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## Mission

The Health Systems 20/20 cooperative agreement, funded by the U.S. Agency for International Development (USAID) for the period 2006-2011, helps USAID-supported countries address health system barriers to the use of life-saving priority health services. Health Systems 20/20 works to strengthen health systems through integrated approaches to improving financing, governance, and operations, and building sustainable capacity of local institutions.

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# ACRONYMS

<b>ARV</b>	antiretroviral
<b>BCC</b>	behavior change communication
<b>BUFMAR</b>	<i>Bureau des Formations Médicales Agrées du Rwanda</i>
<b>CAMERWA</b>	<i>Centrale d'Achats des Médicaments Essentiels du Rwanda</i>
<b>CBHI</b>	community-based health insurance
<b>CBOs</b>	community-based organizations
<b>CDF</b>	Common Development Fund
<b>CEO</b>	chief executive officer
<b>CHWs</b>	community health workers
<b>COGES</b>	<i>comite de gestion</i>
<b>COSA</b>	health center community committees
<b>CSOs</b>	civil society organizations
<b>DOH</b>	Department of Health
<b>EDPRS</b>	Economic Development and Poverty Reduction Strategy
<b>GBV</b>	Gender-Based Violence
<b>GoR</b>	Government of Rwanda
<b>HIV/AIDS</b>	Human Immunodeficiency Syndrome/Acquired Immune Deficiency Syndrome
<b>HSA</b>	Health Sciences Authority
<b>HSSP</b>	Health Sector Strategic Plan
<b>IEC</b>	information, education, and communication
<b>JADF</b>	Joint Action Development Forums
<b>LGU</b>	Local Government Unit
<b>MCC</b>	Millennium Challenge Corporation
<b>MINALOC</b>	Ministry of Local Government, Good Governance, Community Development and Social Affairs
<b>MINECOFIN</b>	Ministry of Economic Planning and Finance
<b>MINIJUSTE</b>	Rwandan Ministry of Justice
<b>MINISANTE</b>	Rwandan Ministry of Health
<b>NGO</b>	nongovernmental organization
<b>NMS</b>	National Medical Stores
<b>PAQ</b>	<i>Partenariat pour l'Amelioration de Qualité</i>

<b>PBF</b>	performance-based financing
<b>PEPFAR</b>	President’s Emergency Plan for AIDS Relief
<b>PTF</b>	Pharmacy Task Force
<b>RALGA</b>	Rwanda Association of Local Governments
<b>RBC</b>	Rwanda Biomedical Center
<b>RFMA</b>	Rwanda Food and Medicines Authority
<b>RPPA</b>	Rwanda Public Procurement Authority
<b>SCMS</b>	Supply Chain Management Systems
<b>UNDP</b>	United Nations Development Program
<b>USAID</b>	U.S. Agency for International Development
<b>USG</b>	U.S. Government
<b>WHO</b>	World Health Organization

# I. INTRODUCTION

## I.1 ASSESSMENT PURPOSE AND METHODOLOGY

Recognizing the close link between good governance and health system strengthening, Rwanda has launched several initiatives to strengthen health governance to date. Government- and nongovernmental organization (NGO)-led programs have been implemented to strengthen the interactions between citizens, health providers, and government agencies. These initiatives range from the Government of Rwanda's (GoR) ambitious and comprehensive decentralization reform to move decision making concerning policy implementation closer to the population, to the use of citizen score cards to make service deliverers more responsive to users.

Benchmarking progress made through these reforms, as well as identifying and addressing existing challenges, is essential if Rwanda is to sustain this momentum and further improve health governance in the country. To this end, the Rwandan Ministry of Health (MINISANTE) identified the need for an independent review of the state of health governance in Rwanda. The U.S. Agency for International Development in Rwanda (USAID/Rwanda) convened a team of international and local consultants through the USAID-funded Health Systems 20/20 project to design and implement a health governance assessment. This report presents the team's findings.

The goals of the assessment were to document successes, identify persisting challenges, and recommend ways by which health governance in Rwanda could be further strengthened. The report provides an in-depth analysis of five themes broken down into two analytic areas:

1. Governance Analysis of the Rwandan Health System
  - Processes for health policy and law formulation
  - Decentralization of policy implementation
  - Citizen participation in health policy decisions and service delivery

Although it is possible to discuss separately issues of policy formulation, health system decentralization, and citizen participation in health on a conceptual level, it is difficult to separate these issues on a practical level. Thus, although we provide individual discussions of the three areas, it should be clear that the conceptual framework of *co-governance* that we have used in our analysis treats these governance issues as integral components of a holistic health system.

2. Application of a Governance Optic to Ongoing Institutional Reforms
  - Creation of the Rwanda Biomedical Center (RBC)
  - Reformation of the pharmaceutical supply and management system

As a subset of the broader governance assessment, the team was asked to review and recommend steps to improve the functioning of the newly created RBC and propose reforms related to the Rwandan pharmaceutical system with a special focus on the *Centrale d'Achats des Médicaments Essentiels du Rwanda* (CAMERWA), the central medical store of Rwanda. Since CAMERWA will become part of the new RBC, the subanalysis will specifically examine the governance arrangements between the two entities and, more generally, the application of good governance practices to the new institution and procurement process.

This assessment was done in consultation with country stakeholders, including GoR, USAID/Rwanda, and development partners working to strengthen health governance in Rwanda. It relied on extensive

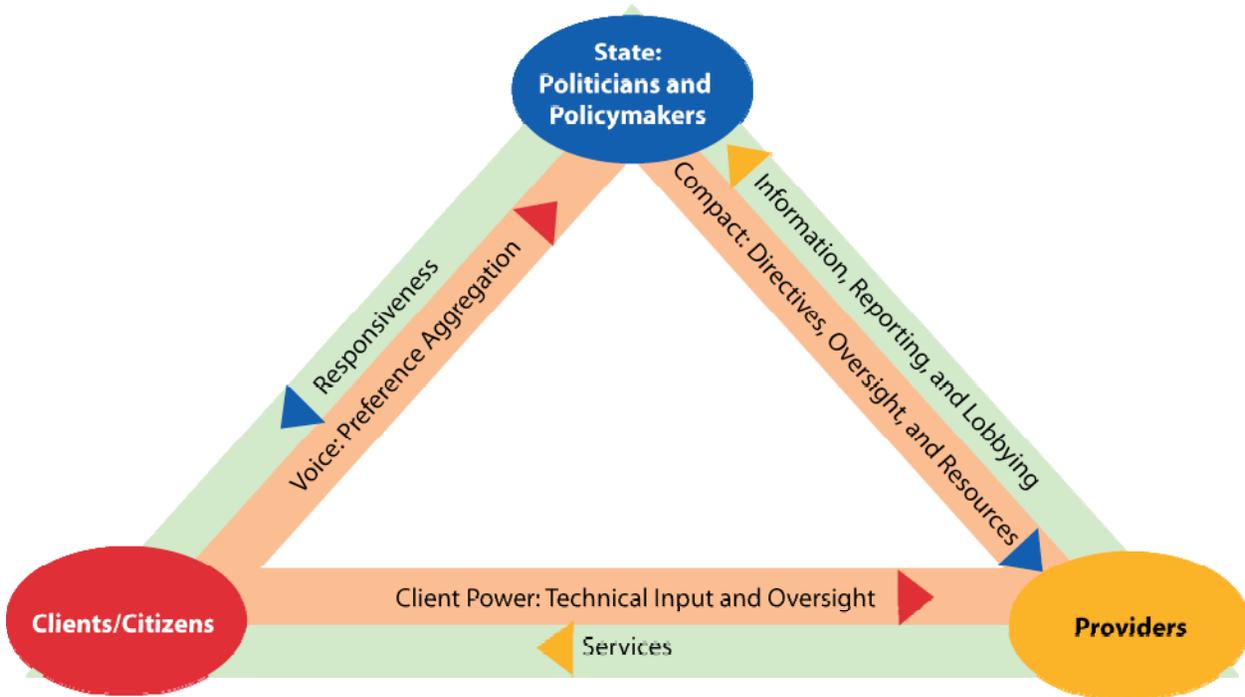
document review, including previous studies of health governance in Rwanda, and key informant interviews with a diverse range of health system actors both at the national and local levels. A complete list of key informant interviews can be found in annex A. The team undertook a systematic analysis to identify key actors, organizations, processes, and structures in each of the five governance focus areas targeted for analysis in this assessment. Next, they undertook an assessment of key challenges and developed recommendations to address the identified weaknesses. In addition, the assessment team reviewed international best practice in the area of health governance, compared it to the gaps identified in the Rwandan context, and incorporated these findings into its recommendations.

## 1.2 FROM GOOD GOVERNANCE TO GOOD HEALTH

The goals of any health system are to (1) improve the health status of the population through equitable access to quality health services, (2) increase the public's satisfaction with the services they receive, and (3) ensure fair financing that protects people against financial risks (World Health Organization 2000). The purpose of a system of good governance is to, *inter-alia*, produce effective societal outcomes, whether in economic, social, or political spheres. Health governance concerns the rules, roles, and responsibilities that shape interactions among the main actors involved in achieving health system goals, i.e., citizens-as-service users (consumers), concerned government institutions and officials, and health service providers (shown in the diagram below) (Brinkerhoff and Bossert 2008). The quality of health governance determines the ability of health systems to fulfill their essential public health functions.

Governance as such is normatively neutral in that countries can have good or bad governance. Although there are multiple political forms of governance (e.g., authoritarian, feudal, democratic), it is generally agreed that democracy is the political system best crafted in terms of rules, institutions, and processes to ensure good governance outcomes (United Nations Development Program 2002). In this regard, good governance has the following characteristics: accountability, transparency, and informational openness; an open, responsive, and evidence-based policy process; inclusion of citizens' views and voice; and operational capacity of government to plan, manage, and regulate policy, financial resources, and service delivery (Brinkerhoff and Bossert 2008). In Figure 1, accountability and transparency apply to all three arms of the triangle.

**FIGURE I: HEALTH GOVERNANCE FRAMEWORK**



Citizens should be able to hold both government actors and service providers accountable, while government through its regulation of providers holds the latter accountable to the state. An open policy process dictates that interest groups, be they representative of citizen views or that of service providers, are able to participate appropriately in the decision-making process. Additionally, the information flow from citizens and providers along the two side arms of the triangle is essential for evidence-based policy making. Since the ultimate goal of the health system is to improve health outcomes in the population, both government and providers should be responding to citizens' views and preferences. Finally, it is essential that government has the necessary capacity to manage resources and the delivery of services.

