



VOLUME I: EVALUATION REPORT

*Thirty Years of Rwandan-German Development
Cooperation in the Health Sector*

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Volume I: Evaluation Report

Volume II: Annexes

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EXECUTIVE SUMMARY

Background, objectives, and methodology

In accordance with the Paris Declaration on Aid Effectiveness and the Accra Agenda for Action, the Government of Rwanda has enhanced the division of labor between the donors that support Rwanda. In 2010, as a consequence, the German Federal Government agreed to the request of the Government of Rwanda to discontinue its support to the health sector by the end of 2012. This has provided a unique opportunity to review and assess 30 years of cooperation in the Rwandan health sector by means of a summative evaluation. There is an overarching interest in striking a balance after so many years of cooperation, based on an array of aid modalities and instruments of German Development Cooperation (GDC) (project- and program-based approaches, basket funding and sector budget support, policy dialogue, technical assistance – including advisory services and training – and financial cooperation (provided by GTZ/GIZ, DED/GIZ, InWEnt/GIZ, and KfW), which have come into play.

The evaluation was conducted by DEval between July 2012 and October 2013.¹ The results shed light on how development cooperation in one sector (health) has developed over many years, while experiencing changing political and socioeconomic contexts and aid modalities. By documenting the entire process, including the phasing out and identifying of successful approaches, Rwandan partners can use the findings for their own management of the health sector and their cooperation with other development partners. GDC, at the same time, can draw lessons for future support to sector development in partner countries.

The specific objectives of the evaluation are to provide evidence and an assessment of the following:

1. How Rwandan-German cooperation has developed in the health sector.
2. The relevance, effectiveness, efficiency, impact, sustainability, coherence, coordination, complementarity, and harmonization of Rwandan-German cooperation in the health sector.
3. Successful and less successful aid modalities and instruments, as well as their interaction and adaptability to changing

conditions within the sector and with regard to socioeconomic and political developments.

4. The phasing out of GDC in the health sector.

To reduce the complexity inherent in the time period covered by the evaluation, German interventions in the Rwandan health sector have been reviewed for paradigmatic shifts that would allow for a temporal disaggregation for this period. Mapping the interventions between 1980 and 2012, according to (1) the implementing agency, (2) their duration, (3) the mode of delivery and strategic alignment, and (4) thematic focus, has implied that 1994/1995 and 2003/2004 can be considered turning points. In addition, the 1994 Rwandan genocide marks a period sufficiently serious to require consideration. The year 2003 constitutes the onset of a transformation within Rwandan-German development cooperation from the standpoint of project-mode to a more integrated form of cooperation. Accordingly, the analysis has focused on three phases: (I) 1980 – 94, (II) 1995 – 2003 and (III) 2004 – 12.

Phases I and II, in particular, posed challenges regarding the availability of interview partners, relevant documentation, and secondary data. While emphasis was placed on documenting the evolution of Rwandan-German cooperation and the adaptation to changing situations during these phases, the focus of Phase III was to provide evidence for a theory-based evaluation design, based on the criteria of the Development Assistance Committee of the Organisation for Economic Cooperation and Development (OECD-DAC): relevance, effectiveness, efficiency, impact, and sustainability. In addition, the design would include criteria formulated by the German Ministry for Economic Cooperation and Development (BMZ): coherence, complementarity, coordination, and harmonization. Evaluation approaches for attributing health effects in the Rwandan population to German support had proved unachievable due to program implementation design. While advantageous, according to the aid effectiveness model, the significant alignment to national health priorities further complicated attribution analysis and, therefore, led to the adoption of a theory-based contribution analysis. Further key questions with regard to the evaluation of Phase III relate to

¹ The draft of the evaluation report was sent to the reference groups on October 31st, 2013.

the phasing out of Rwandan-German cooperation with regard to health and the assignment of the different aid modalities and instruments and their interaction.

The following methods have been applied: (1) document analysis; (2) standardized online survey among former development workers; (3) interviews with different groups of key stakeholders; (4) statistical data analysis of the most recent Demographic and Health Survey in Rwanda; and (5) a comparative case study of four district health systems, using focus group discussions and qualitative interviews.

Key findings and conclusions

Rwandan-German cooperation between 1980 and 1994 (Phase I)

The political situation during this period of Rwandan-German cooperation was characterized by an ideology centered on the idealization of rural farmers and their manual work, represented by the majority ethnic group. This ideology came under considerable pressure at the end of the 1980s, when commodity prices – especially for coffee – fell and the price for imported goods increased, partly as a result of the World Bank's structural adjustment programs. Not only did this challenge food security and nutrition; it also impacted on the economic situation of Rwandan households and had severe implications on the health of the population. GDC reaction to this socioeconomic deterioration has been limited. The motivation for change originated more so from the individual initiatives of development workers in their work place rather than from the directions of GDC organizations.

In accordance with its mandate, GDC contributed to an improvement in health services, especially maternal and child health care and birth assistance, as well as in the supply of medicines for health care facilities. The decrease in the fertility rate and the increase in the use of modern contraceptives suggest positive outcomes from GDC projects and programs. Family planning activities, however, were undermined by the continuing high child mortality rate and by the negative idea of family planning due to conservative Catholicism and traditional beliefs. GDC

family planning activities, in any case, cannot be viewed in opposition to government interests, since the regime appeared to unconditionally support family planning.

German development workers, during this phase, primarily worked to fill the human resources gaps in the rural health sector. They considered the high staff turnover in the public health system and the increased movement of labor to the private sector as major factors hindering development.

Discriminatory treatment of staff in the health sector – based on ethnic group – took place, as well as in daily work life. The interviews that were conducted, however, do not point to open discrimination in the treatment of patients; rather, they point to discrimination based on a patient's socioeconomic situation.

The already volatile socioeconomic situation further deteriorated when the regime of Juvénal Habyarimana was attacked by the Rwandese Patriotic Army in 1990. In 1993, the Arusha Accords ended the three-year civil war, but the negotiated power-sharing agreements between the Government of Rwanda and the Rwandese Patriotic Front were only slowly implemented and did not halt the violence. The ethnically loaded conflict peaked in April 1994, when Hutu extremists seized power within hours after the assassination of Habyarimana, and a state-orchestrated genocide began, resulting in a tremendous death toll.

GDC interventions did not change, in essence, during the first phase. While there was a call for attention from within GDC and internationally on the increasing conflict, GDC misjudged the situation and reacted on the outbreak of violence only by evacuating all German project staff. GDC personnel began returning to Rwanda in March 1995, when it became evident that nearly all effects of their activities from the first phase had been erased as a result of the genocide and its consequences.

Rwandan-German cooperation between 1995 and 2003 (Phase II)

As a consequence of civil war and the genocide, an estimated 80% of health professionals working in Rwanda were killed or

had fled the country by July 1994. For the period directly following the genocide, when Rwanda had received extensive international assistance, the evaluation found no trace of international health policy intervention or initiatives in Rwanda. This, however, changed in 2000, when Rwanda adopted a health development strategy, based on decentralized management and district-level care in the spirit of the Lusaka Declaration of 1985. In alignment with this strategy, GDC activities focused more on strengthening health services at the district level. Consequently, the direct support from development workers to individual health centers within a district was phased out, and a full range of prevention and treatment services was supported. Since the health system, however, needed to be re-established immediately following the genocide, a minimum package of health services to the local population was viewed as a priority.

GDC support in primary health care effectively contributed to a substantial improvement in the provision of health services in specific rural areas. GDC support with regard to HIV prevention contributed to improved services, especially at the health center level. Rwandan partners appreciated the flexibility of GDC in providing support and the participatory project planning process. The qualifications of counterpart staff in health facilities, nevertheless, can be viewed somewhat critically. In 2000, GDC also began to support tertiary-level education in medicine for students and junior doctors, mainly through practical training, which would lead to quantitative and qualitative improvement of the medical education for students and resident doctors.

While there have been some elements of continuity in GDC support during Phase II, its flexibility to a changing situation is seen as a major component. GDC combined advisory and assistance at the national level with support to implementation at the district level. As health became a key sector for GDC in Rwanda in 2002 and program development began in parallel, GDC consequently developed a program-based approach.

Rwandan-German cooperation between 2004 and 2012 (Phase III)

Rwanda strongly commits to the Paris Declaration of 2005 and has developed its aid policy accordingly since 2006. Decentralization of aid began in 2000 and entered its second phase in 2005, with an administrative reorganization in relation to the minimum requirements for geographic coverage. Poverty Reduction Strategies have identified priority areas since 2002, while health sector priorities have been outlined in the form of Health Sector Strategic Plans since 2005.

During Phase III, Rwanda witnessed a major expansion of aid disbursements in the health sector (from USD 32.99 million in 2002 to USD 322.26 million in 2011). Rwanda's health expenditure, therefore, still relies heavily on external funding, with 63% of total health expenditure financed by donors (2010). This expansion of donor support to the health sector has been driven, to a large extent, by population policies and programs and reproductive health aid disbursements (USD 220.8 million in 2011). They have included, in particular, control of sexually transmitted infections, including HIV/AIDS. German bilateral aid disbursements peaked in 2009 when GDC began to engage in budget support to the health sector (EUR 13 million between 2009 and 2012).

GDC support to the health sector was gradually aligned to the Rwandan national health sector planning and implementation process. In 2007, a Memorandum of Understanding between the Government of Rwanda and eight development partners officially launched a sector-wide approach (SWAp) as a mechanism to coordinate and harmonize development partner interventions to the health sector. GDC participated with its first joint program of German implementing organizations. It defined, as its overall cooperation goal, an improvement in the health of the Rwandan population and covered three components: (1) health financing (HF), (2) sexual and reproductive health (SRH) and (3) human resources development (HRD). The other major partner countries were Belgium, Luxembourg, Switzerland, United Kingdom, and United States. The United States, as the major development partner, contributed 39% of external aid to the health sector (2011), while the GDC contribution amounted to 3% (2011).

Sector-wide approach, sector budget support, and capacity development pooled funding:

SWAp comprises an alignment to national priorities, better coordination among donors, and joint financing modalities. Only a few development partners, however (i.e., Belgium, GDC, Switzerland, and United Kingdom), were also engaged in joint financing modalities.

GDC support to SWAp has reflected, to a large extent, the priorities of the Rwandan and German Governments. The same has applied to GDC engagement in joint financing methods. Technical assistance, however, has reflected the priorities of the German Federal Government to a larger extent, given that the Government of Rwanda has given clear preference to budget support and pooled funding. The aid arrangements, supported by GDC, have been appropriate to reach the objectives established with Rwandan partners.

SWAp structures and mechanisms at the national level have worked effectively at varying degrees in terms of different Technical Working Groups. The quality and effectiveness of SWAp have appeared to depend very much on the strength of the respective Technical Working Group. GDC has contributed to the effective performance of these structures and mechanisms. While there is some evidence of positive effects from decentralization in terms of improved coordination among the different stakeholders related to health system development, there are also indications that SWAp structures and mechanisms at decentralized levels (e.g., district health management teams and joint action development forums) are not yet sufficiently effective.

The effectiveness of sector budget support (SBS) has been hampered by the unexpected and considerable delay in the use of these funds. The consequential earmarking of these funds for the provision of equipment to hospitals and health care centers actually has reflected priority interventions in accordance with the national health sector strategy. There is some evidence of a leverage effect through SBS by privileged access to the Ministry of Finance and Economic Planning (MINECOFIN) and by a more focused dialogue on health sector performance. The

opportunities for the leverage effect on policy dialogue, however, have been restrained by the fact that SBS actually constituted a relatively small proportion of aid flowing into the health sector (6.25% of all donor funds in 2010). This has made it difficult to bring up the politically emphasized increase of domestic contribution to the health sector budget as one of the key topics for policy dialogue as had been intended.

The capacity development pooled fund (CDPF) was established in order to effectively coordinate the various efforts of development partners supporting capacity development in the health sector in Rwanda. Evidence on the effectiveness is not conclusive. Capacities (e.g., of managers at the district level or of specific target groups in district hospitals) have been developed and strengthened, but there is no evidence on how these capacities have been made use of. After rechanneling its support in 2011, the CDPF has focused on long-term training of health care staff, particularly in line with secondary health care.

Overall, the SWAp process has lost momentum, despite the strong ownership of MINECOFIN and the Rwandan Ministry of Health (MoH). This is underlined by the fact that the Joint Health Sector Review did not take place as planned in April, 2013, and the health sector working group was not successful in organizing its work effectively and proactively. With some development partners leaving the health sector and others joining, the role of the United States as the major development partner in health care became even more dominating. This is also demonstrated by the major US-funded initiative to support human resources for health care development in Rwanda being implemented through project-directed aid, instead of using the CDPF as a joint financing modality. There are indications that bilateral cooperation (i.e., between the Governments of Rwanda and the United States) has taken the lead, to the detriment of the SWAp process. Development partners joining the health sector may soon display a level of commitment that might contribute to revitalizing SWAp.

Health financing:

The Government of Rwanda was innovative in introducing a country-wide health insurance system, which was previously

considered impossible to establish and sustain in a low-income country. Near-universal coverage was achieved in record time. The global awareness of problems relating to the motivation of health care personnel and the quality of health care delivery influenced the Government of Rwanda to equally address them. Community-based health insurance (CBHI)² and performance-based financing (PBF)³ thus could be considered flagship programs within Rwandan health reform that have been implemented quickly and with strong political commitment.

The Rwandan-German health financing component was aimed at increasing the responsiveness of the Rwandan health system – especially towards the poor – by increasing the percentage of the population covered by health insurance and improving the structural quality of health care services through PBF. CBHI has been accompanied by capacity building, including training and coordination support at different levels (i.e., including Technical Working Groups, the Health Financing Unit at MoH, and the management of CBHI at the district level). The so-called social funds, arranged by GDC, have subsidized the costs relating to medical treatment at the hospital level, which were not covered by CBHI for patients who could not afford them due to a capitation fee system. Furthermore, GDC was the only development partner under the Division of Labor policy to have signed and carried out a local subsidy contract to directly finance PBF in the district hospital of Ruhengeri.

CBHI and PBF were both aligned to Rwanda's national and sector objectives, as well as to BMZ priorities. Following a multi-level approach, the Rwandan-German program was highly relevant in eliminating the weak spots at the district level due to the high pace of implementation. Prior to the replacement of the capitation fee by an income-stratified premium system in the policy reform of 2010, GDC introduced social funds to support the poor. The temporary introduction of social funds, however, created non-aligned and parallel arrangements within the Rwandan health system, despite its relevance for the additional development objective regarding health equity in CBHI.

Policy advice and capacity building by GDC to the CBHI unit at MoH has contributed to harmonized strategies and resources. This has been strengthened by German facilitation of the disbursement of USD 34 million by Global Fund for AIDS, Tuberculosis and Malaria (GFATM) as a direct contribution to CBHI, which was crucial to achieve CBHI coverage and subsidies for the indigenous.

The increase in the rate of CBHI coverage demonstrates a very positive development in achieving a responsive health system. The assessment of health equity shows that the barriers to access to finance have been reduced for the poorest, although the significantly high costs relating to treatment and CBHI fees have been placed on better care for higher income levels. Before the phasing out of social funds in 2010, the GDC approach eased program costs and has, since then, become an effective tool to increase access to finance and the use of health care services. Evidence confirms that PBF increases service distribution and the outputs of health care professionals. It also suggests that the negative motivation and resource constraints, as side effects, are real and may limit overall effectiveness. For this reason, some GDC members, based on experience from Ruhengeri, have seriously questioned the relevance and effectiveness of PBF.

Systemic challenges for the efficiency of CBHI and PBF have fragmented the Rwandan health finance system and have created the sometimes long delays for reimbursement, at the central level, of district facilities (hospitals, health care centers). The high coverage rates of CBHI and the policy reform of 2010, supported by German contributions, indicate that efficiency is now high and that improvements regarding transfer of funds are gaining ground. Regarding PBF, available figures point to sufficient efficiency when measured by the percentage of overhead costs. As overheads do not include all costs related to resource-intensive performance verification and reporting procedures, it remains questionable whether PBF is, as yet, adequately efficient to overcome the lack of quality in the performance of health care services.

² Rwanda's current CBHI has been introduced as a social security system, using risk pooling as a key mechanism to achieve universal coverage. Financial contributions by CBHI members depend on their capacity to pay.

³ Performance-based financing in Rwanda aims to overcome the under-utilization and poor coverage of health services. MoH, therefore, has introduced financial incentives for health service providers to not only quantitatively and qualitatively improve their performance, based on a defined set of services, but also to improve the management of services and facilities.

The evidence that has been gathered suggests that sustainability should continue to be considered low due to the continuing high dependency on external funds. Recent policy and legal reforms, such as the cross-subsidization of the national CBHI risk pool, paired with a large share of household-generated funding, however, promise a positive increase in the sustainability of CBHI in the long term. The GDC social funds have proved to be unsustainable; they were not designed to be self-sustaining arrangements, and while Rwandan arrangements have taken their place, there remain gaps. Since German support of PBF at the district level (i.e., Ruhengeri hospital) has led to a setback in maintenance and recruitment, the German contribution to PBF has been unsustainable.

Sexual and reproductive health:

Within the SWAp architecture, joint efforts in sexual and reproductive health are aimed at reducing the rate of morbidity, infant mortality, and maternal mortality by improving access to quality care and promoting equality and equity among women and men. The overall objective of the program's SRH component, therefore, has been to contribute to the improvement of all aspects of SRH care and family planning, thus focusing on impact indicators as a total of fertility rate, HIV/AIDS prevalence rate, and infant mortality rate.

At the national level, technical support to strategies and national plans were provided through Technical Working Groups in relation to family planning, adolescent SRH, and gender-based violence. At the decentralized level, GDC has continued its long-term support to various levels of the Rwandan health districts. During the course of cooperation, family planning services have been extended to the health care center and community level. GDC also has supported the national concept of peer educators.⁴ One of the most prominent strategies in the SRH component has been to support private sector social marketing.

GDC support to SRH has reflected the priorities of – and is fully aligned with – the objectives set by the Government of Rwanda and the German Federal Government. Its multi-level approach

and its focus on the public and private sectors have enabled it to reach the respective target groups and objectives. Technical and financial support to the private sector, however, has fallen short of sufficiently strengthening the role of the private sector to provide contraception and information services in a sector environment where MoH was required to play a crucial role. Further strengthening of the private sector would have met the priorities of the Government of Rwanda and helped to reduce future public sector costs.

At the decentralized level, GDC has contributed to health care service delivery. This has resulted in a significant improvement in (1) antenatal care, (2) clinical-based deliveries and postnatal care, (3) HIV testing and counseling, (4) coverage of antiretroviral treatment, and (5) treatment of tuberculosis. Joint efforts by MoH and development partners have led to an increase in (1) the rate of modern contraceptive prevalence, (2) condom usage, (3) knowledge relating to family planning and HIV/AIDS, especially among youth, and (4) changed attitudes.

Although service utilization has continuously increased, coverage is still not universal and regional differences remain in terms of access and usage of modern contraceptives. In spite of the remarkable success of extending access to contraceptives through social marketing, the effectiveness of information campaigns on sexually transmitted infections and HIV/AIDS is questionable, especially with regard to rural communities in remote areas.

The main objectives of and targets for SRH have been achieved. GDC, therefore, has contributed effectively to health care service delivery through both technical and financial assistance. Relevant programs have been supported and linkages between the different actors (public and private) and intervention areas (e.g., HIV prevention and tuberculosis) have been implemented. At the national level, Technical Working Groups have been useful and have provided the policies and plans that were appropriate to achieve the objectives set at the national and decentralized levels. GDC has contributed effectively by setting its agenda and carrying out its technical activities (e.g., in relation to adolescent

⁴ The concept of peer education is to establish community-based distribution networks of basic health care and youth-friendly services in sexual and reproductive health. In Rwanda, young educators are selected by local health centers and trained in SRH and communication methods.

SRH care). The financial and technical contributions of GDC to social marketing have been moderately effective in reaching their targets and objectives. While most outcomes have been reached, there remain geographic and socioeconomic differences with regard to access to quality health care services.

The high chance of sustainability of the program's SRH achievements is due to the recognition of SRH as a key priority in the health sector strategy of Rwanda. The technical knowledge of health care professionals, however, remains limited and there are considerable geographic and socioeconomic variances with regard to access and use of health care services. In addition, there has been no proposal to clarify the roles and responsibilities of private and public actors, which is required to foster sustainable development of the private sector and commercial social marketing strategies in Rwanda – outlined in the latest Family Planning Strategic Plan.

Human resources development:

The objective of the HRD component was to increase the number of well-trained health care professionals, who are available to serve the Rwandan population. The component was composed of three sub-components: (1) medical education, (2) hospital management, and (3) health technology management.

Medical education and hospital management reflect the priorities of the Government of Rwanda and the German Federal Government. Partners of GDC at the central and district levels also have confirmed their relevance as part of HRD efforts to strengthen the health sector. There is conclusive evidence that the capacity development interventions, relating to medical education and hospital management that were put in place, have responded to the needs of target groups (health care professionals and hospital managers).