Based on experiences from around the world, the idea of co-governance has emerged as a best practice. Co-governance is characterized by effective participation of all stakeholders (Ackerman 2004). It implies that a rules structure (policies, laws, and regulations) exists that provides a framework of incentives encouraging participation of concerned actors (i.e., public, private, and nongovernmental sectors) in such public functions as joint planning, management, and oversight. It emphasizes the importance of citizens and their voluntarily formed organizations being involved in the making and implementation of public policy. This is particularly relevant to Rwanda, as all government policy documents, from Vision 2020 to the Economic Development and Poverty Reduction Strategy (EDPRS) 2008-2012 and, more practically, policies related to decentralization and national community health, not only promote but depend on the participation of citizens and their communities in the making and implementation of health policy. The fundamental principles of co-governance include the following:

- An open policy process that allows different interest groups to influence policy outcomes.
- Sufficient state capacity, including decentralized government, to plan and implement programs and interventions.

- Effective participation of nonstate actors in policy making, implementation of programs, and monitoring and evaluation of performance.
- Accountability of key actors in the system to the public at large.

In conclusion, the Rwandan health system is itself a governance system bound by rules – largely democratic in content – that drive incentives, which in turn condition the way institutions and individuals will behave. The analysis used in this assessment takes these principles of co-governance and applies them to the health system. It examines the roles and relationships among different actors, both at the national and district levels, and the degree to which these actors work together to achieve improved health outcomes.

## 2. THE EMERGING SYSTEM OF RWANDAN HEALTH GOVERNANCE

The current Rwandan health system is, in practical terms, little more than five-years old. While various elements of the national health policy have been discussed and debated since the early post-genocide years, it was not until the Rwanda Health Sector Strategic Plan (HSSP I 2005–2009) and the complementary National Community Health Policy were developed in 2004 that the country had a blueprint for its health system. More importantly, not until the passage of the decentralization laws and the beginning of their implementation in 2005–2006, including the creation of district governments and corresponding elections, did a true health governance system become fully articulated and operational. The principles and practices that underlie and define the new system include the following:

- It is demand driven with communities identifying their needs and priorities, and the health system responding to them.
- Health districts and administrative districts are coterminous.
- Local governments are now the focal point of accountability for health service facilities and responsible for their operations.
- Health personnel and financial resources have been decentralized to the district level, with MINISANTE bearing responsibility for technical supervision while district governments control the program implementation process.
- The sector,<sup>1</sup> which is the administrative entity below the district, has become the point of service delivery within the new system, with health centers now present in nearly all 416 sectors.
- An expanded community-based health insurance (CBHI) scheme that builds up from sector-level *mutuelles* is the main organizing and financing mechanism for health care.
- A volunteer-based system of community health workers (CHWs) has likewise been expanded and represents the principal point of contact for the majority of citizen-consumers.
- Performance-based financing (PBF) is at the heart of Rwanda’s system for managing human resources for health. Rwanda’s PBF program covers both personnel in formal health institutions (namely, district hospitals and sector health centers) and CHWs at the community level.

It is this “emerging” health governance system that the assessment team was asked to analyze using the good governance optic discussed in the introduction of this report. The team focused on the following three areas: (1) processes for policy and law formation, (2) decentralization of policy implementation, and (3) citizen participation in health policy decisions and service delivery. Each of the following three sections provides a brief overview of the governance area being analyzed, the status or state of play of the health system in that area, an analysis of key governance challenges, and a set of actionable recommendations.

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<sup>1</sup> Under its decentralization plan, Rwanda has the following six levels of administrative entities: the central government, the province (*Intara*), the district (*Akarere*), the sector (*Umurenge*), the cell (*Akagari*), and the village (*Umudugudu*).

## 2.1 PROCESSES FOR POLICY AND LAW FORMULATION

The legal framework of a country provides the overall context of institutions and rules within which the health governance system operates. Rules in turn drive the development of incentive structures that, to a large degree, determine the behavior of individuals and institutions. Getting the “rules right” and developing a legal framework based on the rule of law – well designed and consistent with the constitution as well as predictable in their application and enforcement – rather than the personal rule of man or woman, which is inconsistently applied and arbitrarily enforced – is the first step in creating a health governance system. Our analysis here examines the key law- and policy-making bodies and processes, the extent to which they exhibit good governance characteristics (e.g., transparency, informational openness, participation), and whether they contribute to an effective and democratic health governance system.

### **The State of Play**

The assessment team had several discussions with knowledgeable individuals and organizations concerning the institutions and processes involved in legislating and policy making. The team did not receive a consistent set of responses, which is evidence of some confusion in the broader political environment about the nature of these processes. Provided in the following paragraphs is a summary of the law-making and policy formulation process as the assessment team understands it.

In Rwanda, laws, polices, and the degree to which they are binding and enforceable are defined in and flow from the Rwandan constitution. The constitution lays out in broad terms the nature of the Rwandan governance system, including fundamental principles and vision, as well as the principal political institutions, their mandates, relationships, roles and responsibilities, and other characteristics.

The National Parliament makes both organic and ordinary laws. Organic laws follow from the constitution and define, in slightly more detailed terms, specific dimensions of the constitutional order (e.g., they govern the creation of new institutions and set out dimensions of national policy such as decentralization), while ordinary laws address specific policy issues and fill out to a greater degree the details needed to make organic laws operational. Neither type of law would necessarily be termed “implementing legislation” in that neither provides all the details and directions required by concerned executive branch agencies or decentralized levels of administration to effectively implement the law.

Depending on the nature of the law, the Chamber of Deputies and the Senate are involved in the legislative review and drafting process. Parliamentary committees are the main law-drafting bodies in the Parliament, with the Chamber of Deputies being the principal initiator of legislation. The Social Affairs Committee in the Chamber of Deputies is directly responsible for either initiating laws or taking up executive branch-initiated legislation related to health and deciding whether or not to move the law through the legislative process. The Good Governance Committee handles most issues related to decentralization.

The National Parliament has recently passed an amendment to the constitution that will effectively limit the number of new organic laws that can be initiated to those specified in the constitution. Each ministry is currently determining what laws it believes merit the designation of organic law. The purpose of the new law is to address the proliferation of organic laws, which is viewed as undesirable since organic laws tend to take more time to prepare than ordinary laws. Organic laws also lack operational details, thereby necessitating additional ordinary laws.

Each of the two branches of Parliament has research units, which provide research and drafting support to individual deputies or senators as well as to the Parliamentary committees. Their capacity remains limited, however, as both research units are little more than a year old, and each has only two to three researchers with varying levels of prior experience. They are only now developing databases to store older laws. They lack basic equipment necessary to do their jobs. A new Parliamentary radio station is in

the initial stages of creation. It has potential for informing the public about the laws before it and the issues they address, but it is so far untested. Both the research units and the radio station were initially supported by the United Nations Development Program (UNDP).

The Executive Branch of the Rwandan government plays several important functions. The President's Office issues presidential decrees, which address constitutional issues and fundamental policy matters. The line ministries develop sectoral policy and the legally binding and enforceable instruments that give these policies the force of law. Policy instruments are brought about through ministerial orders, which are approved by the Cabinet and published in the official government gazette. Ministerial orders must refer to a specific organic or ordinary law. In contrast to ministerial orders, ministerial policies are not legally binding documents, nor are ministerial instructions and directives. While policies are approved by the Cabinet, ministerial instructions and directives are issued by the concerned ministry to provide more detailed guidance to concerned staff at all levels of government for the implementation of policies and laws.

Within MINISANTE, the Policy and Planning Unit is responsible for developing policy and drafting legislation. The number of staff involved in drafting policies and legislations is relatively small. The legal team is frequently overextended and does not have easy access to technical expertise when dealing with specialized topics. In the Ministry of Local Government, Good Governance, Community Development and Social Affairs (MINALOC), the Policies and Competence Development Unit is primarily responsible for policy making related to decentralization. The Community Development Division within the unit focuses specifically on health issues. The National Decentralization Implementation Secretariat is increasingly being relied upon to provide expert advice to MINALOC around policy reform and is viewed as a think-tank on decentralization.

The Rwandan Ministry of Justice (MINIJUSTE) provides all line ministries with technical support in law drafting, but only to determine whether draft legislation conforms to the constitution and is written in proper legal language. In fact, all laws must be vetted by MINIJUSTE before they can be introduced before National Parliament. The Rwandan Judiciary has the mandate to interpret laws and policies, both to ensure that they are aligned with the constitution and to adjudicate between different legal interpretations.

There is no provision in the Rwandan constitution for citizens to initiate policy or legislation through referendums. However, various ministries do hold consultations with citizens' groups to solicit their input during the policy-making process. For example, MINISANTE officials informed the assessment team that that civil society organizations (CSOs) had participated in discussions on a range of policy matters, including the CBHI, CHWs, and PBF. Committees in the National Parliament also hold public hearings on the legislation under review, and both deputies and senators have increasingly sought constituent views during their visits to the field. The only legislation that has the imprint of Rwandan citizens is the Gender-Based Violence (GBV) law, although much of the success of this initiative is the result of women parliamentarians making it one of the highest priorities. Recent growth in the number of community radio stations could broaden the policy-making process by increasing the flow of information to and feedback from the public.

### **Governance Analysis and Principal Challenges**

The National Parliament has rarely initiated law making, although this may be changing. As previously noted, the law on GBV is one of the few pieces of legislation to be initiated and passed by Parliament to date. It is the executive agencies, including line ministries and MINALOC, that have and continue to initiate legislation. The draft legislation is then sent to the National Parliament for review, amendment or rejection, final drafting, and passage. The National Parliament has been increasing its legislative capacity over the past several years (e.g., by creating a new research unit and by strengthening Parliamentary

committees), with significant support from development partners, and seems prepared to take a more proactive role in future legislating.

Because many laws passed by the National Parliament lack detailed procedures and instructions necessary for implementation, concerned line ministries must use a great deal of discretion to design the rules required to implement Parliamentary legislation. For example, MINISANTE has played a major role, in conjunction with MINALOC, in defining the key components of the decentralized health governance system, including the PBF program, CBHI, and the roles and responsibilities of CHWs. Much of this policy making has been brought about through Ministerial Order with limited or no input from those most concerned, including the great majority of citizen-consumers. Although it is true that the executing agencies of any major reform initiative should have some flexibility when it comes to the implementation of the concerned policy or law, stakeholder involvement is crucial for the success of these reforms. In the trade-off between efficiency and stakeholder consultation, MINISANTE, like many other government agencies in Rwanda, tends to favor the former. Given the legacy of the genocide, GoR feels an urgency to make up for lost time. With a great deal to achieve in so many areas, the common refrain is that “Rwanda is in a hurry.” Rule by technocrats is favored because it is quicker and easier to manage. A broad-based and participatory policy-making process, which by definition takes time, often gets short-circuited.

Discussions with stakeholders both in and out of MINISANTE revealed that a relatively small group of MINISANTE staff is involved in developing policies and drafting legislation. Few would question their dedication or their understanding and knowledge of many of the issues and challenges facing the health care system. However, best practice in health governance suggests that MINISANTE’s (and MINALOC’s) policy-making process would benefit from greater participation, including from those local-level actors (e.g., health center *titulaires*, sector-level *mutuelle* leaders, community health center management committee members, etc.) that are most directly impacted by these policies.