In particular, the support provided by development workers with regard to internship training and the International Leadership Training program in hospital management has contributed to an increased number of Rwandan health care professionals, enhanced their skills and knowledge, and improved the quality

of care in Rwandan hospitals. The training also has increased motivation, a sense of responsibility, and the ability to take charge of patients. Poor working conditions in district hospitals and poor equipment and their lack of maintenance have negatively affected the motivation of Rwandan doctors to remain in district hospitals.

International Leadership Training alumni, in their place of work, have improved various aspects of hospital management. Many transfer projects have had a positive effect on the quality of care. In their effort to promote change, International Leadership Training alumni often have been confronted with resistance to innovation by staff and a continuing limitation of autonomy by hospitals with regard to the management of human resources. Scaling-up efforts have been achieved through the establishment of a hospital management task force within MoH and a country-wide training program of hospital administrators. The high turnover rate of administrative staff, however, has limited the effectiveness of these short-term, in-service training activities. The effect of the International Leadership Training, which was conducted in Germany, can be considered inferior when compared to the lower cost of a comparable course in Tanzania.

The potential for sustainability lies in the political will of the Government of Rwanda to continue to invest in human resources for health. The Government now places a priority on medical education in the training of specialist physicians. The subsequent long-term engagement of these specialists in public hospitals remains questionable, however, given that the migration of physicians to the private sector could constitute a serious challenge. Rwandan district hospitals, therefore, are most likely to continue to depend on a revolving workforce of well-trained generalist practitioners in the future if working conditions in the public health sector do not substantially improve. The continuation of a practical internship program, therefore, will play an important role in the training of general practitioners. The conclusion, so far, is that the continuation of internship training in the long term can prove to be a positive and systems-building element of GDC support.

Overall assessment according to OECD-DAC criteria:

In terms of *relevance*, the joint health program has significantly reflected the priorities of – and was fully aligned with – the objectives set by the Government of Rwanda and the German Federal Government. GDC support, however (delivered as technical assistance), has reflected the priorities of the German Federal Government, to a larger extent, given that the Government of Rwanda clearly prefers budget support and pooled funding. The social funds, which created non-aligned and parallel arrangements, have not been relevant in terms of design; rather, they have been very relevant to – and have complemented – the aim for CBHI to ensure health equity.

The *effectiveness* of the joint health program can be classified as moderate to high. This is reflected in GDC support to SRH-related health care service delivery and to CBHI, which is demonstrated by the increase in CBHI coverage rates. GDC contribution to make SWAp structures and mechanisms effective can also be highlighted, including its support to HRD (i.e., medical education and hospital management). Effects on SBS have been only moderate due to deficient coherence among development partners and limited leverage, since SBS has constituted only a relatively small proportion of aid to flow into the health sector. GDC support to PBF has contributed to increased services and outputs of health care professionals, but can only be rated as moderately effective due to negative motivational side-effects and resource constraints. GDC has been highly effective in ensuring that pooled funding, relating to capacity development, has been operational and has strengthened its strategic orientation.

The *efficiency* of the joint health program could only partly be assessed, as most GDC inputs contributed to commonly defined outputs and outcomes. The same applies to the evaluation of the efficiency of SBS as it flows into the overall health budget. Evidence suggests GDC support to CBHI has been moderate to high, given its impressive target achievement and its increasing transfer efficiency. With regard to PBF, it is not yet evident whether such a resource-intensive procedure as PBF is yet sufficient to overcome the quality issue in the performance of health care services. The efficiency of the International Leadership

Training on hospital management can be rated as low due to its high cost compared to alternative training opportunities. Providing GDC support in terms of SWAp and joint financing modalities have led, only in part, to reducing transaction costs for MoH, but not for development partners. When efforts were combined with those of development partners, most program performance indicators were achieved on time; some even exceeded their target. In conclusion, the efficiency of the joint health program can be considered moderate.

With regard to *impact*, Rwanda has made impressive progress in terms of family planning and SRH care within the SWAp period (2004 – 12). Since 2005, the program indicator of the total fertility rate decreased from 6.1 to 4.6 children per woman in 2010. In spite of this impressive success, regional, socioeconomic, and age-specific differences remain. First, the total fertility rate is higher in rural areas compared to those in more urban areas. Second, the total fertility rate remains higher for the less educated and low-income population strata. Third, teenage fertility has declined at a slower rate and young motherhood remains more common in rural areas.

GDC support to maternal and child health care has contributed to a decrease in maternal mortality rates, with Rwanda making considerable progress towards achieving the Millennium Development Goal (MDG) target of reducing the rate from 1,300 per 100,000 live births in 1990 to 325 in 2015. By 2010, the maternal mortality rate stood at 487. Rwanda has reduced its maternal mortality rate at an extremely high pace in comparison to other countries in the region within the last decades.

Today, Rwanda has one of the lowest HIV prevalence rates in Sub-Saharan Africa. Besides malaria and HIV/AIDS, tuberculosis and tropical diseases are relevant threats to the health of the Rwandan population, which can best be addressed through integrated strategies. The GDC health system strengthening approach has contributed to integrating prevention and treatment of tuberculosis and HIV. The incidence of tuberculosis significantly has decreased in Rwanda and nearly all registered tuberculosis patients have been tested for HIV.

While the GDC approach to health systems strengthening has been an essential element within the Rwandan health care architecture, a significant part of the impressive progress has depended on the large financial efforts of some vertical programs in the areas of malaria, tuberculosis, and HIV prevention. Moreover, the multi-level approach of GDC has been highly effective with regard to the improvement of overall coverage and access to health care services through the support of flagship programs, such as CBHI and PBF. GDC support, however, has lacked focus on some specific target groups and remote areas. Consequently, socioeconomic, age-, and gender-specific disparities, as well as rural-urban disparities in the health of the Rwandan population, have been reduced only moderately.

By and large, the *sustainability* of the joint health program can be rated as moderate. Despite the strong ownership of the Government of Rwanda, there are indications that the SWAp dynamic has lost momentum during 2013. This also has applied to the scope and prospects of joint financing modalities in a situation where the health sector still very much depends on external funding. This is also the reason why the sustainability of CBHI should continue to be considered as low. Legal and policy reforms, however, promise sustainability of CBHI in the long term. Given that German support to PBF at the district level has led against its intention to setbacks in health maintenance and recruitment, it is considered to be unsustainable. With regard to SRH achievements, sustainability may be high due to SRH having been recognized as a key priority in the future health sector strategy of Rwanda. The same applies to HRD; however, there are questions about the lack of long-term engagement of medical doctors in the public sector due to the difficult working conditions.

In terms of *coherence, complementarity, coordination, and harmonization*, the evaluation revealed that the program is well aligned with the national health strategy and has worked through the structures and mechanisms of SWAp. GDC has been proactive in promoting the notion of SWAp at the level of the various components. Furthermore, it continuously has contributed to key forums for donor coordination.

Regarding SBS, GDC has put special effort into harmonizing the contributions by Belgium, GDC, and the United Kingdom. The SBS provided by Germany and Belgium was jointly designed and included pre-requisites for disbursement, performance triggers, and benchmarks. Yet, as the United Kingdom designed its SBS separately, negative implications arose relating to the ability of the SBS donor group was unable to speak with one voice.

GDC has placed special effort to establish the CDPF. It has proved, however, to be more cumbersome than expected to reach joint understanding of how to support capacity development most effectively and how to agree on joint procedures.

The quality of donor coordination, in general, has relied on key participating actors from development partners to put forward their enthusiasm and commitment, and GDC health sector coordinators have played an important role. Donor coordination weakened during 2013, however, when GDC was no longer in a position to contribute.

There is sufficient evidence to conclude that synergies between technical and financial cooperation have been realized. Coordination and cooperation mechanisms have been developed between both organizations and are proving to be working well. Cooperation between DED and GTZ has become more intense through the gradual process of program development having been, overall, perceived as a difficult integration process.

Successful and less successful aid modalities and instruments:

GDC has played a major role in the process of designing SWAp, as well as in establishing and strengthening the different structures and mechanisms. While GDC has not been one of the major donors in the health sector in terms of aid volume, it has created an increased leverage effect by combining different aid modalities and instruments.

GDC has deliberately focused on health systems strengthening (i.e., a horizontal approach to improve the coverage and quality of health care services) as being complementary to vertical programs. Vertical programs, especially funded by the United

States and the Global Fund to Fight AIDS, Tuberculosis and Malaria, have become increasingly important in terms of aid volume flowing into the health sector. GDC thus has helped towards redressing the balance between vertical and horizontal programs.

SBS can be considered as relatively successful in terms of channeling funds directly to the national budget with a special emphasis on allocating a greater proportion of public funds to district health systems strengthening. SBS could have been more successful if all contributing donors had harmonized their procedures to the point of signing a joint agreement with the Government of Rwanda. The leverage effect of SBS could have been higher if a higher percentage of donor funds had been channeled through SBS.

Technical cooperation has successfully followed the multi-level approach (i.e., combining advisory support on the national and district levels). The same has applied to capacity building. This has placed GDC in a position to apply best practices from implementation at the district level into its concept and strategy development at the national level, with Technical Working Groups playing a major role.

GDC has successfully combined various instruments, such as technical (GTZ/GIZ), financial cooperation (KfW), and advisory services from development workers (DED/GIZ), and it has integrated experts from the Center for International Migration and Development (CIM) and human capacity development (InWEnt/GIZ). In this way, GDC has provided its support through a mix of project-directed aid and joint financing modalities under SWAp. There is sufficient evidence of synergy between the various instruments.

Phasing out process:

While a two-year phase-out period of German support to the Rwandan health sector had been planned, the period proved to be rather short for some interventions. As the transition took effect in parallel to the ongoing program cycle, the handover process was highly challenging. The initial coordination schedule

for the handover process, until the end of 2011, was neither adhered to by the Government of Rwanda nor by the German Federal Government due to other priorities and time constraints at the ministry level. At the same time, some counterparts felt inadequately informed, which led to misunderstandings regarding the division of labor and the implications at the central and decentralized levels. Despite the process having been initiated by the Government of Rwanda with MoH responsible for leading the handover, coordination with other development partners and decentralized levels was limited and, to a great extent, left to GDC.

Recommendations

Sector-wide approach, sector budget support, and capacity development pooled fund

MoH

1. The results of the evaluation clearly support that further improvement in the overall health of the Rwandan population requires the continuation and intensification of poverty-, gender-, and age-specific interventions in order to tackle inequality and inequity in the course of the current Health Sector Strategic Plan.

GDC

2. The evaluation has indicated that there has been a high leverage effect through the combination of different aid modalities and instruments in terms of SWAp to the health sector. A diversified portfolio of aid modalities and instruments, therefore, will have the potential to increase overall effectiveness in implementing program-based approaches. This needs to go hand in hand with sound policy dialogue.
3. To increase the effectiveness of SWAp not only to the health sector, future strategies should put more emphasis on improving coherence among development partners, especially with regard to joint financing modalities. This should be applied in combination with strengthening the commitment of major development partners to align their interventions to a SWAp. This will certainly require the efforts of different development partners in leading roles with regard to SWAp.

GDC should explore the possibilities to act as broker, which would enable it to influence multilateral institutions, such as the World Bank.

4. Future strategies to establish basket funds for capacity building, in relation to program-based approaches in the health sector and beyond, should put more emphasis on their strategic orientation and joint management as a means to increase the effectiveness, efficiency, and sustainability of capacity building in a specific sector. This will require technical assistance to be provided from program inception.
5. More emphasis should be placed on the decentralization of SWAp from program inception, given that core institutional reforms have been initiated. This will allow local actors to participate in the decentralization process, which should be supported by capacity building at both the central and decentralized levels and, ideally, through pooled funding.

Health care financing

MoH

6. Since the payment modalities for CBHI premiums – such as the number of installments; need to enroll the entire family; and one-month waiting period from premium payment to health care entitlement – are perceived to be restrictive, MoH should consider lowering the restrictions to ensure equitable and consistently high CBHI coverage.
7. For a further investigation into the PBF in Rwanda, the aspects of effectiveness and efficiency merit increased methodological research. In particular, the following should be included: (1) ruling out alternative explanations, such as a motivation in terms of increasing health care professional wages without performance evaluation, and (2) appraising the cost-effectiveness of the arduous verification and reporting process.
8. To avoid the lack of motivation and/or manipulation of the PBF system due to its unrealistic goals and indicators, PBF in Rwanda should be combined more concentratedly with capacity development in health care facilities and with improvements to the physical work environment.
9. The speeding up of reimbursements at the decentralized level should be tackled to encourage financial autonomy by health care facilities at the sector or district levels.
10. While the *Ubudehe* classification (the Rwandan participatory poverty assessment tool to classify the population's economic vulnerability) is under the aegis of the Ministry of Local Government, MoH should advocate a more stringent application of the classification system to avoid the misclassification of CBHI members. This would safeguard the trust of CBHI members in the equity of the insurance scheme.

GDC

11. Overall evidence on the effects strictly attributable to PBF, their sustainability, and the efficiency remains shaky. With regard to the research requisites recommended to Rwanda's MoH, GDC should support rigorous methodological studies on these aspects in other contexts to assess the potential of this approach and to broaden the international knowledge base.
12. Future PBF intervention should be combined more systematically with capacity development for supervision and managerial staff with, at best, interventions to improve the physical work environment. Otherwise, the goals and indicators established will be perceived as unachievable and may lead to lack of motivation or false reporting of goal achievement.
13. The existence of a country-wide participatory poverty mapping in Rwanda has facilitated the transition from a capitation arrangement to an income-stratified premium system for CBHI members. Similar categorization systems should be incorporated when designing or supporting equity-oriented social security systems in other partner countries of GDC.
14. The Rwandan case highlights the fact that social funds that guard insurance schemes can temporarily increase equity. For future strategies, social funds should be designed to alleviate the catastrophic costs of health care services that affect the economically vulnerable, especially during a period of policy transition from a capitation arrangement to a more equity-oriented contribution system.

Sexual and reproductive health

MoH

15. Support to the private sector should be encouraged to increase its market share for contraceptives and to strengthen its overall role in the Rwandan health system, in addition to contributing to a decrease in costs to the public health care system. Synergies should, therefore, be encouraged through linkages between the public health system at the community-level and commercial marketing techniques from the private sector. At the policy level, the roles and responsibilities between private and public actors should be clarified to encourage coordination and planning capabilities.
16. Future campaigns in the context of social marketing should focus more explicitly on specific and disadvantaged target groups, especially in remote areas. Accordingly, synergies between large-scale information campaigns and more specific approaches through concepts of community health care workers and peer educators at the community level should be strengthened.

GDC

17. For future social marketing strategies under similar conditions, GDC should put a special emphasis on providing advice to clarify the roles and responsibilities between the public and private sectors, in order to enhance the potential for commercial marketing techniques and to decrease the costs to the public health system.
18. In comparable country contexts, community-oriented concepts, such as peer-educators, should receive further attention. Interventions should focus more specifically on key persons within a community to create a multiplier effect that will also lead to potential synergy between the private and public sectors at the community level.

Human resources development

MoH

19. More emphasis should be placed on strengthening the capacities of district hospitals to properly train and supervise medical students during their internship. This also requires a joint effort by MoH and the Ministry of Education to improve

the direction and monitoring of the national internship program.

20. The potential of International Leadership Training alumni experience in hospital management should be applied to the medical health care curriculum, which is being implemented in cooperation with the School of Public Health and Yale University.

GDC

21. To further strengthen future health system programs, more emphasis should be placed on supporting medical education in partner countries, hand in hand with policy dialogue. This will strengthen the commitment of partner countries to allocate sufficient financial and human resources to medical education. Moreover, a combination of individual knowledge transfer and advisory support at the national level, including the use of pooled funding, should be selected to increase the overall effectiveness of support to HRD.

Phasing out cooperation

GDC

22. The process to phase out cooperation, under similar circumstances, should include relevant stakeholders at the decentralized level, who are strongly committed. Adequate human resources and time should be provided to allow for a gradual process. GDC should encourage policy dialogue as a means to let the line ministry take strong ownership of the phase-out process. This should be seen as a precondition for guaranteeing the sound management of institutional knowledge.

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ABBREVIATIONS

AIDS

Acquired immunodeficiency syndrome

BMZ

Bundesministerium für wirtschaftliche Zusammenarbeit und Entwicklung (German Federal Ministry for Economic Cooperation and Development)

BTC

Belgian Technical Cooperation

BUFMAR

Bureau des Formations Médicales Agréées du Rwanda (Office for Non-profit Medical Facilities in Rwanda)

CBHI

Community-based health insurance

CDPF

Capacity development pooled fund

CHW

Community health worker

CIM

Centrum für Internationale Migration und Entwicklung (Center for International Migration and Development)

DED

Deutscher Entwicklungsdienst (German Development Service)

DEval

Deutsches Evaluierungsinstitut der Entwicklungszusammenarbeit (German Institute for Development Evaluation)

DFID

United Kingdom Department for International Development

DHMT

District health management teams

DHS

Demographic and Health Survey

DP

Development partner

DRC

Democratic Republic of the Congo

EDPRS

Economic Development and Poverty Reduction Strategy

GBS

General budget support

GDC

German Development Cooperation

GFATM

Global Fund to Fight AIDS, Tuberculosis and Malaria

GIZ

Deutsche Gesellschaft für Internationale Zusammenarbeit

GoR

Government of Rwanda

GTZ

Deutsche Gesellschaft für Technische Zusammenarbeit (German Technical Cooperation)

HF

Health financing

HIV

Human immunodeficiency virus

HRD

Human resources development

HRH

Human resources for health

HRTT

Health Resource Tracking Tool

HSSP

Health Sector Strategic Plan

HSWG

Health Sector Working Group (formerly Health Sector Coordination Group)

ILT

International Leadership Training

InWEnt

Internationale Weiterbildung und Entwicklung (Capacity Building International, Germany)

JADF

Joint Action Development Forum (at the district level)

JHSR

Joint Health Sector Review

KfW

KfW Entwicklungsbank

MBA

Master of Business Administration

MDGs

Millennium Development Goals

MINALOC

Republic of Rwanda Ministry of Local Administration, Community Development and Social Affairs

MINECOFIN

Republic of Rwanda Ministry of Finance and Economic Planning

MoH

Republic of Rwanda Ministry of Health

NGO

Non-governmental organization

NISR

National Institute of Statistics of Rwanda

ODA

Official Development Assistance

OECD

Organisation for Economic Co-operation and Development

OECD-DAC

Development Assistance Committee of the Organisation for Economic Co-operation and Development

ONAPO

Office National de la Population (National Population Office)

PBF

Performance-based financing

PHC

Primary health care

PRSP

Poverty Reduction Strategy Paper (replaced by Economic Development and Poverty Reduction Strategy)

PSI

Population Services International

RPF

Rwandese Patriotic Front

SBS

Sector budget support

SDC

Swiss Agency for Development and Cooperation

SPIU

Single Project Implementation Unit (of the Rwandan Ministry of Health)

SRH

Sexual and reproductive health

STI

Sexually Transmitted Infection

SWAp

Sector-wide approach

ToC

Theory of change

TWG

Technical Working Group

UNAIDS

Joint United Nations Program on HIV/AIDS

UNFPA

United Nations Fund for Population Activities

UNICEF

United Nations Emergency Fund for Children

USAID

United States Agency for International Development

US

Unites States

WHO

World Health Organization



A.

BACKGROUND, METHODOLOGY, AND CONTEXT

1. Evaluation background

In accordance with the Paris Declaration on Aid Effectiveness and the Accra Agenda for Action, the Government of Rwanda (GoR) decided to enhance the Division of Labor between donors supporting Rwanda. Consequently, in 2010 the German Federal Government agreed to the request of GoR to end its support to the health sector by the end of 2012 and focus on two priority areas in the future – decentralization and sustainable economic development – with special emphasis on the private sector and vocational training. This provided a unique opportunity to review and assess 30 years of cooperation in the Rwandan health sector, learn from past experiences, and draw lessons to improve aid effectiveness and health management in the future. During the government negotiations in November 2011, therefore, Rwanda and Germany agreed to conduct an independent evaluation prior to the end of German support. The newly founded German Institute for Developmental Evaluation (DEval) was mandated to carry out the evaluation and it began its preparatory work in July 2012.

The evaluation report is divided into three parts: Part A includes the evaluation background and methodology, the context in which the health support was provided, and the limitations faced by the evaluation. Part B provides the findings of the evaluation, according to the various phases of Rwandan-German health cooperation that lasted from 1980 to 2012. It comprises a condensed overview of the evolution of cooperation and an explanation of how cooperation had adapted to changing conditions by referring to the context analysis described in Part A. For the last phase of cooperation, it tackles the criteria of relevance, effectiveness, efficiency, impact, and sustainability, according to each of the Rwandan-German health program's components. The criterion for impact is presented across the components, as are the criteria for coherence, complementarity, coordination, and harmonization. The subsequent section includes an assessment of the theory of change (ToC), reflecting the intervention logic of the Rwandan-German health program between 2007 and

2012. An analysis of two additional key topics concludes Part B: the planning, management, and implications of the phase-out process of Rwandan-German cooperation in the health sector as it came to an end in 2012; and the identification of successful and less successful aid modalities and instruments. Finally, in Part C, conclusions are drawn from the evaluation results and recommendations are provided for decision-makers in the Rwandan MoH, German Ministry for Economic Cooperation and Development (BMZ), and German implementing agencies. The Annexes provide additional detail on the many issues discussed in this report.