At the same time, a review of MINISANTE and, to a lesser extent, MINALOC, policies and orders indicates meaningful progress has been made in addressing several health governance issues related to roles, relationships, and responsibilities of the concerned institutional actors and processes at the district-level and below. For example, recognizing that district auditors have to provide oversight to far too many institutions, the Ombudsman’s Office has increasingly become involved in conducting demand-based financial reviews and audits of health facilities. The office has focused primarily on district hospitals, but has also undertaken some reviews of sector-level health centers. This was the result of a deliberate policy decision, which was inspired by the challenges posed by decentralization more broadly across multiple sectors. It resulted in an amendment to the Ombudsman’s law, which now gives the Ombudsman the right to prosecute as well as investigate corruption.

The ministries’ joint work to address the challenges that have arisen from the decentralization of health care delivery is another example of change in the right direction. Although some confusion remains among district- and national-level actors about who has responsibility for the coordination and supervision of district- and sector-level health facilities and personnel, concerned government personnel at all levels are continuing to address the issue. Through refined policy guidance, the ministries are attempting to create greater clarity about the fundamental authorities and competencies of MINISANTE vis-à-vis district-level governments. Similarly, new policies are being developed around the PBF assessment process to promote greater transparency and to ensure that incentives are being allocated based on merit, not favoritism.

## **Recommendations**

- Development partners should assist to strengthen National Parliament’s ability to initiate and review health legislation, specifically, through the following actions:

- Provide committees that both review and draft legislation related to health (such as Social Affairs and Good Governance) easy access to technical assistance from both short-term and long-term advisors.
- Host training workshops for both individual parliamentarians and concerned committees around the notion of health governance, as well as the substantive component areas of the health system (e.g., CBHI, the PBF, and the roles and responsibilities of the different actors involved in health governance).
- Build the capacity of Parliamentary support structures such as the new research units and the legislative drafting units in the two houses of Parliament. The ability of the newly hired staff in the research unit remains limited in terms of research methodologies, their technical knowledge and understanding of health and decentralization issues, and their ability to provide research findings in a concise and easily understandable document.
- Support increased constituency outreach by senators and deputies to ensure the representation of a diversity of views in the law-making process. Such assistance would allow for more constituency visits, debates, and dialogue forums. Additionally, technical assistance and training to both the National Parliament's new radio station and the growing number of community radio stations would increase their capacity to make information about policy issues available to the public.
- MINISANTE, and MINALOC, should work to make the law and policy formulation process within their ministries more transparent and open. To achieve that, MINISANTE could undertake the following steps:
  - Develop a consultative process that includes concrete mechanisms and protocols for soliciting input from concerned health system stakeholders and partners. Protocols can be formalized by, for instance, holding semiannual national or provincial meetings to discuss the implementation of existing policies and problems encountered as well as new policies being considered, or a set of conditions can be established that trigger both formal and informal mechanisms when a new policy is being developed or when ministerial orders, instructions, and directives are being prepared.
  - With help from development partners, build web-based platforms for disseminating drafts of laws and policies.
  - Use mass media, particularly community radio, to inform and solicit the views of citizens and concerned interest groups (e.g., CHWs, health personnel at the health center level).
- Development partners should provide technical support to the law- and policy-drafting unit within MINISANTE. The following immediate next steps could be taken:
  - Create rapid access mechanisms, such as a web-based consortium of health system experts, that would allow MINISANTE to secure local and international technical expertise.
  - Develop a database on good practice in health governance as well as more specific health system issues.
  - Finance short-term training for MINISANTE staff either in Rwanda or abroad on specialized areas of health systems strengthening.
- MINALOC and MINISANTE should work more closely during the policy formulation process. Both ministries are critical to a successful health governance system; therefore, policy making needs to be better coordinated between them. Although the two ministries conduct periodic meetings to discuss the status of decentralization as it affects the health care system, it does not appear that these meetings are being held regularly. Sustained collaboration would allow the ministries to address systematically the full range of challenges that arise from the decentralized delivery of health

care. This could be achieved by the two ministries working together to periodically conduct a joint assessment of the decentralized health care system, looking at specific policies related to health governance (e.g., roles, relationships, and responsibilities among and between the different levels; implementation performance of the PBF and Common Development Fund). The results of the assessment could become the basis for regular meetings between the two ministries to address and institute policy changes or, where necessary, new laws or amendments to existing ones.

- MINISANTE, with help from development partners, should work to rationalize health laws and policies. As it stands today, there are an unknown number of policies and laws, not to mention ministerial orders, instructions, and directives, dating from the earliest days of independence – if not before – that have not been reviewed, harmonized, and cataloged. Addressing this problem is of critical and immediate importance. The following are some concrete next steps:
  - Partners should provide technical support for the review of relevant laws and policies, harmonizing them and making them consistent, and then developing a database to track and update them on a regular basis.
  - MINISANTE should establish a permanent and formalized mechanism for the periodic review of policies and laws related to the health system to ensure that no inconsistencies exist.

## 2.2 STRENGTHENING DECENTRALIZATION OF THE HEALTH SYSTEM

Decentralization is considered a major governance reform with political, fiscal, and administrative dimensions. Among these, the political dimension indicates the true importance that a country places in multi-level governance, particularly the degree to which local governments are accorded meaningful autonomy. The purpose of decentralization is several fold. Most importantly, it brings decision making, resources, and authorities closer to where the majority of citizens live. In doing so, it opens a space for their participation in the planning, management, and oversight of a wide range of public functions, including the delivery of goods and services. Effective decentralization reforms have been shown to simultaneously increase accountability of those performing public duties, improve the quality of goods and services they deliver, and decrease costs associated with their provision. Decentralization has been attempted in many developing countries, with varying degrees of success. Box 1 showcases the significant health gains that the Philippines achieved through decentralization in the health sector. The best practice of co-governance suggests that citizens, through the organizations they create to represent their interests and enhance their collective action, can work alongside local governments as effective partners in promoting public accountability while enhancing service delivery quality and efficiency.

### The State of Play

Rwanda has recently come to the end of Phase II of its decentralization reforms (Brinkerhoff et al. 2009). It is about to mark 10 years of practical implementation with further reflection on its successes and remaining challenges. The first phase (2000-2005) established the primary democratic and community structures and reinforced the core local government body, namely the district government. The district government oversees the functioning of administrative units within it, namely sectors, cells, and villages. The country's first local government elections – from cell to the district – in 2006 saw the culmination of planning undertaken in Phase I and ushered in the beginning of the second phase of decentralization (2006–2010). Phase II deepened these initial reforms, focusing specifically on enhancing system effectiveness by making the sector or *Umurenge* the focal point of service delivery, including ensuring adequate human, material, and financial capacity, and improving collection of data and information at this level. Phase III, which is now starting, will consolidate these gains and begin a process for rationalizing (and reducing) the levels of decentralized administration and promoting public–private partnerships to enhance the effectiveness, efficiency, and quality of service delivery. Specifically, Phase III

will examine what additional tasks can be decentralized to lower levels of administration, with a focus on the cell as a service delivery point.

### **Box 1: Decentralization in the Philippines**

In the Philippines, the Local Government Code of 1991 has led to devolution of health service delivery from the Department of Health (DOH) to elected Local Government Units (LGUs). This framework has allowed for a wide range of “decision space” for LGUs within the Philippines, resulting from strong fiscal and administrative capacity of the LGUs, significant funding from the central level, and the lack of influence of vertical programming.

As a result of decentralization, the Internal Revenue Allotment, which is a central transfer mechanism, started sending 40 percent of total revenues to LGUs, up from 20 percent previously. This money came with some earmarks, including the requirement that at least 20 percent of the money be spent on “development” projects, 5 percent must be set aside for disaster relief, and no more than 45-55 percent of income could be spent on personnel costs.

Findings showed that LGUs with better health indicators allocated less money to health, while LGUs with poorer indicators prioritized health investments. On the other hand, LGUs uniformly prioritized education spending, increasing spending by 400 percent, in real terms, from 1991/2 to 1993/4. Local government also deviated from national priorities in other areas, including agricultural spending.

These allocation decisions involved significant citizen participation through elections, sector specific councils, and numerous health boards at the province, municipality, and city levels. These boards included representatives from local government, civil servants, (nongovernmental organizations) NGOs, the private sector, and local legislators. By 1998, 17,000 NGOs had been approved to take part in local government activities (Bossert and Beauvais 2002).

LGUs in the Philippines allow local communities to allocate resources to under-prioritized sectors. LGUs with poor health outcomes prioritized their spending on health, and LGUs with good health outcomes reallocated their spending on health to other areas. This reallocation of resources shows that LGUs were attuned to how different sectors were performing and were able to identify the marginal utility of health investments and reallocate investments to get the maximum value from them. In the Philippines elected officials at the LGUs are able to make these types of allocation decisions in order to be responsive to the citizens who elected them. These officials are, therefore, accountable to the citizens who elect them for making good decisions. In Rwanda, accountability flows upward to the President’s office through *imihigo* performance contracts. The decentralized health structures, including the local government authorities (such as the district mayor who oversees them) are, therefore, directly accountable to the President’s office, not to the people who elect them.

Some of the key features of Rwandan decentralization are detailed in the GoR’s policy documents (MINALOC 2000; 2006; 2007). Within Rwanda’s system of decentralized governance, elements of devolution, delegation, and deconcentration<sup>2</sup> are combined as a means of establishing and empowering decentralized administration. The system builds and strengthens traditional community-based institutions and integrates them with more modern governance structures and processes. It empowers citizens to participate in making, implementing, and monitoring both programs and plans that most affect them, their families, and communities. Improving accountability and transparency is an important goal, which is to be achieved by making local leaders directly accountable to the communities they serve as well as to

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<sup>2</sup> Devolution or, as some have called it, democratic decentralization, means the creation of fully autonomous levels of local government, imbued with their own authorities, competences, and resources and responsible for the management of a significant number of public functions including service delivery. Deconcentration, on the other hand, is simply the transfer of resources (e.g., staff and finances), from the national level to lower levels of administration but with no autonomy ceded from the former to the latter. It is, in short, decentralization without the “political” dimension that includes autonomous local governments.

the President through *Imihigo* performance contracts. The system also aims to increase responsiveness of public administration by transferring planning, financing, and control of services to the point closest to where they are delivered.

The district is the sole level of local government that has legal standing with full administrative, political, and financial autonomy; all other levels are sub-territorial units of and accountable to the district. District officials are indirectly elected. The sectors elect the district council, and the councilors in turn elect the mayor and vice mayors. District financing, including funding for district development plans, comes largely from the Ministry of Economic Planning and Finance (MINECOFIN) and covers both block grants to support recurrent costs of a general administrative nature and earmarked grants to cover delegated tasks from line ministries primarily to finance specific types of service delivery. The Common Development Fund (CDF) is the main mechanism for funding the districts. The CDF, which is lodged within MINALOC, also covers development projects. Many donors provide budget support to decentralization through this mechanism.