1.1

Purpose, goal, and objectives

The experience gained from 30 years of Rwandan-German cooperation in the health sector in Rwanda (1980 – 2012) constitutes the object of this evaluation. During this period, a range of aid modalities (project- and program-based approach, basket funding and SBS, policy dialogue, technical assistance, including advisory services and training) and instruments of GDC came into play: financial cooperation was provided by the German Development Bank (KfW); and technical cooperation was conducted by the German Technical Cooperation (GTZ), German Development Service (DED), Center for International Migration and Development (CIM), and Capacity Building International, Germany (InWEnt), all on behalf of BMZ (including KfW). In 2011, GTZ, DED, and InWEnt merged to form the Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ).⁵ The types, importance, and combination of modalities and instruments changed considerably during these three decades. Reflecting on 30 years of Rwandan-German cooperation in the health sector, three distinct phases have been identified: (I) rural health care services and family planning (1980 – 94); (II) primary health care (PHC) services, human immunodeficiency virus (HIV), and acquired immunodeficiency syndrome (AIDS) (1995 – 2003); and (III) health sector, reproductive health, and human resources (2004 – 12).

⁵ This report refers to the implementing agencies of projects and programs before 2011 by the former acronyms GTZ, DED, and InWEnt. The acronyms GTZ/GIZ, DED/GIZ, and InWEnt/GIZ denote the implementing agencies during the transition period. After the merger in 2011, technical cooperation was implemented by GIZ and CIM.

The purpose of this final, summative evaluation is to demonstrate the contribution of the German aid effort to the Rwandan public health sector over the past 30 years, to strengthen the development of German aid policy, and to draw knowledge and learning from German aid strategies in health and from Rwandan strategies in international cooperation.

The evaluation intended to shed light on how development cooperation in the health sector has developed over many years through changing political and socioeconomic contexts and aid modalities. By documenting the entire process and identifying successful approaches, Rwandan partners can use the findings to improve their own management of the health sector and cooperate with other external partners. Given the entire range of aid modalities and instruments that have been applied during Rwandan German Health Cooperation, Germany has an interest to document how these have developed over the years and to assess how they have interacted in the context of a multi-level approach, while at the same time, highlighting the elements of continuity and the process of change. Furthermore, the findings can be of value in the decision of the kinds of aid modalities and instruments that could be applied to health sector development in other countries.

A review of the entire period of Rwandan-German cooperation in the health sector is a means to provide evidence that the results and achievements gained during this period reflect a crucial building block on which the joint health program was based in 2004, leading to the sector-wide approach (SWAp) in 2007.

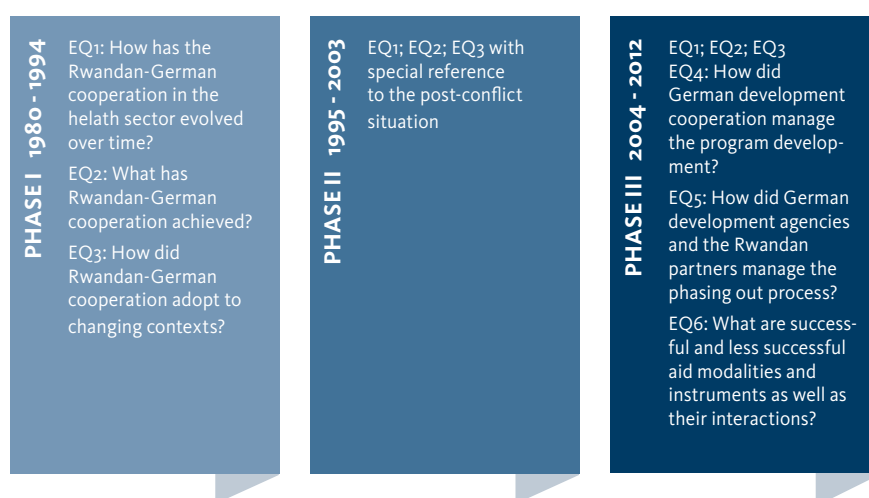
The specific objectives of the evaluation were to provide evidence and an assessment of the following:

1. How Rwandan-German cooperation has developed in the health sector.
2. The relevance, effectiveness, efficiency, impact, sustainability, coherence, coordination, complementarity, and harmonization of Rwandan-German cooperation in the health sector.
3. Successful and less successful aid modalities and instruments and their interaction and adaptability to changing conditions within the sector and with regard to socioeconomic and political developments.
4. The exit strategy with regard to the phase-out process and end of German development cooperation in the health sector.

1.2 Scope and evaluation questions

Together with reference groups in Germany and Rwanda, a set of overarching questions has been developed to assist in fulfilling the evaluation objectives (cf. Chapter A.1.1). During the exploratory phase, however, it became clear that for the relevant period, not all questions could be responded to in a similar way. In order to be able to assess the complexity of the evaluand, DEval has reviewed Germany's activities in the Rwandan health sector for paradigmatic shifts that would allow for a temporal disaggregation of the evaluand in three phases. As expected, it became evident that the earlier the point of interest, the less sources of information were available. It therefore was agreed with the reference groups to apply a different weight on the various phases, focusing on each specific evaluation question. Figure 1 illustrates which evaluation questions were to be answered for each phase.

Figure 1. Overview of key evaluation questions over time



Note: EQ is defined as Evaluation Question.

This set of key questions can be aligned to the evaluation criteria of the Development Assistance Committee of the Organisation for Economic Co-operation and Development (OECD-DAC) (and the BMZ criteria of coherence, complementarity, coordination and harmonization), as presented in Table 1.

With regard to Phase III, the priority of questions was established, based on feedback from the reference groups. The evaluation matrices (cf. Annex A) have been adjusted accordingly.

Table 1. OECD-DAC evaluation criteria over time

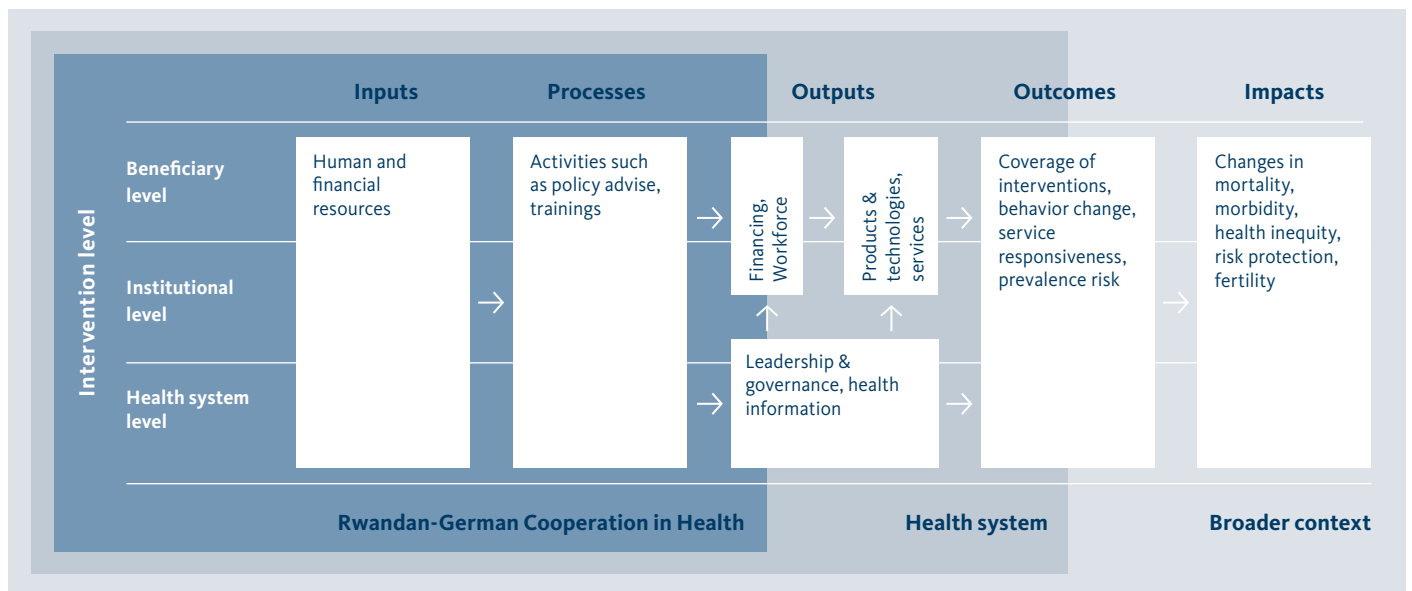
Evaluation Criteria	Phase I	Phase II	Phase III
Relevance	X	X	X
Effectiveness	X	X	X
Efficiency			X
Impact			X
Sustainability	X	X	X
Coherence, Complementarity, Coordination, Harmonization	X	X	X

2. Methodology of the evaluation

The evaluation imposes a methodological challenge of how to manage complexity. To overcome this, DEval reviewed German activities in the Rwandan health sector for paradigmatic shifts that would allow for a temporal disaggregation for this period. Mapping the interventions between 1980 and 2012, according to (1) the implementing agency, (2) duration, (3) mode of delivery and strategic alignment, and (4) thematic focus of the interventions, has suggested that the years 1994 / 1995 and

2003 / 2004 were turning points (cf. Annex C). These phases are characterized by differing thematic priorities of intervention. In addition, the 1994 genocide in Rwanda marked a critical turning point that should be taken into account. On the other hand, 2003 constitutes the onset of transformation within Rwandan-German development cooperation from a project mode to a more integrated form of cooperation. Aside from framing the evaluation, DEval has developed a framework to include the most relevant analytical concepts that make up this assessment. While the following chapter provides an overview of the evaluation's methodology, a more detailed outline is presented in Annex B.

Figure 2. Analytical framework



Sources: Amended from Bryce, Victora, Boerma, Peters, and Black (2011) and WHO (2007, 2009a, 2010).

2.1

Analytical framework

The analytical framework (cf. Figure 2) serves as a tool to disaggregate the object of the evaluation into analytically operable units and defines the key concepts. In accordance with other related frameworks, it maps the relationship between the concepts and identifies them within three overlapping and interlinked layers: (1) Rwandan-German cooperation, (2) Rwandan health system, and (3) broader Rwandan country context. Not only does this generic framework include the theme, it also forms the basis for constructing more detailed theories of change.

2.2

Evaluation designs

The evaluation designs build on phase distinction (Phase I: 1980–94; Phase II: 1995–2003; Phase III: 2004–12) and the analytical framework. Due to the summative character of the evaluation, the availability of resource persons, relevant documentation, and secondary data has been limited, especially in relation to the earlier periods.

Phases I and II

The turbulent political circumstances, open violence, and volatile post-conflict situation in Rwanda from the 1980s until the new regime's consolidation (marked by the 2000 and 2003 elections) called for a more flexible approach to Phases I and II. To ensure that key information was not lost due to the relatively limited availability of official documentation, DEval embarked on a very open, rather inductive data collection approach, guided by the evaluation questions. Given that former DED development workers, who had been seconded on a long-term basis to partner organizations, worked close to the target groups, they filled the need for resource persons. Statements and assessments from both a survey and in-depth follow-up interviews thus provided a fabric reflecting the historical realities and framework conditions on the ground. Time-witness accounts are complemented by reports from implementing agencies, BMZ, and the records of

individuals.⁶ In addition, DEval has interviewed key Rwandan actors in the health system. Project and process documentation, relating to the cooperation (e.g., Minutes of workshops), were useful in identifying the changes in the planning and evolution of development cooperation in the health sector. Interviews with former German staff (development workers and their survey results) and their Rwandan counterparts have been useful in assessing implementation and achievements. Aid disbursements and critical junctures for development cooperation were identified through portfolio and context analysis to assess how GDC performed in the larger country context.

Phase III

The main methodological challenge for Phase III has been to adequately evaluate a program with multiple components and intervention levels in the multi-donor environment of SWAp under strong national ownership.

During the inception phase of the evaluation, the DEval team explored the feasibility of evaluation approaches to attribute the health effects in the Rwandan population to German support. Applying a (quasi-) experimental approach proved impossible, since neither had the Rwandan-German program been implemented following randomization nor would the scarcity of available data allow to satisfactorily eliminate the threat to internal validity. Lastly, by definition, (quasi-) experimentation demands a close control by the evaluator to establish cause-effect relationships and, therefore, it often focuses on a narrowly defined set of variables. The authors of a recent working paper of the United Kingdom's Department for International Development (DFID) highlight the downside to this when they conclude that in evaluation, "there is a tradeoff between scope of a program and strength of causal evidence" (Stern et al., 2012, p. ii). Further aggravating this scoping problem is the degree of alignment of the program to national health priorities in the framework of SWAp. While desirable in itself, according to the Paris and Accra paradigm, this has further complicated attribution analysis and has led the evaluation team to embark on another approach to evaluate Phase III. The DEval team has adopted a contribution

⁶ DEval refers to unpublished documents with the pseudonym "Doc." plus a consecutive number for relevant papers, documents and data sets from both ministries, the development organizations and their implementing partners or if proper citation would infringe on the privacy of the author(s). Interviews are pseudonymized in a similar way (cf. section 2.3 in this chapter).

analysis as the design for evaluating Phase III. Contribution analysis is a theory-based approach (cf. Mayne, 2011) that has been developed for scenarios when attribution analysis is inapplicable or unfeasible. Contribution analysis asks “in light of the multiple factors influencing a result, has the intervention made a noticeable contribution to an observed result and in what way?” (Mayne, 2012, p. 273). As a comparative advantage, the logic behind contribution analysis puts stronger focus on causal mechanisms and the interplay of influencing factors than the (quasi-) experimental rationale. This emphasis makes contribution analysis a suitable tool to take stock of the variety of experiences gained in the course of the Rwandan-German program in a SWAp framework.

Building on the work by Delahais and Toulemonde (2012) and Mayne (2012), DEval adapted the key steps of a contribution analysis: (1) on the basis of the interim/inception report, the reference groups in Rwanda and Germany were invited to discuss the preliminary findings and suggest thematic focuses to be studied in depth in the consolidation phase of the evaluation. DEval gathered the suggestions and decided on the final thematic focuses; (2) to reconstruct the theories of change, the evaluation team identified and screened the relevant planning documents for the Rwandan-German program, using the analytical framework as a filter; composed an overarching ToC (cf. Annex D); and gathered feedback from former program staff for validation, which resulted in a slight adjustment; (3) the evaluation team created *evidence analysis tables* (cf. Delahais & Toulemonde, 2012) for stand-alone branches of the ToC and, therein, collected the existing items of evidence (i.e., information confirming or refuting a causal link as postulated in the ToC) that was gathered during the exploratory phase of the assessment; (4) this exercise allowed for a formal assessment of the extent to which the theories of change had already been evidenced; and (5) the assessment identified those links in the theories of change that still lacked sufficient evidence.

In order to fill the gaps, DEval applied the following methods and data collection tools: (1) a survey among former development workers, (2) interviews with different groups of key players, (3) a

comparative case study of four district health systems, and (4) a statistical data analysis of the latest round of Demographic and Health Surveys (DHS) in Rwanda.

Together, these methodological packages were included in the contribution analysis as an overarching evaluation approach to generate the items of evidence that were necessary for a robust assessment of the program’s contributions. The contribution claim and corresponding evidence are presented in Chapter B.3.3.1 – 3.3.4, under the section relating to effectiveness, and Chapter B.3.4, relating to impact.

Critical appraisal of the evaluation designs

With regard to the approach to Phases I and II, the main limitation was the lack of available data in terms of identifying interviewees for Phases I and II and taking stock of project documentation. The evaluation team invested considerable time and effort to overcome both constraints and it is convinced that it has gathered a critical mass of documentation to outline Rwandan-German cooperation in its early Phases. Nevertheless, the team has ensured that it avoids making detailed assessments of the projects.

Despite reliance on an analytical framework and a contribution analysis to manage the complexity inherent in Phase III, the theories of change underlying the program are still fairly intricate and contain a multitude of causal links to be tested (cf. Annex D). With regard to evaluating this and similar programmatic approaches, two fundamental issues arise. First, every additional link under examination increases the resource demands for the overall study. Only deliberate decisions regarding the scope of an evaluation by its stakeholders and team – taking into account the principle of evaluation efficiency – can, thus, ensure a utilization focus of future and similarly complex studies. For the evaluation at hand, the team is convinced that the contribution analysis has delivered robust results, primarily relating to the OECD-DAC criteria of effectiveness and impact, but it acknowledges that this may have been at the expense of certain questions especially tied to the efficiency criterion. Second, programs operating in a SWAp environment reshape the attribution problem. In the case

of strongly aligned and well-harmonized support, the tracing of more proximal effects back to single development partner (DP) deliverables becomes increasingly difficult. A lesson learned has been that sufficient resources should be devoted to explicitly formulate and collect other influencing factors and rival explanations to question the program's contribution. The team has allocated considerable time and resources to this step to identify the ToC, and it is confident to have gathered sufficient evidence on the mechanisms of the program to solidly back the conclusions drawn. For future complex evaluations, however, the team anticipates untapped potential from a stricter testing of ToCs by placing more focus on competing explanations, invalidating their postulated influence, and focusing more on validating the ToC with key stakeholders.

2.3

Methods and data collection tools

This section outlines the methods and data collection tools applied in this evaluation. It is important to keep in mind its two-fold purpose over the period. While the emphasis of this evaluation of Phases I and II (1980–94 and 1995–2003, respectively) rests on documenting the evolution of Rwandan-German cooperation, the adaptations to the country's contexts and achievements – the focus of Phase III (2004–2012) – lies on the delivery of items of evidence, feeding into the theory-based contribution analysis.

Survey of former DED development workers

Former DED development workers are considered to have been key players by the evaluation team due to their long assignments in the health sector and direct relationship with target groups. In order to document and assess the instrument of development workers, DEval designed a two-stage process balancing both analytical “breadth” and “depth” through (1) a standardized mixed-mode survey (online versus paper-and-pencil mode to the same questionnaire), based on the tailored design method (cf. Dillman, Smyth, & Christian, 2009),⁷ followed by (2) in-depth

semi-structured interviews with a purposive sub-sample of the survey respondents in the first stage.

Of the survey's target population of 111 individuals (equaling the total number of development workers in the Rwandan health sector between 1980 and 2012), 82 were contacted and 52 returned a completed questionnaire, resulting in a response rate of 63% of those contacted and a response rate of 47% of the overall population. Statistical χ^2 -tests have revealed no systematic deviations of the sample from the overall population with regard to gender composition and placement periods. The efforts made for sampling and triangulating survey responses with narratives from follow-up interviews should outweigh problems connected to the small sample size. Nevertheless, one should understand the survey results stated in percentages as an indication of trend rather than a precise statistical estimate.

Interviews

The extended evaluation team conducted 136 interviews with 316 interviewees during the exploratory phase of the evaluation and another 128 interviews during the consolidation phase.⁸ An additional 24 interviews and 28 focus group discussions were held for the comparative case study. The interviews during the exploratory stage emphasized on scoping the evaluation, assessed the feasibility of different evaluation approaches, “getting to know” the program and its context, and gaining preliminary insights for Phase III regarding the OECD-DAC criteria. The interviews conducted during the consolidation stage aimed to corroborate the preliminary results of the exploratory stage by producing items of evidence along the ToC that fed into the contribution analysis for Phase III. The in-depth interviews with former DED development workers marked an exception in that regard by simultaneously serving to test the hypotheses derived in the context analysis.

⁷ Henceforth, items of evidence referring to individual survey respondents will be referred to as SDW [Survey of Development Workers], plus a consecutive number as a pseudonym identifier.

⁸ Note that the overall total number of interviewees during the exploratory phase is due to a double-counting of interviewees who have been interviewed on more than one topic. In fact, 238 people have been met. Some key resource people also were interviewed several times on different topics during the consolidation phase.