### **Governance Analysis and Principal Challenges**

By any standard, Rwandan decentralization reform has been a major success. And, nowhere has this been better demonstrated than in the health sector, the first and most advanced of the sectors to deconcentrate and devolve health system functions, authorities, and resources to the district level and below. A number of traditional and new health-oriented, community-based organizations (CBOs), such as *mutuelles*, health center community committees (COSA), and CHW cooperatives, are now participating in a number of planning, management, and oversight functions at the sector- and district-levels. In the case of the *mutuelles*, they are also key elements of the district and sector health financing system, while CHWs are directly involved in service delivery at the community level. Both the *mutuelles* and the CHWs are the core elements of the community-based primary health care system.

Significant power and resources have been transferred to health facilities at the district (hospital and pharmacy) and sector (health center) levels. District administrations are now directly accountable for the overall management of these facilities while the MINISANTE provides technical oversight. Each of the facilities has internal management committees (*comite de gestion* or COGES in health centers and administrative and finance committees in district hospitals) that together, with the community structures noted above, manage their day-to-day operations.

A system of performance-based accountability is woven throughout local governments. It is administered more broadly through the *Imihigo* system and more specifically through the PBF program for the health sector. Although the district mayor is accountable to the President through *Imihigo* performance contracts, this traditional accountability institution is utilized at each level of decentralized administration as well as at the household level. PBF has put in place its own structures (*comités de pilotage* or steering committees) at both the district and sector levels.

As the country prepares to move into Phase III of decentralization reform implementation, several challenges remain. The accountability framework within the health system – and in general within the district administration – is largely unidirectional and oriented upwards: district mayors to the President, *mutuelles* to district mayors, hospital and health center management to the district mayors and MINISANTE, CHWs and health center workers to the sector, etc. Downwards accountability to citizens and their communities is weak. In contrast, best practice from decentralization experiments around the world, including the Philippines case which is described in Box I, suggests that upward accountability to national government actors should be balanced by downward accountability to the population.

Additionally, roles and responsibilities between different actors within the district health system (e.g., the district administration and health facility managers) and between the district administration and MINISANTE lack clarity. This is partially due to the frequent reorganization of the health system and the district administrative system as decentralization reforms, which are not always in harmony with each

other, continue to unfold at a fast pace. As noted in the previous section concerning policy-making processes, MINALOC and MINISANTE have not always harmonized their policies with each other before implementing them.

Along these lines, the 2008 District Capacity Building Assessment noted that, in general, staff within the district health system lacked knowledge and understanding of the legal framework, especially at the lower levels (MINALOC and MIFOTRA 2008). The assessment also describes other key challenges. It found, for example, that district-level auditors were overburdened and unable to audit all the institutions that fell within their remit, namely the district hospital, health centers, and health post facilities. Frequent meetings, demands for reports, and a myriad of requests for collecting data and indicators collectively place a heavy burden on the district administration. The capacity of key actors at the district and sector levels to adequately manage and provide oversight to health facilities under their jurisdiction remains weak. This includes the district health team vis-à-vis the district hospital and pharmacy; the COSAs and *mutuelles* vis-à-vis the health center COGE; and, in the case of health center *mutuelles*, vis-à-vis the district *mutuelles*.

The ability of the district-level health system to generate sufficient funds to cover its operating costs is, at best, a fragile affair and, at worst, unsustainable. One of the key reasons for this situation is the inability, in many cases, of sector-level *mutuelles* to cover the costs of their members' health facility visits. This is in part due to low premiums, but reports of significant instances of mismanagement of *mutuelles* funds is also a factor. In examining the governance arrangements of the *mutuelles* system, it appears that the accountability framework is not conducive to either good governance or management. *Mutuelle* managers are hired by and report to the district mayor's office; there is no formal mechanism for *mutuelle* members to receive financial reports from managers or hold them accountable directly. It should be noted that in the team's discussions with concerned district personnel, including both the mayor and district health officers during the field visits to Rwamagana, the team was told that *mutuelle* contributions provided roughly six to seven months' funding of health center costs. This could be due to the fact that Rwamagana was a smaller district than Huye, which the team also visited, but even in Huye it was unclear the degree to which *mutuelle* funding covered health center costs.

As a corollary to this point, more than 50 percent of the Rwandan health care system is funded by development partners (Health Systems 20/20 2008). While this shows a tremendous confidence in and commitment to Rwandan governance, it is also a double-edged sword as the system's sustainability and its capacity to expand are largely dependent on external resources. The last five decades of development assistance have shown that partner resources and attention spans are not always predictable.

In summary, the Rwandan health system has developed and performed admirably over the first two phases of decentralization reform. Nearly 85 percent of Rwanda's people are now enrolled in the CBHI program; the demand-side strategy of MINISANTE has seen health facility utilization rates skyrocket to approximately 80 percent; health indicators have returned to pregenocide levels in most areas; and HIV/AIDS and malaria rates seem to have stabilized and begun a downward trajectory (Gellar et al. 2008). Several areas, however, need to be reviewed and addressed as the country moves to Phase III of decentralization. Chief among them is the need to strengthen the CBOs' component of health governance as a means of increasing downward accountability to the citizen-consumers of health services. This in turn is likely to increase both the quality of health services and the efficiency of the health system. Strengthening the various CBOs noted above while simultaneously increasing their responsibilities would allow them to share the responsibility of monitoring the performance of health centers, *mutuelles*, and CHWs with district administrators, thereby reducing the latter's excessive workload. The case of district auditors previously discussed is a prime case where empowered COSA, COGES, and *mutuelles* could share the workload of providing oversight to health facilities and CHWs.

The best practice of co-governance is based on a sharing of planning, management, and oversight activities between district governments and the relevant CSOs. Not only would greater participation by these community organizations in health governance reduce the overloaded district health teams and improve service delivery, it would increase the accountability of the entire system as these organizations would encourage the downward accountability that a range of respondents commented on in field-based interviews.

## Recommendations

- MINISANTE and MINALOC should consider undertaking a review of roles and relationships among and between the key district health system actors in order to rationalize and harmonize their rights and responsibilities. This 10th anniversary year of decentralization is propitious for launching such a review and doing so through a series of consultations at either the district or provincial levels that brings together concerned district actors to present their views to their national counterparts. It might also be useful to create more formal consultative mechanisms between MINALOC and MINISANTE to periodically review health governance arrangements at the decentralized levels.
- The Joint Action Development Forums (JADF) should provide a broad platform for a wide range of stakeholders and citizens to comment on district development performance, including a means to feed into the district development planning process. The JADF are not health system-specific, however, and hence do not have adequate time to address and follow up on important health governance issues on a regular basis. Creating a health technical subcommittee within the JADF would allow concerned stakeholders to discuss health issues more systematically.
- The *Partenariat pour l'Amélioration de Qualité* (PAQ) instituted by the *Twubakane* Project should be replicated throughout the country, as noted by the PAQ Evaluation Study (IntraHealth International 2009). It is perhaps the most effective model to date for promoting community involvement in health sector activities that fosters collaboration between local government representatives and civil society groups to set up commissions to deal with health issues decided by the group. As the Health Sector Anti-Corruption report noted, "This kind of collaboration increases transparency, builds trust, and provides the community with opportunities to monitor health service delivery and influence community healthy priorities." (Gellar et al. 2008)
- All stakeholders should continue to promote the use of traditional institutions such as the *Ubedeho* (traditional approach to problem solving using community mapping) and *Umuganda* (monthly calls to collective service) to increase the capacity of community organizations to analyze and resolve their own problems as well as to increase horizontal and downward accountability.
- Development partners should assist GoR in developing a capacity-building program aimed at strengthening CBOs to, on the one hand, enable them to play a fuller role in holding service providers accountable for their performance, and, on the other, participate more effectively in planning and management of service delivery to increase its quality and efficiency.
- In the case of the *mutuelles*, the team strongly recommends that an independent evaluation of their current governance arrangements be undertaken. Specific attention needs to be given to the fact that the *mutuelle* program has built an accountability framework in which the *mutuelles* are established with a certain degree of autonomy (e.g., boards of directors with many responsibilities) but in which district governments and the MINISANTE control the recruitment of *mutuelles* management staff at the sector and district levels. This dual accountability framework is not conducive to achieve good governance objectives.
- Partners should assist MINISANTE and MINALOC in creating knowledge-sharing mechanisms for use by districts to disseminate best practice and policies on health governance and functioning.

## 2.3 CITIZEN PARTICIPATION IN HEALTH POLICY DECISIONS AND SERVICE DELIVERY

Best practice from around the world acknowledges that citizen participation – either directly through such acts as voting or indirectly through the voluntary organizations they create to represent their interests – enhances the likelihood of achieving good governance outcomes, including greater accountability, transparency, and responsiveness. Equally important, citizen participation has been shown to increase effectiveness and efficiency as well as to improve quality in a range of public functions, including service delivery and policy making. Specifically, participation by CSOs,<sup>3</sup> including CBOs and NGOs, in such areas as planning, management, and oversight has not only increased the quality of services but lowered the costs of delivery.

Healthy citizens (their families and communities) are active participants in their own health care. Correspondingly, active citizens and CBOs are informed citizens and CBOs. Thus, in order for citizens to be able to fully participate in health governance matters, including the making and implementation of health policy, they need access to relevant information. In addition, active citizens need to have strong organizations through which they can participate in health planning, management, and oversight, as well as a legal context that provides them with the space to do so. Emerging best practice posits that a system of co-governance in which citizens and their organizations participate in and share these tasks, risks, and benefits with their governments is the type of governance system most likely to produce good health outcomes.

### The State of Play

All the policy documents discussing and describing Rwanda’s development plans place the citizen at the center of national development institutions and processes. In the case of the health system, both decentralization-related policies and health policies have established a favorable legal context for greater citizen and CBO participation in health governance functions, including planning, management, and oversight. The policy framework has also provided for the structures and processes necessary for their effective participation in the delivery of health services. As noted in previous sections, many of these structures and processes promoting citizen participation quickly reprise some of the more important ones.

The decentralized administrative system of elected councils (from household and cell to sector and district) provides a general mechanism for citizens to participate in planning matters as well as an information grid to disseminate information upwards and downwards. The lack of direct voting for elected leaders at the sector and district levels, however, does decrease the power of elections to serve as an accountability mechanism, particularly vis-à-vis mayors and vice mayors.