Table 2. Interview of target populations

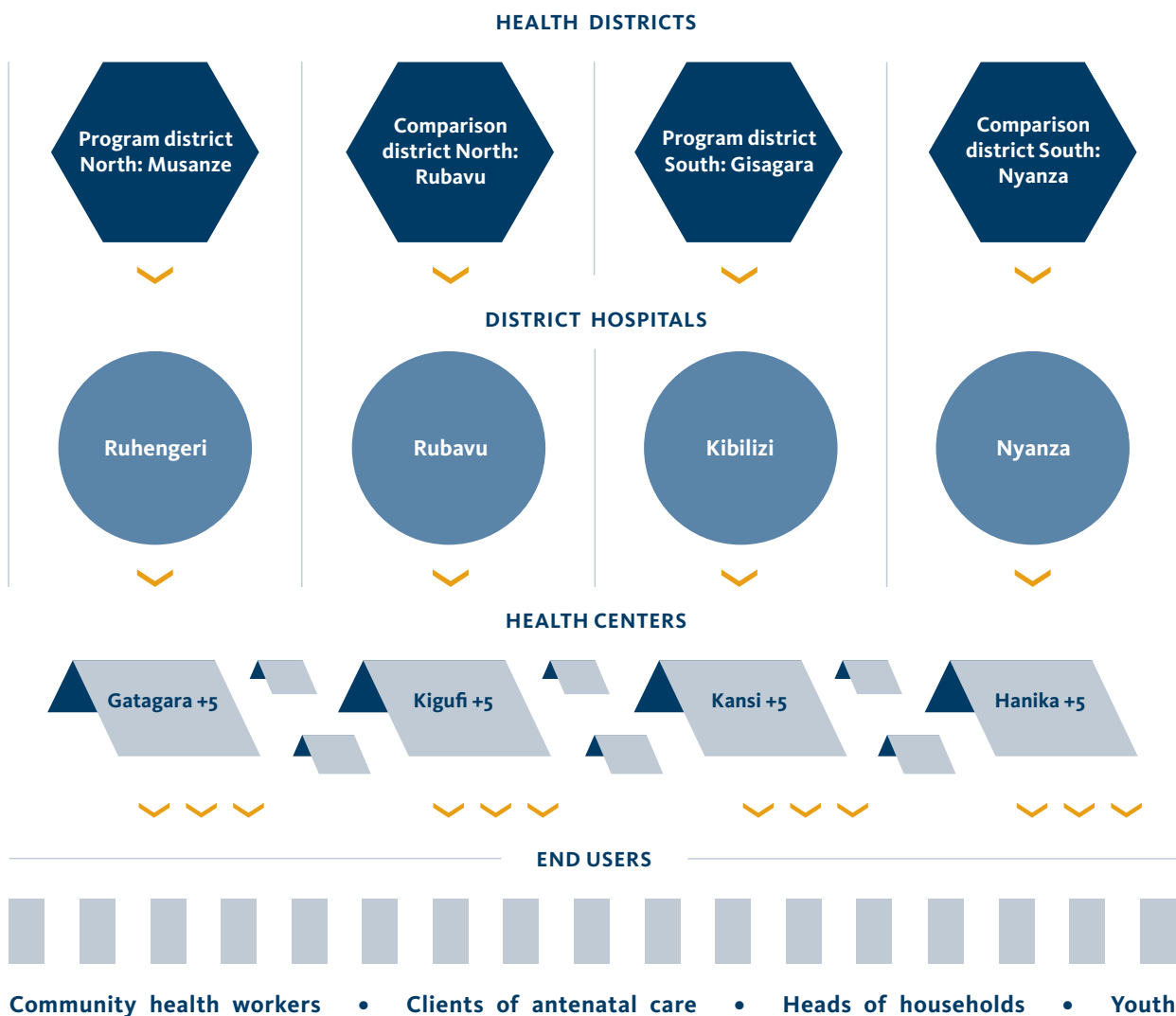
Target population	Pseudonym	Number of interviews
Former DED development workers	INT InD DW	13
Former development workers in junior doctor/intern program	INT HRD DW	9
Former beneficiaries of International Leadership Training (ILT)	INT HRD HM	15
Former junior doctors/interns trained by development workers	INT RP	20
Rwandan project/program staff, counterparts, resource persons	INT RP	17
Resource persons of other DPs	INT DP	4
German project/program and headquarters staff	INT EXP	22
CIM integrated experts	INT EXP	3
Resource persons regarding SWAp	INT SWAp	25

Note: This table provides an overview of interview target populations, their pseudonyms, and the number of interviews conducted in the consolidation stage. Interviews conducted in the exploratory stage were coded in the following way: G = Group; INT = Interview; GEN = General (not component-specific); SWAp, HF, HRD, SRH = component abbreviations. The last number is randomly assigned for each of the interviews. In addition, the following pseudonyms are used: InD = In-depth interview; EXP = German experts; RP = Rwandan partners. For a more comprehensive overview containing the interviews conducted during the exploratory phase, please refer to Annex B.

Main target groups for the interviews during the consolidation stage comprised former beneficiaries of human capacity development interventions (35), former project and program staff (including development workers and CIM integrated experts (47), former counterparts and Rwandan project/program staff (17), key informants in the health SWAp (25), and other DPs in the Rwandan health sector (4). To safeguard respondents' privacy,

items of evidence generated in the interviews are referred to by pseudonym identifiers, consisting of an acronym for the target population and a consecutive number for the interviewee (cf. Table 2). In some cases, target populations share the same acronym to avoid the traceability of their identity. End-users of health services were targeted by the comparative case study approach.

Figure 3. Comparative case study approach



To avoid the negative influence of self-assessments on the data quality, the evaluation team put special emphasis on diminishing privacy concerns and memory effects, while capitalizing on triangulation in collecting and analyzing interview data.

Comparative case study of four district health systems

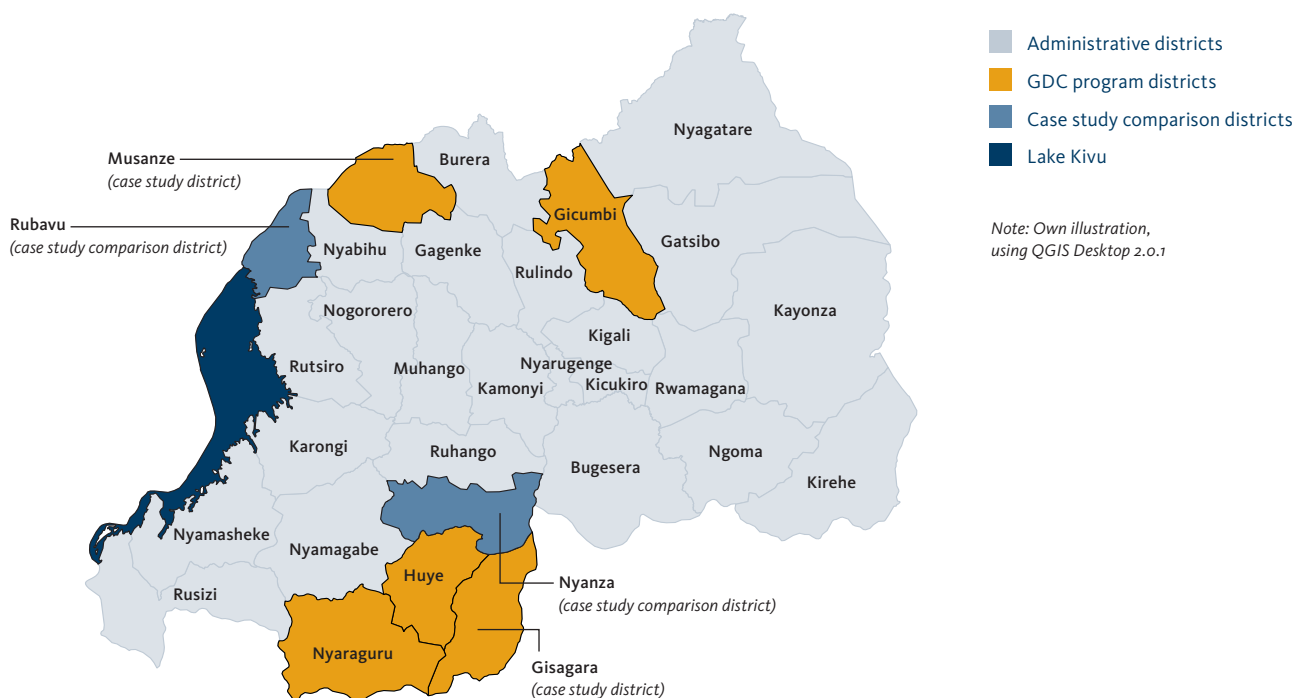
The comparative case study was designed to scrutinize whether Rwandan-German cooperation in the health sector has contributed to addressing the core problems of (1) unattainable health

service costs, (2) low service quality, and consequently (3) low health care utilization. Case studies, especially with further sub-cases, are suitable for collecting evidence that covers the large range of a ToC (Delahais & Toulemonde, 2012, p. 285). DEval thus commissioned a Rwandan research team to assess four district health systems as cases⁹ to focus on the following key stakeholders representing further sub-cases (cf. Figure 3): (1) health care providers at different care levels, (2) end users/patients, and (3) those responsible for steering and managing the health system at the district level. Health equity is treated as a cross-cutting issue along the aspects previously mentioned. In total, the study team conducted 28 focus-group discussions and 24 interviews to collect and compare appraisals and perceptions (building on Krueger & Casey, 2009). Two of the four district health systems under study were previously supported by the program and were purposely selected, while the other two allow

for a comparative perspective on the program’s contribution, both within and between the districts.

Deviations from the study design during implementation, limiting the comparative aspect of the case study approach, have received too little attention in the analysis. While DEval reallocated internal resources to overcome this constraint, the endeavor was rather diminished when compared to comparatively connecting case studies, making it difficult to carve out the unique characteristics of the districts and to conclude whether cooperation did, indeed, provide added value compared to other districts. Despite this limitation and the minor deviations from the sampling design with regard to the end users, however, the four case studies fulfilled, by and large, their designated purpose and provided useful insights from key groups regarding the decentralization of the Rwandan health system.

Figure 4: GDC program districts and comparison districts



⁹ Items of evidence, generated by the comparative case study, will be henceforth quoted as such.

Secondary data analysis of Demographic and Health Surveys

In the frame of the contribution analysis, specific links between the concepts as specified in the ToC have been tested using statistical and econometric analysis. The main constraint in applying such methods is a lack of data availability. With regard to the evaluand, the DHS provide the most reliable and relevant data set. Using the latest survey round of 2010, the secondary data analysis focused on quantifying the outcome of social interactions in the adoption of modern contraceptives and desired fertility to provide a link between direct outputs of the program and resulting effects (outcome) of the social marketing projects. The methodology applied was a spatial autoregressive model with overlapping peer groups and instrumental variables for identification. Limitations of the study derived from strong assumptions about both peer groups and instrumental variables. The study's results are representative for women between 15 and 49 years of age at the national level in Rwanda.

3. Context of Rwandan-German cooperation in the health sector

The following chapter sheds light on the context in which Rwandan-German development cooperation has operated over 30 years. The analyses in the following approach are undertaken from two different angles. The first is a context analysis that identifies the long-term performance of the health sector in relation to the socioeconomic and political development of Rwanda. The second is a portfolio analysis, outlining the monetary framework conditions prevailing in Rwanda, the Rwandan health sector, and the German portfolio. In combination, both approaches should provide useful background knowledge and are drawn upon in later chapters to assess the contributions of the Rwandan-German cooperation over time.

3.1 Context analysis

The context analysis attempts to embed Rwanda's health policy on a broader canvas and seeks to establish links between the health sector and the "big" political arena in the turbulent years between the 1980s and 2012. Against this background scenario, the context analysis distinguishes three phases (1980–94; 1995–2003; 2004–12) and deduces hypotheses relating to context factors. The respective chapters for each phase include these hypotheses and seek to prove or invalidate them, based on interviews¹⁰ and document reviews. The findings are assessed for relevance and effectiveness (cf. Chapter B.1.1.2. and B.2.2.2.). An exception to this relates to Phase III, which outlines Rwanda's overarching policy architecture and major international trends, while further framework conditions relating to the program and its components are more detailed and, therefore, assessed in-depth elsewhere (cf. Chapter B.3.3.1–B.3.3.4). Furthermore, the context analysis will inform readers, who are unfamiliar with Rwanda's history, about the larger framework conditions in which Rwandan-German development cooperation took place.

The findings presented here derive from a review of academic and grey literature, interviews with time witnesses, and an appraisal of selected health-related indicators (Annex F). The main limitation of this context analysis is the absence of a meta-theory on health sector development over time to help identify which influencing factors should be taken into account and which are irrelevant. While the DEval team is confident that it has managed to carve out some context conditions that merited closer examination in this evaluation, it would be overconfident to claim completeness. A second caveat relates to the phase distinction of the context analysis: cutting the historical continuities of a country context into mutually exclusive phases is, strictly speaking, impossible. The evaluation team, however, deliberately decided to define phases bound by specific years that signify major changes from the perspective of Rwandan-German cooperation. By structuring the following section along these three phases (1980–94; 1995–2003; 2004–12), it knowingly

¹⁰ The same methodological caveats, outlined in the chapter on the methodology (A.2.3.) relating to interviews, hence, apply to this approach of hypothesis testing.

accepts an oversimplification of the fuzziness that is inherent in such a distinction.

3.1.1 Economic decline and growing political tension (1980 – 94)

Having been a German colony under indirect rule (1897 – 1916) and, subsequently, a Belgian colony (1916 – 59), Rwanda formally became an independent republic, headed by President Grégoire Kayibanda in 1962. The first independent government ended when the then Major General Juvénal Habyarimana seized power in a bloodless military coup in 1973, ousting former President Kayibanda (cf. Prunier, 1995).

The second republic under President Juvénal Habyarimana (1973 – 94), was deeply influenced by an ideology centered on the glorification of rural farmers, manual work, and the majority ethnic group supposed to represent this idea: the Hutu (Lemarchand, 1970; cf. also Verwimp, 2000). This strong and centralist single-party state was backed by the military and strived for a predominantly agrarian development ideal with clear political instructions, demanding subordination from every single citizen (Mamdani, 2001). In addition to the omnipresent ethnic division of Hutu and Tutsi, there were at least two other main features of clientelistic stratification at that time: clans and regions (cf. Asche, 1995; Orth, 2001; Prunier, 1995; Verwimp, 2000).

This ideology of a developmental dictatorship came under severe pressure at the end of the 1980s and the beginning of the 1990s, when commodity prices – especially for coffee – fell and prices for imported goods, in turn, increased, partly because of the World Bank's structural adjustment programs (Schicho, 1999; Uvin, 1998). Disputes in the population occurred more often about the unequal distribution of land and, more generally, about the increased inability to meet basic needs from subsistence agriculture due to a significantly increasing population density. The regime's stability also was endangered by external pressure. On October 1, 1990, the *Rwandan Patriotic Army*, the armed wing of the *Rwandese Patriotic Front* (RPF), launched an offensive to capture their Rwandan homeland and take over power. In 1993, the Arusha Accords ended the three-year civil war, but the negotiated power-sharing agreements between GoR and RPF

were only slowly implemented and did not halt the violence (Stettenheim, 2002; Straus, 2006).

Given the overall economic decline and ethnic tensions, there are indications that the overall health situation worsened. This notion is supported by socioeconomic data from that period regarding life expectancy and undernourishment (cf. World Bank, 2014, and Annex F). To assess the relevance and effectiveness of GDC engagement in the Rwandan health sector, this points to a first critical juncture to be examined in more detail.

Context Hypothesis 1: Rwandan-German interventions in the health sector have been sufficiently adapted to the deterioration of the socioeconomic conditions in Rwanda since the mid-1980s to remain relevant and effective.

While all kinds of social and partly economic indicators presented Rwanda as a declining society under stress at the end of the 1980s, the international donor community remained convinced that it was worthwhile to continue development cooperation with Rwanda throughout the years until the genocide of 1994 (cf. Uvin, 1998, p. 41). The positive image Rwanda maintained was based on the perception of having a low incidence of corruption, an efficient administration, and the general belief of donors – arguably best summarized – that Rwanda was able to 'get things done' (cf. Uvin, 1998). What does not appear in this scenario, however, is the precarious socio-political and ideological background of the regime of an ethnically divided society and a region- and clan-based power system that excluded many relevant societal actors. Nevertheless, the policies of GoR in the 1980s followed an ethnically discriminatory motive in different sectors and politics: favoring Hutu was the rule rather than the exception. Tutsi, for example, were systematically excluded from higher positions in the political system and the military; Tutsi had a 9% quota in the education system – at first loosely enforced and, with the upcoming political crisis that occurred later, more so strictly (Prunier, 1995, pp. 74 – 92). Against this background scenario, it appears likely that similar policies discriminating against the Tutsi minority group existed in the health sector. Obviously, this kind of policies stood in sharp contrast to the

human rights obligations of GoR, as Rwanda had ratified the International Covenant on Economic, Social and Cultural Rights (UN, 1966a) and the International Covenant on Civil and Political Rights (UN, 1966b) in 1975. Regarding the provision of services in the health sector, the ethnocentric second Rwandan republic might have been opposed to the principle of non-discriminatory treatment, outlined in these covenants, as well as to the universal access to PHC, outlined in the Declaration of Alma-Ata (WHO 1978). To assess how GDC has steered through these scenarios during the 1980s, the evaluation team has probed into another context hypothesis.

Context Hypothesis 2: Health policies during the Habyarimana regime negatively influenced Rwandan-German interventions in the health sector with regard to protection of minorities and the health equity of services.

Since the 1980s, PHC has been a key strategy to improve the health of the Rwandan population. The GoR appears to have adopted the PHC strategy shortly after the Alma-Ata conference (Mirasano, 1984, p. 33; cf. also Mungwakuzwe, 1985) (cf. Box 1 and Annex G). Further governmental priorities were the decentralization of tasks, responsibilities, and resource allocations for health (INT EXP 21). Rwanda expanded the geographic coverage with primary healthcare services and invested in the training of health personnel, focusing on PHC professionals and not on specialists.

Box 1. Declaration of Alma-Ata and primary health care

The Declaration of Alma-Ata (1978) can arguably be considered as the single most relevant international agreement on health for developing countries and has led to the adoption of the concept of PHC as a blueprint for universal coverage with essential primary health services. To date, PHC has become – and remains – an important health-policy issue in many developing countries.

PHC is defined as “essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination” (WHO 1978: Article VI).

In 1985, Rwanda adopted a health development strategy in the spirit of the Lusaka Declaration, building on decentralized management and district-level care (GoR, 2005a), which would also be revitalized during the country’s decentralization process in the late 1990s (cf. Box 3 in Section 3.1.2 and Annex G). The strategy guided forthcoming investment in the Rwandan health care sector and helped the country to develop a clear-cut planning for hospitals, thus avoiding duplication of financing facilities. This was particularly relevant in view of the fact that beyond the state, other organizations were providing health care to the Rwandan population.¹¹ The previously mentioned drop in the price of coffee, combined with external pressure for structural adjustments, had severe consequences on the economic situation of Rwandan households, reducing their resources for healthy nourishment. By 1989, the government budget was so sharply reduced that the major coping strategy was to cut social services (cf. Prunier, 1995, p. 93). From 1975 Rwandans were made to pay for health care – exceptions were only made for the indigenous and only if facilities had abundant external funds (INT EXP 21). Rwanda began to implement the HF policy of the Bamako Initiative as of 1989 (cf. Box 2 and Annex G) with the principal objective of cost recovery (Schneider, Diop, & Bucyana, 2000, p. 10).¹²

Box 2. Bamako Initiative

The Bamako Initiative (1987) was an early expression of “structural-adjustment” policies, resulting from a meeting of African ministers of health. The Initiative proposed decentralizing health decision-making to local levels and establishing realistic national drug policies to enhance the provision of essential drugs for sub-Saharan Africans. The resolution of the Bamako conference referred explicitly to Alma-Ata and called for promoting PHC by defining and implementing self-financing mechanisms at the district level, encouraging social mobilization, and ensuring a regular drug supply. The most relevant, well known, and most controversial innovation of the Bamako Initiative was the implementation of user fees in public health facilities in many African countries.

In addition to these influences on the Rwandan health sector, one of the most important and controversial topics of health

¹¹ In particular, religious and charitable organizations had set up a country-wide provider system aligned with public facilities. Approximately 60% of the 272 health facilities that were effective in 1986 were operated by the public sector and 50 – 60% percent of the Rwandans seeking clinical services turned to private centers, mostly operated by the Catholic Church (cf. May, Mukamanzi, & Vekemans, 1990).

¹² The highly controversial report, “Financing Health Services in Developing Countries: An Agenda for Reform”, underscored the need for improved health sector financing and prioritized user fees and patient charges as a means to mobilize resources and make health financing more sustainable (Akin, Birdsall, & de Ferranti, 1987). The report refers explicitly to the Alma-Ata Declaration and considers primary health care principally under financial criteria.

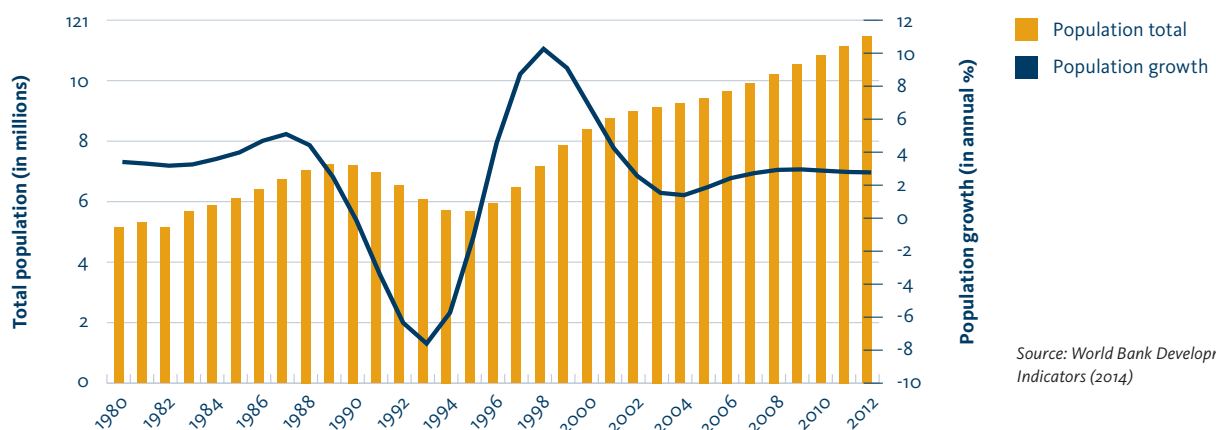
politics at that time should be examined: family planning. It appears unlikely that the Habyarimana regime applied the same stance on every family in Rwanda, disregarding the respective ethnic and, possibly, clan background. Although programmatically outlined and formally supported by GoR, family planning could have been contrary to the politics of Habyarimana of glorifying the peasant life-style and to his traditional beliefs in the need to have many children in order to guarantee self-sustainability in a rural context. For a long time, Habyarimana was reluctant to introduce a comprehensive policy to reduce the birth rate (Verwimp, 2000) and there are accounts of raids on pharmacies selling condoms, which was tolerated by the Ministry of the Interior (Prunier, 1995, p. 89). Indeed, population pressure was picking up in Rwanda (cf. figure 5) and by 1993, Rwanda ranked among the top ten countries in the world with the highest population density exceeding 3,000 people per 1,000 hectares, on average (World Resources Institute, 1994). This imbalance between policy decision and demographic trends leads to a third context hypothesis.

Context Hypothesis 3: A lack of genuine political backing during the Habyarimana regime reduced the relevance and results of Rwandan-German interventions in family planning.

During the volatile period between the onset of the civil war in 1990 and the Arusha peace process, it became clear fairly soon that the old regime would not be able to maintain its exclusive grip to power (Prunier, 1995: 367). International mediators pressed for the introduction of a multi-party system and an interim government with a proportionate ethnic distribution. The prospect of a forced opening up of the political arena drove hardliners of the Habyarimana government into an extreme “instrumentalization” of ethnicity. Ultimately, parties were centered only on ethnic considerations and there was a perception of one key alternative: Hutu or Tutsi – ‘us or them’.

The ethnically loaded conflict peaked when the airplane, on which President Habyarimana was on board, was shot down over Kigali in April 1994. Hutu extremists seized power within hours and the state-orchestrated genocide commenced.¹³ Ethnic hardliners of the Hutu majority systematically exterminated Tutsi and moderate Hutu, with an estimated death toll ranging between 500,000 (Des Forges, 1999; Melvern, 2000) and over one million (GoR, 2013). Concomitantly, the Rwandan Patriotic Front started to invade the country from its Ugandan exile. When the offensive gained ground, it triggered the mass exodus of an estimated 2.1 million Rwandans to the Democratic Republic of the Congo (DRC; at that time, known as Zaire).

Figure 5: Rwanda – Population (total) and population growth (annual %) 1980-2010.



¹³ As this evaluation focuses on the health sector, the genocide is only briefly covered to ensure continuity for readers not familiar with Rwanda's history. For more detailed accounts that render justice to this undoubtedly worst period of Rwanda's history, covering the causes leading to the genocide, its onset, and its course of events, refer to the seminal works by Des Forges (1999), Prunier (1995), and Straus (2006).

3.1.2 Emergency relief, continued insecurity, and consolidation (1995 – 2003)

Following its military victory, the RPF established a new government in Kigali on July 19, 1994. The remainder of the old Habyarimana regime reorganized and continued carrying out incursions into Rwandan territory from their DRC-based refugee camps. In 1996, the RPF responded with troop deployments to the DRC, marking the onset of a series of wars that, ultimately, involved not only the governments of the DRC and Rwanda, but also seven other African countries and numerous irregular movements and forces (cf. Prunier, 2009a; Prunier, 2009b). This gave rise to a constant feeling of insecurity and an overall threatening environment in Rwanda (Ingelaere, 2009), especially in the North-West. Domestic security and political stability were consolidated several years later.

An international joint evaluation, commissioned to take stock of the complex Rwandan emergency, has demonstrated a dramatically changed environment following the genocide (cf. Eriksson et al., 1996). An estimated 80% of health professionals, who had worked in Rwanda, were killed or had fled the country by mid-July 1994. Emergency assistance, mainly provided by non-governmental organizations (NGOs) and multilateral agencies, focused on internally displaced people and refugees with at least 200 NGOs involved in the overall emergency response. While efforts to rebuild the country's infrastructure quickly showed results (by 1996, health delivery systems had largely been rebuilt to pre-1994 levels), formal cooperation between the international community and MoH, however, only progressed slowly due to accountability and legitimacy concerns relating to GoR at that time.

To prepare for bilateral government negotiations for development cooperation in this context, BMZ commissioned an evaluation in 1998 of a selection of projects in the German health portfolio (Wolff & Mehler, 1998). The aim was whether projects in the areas of refugee reintegration, justice, education, and media¹⁴ since 1994 could alleviate the drivers of conflict. In 1998, armed unrest in Rwanda was still widespread, resulting in about one

third of the country classified as insecure and, therefore, making it impossible for access to external assistance. As a corollary to the report by Wolff and Mehler, the German health portfolio was not subjected to fundamental strategic re-orientation at the time. The evaluation, however, provided an overview of the health sector. While 86% of the government's total health expenditure came from foreign sources, Wolff and Mehler report that health spending by an average household was about 5.4% of annual income (between 2,700 and 3,700 RWF at that time). Consistent with the findings of the joint evaluation, the evaluation study also found that nearly all health facilities had been rehabilitated and re-opened, albeit the proliferation of health staff and drugs and the geographic and financial access to health care were problematic. Directly after the genocide, Rwanda received extensive and relevant international assistance. This allowed for health services to be free of charge until the end of 1996, when most international NGOs phased out their support (INT HF 32; cf. Soeters, Musango, & Meessen, 2005). As a consequence, the use of health services dropped to 0.25 consultations per capita per annum by 1999 (INT RP 1; cf. also Schneider, 2005).

Further core problems, identified by Wolff and Mehler and relating to health, were the high proliferation of poverty, low-quality, and coverage of social services (especially health), and demography. The genocide's death toll, by 1998, was balanced by the large repatriation of refugees,¹⁵ which led to an estimated population of approximately 8 million and equaling the pre-genocide level (cf. also Figure 5). The core issues relating to health before the genocide, therefore, were still relevant, and the volatile post-conflict period presented even more problems to resolve. To assess their relevance and effectiveness, it is necessary to examine how German development cooperation has responded to this challenging situation, which leads to the following context hypothesis:

Context Hypothesis 4: German bilateral cooperation followed its pre-genocide agenda in the health sector rather than having delivered strategic and programmatic support.

¹⁴ Media projects refer to support to Radio Rwanda. It should be noted that the media (especially Radio Télévision Libre de Mille Collines, RTML) played a significant role in igniting hatred and mobilizing for the genocide. All projects under evaluation in 1998, therefore, conform to a wider definition of today's concept of "transitional justice".

¹⁵ A period of tension between the Tutsi and Hutu groups in the late 1950s and early 1960s, the so-called Rwandan Revolution, led to the flight of an estimated 600,000–700,000 Tutsi to countries neighboring Rwanda (Prunier, 1995, p. 63). Many of these refugees and their descendants returned after the RPF captured Rwanda.

On the individual level, the Rwandan population had to cope with *imitima yarakomeretse*, “the disease of the wounded hearts” (Prunier, 2009a, p. 37) after the traumatic events experienced during the civil war of 1990, the genocide, the RPF invasion, and regime change. About 73% of the population reported having lost at least one family member (Pham, Weinstein, & Longman, 2004). Rural families, therefore, were not receptive to the family planning communication after 1994 (INT InD 12, 33), which leads to the next context hypothesis:

Context Hypothesis 5: German cooperation continued to support family planning after the genocide without major changes, rather than having adapted it to a changed scenario to ensure relevance.

The evaluation team found no trace of Rwanda having adopted, in the mid- and late 1990s, any significant international health policies or initiatives (cf. Annex G). Therefore, the period since the onset of the civil war in 1990 to the turn of the 21st Century could be considered as the country’s “lost decade”. There has been, however, impressive progress since 2000, when Rwanda adopted a health development strategy, based on decentralized management and district-level care in the spirit of the Lusaka Declaration of 1985 (cf. GoR, 2005b).

Box 3. Lusaka Declaration

The Lusaka Declaration (1985) on the decentralization of the national and district health systems has neither significantly attracted the attention of policymakers nor of scholars. In Rwanda, however, the declaration was pronounced loudly in Rwandan policy papers ten or more years later (GoR, 2005a, 2005b). The Lusaka Declaration promotes three strategies to improve the quality and access to health services: (1) decentralization of the health system using the health district as the basic operational unit; (2) development of PHC systems; and (3) reinforcement of community participation in the management and financing of services (GoR, 2005b, p. 5).

3.1.3 Reconciliation – security – development (2004 – 12)

While it is a challenge to provide a clear-cut end to the post-conflict period, this evaluation considers 2000 and 2003 as critical periods. The security situation in Rwanda drastically improved following the Lusaka Accords of 1999 and the Pretoria Agreement of 2002. Ever since, domestic peace in Rwanda has remained stable.¹⁶ Furthermore, the first presidential election following the genocide reflected improved political consolidation.¹⁷ The government under Paul Kagame has pursued a comprehensive and deliberate policy to bridge the ethnic rift in Rwanda’s society and to rebuild the Rwandan nation. Major building blocks can be summarized along a legal, social, and security dimension. From a legal aspect, a three-level judiciary system is responsible for genocide perpetrators. The United Nations International Tribunal for Rwanda has sought to prosecute individuals accused of planning the genocide and crimes against humanity, while the Rwandan national court system and the Gacaca lay courts (with elected judges at the community level) handles the trials of genocide suspects accused of all other genocide-related crimes (UN, 2013). A leading principle of these Gacaca courts is forgiveness, in which perpetrators confess, apologize, and are sent to serve their sentences by doing community service activities (Rugege, 2006). From a social angle, the creation of the National Unity and Reconciliation Commission can be considered a major policy effort. Created in 1999, its goal promotes freedom and mutual respect, denouncing destructive actions in an effort to erase the negative consequences of the genocide on the Rwandan people (GoR, 1999). By organizing national summits, meetings, and conferences on unity and reconciliation, as well as workshops as part of ‘civic reeducation’ or ‘solidarity’ camps, the National Unity and Reconciliation Commission aims to reduce tensions within the population (Zorbas, 2004). With regard to security, domestic and external resources have been allocated to regional frameworks to support disarmament, demobilization, and the reintegration of ex-combatants in the greater Great Lakes region, such as the Multi-Country Demobilization and Reintegration program from

¹⁶ In these accords, the DRC committed to handle the presence of irregular fighters threatening Rwanda from Congolese soil. The GoR, in turn, was to draw back its military forces (International Crisis Group, 2005). The conflict in Kivu in the east of DRC continued after the Rwandan withdrawal on a geographically smaller, but by no means less bloody, degree. In 2009, Rwanda intervened a third time in the DRC with the Congolese Government during the joint military operation, *Umoja Wetu* (“Our unity”). Until today, sporadic explosions on Rwandan territory and artillery ricochets from the DRC prevail.

¹⁷ The former commander of the RPF and then Vice-President and Minister of Defense, Paul Kagame, was voted for President by Parliament in 2000 and was reconfirmed by the 2003 elections. However, international observer groups do not yet rate Rwanda as a consolidated democracy. Compare this to the country profile of Freedom House (Freedom House, 2013) or the Bertelsmann Transformation Index for Rwanda (Bertelsmann Foundation, 2012). Both indices go back to a liberal understanding of democracy and, more concretely, to Dahl’s concept of ‘polyarchy’ (Dahl, 1989), which may prove difficult when applying it to a country with a similar history to that of Rwanda.

2002 to 2009 and its successive program, currently in operation (World Bank, 2010).

The shift towards legal reform and the safety of Rwandan citizens has been accompanied by a development-oriented administration, the latter of which is a continuation rather than an innovation in the Rwandan context.¹⁸ Rwanda has maintained its pragmatism and its relatively low degree of corruption from the pre-genocide years, and the West has continued to provide Rwanda with aid at an exceedingly high rate (cf. Zorbas, 2011, and the portfolio analysis chapter). Together, these trends mark the end of the post-conflict situation and provide the basis for increased legitimacy and stability to tackle policy reform.

In the meantime, Rwanda has become one of the permanent drivers of the ongoing African economic revival. The Rwandan economy has continuously shown growth rates above 7% (except in 2003, 2007, and 2009 due to the global financial crises). According to the World Bank, gross domestic product per capita has more than doubled between 2000 (USD 580 per capita in purchasing power parities) and 2011 (USD 1,251 per capita in purchasing power parities) (World Bank, 2014). Economic and administrative efficiency, consequently, have been, and are, at the forefront of many initiatives of Rwanda's government subsequent to 2000. While a degree of domestic security not witnessed for a long spell prevails in Rwanda, this comes at the cost of a restriction on democratic rights, such as freedom of speech and the right to form associations and parties (Longman, 2011).

Currently, GoR has embarked on a number of high-level policy processes. The single most important policy statement for Rwanda stems from the so-called Vision 2020: "The VISION seeks to fundamentally transform Rwanda into a middle-income country by the year 2020." (GoR & MINECOFIN, 2000, p. 9). Rwanda expects to reach this goal in a pro-poor way, with six pillars comprising sub-targets, including ones to lower population growth and improve citizens' health (p. 14). The building blocks of the Rwandan policy architecture are aligned with Vision 2020. The commitment to achieve the MDGs by 2015 (cf. Box 4) and

the Poverty Reduction Strategy Paper (PRSP) process are seen as intermediate steps leading to the long-term goal of Vision 2020.

Box 4. Millennium Development Goals (MDGs)

The Millennium Development Goals, following the United Nations Millennium Summit and Millennium Declaration in 2000, define eight time-bound targets that, when achieved, would end extreme poverty worldwide by 2015 (UN, 2000). In particular, MDGs 4 (reduce child mortality), 5 (improve maternal health), and 6 (combat HIV/AIDS, malaria, and other diseases) relate to health. The MDGs arguably have become the most relevant landmark in international cooperation.

Based on an interim PRSP (GoR 2000), the first large-scale efforts for medium-term planning began in 2002. The first PRSP (PRSP I; GoR, 2002) identified priority areas that were strongly influenced as a result of the closing of the emergency period, and it aimed to assist in a recovery from the genocide legacy and to consolidate the achievements up until 2002 (GoR, 2007, p. 7). It also reflected the findings of the Commission on Macroeconomics and Health (Sachs, 2001) by following the new paradigm that investment in health be considered an important condition for development and poverty reduction (cf. Annex G). The focus on health included an emphasis on the strong potential to prevent diseases and PHC, as stated in the Declaration of Alma-Ata, with priority set on selected infectious diseases – prompted by the MDGs and GFATM (cf. also Box 5) – pro-poor HF, and health systems strengthening, according to World Bank policies of that time.

Box 5. Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM)

The Global Fund to Fight AIDS, Tuberculosis and Malaria was created in 2002 as a consequence of the United Nations Special Session on HIV/AIDS (cf. Annex G) of 2001 to tackle the challenge of achieving MDG 6 (to combat HIV/AIDS, malaria, and other diseases) by 2015. The GFATM began operations in January 2002 as an international finance organization to generate and allocate additional resources to prevent and treat the three diseases. The main role of the GFATM is a financial mechanism where implementation is done by the in-country Country Coordinating Mechanisms that include the various national stakeholders involved.

The successor to PRSP, the Economic Development and Poverty Reduction Strategy (EDPRS), covered the period 2008–12. The

¹⁸ On the other hand, compare this to (Booth & Golooba-Mutebi, 2012), who attempt to demonstrate a new aspect of Kagame's policy, which they term 'developmental patrimonialism'.

EDPRS contained three “flagship programs” (GoR, 2007): (1) sustainable growth for jobs and exports, (2) poverty reduction in rural areas through the Vision 2020 *Umurenge* Program; and (3) governance. The EDPRS, furthermore, provided the national priorities within which the strategic sector plans should be developed. Health is anchored under “complementary sectoral interventions to achieve the EDPRS targets” (p. 91), with special emphasis on strengthening health programs, slowing down population growth, and extending social protection (cf. also Doc.41).¹⁹

The 2002 PRSP already had acknowledged the importance of elaborating and harmonizing sector strategies to achieve the formulated goals (GoR, 2002, p. 35). The first Health Sector Strategic Plan (HSSP I) dates back to 2005 and outlined the health sector priorities of the Rwandan MoH until 2009 (GoR, 2005b): (1) ensuring the availability of human resources; (2) ensuring the availability of quality drugs, vaccines, and consumables; (3) expanding geographic accessibility; (4) improving financial accessibility of health services, (5) ensuring quality of and demand for services in controlling disease, (6) ensuring the quality of and demand for services in national referral hospitals and research and treatment institutions; and (7) reinforcing institutional capacity. The subsequent HSSP II for 2009–12 (GoR & MoH, 2009) categorized program areas along two pillars: client-centered service delivery and support services. Client-centered services included “all objectives and outputs directly related to improving the health of the people” (p. 21), such as family planning, SRH, maternal and child health, and prevention through attitude and behavior change. The support services included “objectives and outputs that provide an enabling environment for service delivery to be optimally effective and efficient”, thus relating to health systems strengthening (p. 21). German program areas, such as HF and HRH were explicitly stated. HSSP II underwent a mid-term review in 2011 (IHP+, 2011), combined with a Joint Assessment of National Strategies (IHP+, 2012), which has fed into what is now HSSP III (cf. Doc.28). The HSSPs were, in turn, operationalized through more specialized policies – e.g., for CBHI (MoH, 2010a) or Human Resources (GoR & MoH, 2006a) – which are reflected

when assessing the components of the Rwandan-German program.

Rwanda was very effective in applying for funds from the GFATM (cf. Box 5 and Annex G). It became the largest grant recipient at the regional level. More recently, Rwanda has appeared among the few countries that have attained universal access to antiretroviral therapy, which is defined as coverage of at least 80% of the population in need (UN, 2012, p. 42). In addition, GFATM resources have paid over 1.5 million annual insurance premiums for very poor people and 146,130 annual premiums provided for people living with HIV/AIDS (Benn, 2009, p. 65). Rwanda presents a noteworthy exception to the usual *modus operandi* of GFATM: GFATM resources were not only used to finance vertical efforts, but also used to cover the poor with social health protection (cf. Schmidt, 2012, p. 134). There is an on-going debate on whether the vertical approach (versus horizontal or health sector approaches) undermines the overall health of large populations and fosters an imbalance in the provision of health care services by focusing on specific illnesses and, thus, diverting human and capital resources from PHC services, contradicting the Alma-Ata Declaration (Global Health Watch, 2011). The international community has, in the meantime, started to recognize the counter-productive effects of illness-related programs and has begun to shift the debate back to horizontal schemes. The understanding of what health systems strengthening means, however, is quite unclear and variable and, as observed in the Lancet, “no consensus exists for the operational definition of health-system strengthening” (Reich & Takemi, 2009, p. 509).

Two other policy strands merit description when outlining the health sector policy architecture, and they will be addressed more depth elsewhere. These are the development effectiveness agenda and decentralization (cf. also B.3.7 and B.3.3.1). Rwanda strongly commits to the agenda laid out in the Paris Declaration of 2005 (cf. Box 6) and issued an aid policy as early as 2006 to manage external support, according to the Paris principles (GoR, 2006). The policy also raises critical questions with regard to international aid, in particular vertical programs, and it calls for

¹⁹ EDPRS 2, implemented in 2013/14 and setting Rwanda’s agenda until 2017/18, was in progress when this report was drafted. In future, health will be factored in less prominently (cf. INT EXP 9) under “foundational” issues or, in the case of HIV/AIDS, “cross-cutting” issues (cf. GoR 2013).

aid effectiveness and alignment with government priorities and systems (cf. also Box 6). To harmonize development support and make international aid more effective in accordance with its national priorities, Rwanda introduced a policy of Division of Labor among the DPs for implementation in 2010 (MINECOFIN, 2013). The cessation of German support to the health sector, due to the Division of Labor policy among DPs, can be traced back to this agenda.

The decentralization process commenced in 2000 and entered its second phase in 2005, with an administrative reorganization,²⁰ including the minimum requirements for geographic coverage (one hospital per district; one health center per sector; one health post per cell. Throughout all the levels of administration, accountability has been included as a key principle for the GoR to follow. Despite these decentralization efforts, a study by the United States Agency for International Development (USAID) (Fox, Ravishankar, Squires, Williamson, & Brinkerhoff, 2010) shows, that the institutional accountability for end users of health services remains insufficient. Key managers of the health sector (e.g., CBHI) often do not have the capacity to supervise and monitor the daily activities of local health facilities (cf. MoH, 2011b). Due to misinformation and a lack of clearly defined responsibilities, they often do time-consuming work, for which they are not responsible and their relationships between the district person “in-charge-of-health”, health facility managers, and district council are ill-defined.