The *Imihigo* performance contracts are both a planning and an accountability tool in that they require each of the levels of administration, as well as households, to formulate a set of actions that will be used to achieve specific performance indicators tied to concrete development results. Since most of the health-related results and indicators are linked to the district mayor’s own performance contract, which is in turn tied to and consistent with national-level health policy, an integrated system of health planning and accountability is in place. In addition to the *Imihigo* system, another planning and accountability mechanism is operating at the district level, namely that of the district development planning process. In

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<sup>3</sup> The term “civil society” refers to all forms of voluntarily formed and autonomous organizations that pursue public purposes and stand between citizens (and society more broadly) on the one hand and the state and market on the other. In this conception of civil society, CSOs is an inclusive term that includes both NGOs and CBOs – two of the many subsets of civil society. Development NGOs work in a range of programmatic sectors (economic, social, and governance), normally have a small group of founder members, and largely depend on donor funding. They often support CBOs, which are grassroots, membership-based organizations that address the immediate needs of their citizen members.

the former, accountability for the achievement of results is upwards from the mayors to the President, while the latter constitutes downward accountability to the people.

A number of consultative mechanisms are operating at the district level and below; general mechanisms, such as the JADFs, and health-specific mechanisms, such as the PAQs, provide a wide range of stakeholders an opportunity to participate in district and sector planning. Moreover, PAQs provide a structure that brings together local leaders, health center medical providers, health center managers, and community representatives to improve services provided by health centers. The strengthening of PAQs was a major component of the recently concluded *Twubakane* Project. Evaluations show that PAQs were highly effective. Based on the team's field visits, PAQs still seem to be functioning and are valued by concerned health center stakeholders. CHWs and the *Umuganda* provide other means for individuals, families, and communities to participate in health planning and to receive health-related information. The recent MINISANTE policy of strongly encouraging CHWs to form cooperatives as a precondition to receiving community PBF contributions may have a significant and possibly negative impact on the CHWs' close links to their communities; the community PBF may reorient CHWs' accountability away from their communities to the *comite de pilotage*, which determines whether the CHW will receive a merit payment or not. CBOs in the form of community health associations, *mutuelles*, and CHW cooperatives provide citizens with co-governance structures to participate in health planning, management, and oversight.

### **Governance Analysis and Principal Challenges**

The Rwandan system of democratic governance has stipulated a very real role for citizens in many areas of the health governance system, including health policy making and service delivery, particularly at the district level and below. In turn, citizens and their organizations have taken advantage of this space to participate effectively in the full range of functions that define an effective system of health co-governance. Our assessment, however, notes several areas where citizen and CBO participation can be strengthened to increase their ability to better help “co-produce” good health system outcomes.

Citizens and CBOs still have an incomplete understanding of the health governance system and their role in it, including the many structures and processes of decentralized health reform that have been introduced over the past decade, particularly the past three to five years, and which continue to be reengineered periodically. Citizen and CBO participation in health governance is not as high as it could be. This is due to a combination of factors, including insufficient information flowing from all levels of the system, the weakness of existing community-based structures, and a general dearth of CBOs at the local level and NGOs/CSOs at the district level and above. NGOs/CSOs play an important intermediating role in linking citizens to policy-making processes at higher levels of governance and representing their interests through the evidence-based policy advocacy process (from policy research through monitoring).

The health system generates significant information and data from the *Umudugudu* to district levels. Much of this information and its subsequent analysis, however, are sent upwards to and from the district to MINISANTE; little of it flows downward to other parts of the system and citizens more specifically. As a result, citizens and CBOs are not able to take full advantage of these data and analysis concerning health governance issues in their planning, management, and oversight functions, and, therefore, an important opportunity for learning is lost throughout the system. Citizens can, and have in other parts of the world, play a more substantive role in planning and budgeting. Box 2 presents the case of participatory budgeting in Brazil as an example.

Health *mutuelles* are a key element of the CBHI system. They have largely been used to mobilize citizen contributions to the health insurance system and provide co-management and oversight functions at health centers and, to a lesser extent, at the district levels. In the former instance, they have primarily provided manpower to supplement health center personnel for the specific purpose of administering the

health insurance scheme during health center operations. In terms of the latter function, *mutuelles'* personnel do not appear to have the capacity to provide the type of oversight of health personnel at either the health centers or district hospitals, yet this is necessary to ensure their probity in patient billings among other areas. Although the *mutuelles* are supposed to have a significant degree of autonomy from MINISANTE and district administration, in reality they are relatively weak structures: at the district levels, the personnel are appointed by the mayor and are considered district personnel, and their roles and responsibilities in the broader health governance system are blurred with those of the district and MINISANTE.

Based on lessons learned concerning the overly directive, top-down formation of cooperatives in Africa, there is some level of concern that the CHW cooperatives may lose their focus on their primary work of providing primary health care to Rwanda's communities. Cooperatives, like most CSOs, are based on voluntary association. MINISANTE's strong push on CHWs to form cooperatives may eventually have a negative impact on their operations and sustainability. There will surely be a trade-off between pure voluntarism upon which the CHW program was developed and the PBF cooperative linkage, which has just been introduced.

### **Recommendations**

- Support national- and district-level CSOs to develop and implement a communication and dissemination strategy in collaboration with concerned stakeholders to increase awareness about citizens'/CBOs' roles, rights, and responsibilities in a system of health co-governance. Consider utilizing community radio and other forms of broad-based dissemination. Perhaps one of the two Millennium Challenge Corporation (MCC) civil society support projects could provide assistance.

### **Box 2: Participatory Budgeting in Brazil**

In Porto Alegre, Brazil, participatory budgeting processes allow for citizens to decide how 10 percent of the city budget will be spent. Through a system of neighborhood meetings, regional assemblies, and thematic meetings, 14,000 citizens come together to set priorities in basic social services and infrastructure improvements. This participatory process has had a number of impacts. First, corrupt practices have been de-incentivized as each neighborhood is informed of the exact amount of funding that will be spent in their area. Second, the system has reduced the influence of politics into the budgeting process by opening the budgeting process to all citizens, not only those who are well connected. Third, the influence of money in the budget process is reduced through the transparent nature of decision making. Additionally, priority for investments is given to poorer neighborhoods through the algorithm used to allocate funding by neighborhood, demonstrating a pro-poor bias.

There are many lessons to be learned from Porto Alegre's experience. First, poor people can and do participate in budgeting, as 45 percent of the budget participants earned less than three times the minimum wage. Second, the city made strong efforts to include citizens by using community organizers to inform citizens about budgeting issues and encourage them to participate in the meetings. These efforts were necessary in order to have an educated and informed citizenry that was able to participate in government. Third, participatory budgeting came out of civil society pressure for more openness and transparency. In fact, the process was modeled on existing practices within civil society in Porto Alegre. When government incorporated these ideas from civil society, it was able to create a process that improved citizen participation and transparency (Ackerman 2004).

- Strengthen grassroots CBOs to become informed, active, and effective partners (e.g., increase their participation in joint planning, management, and oversight) in a system of health co-governance. Specific training programs could be developed for those members of these CBOs that interact with local government staff, including at the district hospitals and pharmacies and at the health centers.
- Place a specific focus on health *mutuelles* so that they can play an effective role in the co-governance of the health system. Again, there is a role for national-level CSOs with experience in CBO capacity-building to undertake this function for the *mutuelles*. One consideration might be to encourage the MCC projects that are working with and strengthening national-level CSOs to support grassroots CBOs by taking a lead role in working with them in general and the *mutuelles* in particular.
- Begin targeting those NGOs and CSOs working at the district level and above that can extend the voice of citizens in the policy-making process in higher level governance arenas. Consideration should be given to developing a training curriculum for grassroots CBOs and the NGOs/CSOs that help them to become more effective partners alongside government in making health policy and in delivering health services.
- Assist MINISANTE and district administration, in collaboration with concerned local government and citizen stakeholders, in discussing ways in which citizens and CBOs can use reports and analysis emanating from the decentralized health system as both learning and planning tools. CHWs should be principal actors in disseminating this information to citizens and in helping them to use it in improving their health as well as in performing their roles as partners in the health governance system. MINISANTE is expanding a rapid cell-phone text data system utilizing CHWs that may form the basis of such a dissemination system.
- Enlist the Rwanda Association of Local Governments (RALGA) to develop and manage a range of consultative mechanisms that bring together citizens, citizens' organizations, and other district-level stakeholders, including local governments, MINISANTE, and MINALOC, to ensure that citizens' interests are being incorporated into the district and national planning and policy-making processes. Mechanisms could include national- and local-level workshops on specific topics related to the health sector, town meetings, Question and Answer Sessions, etc.

# 3. APPLICATION OF A GOVERNANCE OPTIC TO ONGOING INSTITUTIONAL REFORMS

Rwanda has a relatively young health system, the foundations of which were laid in the post-genocide years. Hence, it is no surprise that GoR continues to develop and refine the institutional make-up of its health system, be it through the creation of new entities or the reorganization of existing entities. As part of this assessment, the team was asked to review two areas where major institutional reforms are currently underway: (1) the creation of the RBC, and (2) reforms within the pharmaceutical supply and management system. Each of these reforms is complex and involves a host of technical and managerial questions. Indeed, a report of at least this length could be written about each area. For the purposes of this assessment, the team reviewed the two areas through a governance optic so as to identify key governance challenges. The two reforms are closely related since CAMERWA, the central medical store responsible for 60 percent of the medicines procured in Rwanda, is being merged into the RBC. The governance issues that emanate from the creation of the RBC are analyzed in the following paragraphs. We then discuss, against that backdrop, the governance challenges facing the pharmaceutical supply and management system of Rwanda.

## 3.1 THE RWANDA BIOMEDICAL CENTER

The governance structure of an organization is the set of rules (laws, regulations, and policies) and procedures that define its mandate, stipulate its structure, condition the way it operates both internally and externally, and create accountability mechanisms through which its performance is monitored. Getting the governance system right is crucial for good performance. GoR is in the process of undertaking a large-scale reorganization of several health institutions into an entity called the Rwanda Biomedical Center. In this section, we first describe the structure of the RBC as it is posited in the law, analyze the key challenges that MINISANTE and the leadership of the RBC will need to address as they work towards developing a governance structure for the RBC, and propose some next steps.

### State of Play

Through the enactment of an organic law,<sup>4</sup> GoR is combining several health sector-related institutions that are currently categorized as autonomous (either for-profit or not-for-profit) into one autonomous institution called RBC. This merger in the health sector mirrors similar mergers in other areas such as economic development, agriculture, and education, which led to the creation of, *inter-alia*, the Rwanda Development Board, Rwanda Agriculture Board, and Rwanda Education Board, respectively. The 14 merging entities in the health sector (see Table 1) currently serve a wide range of functions. Under the RBC, these 14 entities will be reorganized into new units or departments. The law stipulates that the RBC will be managed by a general directorate that is headed by a chief executive officer (CEO). The CEO will be answerable to the RBC's Board of Directors. MINISANTE will supervise the functioning of the RBC. MINISANTE and the Board of Directors will put in place a contract that will detail the responsibilities of the Board and the general directorate of the RBC, the expected results of the RBC, its financial sources and functioning procedures, and an audit framework. Additionally, the law states that the internal rules for the RBC, which the Board must approve, will be set by a Ministerial Order from

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<sup>4</sup> RBC Organic Law (draft received from MINISANTE).