Box 6. Paris Declaration on Aid Effectiveness

The Paris Declaration on Aid Effectiveness of 2005 addresses the absence of coordination between national and international development efforts and the lack of harmonization of international aid. The five fundamental principles of the Declaration (ownership, alignment, harmonization, managing for results, mutual accountability) have gained significant momentum in the health sector, where partners work together to support a single, country-led national strategy in a well-coordinated way.

The specific relevance of the Paris Declaration for development strategies in the health sector lies in achieving the right mix of flexibility and predictability; alignment to country priorities and reduced transaction costs associated with donor finance for better planning; budgeting; and implementation capacity in the health sector.

The relative ease with which GDC was able to cooperate with GoR throughout the time under scrutiny and, especially during the last decade, partly can be explained by the Rwandan stance on development, which paralleled international development paradigms to a high degree. Although Rwanda can also claim ownership of development processes, there is doubt whether government ownership includes the Rwandan people. On the other hand, however, one can conclude that policies are mostly linked to periodic checks and, more often than not, this is done with clear indicators. Ultimately, Rwanda’s success, in economic terms, is one of the many indicators legitimizing Rwanda’s approach for the time being.

3.2 Portfolio analysis

The portfolio analysis aims to provide information about the resource allocation across sectors and over time by GoR, DPs, and bilateral Rwandan-German development cooperation. This is relevant in order to understand the role of GDC in the health sector and to examine the size of the aid contribution in absolute and relative terms. The analysis, therefore, focuses on change over time and investigates the flow of aid to the health and other sectors. The analysis covers the period 1980–2012 in terms of bilateral cooperation through the data information system of BMZ (BMZ, 2012b), donor contributions in the period 2002–11 through the Creditor Reporting System²¹ of the OECD, and all health expenditures for the latest financial year of 2011/12 through the Rwandan Health Resource Tracking Tool (HRTT).²² In addition, public expenditures are analyzed using available National Health Accounts.²³ The main limitation of the portfolio

²⁰ During this phase, the number of provinces (previously called *préfectures*) was reduced from 15 to four (in addition to Kigali) and the number of districts from 106 to 30. Below the district level, there are 416 sectors (*imirenge*), 2,150 cells (*akagari*) and almost 14,826 villages (*imidugudu*) (cf. GoR & MoH, 2009, p. 15).

²¹ The Creditor Reporting System is maintained by the Development Assistance Committee (DAC) of the OECD. The information in the Creditor Reporting System database is submitted by donor agencies and verified by the OECD. Information is published annually. The data cover the commitments of official development assistance (ODA) (as of 1995) and disbursements (as of 2002).

²² The HRTT was established in 2010 with the support of the Clinton Health Access Initiative and the US Government to track funds provided to the health sector by DPs. The tool is meant to support planning capacities of public administration and to identify the gaps in allocative effectiveness. The tool, therefore, supports public financial management, especially at decentralized levels.

²³ National Health Accounts 2006 (GoR & MoH, 2008), 2003 (GoR & MoH, 2006b), 1998 (PHR, 2000).

analysis, however, has been the lack of data. The evaluation has very limited information about Rwanda's national budget, the contributions of donors, and the various aid modalities across sectors and time.

In addition to this chapter, more detailed and comprehensive information is provided in additional tables and figures in Annex H. As the focus of the evaluation is beyond the project level, information on the disbursements of single projects is not part of the portfolio analysis. Relevant information at the project level is provided within the respective parts of Phases I-III (Chapter B.1.-B.3.).

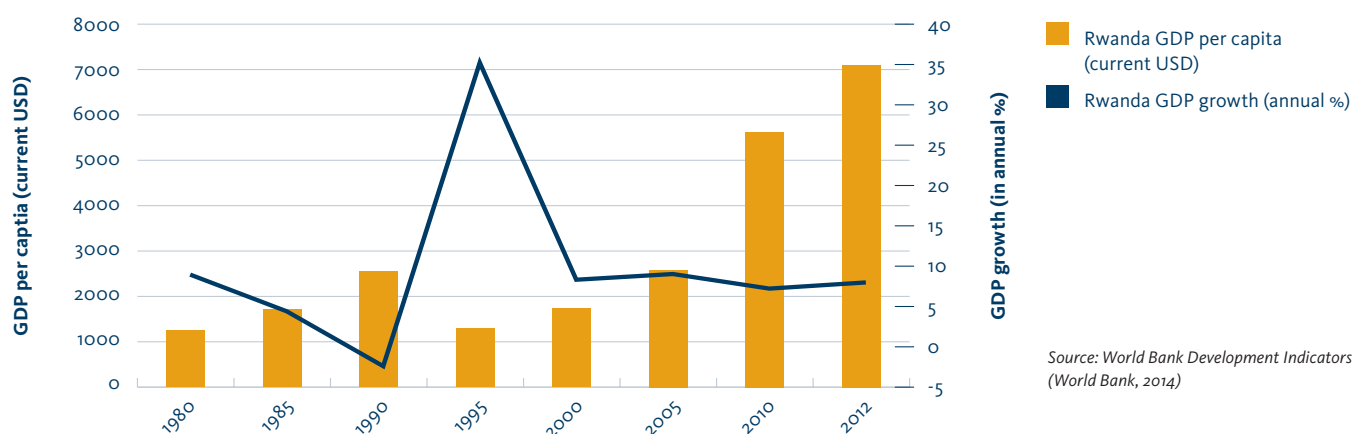
Government spending and the role of aid

Rwanda, while still among the poorest countries in the world today, has made remarkable progress since the dramatic event of the genocide, which severely affected Rwanda's social and

economic development in the mid-1990s. While gross domestic product (GDP) dropped below USD 800 million during the war (1994), GDP per capita amounted only to USD 130 in 1995 (measured in current US dollars) (World Bank, 2014). Since then, continuous GDP growth above 5% has led to a GDP of USD 6.4 billion in 2011 (Figure 6) with a GDP per capita of USD 570 (World Bank, 2014). Nevertheless, this still leaves about 80% of the population (11 million) under the poverty line at USD 2 per capital per diem (NISR, 2012).

Today Rwanda's development strategy is based on economic growth, transformation, reduced aid dependency, and pro-poor development, and the country is now on track to achieve most MDG targets by 2015. It remains, nevertheless, the fifth most aid-dependent country in the world, accompanied by high poverty levels and economic inequality (Abbott & Rwirahira, 2012).

Figure 6: Rwanda – GDP per capita (current USD) and GDP growth (annual %)



Source: World Bank Development Indicators (World Bank, 2014)

In 2011, the Rwandan national budget stood at RWF 1.1 trillion (USD 1.9 billion) (MINECOFIN, 2012b), with the amount of RWF 129.6 billion (USD 218 million) – or 11.5% in 2010 – allocated to the health sector. This was well below the minimum target of 15% for health that was stated in the 2001 Abuja Declaration²⁴ (GoR & MoH, 2012). The latest budget plan further reduces this share to 9.5% for Fiscal Year 2013/14 (Abbott & Malunda, 2013).

In comparison, the national budget for infrastructure, education, and agriculture accounted for 22%, 15% and 6%, respectively (OECD, 2013).

Overall, ODA disbursements in Rwanda have been steadily increasing between 2002 and 2011 – from USD 335.9 million to USD 1.3 billion (Table 3) (OECD, 2013). This development was

²⁴ In 2006, the 15% target of the Abuja Declaration was also included in the Maputo Plan of Action, agreed by 48 African countries, among them Rwanda.

accompanied by a shift from humanitarian-oriented assistance in the post-genocide period to a development-oriented type of assistance. SWAp agreements have been signed with DPs in seven sectors to reduce transaction costs and fragmentation. ODA disbursements peaked in 2006, when Rwanda was given debt relief, most of which was provided by the World Bank's

International Development Assistance (USD 877.1 million) and the African Development Fund (USD 315.2 million) (OECD, 2013). Aid dependency fell from 86% in 2000 to around 40% in 2011 (Abbott & Rwirahira, 2012; OECD, 2013). This change of direction will be pursued in accordance with Vision 2020 and EDPRS 2 (Abbott & Malunda, 2013).

Table 3. Total aid disbursements in the Rwandan health sector (in millions of current US dollars)

	DAC 5 Code*	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Health	120 & 130	32.99	36.16	85.20	99.51	141.9	166.06	245.56	258.32	305.79	322.26
%/all		9.8%	11.4%	17.4%	16.3%	7.4%	24.3%	27.8%	28.1%	29.8%	25.3%
All		335.87	318.12	488.76	611.63	1,909.67	682.54	881.90	918.56	1,024.6	1,272.53

Source: Creditor Reporting System database (OECD, 2013).

Note: In the Creditor Reporting System, data on the sector of destination are recorded using five-digit purpose codes. The first three digits of the code refer to the corresponding DAC5 sector or category. Code 120 includes general health (e.g., health policy, medical education and research) and basic health (e.g., health infrastructure, disease control, nutrition and basic health care). Code 130 includes population policies and reproductive health (e.g., reproductive health care, family planning, STI control and HIV/AIDS).

In Rwanda, program- and project-based support accounts for the biggest share of ODA. However, the 2006 Rwandan Aid Policy prefers General Budget Support (GBS), sector budget support (SBS) and basket funds to ensure alignment with government priorities and to reduce delivery and transaction costs (MINECOFIN, 2011b). Before 2004, up to 30% of Rwanda's aid was delivered through budget support and remained, on average, between 10–20% in the subsequent years. Budget support was mainly provided by donors, such as the European Union, Sweden, United Kingdom, and World Bank. Other donors, such as Belgium, France, Germany, Japan, and United States have recently joined this group. In the period between 2009 and 2012, GDC was engaged in GBS and SBS with a total of EUR 31 million and EUR 13 million, respectively. GDC support to SBS was only provided to the health sector. Basket funding of EUR 0.6 million in the health sector was provided in the form of the CDPF. Program- and project-based support is managed through Single Project Implementation Units²⁵ (Versailles, 2012).

According to OECD-DAC categories 120 (health) and 130 (population policies/programs and reproductive health), the share of aid disbursements on health relative to total aid disbursements peaked in 2010 (29.8%), forming the most important sector assisted by foreign donors in that year (Table 3). The period 2002–11 has witnessed a major expansion of aid disbursements in the health sector, rising from USD 32.99 million in 2002 to USD 322.26 million in 2011 (measured in current US dollars). This expansion of donor support to the health sector has been driven, to a large extent, by population policies and programs and reproductive health aid disbursements (USD 220.8 million in 2011), in particular, STI control (including HIV/AIDS).

The major donors financing STI control, including HIV/AIDS, have been GFATM and the United States.²⁶ Germany had also provided considerable funds between 2008 and 2011 (Table 4). Besides HIV/AIDS, Germany has focused on reproductive health issues through GTZ/GIZ, DED/GIZ, and KfW (DSW, 2010).

²⁵ In order to keep best practices in project implementation identified in the Paris Declaration and the Accra Agenda for Action, GoR established Single Project Implementation Units across all government ministries and project implementation agencies in 2011 to coordinate program- and project-based support.

²⁶ Worldwide, the GFATM made a total of USD 22.9 billion available for some 1,000 programs in 151 countries from 2001 to 2011; Germany has committed more than EUR 1.3 billion (approximately USD 1.6 billion) to the GFATM since it was set up, contributing approximately 7% overall.

Table 4. STI control including HIV/AIDS in Rwanda (in millions of current US dollars)

	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
United States	1.64	11.15	19.72	24.08	43.15	57.25	66.31	84.49	92.34	102.09
GFATM		2.11	10.50	15.64	12.87	31.48	47.26	31.35	103.37	101.26
Germany	0.40	0.87	0.99	1.45	0.68	0.79	2.47	11.31	3.00	3.45
Other donors	0.73	3.76	9.91	14.83	19.93	17.84	14.61	7.93	4.12	2.37
All GFATM	2.77	17.89	41.12	56.00	76.63	107.36	130.65	135.08	202.85	209.18

Source: Credit Reporting System database (OECD, 2013).

Note: In the Creditor Reporting System, STI control (including HIV/AIDS) is recorded under code 13040, the first three digits referring to the DAC5 category 130 (Population Policies/Programmes and Reproductive Health).

Portfolio development of the Rwandan health sector

Between 2000 and 2010, total health expenditure quintupled, from USD 73 million to USD 401 million (GoR & MoH, 2012) – USD 39 per capita per annum (compared to USD 34 in 2006) – a low average compared to international standards. Against the macroeconomic trend of reduced aid dependency in Rwanda within the last decade, health expenditures relied heavily on external funding, with 63% of total health expenditure having been financed by donors in 2010, compared to 33% in 2002 (GoR & MoH, 2012). While the World Bank (2013) estimates of external

resources to the Rwandan health sector differ in absolute terms, the relative share of external funds in the Rwandan health sector is high in comparison to other countries in sub-Saharan Africa (Figure 7). Including private sources, all external funds amounted to USD 336 million, or 84%, in 2010 (Table 5). The largest share of funds, therefore, came from new global disease initiatives, such as GFATM, the President's Emergency Plan for AIDS Relief, and his Malaria Initiative. At the same time, the government share in total health expenditure declined from 25% (2002) to 16% (2010).

Figure 7: External resources for health (% of total expenditure on health)

Source: World Bank Development Indicators (World Bank, 2014)

German development cooperation to the health sector peaked in 2009 (USD 12.9 million) and 2010 (USD 10.1 million), when most of the funds were disbursed among the population and to the reproductive health sub-sector. The bulk of German bilateral aid, however, had been disbursed to the general health sub-sector since 2002 (DAC 5 code 120). This is in contrast to other donors

who focused mainly on the population and reproductive health sub-sector (DAC 5 code 130). The funding priorities also underlined the GDC focus on broader health systems strengthening. Over the years, the US Government has been the largest donor in terms of health. In 2011, USD 126.9 million was disbursed, which accounted for 39% of donor funding (USD 322 million) (Table 6).

Table 5. National health expenditures

	1998	2000	2002	2003	2006	2010
Total GoR expenditure (millions of US dollars)	304.5	384.8	327.7	432.7	756.2	
Total health expenditure (public, private, donor) (millions of US dollars)	82.4	73.0	80.8	142.1	307.3	401.0
GoR health expenditure as % of GoR total expenditure	2.50	4.70	6.10	9	6.50	11.5
Financing sources distribution as a % of total health expenditure						
Public (in %)	10	18	25	32	19	16
Private (in %)	40	30	42	25	28	21
Donor (in %)	50	52	33	42	53	63

Source: Data for 1998–2006 from National Health Accounts 2006 (GoR & MoH, 2008); data for 2010 from HSSP III (GoR & MoH, 2012). Note: The figures in this table do not allow for recalculation of total GoR expenditure and are not directly comparable to the data provided in Table 6 due to different data sources and definitions. All US dollar amounts are in constant 2006 US dollars.

Multilateral aid disbursements to the population and the reproductive health sub-sector soared in 2010; this large increase was driven by a rise in GFATM disbursements (cf. Table 4).

Consequently, multilateral aid disbursed to the population and reproductive health sub-sector surpassed multilateral aid disbursements in the general health sub-sector from 2010 onwards.

Table 6. ODA health disbursements in Rwanda (in millions of current US dollars)

	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
All Donors	32.99	36.16	85.2	99.51	141.9	166.06	245.56	258.32	305.79	322.26
Bilateral (all)	22.38	27.45	39.24	45	71.88	92.93	137.38	157.27	154.62	166.91
Germany	0.57	1.86	2.87	3.72	4.31	3.72	5.5	12.94	10.1	9.39
USA	9.51	15.43	23.85	27.81	49.03	68.67	93.59	113.42	113.06	126.93
Multilateral	10.61	8.71	45.96	54.51	70.02	73.14	108.18	101.05	151.17	155.36

Source: Creditor Reporting System database (OECD, 2013).

Program- and project-based aid remain the dominant aid modalities in the health sector. Between 2008 and 2012, only USD 61.6

million had been disbursed through SBS (Synergy International Systems, 2013). In 2010, the share of SBS to total donor funding

amounted to 6.25 % (USD 16 million). Three donors contributed to SBS between 2008 and 2012, including Belgium, Germany, and United Kingdom (Table 7). In addition, basket funding in the form of the CDPF was provided by these three donors, together with Switzerland (Doc.53). Between 2009 and 2012, a total of EUR 3.1 million CDPF funds had been disbursed.²⁷ GDC contribution to

CDPF included EUR 0.5 million from GIZ and EUR 0.1 million from KfW until mid-2011. EUR 1.3 million, EUR 0.9 million, and EUR 0.5 million was provided by the Belgian Technical Cooperation (BTC), DFID, and the Swiss Agency for Development and Cooperation (SDC), respectively (Doc.53).

Table 7. SBS in the health SWAp (in millions of disbursed US dollars)

	2008	2009	2010	2011	2012	Total
Belgium	4.76	5.55	6.57		6.25	24.27
DFID	8.62	5.17	4.31	2.58		20.68
Germany		7.14	4.90	4.62		16.67
Total	13.38	17.86	15.78	7.20	6.25	61.63

Source: Development Assistance Database for Rwanda (Synergy International Systems, 2013).

The 2011 mid-term review of the second Rwandan Health Sector Strategic Plan (HSSPII) identified the large share of off-budget funds²⁸ as a key challenge with regard to donor harmonization and alignment to Rwandan priorities. Very few donors are using the available pooled funding mechanisms, such as SBS or CDPF. The high share of off-budget aid flow, thus, is perceived as one of the largest constraints to strategic resource allocation and management at the central and district levels.

A comparative view at the central and district levels shows that in 2010, 74 % of the budget related to national-level spending (GoR & MoH, 2011b). Bilateral and multilateral aid, however, played a significant role at the district level. The German development cooperation disbursements targeted Gicumbi, Gisagara, Huye, Musanze, and Nyaruguru districts (cf. Annex H). In these districts, German aid played a significant role, relative to overall bilateral disbursements, particularly in Musanze where GDC provided a share of approximately one third of overall bilateral health disbursements for Ruhengeri hospital (HRTT, 2012).

Portfolio of Rwandan-German cooperation in health development

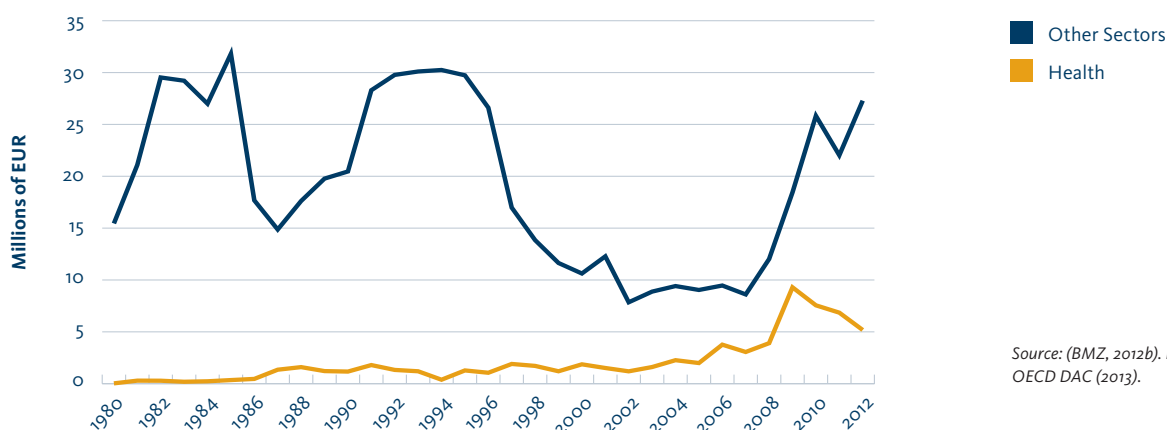
German bilateral cooperation with Rwanda began with the country's independence in 1962. Since then, various forms of assistance, instruments, and modalities have been applied in different sectors. Between 1980 and 2012, disbursed German bilateral aid totaled EUR 690.3 million²⁹ (BMZ, 2012b). During this period, the budget allocation to health was EUR 66.4 million, approximately 10 % of total aid. In the early 1980s and mid-1990s, priorities were placed on other sectors and interventions, including infrastructure and emergency aid, with health being less important in financial terms (Figure 8). Since the introduction of three priority sectors in Rwanda in 2003, however, the health sector has gained relative importance and total bilateral ODA increased significantly in terms of health, justice, and good governance/decentralization. In the context of SWAp, EUR 26.7 million had been disbursed in health, including EUR 16.4 million in financial cooperation, of which 80 % was allocated through joint financing modalities and 20 % through project funding, as well as EUR 9.8 million for technical cooperation, making Germany a medium-sized donor in the Rwandan health sector.

²⁷ Since January 2012, CDPF funds are managed by SPIU (Doc.53).

²⁸ Government Revenues that include revenues generated from taxation, loans, grants, donations, and DP contributions through government procurement systems, such as GBS, SBS, or pooled funding, are understood as "on budget"; project- and program-based aid as "off budget".

²⁹ In 2002, BMZ had transferred all funds previously recorded in deutsche marks at the official exchange rate of 1.95583 (EUR 1 = DM 1.95583).

Figure 8: Total German bilateral ODA in Rwanda and the health sector (in millions of EUR)



Source: (BMZ, 2012b). Data for 2012 from OECD DAC (2013).

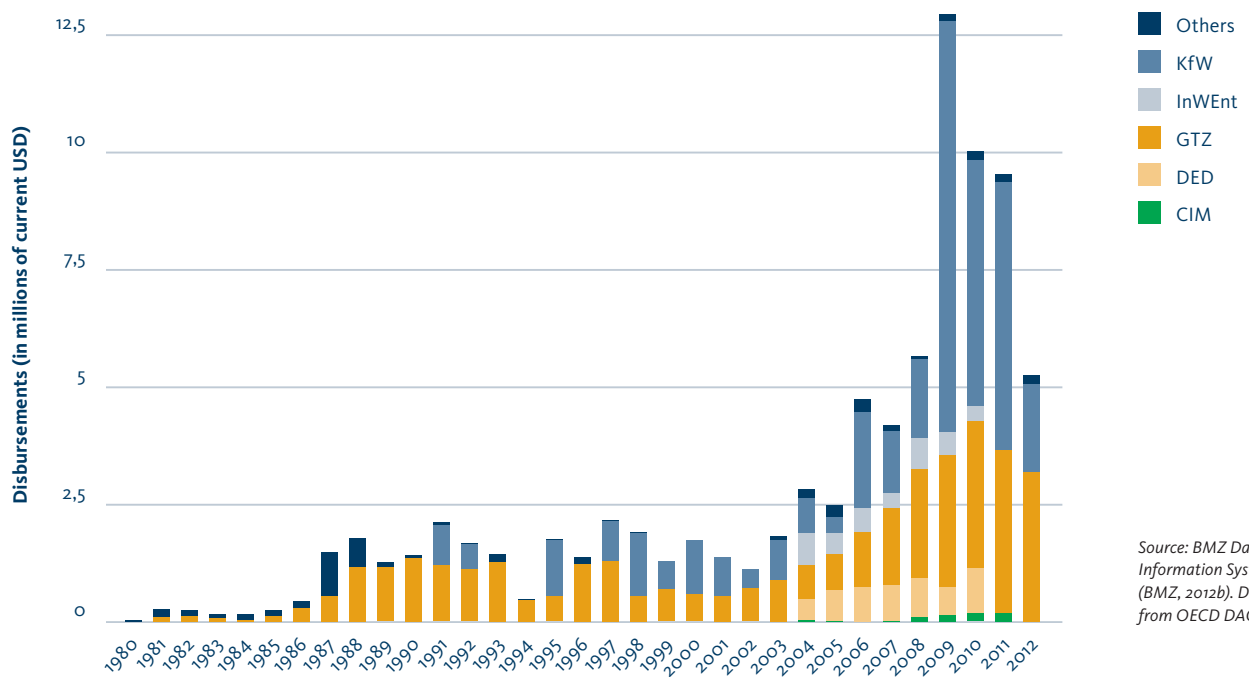
Figure 9 presents German ODA disbursements in the health sector by implementing agency. In the 1980s, German bilateral aid was provided, primarily, through GTZ and the Protestant and Catholic churches. Overall, German bilateral aid disbursements in the health sector between 1980 and 1986 played only a minor role, relative to the subsequent years when cooperation in health was enhanced. During this period, most DED placements were financed through the GTZ project in rural health and family planning; hence, no direct DED funding is recorded for this period. In the late 1980s, GTZ gradually increased aid disbursements. At the same time, aid disbursed through the Protestant and Catholic churches reached its highest level. In 1991, KfW began to deliver financial assistance to the Rwandan health sector. Since 2004, InWEnt/GIZ and DED/GIZ funds have been separately recorded and account for a significant share of German technical assistance. This also marked the beginning of the health sector as a priority sector of bilateral cooperation between Rwanda and Germany. Since the 1990s, ODA disbursements have been partially delivered through CIM, with the largest contributions taking place between 2008 and 2011. German bilateral aid disbursements peaked in 2009 when GDC began SBS. The largest disbursements of German bilateral aid to the health sector occurred during the SWAp period, when annual disbursements totaled between USD 3.2 and USD 12.3 million (BMZ, 2012b).

Between 1980 and 2012, technical and financial cooperation³⁰ followed similar trends, with only few exceptions between 2003 and 2006. In terms of aid volume, technical and financial cooperation have been rather similar, except for 2009, when financial cooperation disbursements peaked at USD 8.77 million with the introduction of SBS. Technical cooperation reached its highest level in 2010, with USD 4.8 million disbursed. Between 1980 and 2012, disbursed financial cooperation totaled EUR 28.2 million (USD 36.2 million), while technical cooperation disbursements amounted to EUR 38.1 million (USD 46.8 million) (BMZ, 2012b).

The portfolio analysis emphasizes Rwanda's persistent aid dependency for all sectors, especially for that of health. While the most donor contributions targeted vertical programs, such as STI control (including HIV/AIDS), GDC focused on health systems strengthening, mainly through the OECD-DAC category of general health (120). The German bilateral contribution in health was significantly increased, when health became the priority sector in 2003. In the context of SWAp, innovative aid modalities (e.g., SBS and basket funding) had been used, supported by both financial and technical cooperation.

³⁰ Financial cooperation includes bilateral aid implemented by KfW, while technical cooperation includes bilateral aid from all remaining German implementing agencies, including churches and NGOs.

Figure 9: Disbursements by implementing agency (1980-2012) (in millions of current USD)



Source: BMZ Data Information System (DASY) (BMZ, 2012b). Data for 2012 from OECD DAC (2013).



B.

RWANDAN-GERMAN COOPERATION IN THE HEALTH SECTOR

This part presents the evaluation results according to phases, with a special emphasis on Phase III (2004–12). For Phases I and II, Sections B.1 and B.2, in line with the major evaluation questions (cf. Chapter A.1.2), will focus on how Rwandan-German development cooperation has evolved in the respective periods. Similarly, the sections focusing on “Adapting to the changing context” and on “Achievements” take a more analytical perspective. There is a special feature for Phases I and II; that is, the testing of hypotheses derived from the context analysis (cf. A.3.1).

With regard to Phase III, the sections on “Evolution of Rwandan-German cooperation” and on “Adapting to the changing context” are intentionally less comprehensive, compared to Phases I and II. This is due to the completely different structure of the section on “Achievements”. This section actually follows the structure of the joint health program being comprised by three components: (1) HF, (2) SRH, and (3) HRD. The respective sections (B.3.3.2–3.3.4) are preceded by a section focusing on the overarching function of SWAp, SBS, and CDPF within the joint health program.

1. Rwandan-German cooperation (1980–94)

Rwandan-German cooperation in the health sector began in 1979 with two DED development workers, followed by a DED-GTZ Improvement of Rural Health Services project in 1981 (GIZ & KfW, 2012). In addition, there was a position for one CIM hospital technician outside the project structure. In 1986, GTZ launched the Promotion of Family Planning project, in cooperation with the *Office National de la Population* (ONAPO) (cf. Box 8). Financial cooperation commenced in 1991 with KfW’s Sector Program Family Health supporting the GTZ cooperation with ONAPO.

The first section of the chapter takes a closer look at the evolution of GDC interventions along two focal themes: rural

health and family planning. A second section identifies influential context factors and GDC reactions to them, testing the hypotheses formulated in the context analysis (Chapter A.3.1.1). The third and final sections examine project achievements.

1.1

Evolution of Rwandan-German cooperation

Rural health

Due to large disparities among the rural and urban populations at the beginning of the 1980s and insufficient service supply in rural areas, the main GDC target group was the rural population. The joint DED-GTZ project, Improvement of Rural Health Services, integrated up to 18 development workers (increasing until 1994), simultaneously, into the Rwandan public health system. The project’s mode of intervention and geographic scope focused on the health center and hospital levels in the *préfectures* of Cyangugu, Kibuye, Kabaya, and Byumba. The joint project structure between DED and GTZ included a combination of experiences from other countries (INT EXP 7). In order to improve their effectiveness, development workers relied on financial inputs provided by GTZ. GTZ did not, however, provide staff or conceptual inputs (INT InD DW 19, 37). The project cooperated mainly with public – and only sporadically with private, especially Catholic – health facilities. Private health providers, in general, benefited from more generous funding sources and, therefore, from higher equipment standards at that time (Diesfeld, Reitmaier, & Berg, 1987). In addition, development workers provided training in nursing and laboratory schools. Between 1980 and 1994, GDC contributed 256 development worker years (Doc.16) and approximately EUR 3.6 million³⁾ to the project.

The main objective of the project was to improve curative and preventive services, promote basic health services in rural areas, and provide training for paramedical staff. Further priorities of the project were to enhance the functionality of health facilities through better quality equipment, increased service uptake, and capacity building. The project intervened at the nexus of health and agriculture through a component on nutritional education

³⁾ Own calculation, based on BMZ Data Information System (BMZ, 2012b). DED project documentation (Doc.16) provides a sum of approximately EUR 3.1 million. The difference relates to administrative and overhead costs.

and it contributed innovative approaches to Rwanda's national health strategy, such as the integration of traditional midwifery into the national health system. Activities in mother-child care were implemented in close cooperation with other organizations including, for example, MoH and the United Nations International Emergency Fund for Children (UNICEF) for vaccination programs, ONAPO for family planning, and the *Bureau des Formations Médicales Agréées du Rwanda* (BUFMAR) (cf. Box 7) for medical training and seminars (Doc.13).³²

Box 7. Bureau des Formations Médicales Agréées du Rwanda (BUFMAR)

The *Bureau des Formations Médicales Agréées du Rwanda* is an umbrella NGO of all Christian health facilities. DED cooperation started in 1983 in the Department of Health Education and Production of Educational Material, which was understood to be financially independent from BUFMAR leadership. It was responsible for family planning (Doc.7) and the production of material for ONAPO and the Ministry of Health. In 1994, a new program, coordinated with BUFMAR leadership, was designed in cooperation with national programs, including an integrated family planning concept (with the promotion of condoms) (Doc.8). Following the genocide, a significant lack of staff, the problematic political situation, and the absence of earlier promised support brought BUFMAR into crisis. DED resumed its support in 1995 and assigned a short-term technical assistant in 1995 and 1997, respectively (Doc.8).

When assessing the project, the development workers who were interviewed reported that “a strategy in terms of DED or BMZ standards for [their] work didn't exist” (INT InD DW 37; cf. also INT EXP 7; INT InD DW 10, 12, 17, 33). A project evaluation reports, “In the beginning of the project neither a fixed written concept existed nor quantifiable project goals had been defined” (Diesfeld et al., 1987; Doc.18). This lack of strategy was substituted by knowledge and learning and, later, by operational planning between development workers, counterparts, and delegates of MoH in quarterly meetings (INT InD DW 19, 25; Doc.6; Diesfeld et al., 1987). A part-time coordinator supervised DED employees on the project, remained in contact with MoH, and represented the link between DED development workers and GTZ (Doc.6).

Apart from DED project staff, CIM sent a hospital technician to a Catholic hospital in the *préfecture* of Gisenyi from 1991 to 1993. The aim was to maintain the technical infrastructure of the hospital and ensure its operability.

Family planning

The increasing population density and the unstable economic situation in Rwanda endangered food security. Family planning, hence, became increasingly important and an indispensable component of GDC in the health sector, aligned to the national strategy on food security of 1985. Family planning was not only a component of the Improvement of Rural Health Services project, but it was also the main focus of the Promotion of Family Planning project, implemented by GTZ in partnership with ONAPO between 1986 and 1994³³ in the *préfectures* of Gikongoro, Butare (from 1989), and Cyangugu (from 1991). GTZ provided long-term experts, short-term professionals, and funds for the construction of two ONAPO department offices and health centers, educational material, and media and education programs (Doc.42). Until 1994, the funds disbursed for the project amounted to approximately EUR 4.3 million (BMZ, 2012b).

The main objective of the project was to increase the usage of modern family planning methods. Particular emphasis was placed on increasing the demand for family planning services and on improving the quality of these services, while focusing on the advanced training of health staff, sensitization of administrative staff at the community and prefecture levels, sex education in schools, assistance with the procurement and distribution of contraceptives, and improved access to contraceptives (Doc.31; Doc.33).

Box 8. L'office national de la population (ONAPO)

The *Office National de la Population* was created by law in 1981 (May, 1995). It was responsible for the promoting family planning and providing consultation services in order to maintain the equilibrium between agricultural production and demographic growth (Doc.30). As ONAPO was affiliated at the national level, it had no direct intervention mechanism at the prefecture level. ONAPO was basically financed through donors (the United Nations Fund for Population

³² Similar to the pseudonymization of interviews (cf. Chapter A 2.3), D'Éval refers to unpublished documents with the pseudonym “Doc.”, plus a consecutive number if proper citation could infringe on the privacy of the author(s).

³³ The project was envisaged to continue until 1996, but subsequent to 1994, resources were reallocated to another project.

Activities (UNFPA, USAID, World Bank, and others) (Doc.30). The World Bank ended its support 1987 due to deficiencies in the application of funds (Doc.1). Close organizational and staff links between ONAPO and the (former) unity party of Habyarimana (INT EXP 7; Doc.32) evoked the criticism that party politics in the 1990s were extended to ONAPO and family planning, in general. GTZ's final report apprehensively mentions Rwandan ONAPO resources as having been, instead, spent on war and military defense (Doc.32). With the genocide in 1994, family planning activities were suspended and ONAPO was dissolved in 2000 (Muhoza, Rutayisire, & Umubyeyi, 2013).

In 1991, KfW added an innovation to GDC intervention: the financial cooperation project, Sector Program Family Health, implemented by GTZ, was executed in close cooperation with the above-mentioned GTZ-ONAPO project. MoH and Population Service International (PSI), a US-based NGO, became the implementation partners from 1994 onwards until the end of the country-wide project in 1997. Over the entire period, the financial input totaled approximately EUR 1.99 million (EUR 1.1 million until 1994) (BMZ, 2012b). The program met mainly material needs, such as staff wages, offices, vehicles, contraceptives, and operating costs (Doc.42). The main objectives before 1994 were to enhance ONAPO services, strengthen the distribution of contraceptives (as requested by the Rwandan partners), and improve maternal health care in cooperation with the Rwandan health facilities included in the GTZ-DED project (Doc.42). There was synergy between technical and financial cooperation and the links to DED personnel (Doc.42).

1.2

Adapting to changing contexts

This section provides an overview of how the Rwandan-German development program steered through the large-scale socio-economic conditions at that time and scrutinizes the context hypotheses outlined in Chapter A.3.1.1.

GDC support during socioeconomic deterioration

Socioeconomic deterioration since the mid-1980s affected the health status of the Rwandan population and health service provision. There are reports on poor health conditions for parts of the population (Doc.18) due to a lack of financial access to health services (INT InD DW 10). On the supply side, salaries in

the health sector were not adjusted, although the Rwandan franc lost 60 % of its value (Doc.6). This pushed medical staff to transfer from the public into the private sector, worsened the already severe lack of staff (Doc.6), and further deteriorated the national health system. Preventive activities, such as nutrition counseling, became impractical considering the severe lack of food supply for target groups (Doc.6; Doc.18). These repercussions of deteriorating socioeconomic conditions raised the question whether the Rwandan-German interventions in the health sector sufficiently adapted to the changing context in Rwanda as of the mid-1980s in order to stay relevant and effective (Context Hypothesis 1: *Rwandan-German interventions in the health sector have been sufficiently adapted to the deterioration of the socioeconomic conditions in Rwanda since the mid-1980s to remain relevant and effective*).

The adaptation of services according to socioeconomic changes was reported only in single cases (Doc.6): Examples provided during the interviews include the combination of nutritional and agriculture counseling (INT InD DW 19) and the provision of meals for children in order to attract mothers to attend nutrition counseling (INT InD DW 10; Doc.6). When the national government reacted to the crisis by reducing its financial support to the health sector, a different political strand became increasingly important to GDC. The GoR had implemented the Bamako Initiative of 1987 in 1990 with the primary goal of recovering the cost of essential drugs through patient payments. Along this government line, the population was made to self-finance medicines and examinations. In addition to its main goals, the Rural Health project therefore promoted self-financing initiatives and supported the establishment of community pharmacies to improve the supply of medicines for the rural population (Doc.15). GDC also took part in a MoH working group to lay the legal foundations for this (Doc.18).

The geographic scope for implementing the Bamako Initiative, however, was limited to only 124 of 166 public health facilities (Habiymbere & Wertheimer, 1993). The World Health Organization (WHO) study also shows that cost recovery practices were not only bound to health facilities participating in the Bamako initiative; rather, some nonparticipating public facilities also

charged patients for medications. While the study concludes that cost recovery, in general, did improve the availability of facilities, only those participating achieved a reduction in price. Qualitative interviews have revealed that patient payments for health services had a negative influence on access to health services by vulnerable groups (INT InD DW 17, 45). Given the unclear geographic scope, it was impossible to retrospectively establish whether and how these negative influences, originating from the Bamako Initiative, differed from the costs claimed by other health service providers.

It can be concluded that GDC reactions to socioeconomic deterioration have been limited: the impetus to change directions emerged, rather, from the individual initiatives of development workers in their work place than from GDC direction. Whether or not the resulting problems evoked GDC reaction within other sectors beyond health or not has not been examined.

Policies of inequality?

The Habyarimana regime privileged the majority group of Hutu and undoubtedly fueled the ethnic conflict (cf. Prunier, 1995; Verwimp, 1999). The discriminatory treatment against Tutsi was also witnessed by development workers. In an open question, six of 30 survey interviewees explicitly identified the ethnic conflict as having been detrimental to their work.

With regard to the evidences with regard to Context Hypothesis 2 (*Health policies during the Habyarimana regime negatively influenced Rwandan-German interventions in the health sector with regard to protection of minorities and health equity of services*), interviewees did not report on differences in the treatment of patients due to their ethnicity (INT InD DW 10, 17, 19, 37, 45, 46). Preferential treatment did exist, however, based on the economic situation and political affiliations of patients, thus indicating a clientelistic structure (INT InD DW 10, 37, 45). Discriminatory treatment, based on ethnicity, may have manifested itself in terms of employment quotas in the health sector. The share of Tutsi personnel was set at 11% and similar quotas in the education system are reported, although not all respondents confirmed the implementation of such quotas within their partner organization.

Tensions among the medical staff due to ethnic difference, were stated as having been a hindrance to daily work (INT InD DW 10, 25). According to qualitative interviewees, GDC neither prepared its employees to cope with the ethnic conflict nor gave them instructions on how to cope with the growing conflict.

In conclusion, there has been discriminatory treatment, based on ethnic assignment with regard to staffing and daily work life. The conducted interviews, however, did not point to openly practiced ethnic discrimination in the treatment of patients; rather, they pointed to discriminatory treatment, based on the socioeconomic situation of a patient.

Lack of political backing in family planning?

Habyarimana pursued the politics of an idealized peasant life-style and his traditional beliefs in the need to procreate. Simultaneously, population was increasing in Rwanda. With regard to Context Hypothesis 3 (*A lack of genuine political backing during the Habyarimana regime reduced the relevance and results of Rwandan-German interventions in family planning*) and according to the survey, most development workers who had worked in Rwanda during Phase I generally did not consider national health strategies and the general political situation as having hampered their work (Survey). In-depth interviews, in addition, only partially confirmed a lack of genuine political interest on behalf of the Government. Several respondents reported on the strong ambitions of the Government, especially with respect to President Habyarimana himself, and the high commitment to family planning by the ONAPO leadership (INT InD DW 10, 19, 25, 37; INT EXP 7). Others, nevertheless, reported reluctant implementation (INT InD DW 17), a lack of focus on vulnerable groups, and a limited success of ONAPO interventions (INT EXP 14). Furthermore, interviewees emphasized the ideological proximity of ONAPO to Habyarimana's National Republican Movement for Democracy and Development (single party) and reported ONAPO as being considered "Hutu-focused" (INT InD DW 46). Politicians are stated to have used rhetoric on family planning that supported the ethnic conflict and made work in family planning difficult (INT RP 6).

GDC activities with regard to family planning cannot be considered contrary to government interests, in general, since the regime appears to have supported family planning activities. The results of these activities, in any case, may be limited due to political interests.

Discovery of HIV/AIDS

The first cases of AIDS were identified in Rwanda in 1983. As of the 1990s, HIV prevention became increasingly important. Facing tremendous prevalence rates in urban (17.8%) and rural areas (1.3%) in 1986 (Rwandan HIV seroprevalence study group, 1989),³⁴ the response to HIV and AIDS was reflected in the Rwandan-German health program. Since 1992, DED-GTZ cooperated with the Center for Aids Prevention Studies of the University of California in San Francisco, which was financed by the US National Institutes of Health (Doc.17). The fight against HIV/AIDS was integrated into cooperation with ONAPO (Weis, 1992).