MINISANTE. The Board will submit quarterly activity reports and financial reports to MINISANTE. The RBC has a period of one year from the date when the organic law is published in the Official Gazette to complete the merger process and draft internal rules and regulations.

When this assessment was undertaken, Parliament was still amending the RBC law. The team did not have access to any documentation regarding the RBC beyond the draft law, which articulates a general vision for the RBC and preliminary charts of the RBC's organizational structure developed by MINISANTE. Detailed rules and regulations for the RBC and guidance on specific roles and responsibilities for different actors and entities within the RBC had not been drafted yet, and MINISANTE was awaiting the final passage of the law to initiate this work. This report, therefore, relies on details contained in the draft law as well as information gathered through key informant interviews.

**TABLE I. RWANDAN HEALTH SECTOR-RELATED INSTITUTIONS**

Name of Institution	Description
King Faisal Hospital	Parastatal Hospital
Center for Treatment and Research on AIDS, Malaria, Tuberculosis and Other Epidemics (TRAC PLUS)	National Center for Infectious Disease Control and Prevention
Expanded Program of Immunization (EPI)	National vaccination program for childhood diseases
Health Communication Center	National information, education and communication (IEC) and behavior change communication (BCC) center
<i>Commission Nationale de Lutte Contre le SIDA (CNLS)</i>	Coordinator of the national HIV/AIDS response
Pharmaceutical Laboratory of Rwanda (LABOPHAR)	Pharmaceutical company for producing local essential drugs
<i>Centrale d'Achat de Medicaments Essentiels du Rwanda (CAMERWA)</i>	National pharmaceutical procurement agency
Kigali Health Institute	Training institution for nurses and paramedics
Service de Consultation Psycho Social (SCPS)	Nodal agency for mental health services
National Reference Laboratory	Central laboratory for disease testing and diagnosis
<i>Atelier Central de Maintenance (ACM)</i>	Medical equipment and infrastructure maintenance unit
National Centre for Blood Transfusion	Public autonomous entity in charge of blood transfusion
Faculty of Medicine of the National University of Rwanda	Medical training and research institution
National University of Rwanda School of Public Health	National school of public health

### **Governance Analysis and Principal Challenges**

The RBC has the potential for creating synergies and economies of scale in areas such as medical education, disease control and surveillance, and pharmaceutical production and management. For example, the merger of medical education and training institutions will allow scarce resources such as qualified teaching staff and laboratories to be shared. Additionally, it will enable MINISANTE to plan and supervise the training of much-needed medical personnel. While the rationale for coordinating the activities of agencies working in similar areas within the health sector is clear, the gains from merging entities working in disparate areas, such as medical education and pharmaceutical production, into one entity are less obvious. Bringing together such a large group of important health sector institutions with varying mandates demands the creation of a coherent structure and a suitable governance system.

The lack of a participatory approach to organizational development poses a key challenge in this respect. As the law stipulates, MINISANTE and the RBC's leadership will develop the internal rules, regulations, and procedures that will govern the operations of the RBC once the law is passed. The assessment team

found that although a core group of staff within the MINISANTE had an advanced vision for the governance structure of the RBC, most of those interviewed, whether from entities that will soon join the RBC or from institutions that are key stakeholders in the health sector, did not have a clear understanding of how the RBC would function in practice. Establishing clarity among all stakeholders and member entities of the RBC and involving them in the development of the RBC's governance system is important for creating buy-in, ensuring that the specialized needs of the constituent entities are addressed, and enabling staff within these organizations to transition smoothly into a new work environment.

MINISANTE is committed to creating operational autonomy for the various constituent parts of the RBC. In the absence of effective operational autonomy, RBC has the potential for introducing additional bureaucratic procedures and red-tapism that could lead to unnecessary delays and inefficiencies. How will individual departments plan their activities and develop their budgets? Will each department manage its own staffing and recruitment, or will human resource management be centralized within the RBC? How much control will individual units have over day-to-day programmatic decisions? The extent to which decision making is centralized, as well as the types of decisions that are centralized within the RBC, will determine the ability of the merging entities to perform their mandated functions efficiently.

The new structure and rules also have the potential for blurring accountability and performance incentives. Will the financial management systems of the RBC allow each department's performance to be tracked separately? Will each department have its own output targets? How will any profits generated by profit-making entities within the RBC (e.g., King Faisal Hospital) be reinvested? RBC's financial management and performance evaluation systems will impact whether the general directorate can identify and then address the needs of different departments. Additionally, it will determine the Board's ability to monitor performance and provide effective oversight. It may also determine the extent to which international development partners are able to support different departments within the RBC. Many donors prefer to be able to track performance against their financial investments. For example, a donor interested in supporting the behavior change communication (BCC) activities of the health communication unit within RBC may want to first earmark its support for such activities and, second, track what was achieved as a result of its grant. The extent to which the financial management and performance monitoring systems of the RBC allow for individual departments' actions and outputs to be tracked separately will influence the actions of such donors.

The RBC's management will have the responsibility of supervising a wide array of entities, many of which have markedly different functions and mandates. As such, selecting appropriate people who have the range of knowledge and skills needed to manage the RBC poses a challenge. The management team in turn will report to the RBC's Board, which is answerable to MINISANTE. Hence, several layers of oversight exist within the RBC's governance structure. It is important that the meaning of "oversight" in terms of scope and jurisdiction for each entity be clearly delineated to avoid much lost time in unnecessary or duplicative oversight. In other words, it should be clear which issues can be settled by the RBC's management, versus issues that need to be adjudicated by the Board, versus issues that require MINISANTE's approval.

## **Recommendations**

- MINISANTE, the RBC leadership, and development partners should work together to develop a

governance structure for the RBC that enables the individual units to perform their mandates and that has a well-defined concept of operational autonomy at its core. Recommendations for this institutional analysis and design process include the following:

- Review the experiences of other entities such as the Rwanda Development Board, as well as experiences from other countries (see the Singapore case study in Box 3) to learn from their mistakes and successes.
- Undertake a comprehensive institutional mapping exercise that analyzes the mandate and functions of each department to identify areas of overlap or duplication, the relationships between the merging entities and how they might change within the RBC, and the relationships the merging entities have with external agencies that may be impacted by the creation of the RBC.
- Develop and operationalize a transparent and participatory process; develop RBC's organizational structure, internal rules and regulations, and operational guidelines and protocols for overall governance and management arrangements as well as for addressing issues of accountability, profit sharing, etc.
- Assist and facilitate a process so that the RBC develops a strategic guidance document with a corresponding action plan that lays out how RBC will develop as an organization in the next few years

### **Box 3: Singapore's Health Sciences Authority (HSA)**

The Singapore Health Sciences Authority (HSA) is an example of how different health institutions have been consolidated under one umbrella organization and could offer some lessons for the Rwanda Biomedical Center. In fact, Singapore's government structures have influenced other Rwandan boards, including the Rwanda Development Board, which is deliberately based on Singapore's Economic Development Board (Chu 2009; Kiang 2001).

Formed in 2001 from the merger of the Product Regulation Department, the National Pharmaceutical Administration, the Centre for Drug Evaluation, the Institute of Science and Forensic Medicine, and the Singapore Blood Transfusion Service, the HSA covers a wide range of functions in the health sector. First, it regulates health products, including medicines and medical devices, to ensure quality, safety, and efficacy. Second, it operates the national blood bank. Third, it provides forensic expertise to various police departments for criminal cases. Fourth, it supplies other agencies with laboratory and analytical expertise.

These four functions were identified as needed prerequisites for an institution to act as a "one-stop shop" for all regulations and approvals in the health system, including medical devices, pharmaceuticals, and blood products. It was expected that the HSA would be able to better coordinate these evaluations and approvals for therapeutic products with both medicines and medical products under their purview. Additionally, Singapore wanted to bring scientific expertise into the new agency, as it is expected that future innovations in medical products and pharmaceuticals will require expertise in molecular biology, genetics, toxicology and preclinical evaluation. Including the Institute of Science and Forensic Medicine into the HSA, which has a wealth of experience in forensic medicine and scientific testing, achieved this goal.

The result was to create an authority with expertise in a wide range of areas that support the core regulatory functions of the HSA. Each of the separate departments brought its own area of expertise to provide synergies across the HSA, streamlining regulatory approvals and bringing needed scientific expertise into the regulation agency.

The government of Singapore provided clear goals for the HSA and identified the institutions necessary to fulfill those goals. Offering an unambiguous rationale for the merger of the five institutions, the government was able to provide benchmarks for the authority's success and benefit from the planned synergies generated from the merger of the five institutions.

- Individual departments will require training and specialized technical assistance to transition to their new role. Partners should assist MINISANTE and the RBC leadership to design orientation and organizational development activities that help staff acclimate to the new procedures and function as a cohesive team.
- Consideration should be given to creating an Ombudsman position at the level of the RBC Board of Directors. The purpose of the position is not to monitor or provide oversight of the overall RBC management or of any of the individual organizations that have been merged into it. Rather, the function of the Ombudsman is to provide an “honest broker” function between overall RBC management and those of the individual organizations composing it. The various levels of governance are likely to have disagreements over authorities, responsibilities, and competencies. An Ombudsman would help negotiate agreements between the parties on behalf of the overall Board based on the founding documents.

## 3.2 REFORMS IN THE PHARMACEUTICAL PROCUREMENT SYSTEM

A well-functioning pharmaceutical supply and management system is essential for effective health service delivery. MINISANTE is in the process of introducing several reforms that will radically change the institutional landscape of the pharmaceutical supply and management system. Like many developing countries, Rwanda has centralized the procurement of pharmaceutical products by creating a central medical store that procures a majority of the medicines the country consumes (see Box 4 for historical context on the creation of central medical stores). This entity will soon be joining the RBC. Rwanda currently does not have an autonomous regulatory body for registering medicines entering Rwanda or for setting and maintaining quality standards for these commodities. MINISANTE is drafting legislation that would create such a body. This section provides an overview of the pharmaceutical sector and the institutional reforms that are underway and discusses the main governance challenges that the sector faces.

### State of Play

Most procurement of pharmaceuticals (60 percent) is done through the central medical store called the *Centrale d’Achats des Médicaments Essentiels du Rwanda* (CAMERWA). The remainder is procured through the *Bureau des Formations Médicales Agréées du Rwanda* (BUFMAR) (10 percent) and private wholesalers (30 percent). BUFMAR delivers essential medicines and medical supplies, which it either procures commercially or receives as donations, to faith-based facilities throughout the country. Private wholesalers mainly supply private health facilities and pharmacies, but are also accessed by public facilities.

CAMERWA is one of the 14 entities that will be merged to form the RBC. Within the RBC, CAMERWA will be a part of a newly created medical production and procurement unit, which will also be the home for LABOPHAR, the local drug production company, and the National Centre for Blood Transfusion. Currently, CAMERWA operates as an autonomous entity under the supervision of MINISANTE. It was established by the Rwandan government in 1998 for the purpose of procuring, storing, and distributing pharmaceutical commodities. CAMERWA is the primary supplier of pharmaceutical commodities, including generic essential medicines, medical supplies, and laboratory reagents. It is the only supplier in Rwanda that is authorized to import antiretroviral (ARV) drugs.

In theory, CAMERWA is supposed to provide pharmaceutical commodities to public and private referral hospitals, district pharmacies, and other health sector institutions such as the National Reference Laboratory. District pharmacies in turn are meant to sell pharmaceutical commodities to district hospitals and health centers. In practice, referral hospitals procure some pharmaceutical commodities from CAMERWA, but also rely heavily on private suppliers. Similarly, district hospitals and health centers

access the private sector for any commodities that they are not able to procure from CAMERWA or BUFMAR.

CAMERWA undertakes open tendering for selecting vendors for all drugs on the essential medicines list. It also manages all procurements funded by donors, which are typically for priority diseases such as HIV/AIDS and malaria. In the case of the U.S. Government (USG) alone, the payments are made not by CAMERWA but by a USG implementing partner, Supply Chain Management Systems (SCMS). Within CAMERWA, the warehouse section works on forecasting pharmaceutical needs. In the area of HIV/AIDS alone, CAMERWA works closely with the Coordinated Procurement and Distribution System to manage the procurement of ARVs. This standing committee includes MINISANTE, CAMERWA, and various international partners such as the Global Fund to Fight AIDS, Tuberculosis and Malaria; the President's Emergency Plan for AIDS Relief (PEPFAR); and the Clinton Foundation that fund ARV delivery in Rwanda.

#### **Box 4: Pharmaceutical Policies in Sri Lanka**

In the 1970s, Sri Lanka showed that centralized purchasing of essential medicines could reduce costs, rationalize drug use, and supply essential drugs without compromising quality. Since then many countries have adopted the methods that Sri Lanka used, including the following:

- Select drugs for an essential medicines list
- Implement a national pharmaceutical plan
- Create a state procurement agency
- Develop large procurement tenders, including generics
- Provide drug information from the government to all providers

These reforms in Sri Lanka promoted competition among pharmaceutical companies, including generic manufacturers, and increased efficiency through bulk ordering, leading to a reduction in the price of essential drugs by one-half to two-thirds.

The Sri Lanka example led to the development of a study by the United National Conference on Trade and Development that laid the groundwork for other countries to institute these policies on their own (Balasubramaniam 2009). Currently, the Clinton Health Access Initiative advises clients to take a 70/30 split between two main suppliers, allowing for pricing discounts based on volume and a reduction in procurement risks by sourcing from multiple suppliers (Cao 2007).

The advantages of centralizing medical stores and pharmaceutical procurement included rationalizing drug purchasing, purchasing bulk, and increasing competition among suppliers, all of which decreased costs in Sri Lanka. There are, however, some drawbacks to this structure, especially if the distribution system is not well managed. For example, Uganda's National Medical Stores (NMS) allowed \$550,000 worth of antiretrovirals to expire in 2006 due to poor coordination between the NMS and the Ministry of Health, policy changes, and weak stock monitoring. Additionally, centralized stores are prone to corruption, including theft and unauthorized resale of drugs.

Rwanda currently does not have a food and medicines regulatory authority. The Pharmacy Task Force (PTF) within MINISANTE performs a wide range of functions relating to pharmaceutical regulation in Rwanda, including the development and implementation of national drug policies, selection of essential medicines, registration of drugs, licensing of providers, and quality inspection. In addition, PTF monitors the purchase of commodities by public facilities from private vendors as well as the import of medicines by CAMERWA.

In a recent study, SCMS evaluated the Rwandan pharmaceutical supply and management system's vulnerability to corruption by using an assessment methodology designed by the World Health Organization (WHO) to gauge weaknesses in six functional areas (registration of medicines, licensing, inspection of establishments, selection of medicines, procurements, and distribution of pharmaceuticals)

(Rugina 2009). The study found that the area of medicine registration is extremely weak, with the country receiving the lowest score possible in the assessment scale due to the absence of a drug registration system that would allow Rwanda to keep track of all the drugs that enter its borders. Rwanda's performance is somewhat better but still weak in the areas of medicine selection and inspection of facilities. Rwanda's areas of least vulnerability are in licensing, procurement, and distribution. Authors of the study offer a wide range of technical recommendations based on WHO's Good Governance for Medicines program (WHO 2010).

A key issue is the absence of a medicine regulatory authority. MINISANTE has developed draft legislation to create an autonomous Rwanda Food and Medicines Authority (RFMA) to provide comprehensive regulation of foods, cosmetics, and medical commodities. They are soliciting feedback from other stakeholders to further refine the law, which will then be presented to Parliament. The RFMA's mandate, as it is currently envisioned, is much more expansive than that of the PTF; while the latter focuses on the pharmaceutical sector, the former's mandate will allow regulation of a broader array of commodities, including foods, cosmetics, medicines, herbal remedies, and medical devices. According to the draft legislation,<sup>5</sup> RFMA will register commodities and approve their distribution in Rwanda; inspect manufacturers, wholesalers, and retailers, both public and private, to enforce quality standards; monitor the post-marketing safety of the commodities; carry out laboratory analysis to test for quality and safety; control the import and export of the commodities; and regulate the promotion of the commodities. If implemented well, the law will go a long way in institutionalizing pharmaceutical regulation in Rwanda.

Several other entities are involved in regulating and coordinating pharmaceutical procurements. Under Rwanda's public procurement laws, the Rwanda Public Procurement Authority (RPPA) standardizes and regulates all public procurements. Although its rules and procedures are applicable to CAMERWA, the RPPA has also shown flexibility by allowing CAMERWA to tailor some of the procedures to suit its needs. The auditor general also has the jurisdiction to audit CAMERWA and has done so on a few occasions.

### **Governance Analysis and Principal Challenges**

The main challenges the team identified are in the areas of capacity, financial accountability, and planning. Previous reports on pharmaceutical management in Rwanda have described capacity constraints within CAMERWA (Lijdsman et al. 2003), and the assessment team's interviews confirmed that these constraints continue to be a challenge. The lack of trained personnel hampers CAMERWA's ability to manage its current volume of procurements. New policies that will lead to increased procurements will likely exacerbate the problem. District and referral hospitals have hitherto been procuring from private vendors any medicines that were not on the essential medicines list and hence not available through CAMERWA. However, MINISANTE is now encouraging all public facilities to procure all commodities through CAMERWA. This will add to the size and complexity of procurements that CAMERWA has to process.

Currently, stock-outs and wastage occur at various points along the procurement and distribution chain. The lack of continuous stock monitoring at the facility level leads to poor planning and management. In the case of essential medicines, CAMERWA uses past sales to predict need, which is not as accurate as more sophisticated quantification methods. The auditor general's 2007 Annual Report noted that CAMERWA had stocks of expired drugs that had not been disposed of, which represented a health and environmental hazard. The Rwanda Health Corruption Assessment finds that stock-outs and the consequent urgent need for medicines often lead to the relaxation of procurement rules and procedures in the interest of expediency. This increases the threat of corruption and abuse within the system. Better quantification and planning systems can minimize stock-outs, thereby addressing this problem to some extent. Setting up systems for expedited procurements that still live up to the standards of open and

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<sup>5</sup> Rwanda Food and Medicines Authority Law (draft received from MINISANTE).

competitive bidding can additionally minimize the danger of abuse during stock-outs. Although Rwanda's procurement laws do not proscribe the use of framework agreements with vendors, which would allow CAMERWA to purchase from a competitively selected vendor over an extended period of three years (also referred to as prequalification in the procurement laws of Rwanda), procedures for using such a contract mechanism either do not exist or are currently not being used by CAMERWA.

Although donors pay for drugs in the case of priority diseases such as HIV/AIDS, CAMERWA finances the purchase of other essential medicines through the sale of those drugs to district pharmacies and referral hospitals. These sales allow CAMERWA to maintain a revolving fund and a certain level of autonomy. CAMERWA's financial solvency, however, depends on the ability of district pharmacies to pay for shipments received. District pharmacies depend on health centers to pay for commodities, health centers depend on reimbursements from *mutuelles*, and *mutuelles* are chronically underfinanced because of low premiums. Therefore, the *mutuelles'* frequent inability to reimburse for drugs consumed by its members has a domino effect in this system, leading to stock-outs and delays at multiple levels all the way up to CAMERWA.

In the absence of a food and drug regulatory body, PTF has been performing a wide range of tasks. The transition of these responsibilities to the newly created RFMA needs to be carefully managed. The PTF is currently overextended and acknowledges that its staff is unable to properly implement all of the body's mandated technical functions such as drug registration and post-marketing surveillance of commodities. Creating the RFMA alone will not miraculously solve these problems. New systems and procedures need to be developed and staff at the RFMA will have to receive training to undertake the full spectrum of responsibilities that the new law accords to this body.

## Recommendations

- Review procedures and develop methods to increase efficiencies within CAMERWA: In many areas, CAMERWA's operational procedures can be modified to increase efficiencies. For example, preapproval of vendors can reduce delays in individual purchases, thereby speeding up procurement processes. A reserve fund could be developed to fill emergency funding gaps and reduce financial vulnerability to delays in reimbursements and payments. More sophisticated quantification methods that take a variety of factors into account rather than relying solely on past sales data can reduce stock-outs and wastage.
- Improve stock management at the facility level: The capacity of district pharmacies and health centers to better forecast needs, monitor stocks, and undertake advance planning remains limited. Development partners should expand their work with facilities at the district level and lower to improve their performance in this area.
- Build operation capacity of staff all along the pharmaceutical supply chain: The capacity of CAMERWA staff to handle a growing volume of procurements is limited. Similarly, staff working within district pharmacies need to be further trained to better plan for their needs and manage their stocks. Development partners should provide support for programs geared towards strengthening the supply chain system through targeted capacity-building activities.
- Build the technical capacity of the RFMA: The RFMA will take on many of the responsibilities that the PTF currently assumes with varying degrees of success. The creation of this new body presents a unique opportunity to carefully review the pharmaceutical regulatory practices of the PTF, revamp any weak areas, and build new systems that are needed. MINISANTE and development partners should work with the newly created RFMA to develop detailed and clear rules and procedures for the RFMA (including the ministerial instructions that will govern its daily functioning) and strengthen the technical capacity of its staff.
- Assess vulnerabilities and institute checks and balances through well-defined legal frameworks,

procedures, and guidelines: With the implementation of the RBC, a specific legal framework should be drafted that maintains the essential autonomous functions within CAMERWA and empowers CAMERWA with the flexibility required to fulfill its mandate. Specifically, CAMERWA should maintain procurement autonomy. Potential issues of conflict of interest should be addressed in the framework along with policies and procedures that reduce bureaucratic delays.

- Directly fund CAMERWA with earmarked budget support: Donors investing in teaching good procurement practices is as important, if not more important, than procuring drugs (World Health Organization 1999). CAMERWA will be funded through the RBC budget, but should maintain a level of budgetary autonomy that allows for direct contributions to CAMERWA without requiring that donated funds go through the RBC. Ability to receive earmarked funds is essential in meeting resource tracking and reporting requirements of large donor agencies.



## 4. CONCLUSION

Rwanda has made tremendous strides in improving the health of its citizens in recent years. This bears testimony to the strength of the Rwandan health system, as well as to the quality of health governance that conditions interactions among actors within it. There are, however, several aspects of the broader governance environment that may constrain further improvements in health governance. The objective of this assessment of Rwandan health governance was primarily to find these weaknesses and suggest ways in which they may be addressed. The following paragraphs present a summary of the central findings of the report.

Decision-making power in Rwanda is highly centralized, both horizontally within the national government and vertically across the different levels of government. At the national level, the executive branch continues to take the lead in crafting laws and policies, while the National Parliament has a supporting role wherein it largely reviews and ratifies legislation proposed by the executive. The legislative branch of the Rwandan government constitutes an underutilized resource for health policy making. Parliamentarians could play a stronger role in representing their constituents' views regarding health issues to executive agencies and could serve as a conduit to communicate with, and educate, the electorate on health issues and policies.

Across the vertical levels of government, policy implementation has been effectively decentralized to the district and below in Rwanda. However, performance standards for district mayors are set from the top, which creates an incentive structure oriented largely toward upward accountability to the President through the *Imihigo*. This type of top-down priority setting delinks the accountability framework that binds district officials with their citizens. District governments, while having some degree of autonomy, are weak by comparison with the center. This is likely to remain the case for the foreseeable future given the low capacity levels.

There is a tendency at all levels for government to sidestep effective participation by giving citizens and their organizations a minimal role in the policy-making and planning processes. Few decisions about the design of health programs or health priorities are made at the local level. Although some policy and programmatic decisions are appropriately made at the center (e.g., national health priorities, regulation, and technical standards), the system runs the risk of missing feedback on health needs and on uptake of health programs from the district and its citizens. It is understandable that Rwanda's leaders want to accelerate the development process and make up for lost time. However, at a certain point, the lack of broad-based societal participation may slow down and even constrain the very development that is being sought. A society moves no faster than its slowest citizen, community, or district. Civil society remains a weak partner within Rwanda's health governance system. This is partially due to the devastation of associational life that was wrought by the genocide and the consequent loss of social capital upon which reciprocity, social networks, and voluntary association are constructed. CSOs are not only weak, but in short supply. Co-governance requires both government and civil society to be strong partners.

Against this backdrop of a systems-level analysis of health governance, the report examines two key institutional reform initiatives launched by MINISANTE that will fundamentally change the landscape of Rwanda's health sector: the creation of the RBC and the closely linked reorganization of the pharmaceutical supply and management system. The creation of new institutions and structures offers Rwanda a unique opportunity to change the rules of the game and patterns of behavior associated with it. Such opportunities arise infrequently in the course of development of a country's health system. The institutions impacted by these reforms span the six key functional areas of the health system as envisioned in WHO's health systems building blocks framework. They serve vital functions within the

health system, such as delivering preventive care through childhood immunizations, procuring medical supplies, regulating the quality of health commodities, and training the next generation of medical and public health professionals.

In large-scale reform efforts of this kind, the process of undertaking fundamental institutional change is important, because the process frequently influences the outcome. It seems nearly impossible that a small group of technocrats, however knowledgeable, can have all the information necessary to find the right balance between operational autonomy and oversight within RBC's governance structure or can anticipate how CAMERWA's capacity for handling a growing volume of procurements will best be enhanced once it joins the RBC. A participatory process that involves all stakeholders, especially the entities that are being merged, is vital to ensure that all interests and perspectives are considered. Such a process also creates wide buy-in and ensures a smooth transition. Even with such a process, it seems unlikely that the internal rules and procedures that emerge will be perfect when they are first created. Hence, to be successful, the process has to be iterative, leaving open the option for further refinement and mid-course corrections in the future.

Rwandan institutions and citizens have been imbued with significant power to participate in the country's health system and health governance processes through the constitution and through a range of laws and regulations. The legal framework of the health system creates spaces in which power and authority can be exercised, but they cannot force those whom the law empowers to exercise that authority. The reasons for passivity could be several, including (1) a history and culture in which an ordinary person does not question authority, which in turn determines organizational culture within institutions; and (2) an understanding that maintaining the social peace and political stability means there are lines limiting participation and it is imprudent to cross them. Since these lines are not always clearly demarcated, it may lead to a reticence to test them.

Rwanda has been blessed with strong and effective leadership since the end of the genocide in 1994. The leadership's emphasis on reconciliation and development within a results or performance-based framework has led to some very impressive social and economic outcomes, with the health sector exhibiting some of the more spectacular ones. Like any fledging health system, significant challenges remain. There are signs that a system of good health co-governance is taking hold, and this study is intended to contribute to that process. Given Rwanda's track record, it seems more than likely that further progress will be made.

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# ANNEX A: LIST OF KEY INFORMANT INTERVIEWS

## **Government of Rwanda**

### **MINISANTE:**

Agnes Binagwaho, Permanent Secretary  
Stephen Karengera, Director of Policy, Planning and Capacity Building Unit  
Hertilan Inyarubuga, Director of CETAMS/Mutuelles de Sante  
Ida Kankindi, Decentralization Officer  
Spencer Bugingo, Legal Team  
Jean Patrick, Pharmacy Task Force  
Louis Rusa, Director, The Contractual Approach Support Cell

### **Other:**

Augustin Nzindukiyimana, Deputy Ombudsman, Office of the Ombudsman  
Eric Nyiligira, CAMERWA, Acting Head/Warehouse Manager  
Seminega Augustus, Director, Rwanda Public Procurement Authority  
Kayaranga Bernard, Director, Legal Affairs, Rwanda Public Procurement Authority  
Marie Mukantanbana, Deputy Speaker of the Senate  
Alfred Gasana, Political Affairs Committee  
Fidele Kayira, Community Development Unit, MINALOC  
Chris Ayebarec, Social Protection Unit, MINALOC

## **Development Partners**

Yogesh Rajkotia, Senior Health Economist Team Lead, USAID/Rwanda  
Vandana Stapleton, Health Officer, USAID/Rwanda  
Tye Ferrell, Democracy and Governance Team Leader, USAID/Rwanda  
Paul Kaiser, Democracy and Governance Advisor, USAID/Rwanda  
Joseph Tuzatsinda Rurangwa, MCC Governance Specialist, USAID/Rwanda  
Victoria Donovan, Democracy and Governance, USAID/Washington  
Jean Louis Lambeau, Decentralization Specialist, Lux-Development  
Yvonne Serubibi Umurungi, National Coordinator, Lux-Development  
Willy Janssen, Co-Director, Belgian Technical Cooperation (BTC)  
Remo Meloni, Health Sector Advisor, Belgian Technical Cooperation (BTC)  
Anja Fischer, Technical Advisor/Health, German Technical Cooperation (GTZ)  
Christoph H. Larsen, Technical Advisor/Health, German Technical Cooperation (GTZ)  
David Lahl, Technical Advisor/Decentralization, German Technical Cooperation (GTZ)  
Marie Gilbrin, Swiss Development Cooperation (SDC)  
Patrick Ososdo, Program Manager, Norwegian People's Aid (NPA)  
Claude R. Sekabaraga, Senior Health Systems Strengthening and Results Based Financing Specialist, The World Bank

Djordje Gikic, Country Director Rwanda, Clinton Health Access Initiative (CHAI)  
Erik Josephson, Deputy Country Director, Rwanda/Program Manager, Clinton Health Access Initiative (CHAI)  
Richard Arden, DFID  
Aline Mukerabirori, Technical Advisor, Strengthening Pharmaceutical Systems, Management Sciences for Health  
Felix Hitayezu, Strengthening Pharmaceutical Systems, Management Sciences for Health  
Geoffrey Ngwira, Procurement Advisor to CAMERWA, Supply Chain Management Systems  
Antoine Gatera, Senior Technical Advisor, Supply Chain Management Systems  
Kathy Kantengwa, Integrated Health Systems Strengthening Project (IHSSP), Management Sciences for Health  
Moses Munyamahoro, Decentralization & Field Support Coordinator, Integrated Health Systems Strengthening Project (IHSSP), Management Sciences for Health  
Bob de'Wolf, Integrated Health Systems Strengthening Project (IHSSP), Management Sciences for Health  
Anne Smith, Country Director, Higa Ubeho  
Dieudonné Haguminshuti, Capacity Building Team Leader, Higa Ubeho  
Serena Williams, Program Coordinator, Higa Ubeho  
Tito Farías, Civil Society Strengthening Project, USAID/Rwanda MCC Threshold Program  
Alphonse Rubagumya, Senior Technical Advisor, Civil Society Strengthening Project  
USAID/Rwanda MCC Threshold Program  
Fiacre Bienvenu, M&E Manager, Civil Society Strengthening Project, USAID/Rwanda MCC Threshold Program  
Linda Trudel, Chief of Party, Strengthening Civic Participation Project USAID/Rwanda MCC Threshold Program  
Daniel Kagina, Team Leader, Local Government Capacity Building Specialist, Strengthening Civic Participation Project, USAID/Rwanda MCC Threshold Program  
Jennifer Orgle, Civil Society Technical Advisor Strengthening Civic Participation Project, USAID/Rwanda MCC Threshold Program  
John W. Bosley, Senior Legal Advisor Justice Strengthening Project, USAID/Rwanda MCC Threshold Program  
Louise Brunet, Chief of Party, Media Strengthening Project, USAID/Rwanda MCC Threshold Program  
Denis Roumestan, Consultant, ARD  
Christine Gashayija, National Women's Council

### **Civil Society Groups**

Théogène Karake, Secretary General, Rwandese Association of Local Government Authorities (RALGA)  
Alexis Rukundo, Project Coordinator, Rwandese Association of Local Government Authorities (RALGA)  
Aimable Mwanawe, President and Legal Representative Rwanda NGOs forum on HIV/AIDS  
Rwego K. Albert, Program Manager Transparency Rwanda  
Faustin Vuningoma, Executive Secretary, Le Conseil de Concertation des Organisations d'Appui aux Initiatives de Base (CCOAI B)  
Dr. Nasson, Institute of Research and Dialogue for Peace (IDRP)

### **Field Visits**

Rwamagana District  
Huye District