The “time of uncertainty” between 1990 and 1993

The already unstable political circumstances were aggravated when the RPF started its invasion in October 1990, leading to the evacuation of all DED development workers and GTZ staff. The majority returned to Rwanda in December of the same year (Doc.15). After the evacuation, several positions at the northern borders were temporarily vacant due to the higher security risk in the *préfectures* of Gisenyi, Ruhengeri and Byumba. Three development workers were sent to support refugee camps (Doc.18). The period between the onset of the civil war in 1990 and the Arusha peace process has been referred to as *Igihirahiro*, “the time of uncertainty” (Prunier, 1995, p. 367). The deception of the international community for a multiparty system to resolve the conflict was also shared by GDC employees,³⁵ although there were calls for attention to the intensifying situation within GDC (INT EXP 12) and in the international arena (Commission Internationale, 1993). A reaction to the conflict only transpired in April 1994, when the extensive outbreak of violence led to the evacuation of all German project staff, ceasing the work of national project staff. GDC personnel began to return to Rwanda after the genocide in March 1995 (Doc.10).

1.3 Achievements

The following section assesses GDC interventions in terms of the achieved objectives and major challenges. Detailed indicators, measuring the progress and effects of the joint project “Improvement of Rural Health Services”, were not defined before 1995. Project progress reviews in 1987, 1990, and 1993, hence, do not go beyond assessing the activities and describing the main results. Improvements in health services, especially mother-child care, birth assistance, and improved drug supply, are reported for facilities in areas not affected by war (Doc.18). It is, nevertheless, evident that DED staff, during this phase, primarily filled human resources gaps in the rural health sector. By not being able to fully live up to their intended role as advisor, the goals regarding preventive and promotional activities were not met (INT EXP 7; INT InD DW 37, 45; Diesfeld et al., 1987). The development workers, however, did bolster staff shortages for curative activities (Diesfeld et al., 1987), confirmed by survey participants. At the beginning of the 1990s, preventive activities became even less important. This is consistent with the progressive trend of economic deterioration, which began in the 1980s, and which put pressure on Rwandan households, worsened their health situation, and made curative activities more crucial.

Interviewees repeatedly reported the constant change of Rwandan personnel as being a detrimental factor, especially with regard to the sustainability of their work (INT InD DW 19, 25, 45, INT EXP 13; Diesfeld et al., 1987). The situation worsened due to the increasing drain of personnel into the private sector (INT InD 45, INT EXP 13; Doc.6; Doc.12; Diesfeld et al., 1987). The majority of survey participants in Phase I (22 out of 30) however reported, based on self-assessments, to have (rather) achieved the respective goals for their workplace while about 20% of the respondents express that they have rather not or have not achieved their intended changes.

With regard to family planning, the trend in indicators (e.g., the decreasing national total fertility rate from 8.6 children per

³⁴ The World Bank estimates a national average of 5.3% prevalence of HIV (percent of population ages 15 – 49) in 1990 (World Bank, 2014).

³⁵ October 26 in 1993 a GDC employee in Rwanda announces: “despite the events in Burundi there are currently no special problems for our cooperation in Rwanda” (Doc.11).

woman in 1984 to 6.2 in 1992, as well as the increase of modern contraceptive use from 3–4 % in 1988 to 12.9 % in 1992 (May, 1995; May et al., 1990)), suggest positive project contributions. In relation to other sources, these exceptional changes, at least, may be explained by higher school enrollment rates and an increase in the age at marriage (Doc.32; May, 1995). In addition, the final project report acknowledges significant differences in the program's performance and results; in particular, close organizational and staff relations to the Habyarimana unity party and the lack of cooperation with the regional level of the health system are stated as having hindered project success (Doc.42; Doc.6). Although the provision of PHC had improved, child mortality rates were reported to have remained comparatively high and were perceived as a motive to give birth to many children, thus further undermining family planning activities. Another challenge to the success of family planning was its negative connotation due to conservative Catholicism. The church refused to support family planning activities (modern contraceptives). Because approximately 40 % of health facilities were operated by the church (May et al., 1990), this did not provide an enabling environment (Survey; Weis, 1987).

With the effects of war and genocide, the program's long-term achievements were severely limited due to the damage to its infrastructure and, especially, in view of the high loss of health care staff. Survey respondents have confirmed this: approximately 70 % assessed the positive effects of their work as rather impermanent subsequent to their departure.

In conclusion, a range of instruments involving technical, financial, and personnel cooperation were implemented. The interventions between 1980 and 1994 focused at the decentralized level, with the exception of the national level. Based on the scarce but available documentation, the project's objectives, and the mix of interventional instruments, GDC can be rated as having been complementary, leading to a realization of synergies. GDC interventions in the first phase can be considered relevant, given their high alignment to Rwandan priorities and their focus on the major deficits within the Rwandan health system

at inception. The larger political and socioeconomic trends, however, would have demanded a change in the direction of cooperation. Development workers within the country appeared to have been left on their own to cope with the challenges. When this grew more serious, effectiveness became very limited. The tragic escalation of the socioeconomic downward spiral due to the genocide, which resulted in the tremendous death toll and destruction, quashed interventional effects and was not conducive to sustaining the support by GDC.

2. Rwandan-German cooperation (1995–2003)

The Rwandan health sector faced serious challenges after the genocide, since many doctors and nurses had been killed or had fled the country; most of the health infrastructure was either destroyed or damaged; and most of the health indicators had dropped sharply. In this desperate situation, the country was forced to rely on emergency aid provided by various bilateral and multilateral donors and international NGOs (cf. Chapter A.3.1.2 for more details). GDC joined these efforts to support the reconstruction and rehabilitation of health infrastructure, in combination with technical assistance in hospitals and health centers that suffered from dramatic understaffing. This focus was at center stage during the years 1995/96, hand in hand with GDC support that concentrated on PHC in two *préfectures*: Byumba and Butare.³⁶ Due to the increased HIV prevalence after the genocide, GDC support placed emphasis on HIV prevention, with family planning – at center stage during Phase I – becoming less important.³⁷

³⁶ The project titles were "improvement of rural health in Byumba Prefecture" and "improvement of primary health care in Butare Prefecture", respectively.

³⁷ "Sector Program Family Health" (1995–96), "HIV-Prevention (Social Marketing) I+II" (1997–2003)

2.1 Evolution of Rwandan-German cooperation

Primary health care

In Byumba *prefecture*, the joint DED-GTZ project “Improvement of Rural Health Services” began in March 1995.³⁸ The concentration of efforts in one region came as a result of the lesson learned from having dispersed development efforts in different regions during Phase I, together with the fact that partly isolated health centers had been supported by development workers, whose work had not been properly coordinated. For this reason, DED ensured coordination of its activities in the health sector.³⁹ MoH also wanted to strengthen the decentralized management of the health system and the provision of PHC (Doc.16). The project, therefore, focused more on the strengthening of district health services, with the phasing out of direct support from development workers to health centers.⁴⁰ The project supported the full range of prevention and treatment services. At first, however, it was a matter of offering the minimum package of health services to the local population.⁴¹

Butare was the other priority region for GDC where a GTZ project offered – similar to the project in Byumba – a minimum package of prevention, treatment, and health promotion services to the local population.⁴² The focus was, therefore, much broader in comparison to the GTZ project, which focused on family planning in the same region during Phase I.

In both regions, it was a challenge to finance the health system, given that subsequent to the phase-out of emergency assistance in 1996, the free provision of all health services could not be continued. The introduction of payments for health services, including medicine, resulted in a considerable decrease in the use of services (INT RP 1; Doc.36; ; cf. also A.3.1.2). Adjusting the rules to reflect a payment for services (e.g., with the exemption

of antenatal care) did not provide a long-term solution to a situation whereby an important segment of the local population were unable to afford the payments. This triggered the concept of CBHI schemes (*mutuelles*). Since 1999, both regions have been pilot test areas and have developed the CBHI system with support from GDC (INT RP 1, 5, 8; INT EXP 18) and in cooperation with the international NGO, Partnerships for Health Reform.

The low wages for health staff encouraged the projects to provide additional payments in order to motivate counterparts and other staff members. Since this extra payment, however, was not linked to performance, it was soon perceived as a part of the salary and, thus, lost its motivational effect. As a result, the idea of performance-based financing (PBF) was developed, for which both regions served as pilot areas (INT RP 1, 5; INT EXP 18; Doc.37).⁴³ Distortions in the salary system made the introduction of PBF very challenging.⁴⁴

The financial input from 1994 to 2003 for both projects amounted to approximately EUR 3.46 million.

HIV prevention and social marketing

While family planning was one of the main themes of GDC support during Phase I, 1995 saw a completely different situation, when family planning no longer featured as a health policy priority in cases where families, having lost their loved ones during the genocide, were not receptive to the family planning recommendation. At the same time, with the increase of HIV, its prevention deserved special attention (Eriksson et al., 1996). This resulted in KfW designing, in cooperation with MoH, the HIV-Prevention (social marketing) Program, which was implemented from 1997 onwards. The preceding Family Health Sector Program (KfW), having begun during Phase I, rechanneled its support to HIV prevention in collaboration with the GDC-supported projects in Butare and Byumba.

³⁸ Byumba *prefecture* was selected due to the largely varying socioeconomic situations of the population throughout the *prefecture* and the massive refugee inflows (Doc.16).

³⁹ DED created the position of Health Coordinator in 1996. Coordination covered all development workers in the health sector and also the collaboration with GTZ.

⁴⁰ This concerned, for example, health centers in Kinjama and Cyanguu. The last work place at the level of a health center was phased out in 1999. This was not only based on DED policy, but responded to the concerns of the Rwandan partner (MoH).

⁴¹ At the start, aide-infirmiers were trained in crash courses (three to four months) in order to allow health centers to operate. They were then gradually replaced by qualified nurses (INT EXP 18), whose training was directly supported by DED development workers at the Byumba Nursing School.

⁴² While the project in Byumba was financed through GTZ, but steered by the DED Country Director, the Butare project was led by a national expert, supported by a DED technical assistant.

⁴³ At that time, it was known as *approche contractuelle*. The concept was developed in collaboration with the international NGO, HealthNET.

⁴⁴ In 1999, a nurse at the University Teaching Hospital in Butare earned a higher salary than a doctor at Kabutare district hospital (INT RP 1).

The new program focused on controlling HIV prevalence rates and reducing STIs and unwanted pregnancies among high-risk groups during the first program phase (1995–98), as well as broadening the target group to include the general population. HIV prevention was combined with the social marketing of condoms in collaboration with the private sector. This program was implemented nationally through PSI as the implementing agency. For the *préfectures* of Byumba and Butare, there was strong cooperation with regard to the respective projects. The financial inputs in the first and second phases of the project were EUR 2.556 million, respectively, while the costs in phase III amounted to EUR 3.067 million.

InWEnt offered capacity building for staff involved in family planning, HIV prevention, and sexual education – including Butare and Byumba *préfectures* – in order to improve access to family planning and HIV prevention services (Doc.52). The format comprised international training programs in Germany on various topics related to SRH. InWEnt also provided advanced training for district health professionals. The financial input amounted to approximately EUR 670,000 between 2000 and 2005 (Doc.51).

In 2000, GDC began to support medical education at the University Teaching Hospital in Butare. DED support to the medical faculty comprised (1) practical training of medical students and junior doctors, including bed-side instruction, and (2) contributions to clinical practice and patient care, which led to a quantitative and qualitative improvement of the medical education of students and resident doctors. The focus was on areas and departments that needed to be bolstered to enable them to offer post-graduation training: internal medicine, surgery, gynecology/obstetrics, and pediatrics. In 2000, the first three development workers commenced work in Butare in internal medicine, pediatrics, and gynecology, respectively.

Following a general global shift by GDC from 2000, collaboration relating to the Byumba and Butare projects intensified

subsequent to 2002, when a joint project progress review was undertaken (Doc.36).⁴⁵ While both projects were managed separately until the end of 2003, they were integrated into a joint program in 2004. Program development promoted stronger coordination of technical assistance projects (GTZ) and financial programs (KfW). It was made easier by the fact that there already existed strong cooperation between DED and GTZ with regard to the Byumba project (INT EXP 18), as well as by the assignment of a GTZ expatriate expert to coordinate project activities in Byumba and Butare (INT EXP 16).

2.2

Adapting to changing contexts

Hypothesis 4 from the context analysis (*German bilateral cooperation followed its pre-genocide agenda in the health sector rather than having delivered strategic and programmatic support.*) could only partly be verified. According to some interviewees, GDC responded well to the emergency situation in 1995–96 by providing support for rehabilitation and the reconstruction of health facilities (INT RP 1, 8, 23; S DW 48). By concentrating its support in two regions, GDC was able to respond to national health policy priorities. Focusing on HIV prevention instead of family planning also indicated a reorientation of GDC support. But despite this – which mainly concerned the Family Health Sector Program – support to family planning services continued in the Byumba and Butare projects, despite the national low priority for family planning.⁴⁶ Achievements, therefore, were moderate (Doc.36) (cf. also the following paragraph). Focusing GDC support on a regional basis, already a priority area in the pre-conflict period, can be considered a sign of continuity.

It can be concluded that while there have been some elements of continuity in GDC support, its reorientation, according to the changing context, can be viewed as the dominant feature.

Hypothesis 5 from the context analysis (*German cooperation continued to support family planning after the genocide without*

⁴⁵ This “program development” was closely linked to the process initiated by BMZ to identify priority intervention areas for partner countries. In this respect, health became a priority intervention in Rwanda in 2002 (Doc.36).

⁴⁶ It was only after 2000 that family planning reemerged as a thematic area in terms of reproductive health (GoR 2000).

major changes, rather than having adapted it to a changed scenario to ensure relevance.) could not be verified. There was a clear shift in priorities in the Family Health Sector Program, leading to a discontinuation of family planning activities. The focus, thus, was transferred to HIV prevention and on equipment for health facilities at the district and health center levels, and support was provided in collaboration with the Byumba and Butare projects. Family planning services, however, remained a component of both projects as part of reproductive health services.⁴⁷ This also reflected the view of health professionals who believed that there was still a need for family planning, regardless of whether it was backed or not by national policy (INT RP 1). Both projects continued with the cooperation of ONAPO, already a partner to GTZ during Phase I. ONAPO, however, had broadened its mandate and focused more on general education programs on family and reproductive health – in cooperation with the Ministry of Education – than on family planning (INT RP 1). There is sufficient evidence that the local population was not receptive to the family planning communication, especially during the four or five years following the genocide (INT InD DW 12, 33; Doc.36).

The fact that both project regions (Byumba and Butare) became pilot areas for CBHI and PBF can be viewed as a positive indicator of GDC's adaptive ability. The CBHI pilot projects, conducted in collaboration with Partnerships for Health Reform, revealed important insights and experiences on how to develop a community-based insurance scheme to feed into the process of scaling up CBHI as of 2004 (INT RP 23; cf. Chapter B.2.1 for further information). The results of the pilot projects on PBF also fed into the design of a broader PBF system in 2002 (Doc.36; Doc.39; Meessen, Musango, Kashala, & Lemlin, 2006).

GDC demonstrated its flexibility when it established an innovative project management structure in the Butare project in 1998 (INT RP 1; Doc.35; Doc.36). The project was managed – without expatriate long-term experts from GTZ – by the medical director in the region also assuming the role of GTZ Project Manager. This

changed in 2001 when the roles were once more separated after it became evident that the combination of both functions proved too challenging. Instead of assigning a GTZ expert from abroad, however, a Rwandan health specialist took over the position as GTZ Project Manager.⁴⁸

The so-called German cash crisis⁴⁹ of 1999 – 2000 had negative repercussions on the ability of GTZ to adapt to changing situations. It not only affected the Butare and Byumba projects and led to a revision of project activities, based on restricted budgets; it also created a perception by partner organizations of a lack of transparency regarding the reasons and implications for the cash crisis. (INT EXP 18; Doc.36).

2.3 Achievements

GDC support in PHC contributed effectively towards a substantial improvement in the provision of health services in specific rural areas (GTZ 2002; GTZ 2003; INT RP 6, 37; INT EXP 18). This comprised a minimum package of curative and preventive services being offered, especially by health centers.⁵⁰ There were no indications of increased usage rates because of the persisting difficulty for poorer segments of the end users to make the required payments.⁵¹ Substantial improvements have been achieved for antenatal care and vaccination programs – the two major pillars of preventive services. With GDC contribution, standards for the provision of services in combination with regular supervision were introduced and applied to improve service delivery. GDC also contributed effectively to strengthen the role of the district authorities for health system development (INT RP 37; GTZ, 2002). GDC, nevertheless, constantly faced the challenge of high staff turnover at the hospital level, in combination with a lack of qualified staff (INT InD DW 33; S DW 18; Doc.36; Doc.42).

GDC support to HIV prevention contributed to improve the provision of services, especially at health centers. Local innovations,

⁴⁷ The project progress review, conducted on the project in Byumba préfecture in 1997, recommended stronger emphasis to be placed on family planning (Doc.33).

⁴⁸ The project progress review, conducted in 2002, draws fairly critical conclusions about the results of this innovative project management structure (Doc.36).

⁴⁹ The so-called cash crisis ("Barmittelkrise") affected GTZ-supported programs and projects, worldwide, but especially in sub-Saharan Africa. It was due to unexpected cuts in commitment authorizations from the German Federal General Budget in 1999 (Doc.34).

⁵⁰ Despite support at the policy level, the use of family planning services remained unsatisfactory and the services were not offered by all health centers (Doc.37).

⁵¹ This was due to a health insurance scheme being at an early stage and rural health centers relying, to a large extent, on self-financing.

initiated by GDC, comprised voluntary counseling and testing services, as well as the use of peer educators for the sensitization of young adults (Doc.54). GDC help to improve access to condoms⁵² went hand in hand with education and sensitization activities for the behavior change of a sexually active population, in general, and young adults in particular. There were some indications of behavior change, but there was no evidence that the declining birth rate was related to the increased use of condoms. The challenges with regard to HIV prevention were a result of a lack of support by local leaders and the Catholic Church because of their view that the use of condoms promoted promiscuity (Doc.54). Other challenges were related to the reluctance of the MoH to increase the price for condoms and to reduce the number of condoms being distributed for free (Doc.54).

Rwandan partners appreciated the flexibility of GDC in providing support and its participatory project planning process (INT RP 1, 8, 37). While they mentioned the importance of technical assistance (DED and GTZ), they especially emphasized GDC support for health equipment and infrastructure.⁵³ GDC support for capacity building of health staff was considered very valuable.

The development worker survey⁵⁴ revealed a fairly critical scenario of the qualification level of counterpart staff in health facilities. Nearly half of all respondents considered the qualification of their colleagues as “rather bad”. They were also fairly critical regarding the complementarity of their qualifications to those of their counterparts and to their overall ability to reach the objectives set for the work place. While most respondents considered their work as having been effective, more than half of them had doubts regarding its sustainability.

It is concluded, therefore, that while there have been some elements of continuity in GDC support during Phase II, its reorientation according to the changing context can be viewed as the dominant feature. In response to national priorities, GDC was more oriented towards HIV prevention and less to family planning. By concentrating on two regions and following the

comprehensive PHC approach, it also reflected national priorities at the same time as the priorities of German cooperation. Despite the challenges, however, GDC can be considered as having been effective. By program development proceeding in parallel to national health policies, the sustainability of achievements from this cooperation in the health sector was favorable during the transition from Phase II to Phase III.

3. Rwandan-German cooperation (2004 – 12)

The following chapter focuses on Rwandan-German development cooperation between 2004 and 2012 (Phase III), with the sections on “Evolution of Rwandan-German cooperation” and on “Adapting to the changing context” being intentionally less comprehensive, compared to Phases I and II. This is due to the difference in the structure relating to “Achievements” (B.3.3), and it follows the joint health program, comprised of three components: (1) health financing, (2) sexual and reproductive health, and (3) human resource development. The respective sections (B.3.3.2 – 3.3.4) are preceded by one focusing on the overarching role of SWAP, SBS, and CDPF within the joint health program.

Sections B.3.3.1 – 3.3.4 present the results of the contribution analysis (cf. A.2.2), according to OECD-DAC criteria. For the sake of readability, no explicit reference to causal links and pathways is made. The focus of attention, thus, is drawn to the achievements of the joint health program, according to the following OECD-DAC criteria: (1) relevance, (2) effectiveness, (3) efficiency and (4) sustainability.

The fifth criterion (impact) and the additional criteria coherence, complementarity, and coordination, privileged by BMZ, are intentionally addressed in separate sections (B.3.4 and B.3.5) as evaluation results, according to the criteria cutting across the various components of the joint health program.

⁵² A total of 23 million condoms were provided (through sales and distribution) between 1997 and 2003 (Doc.54).

⁵³ They also made it clear that they would have preferred if GDC had contributed more in this area. Part of the planned support for construction and equipment had to be canceled because of the cash crisis (GTZ 2003).

⁵⁴ The survey of development workers yielded 7 respondents for Phase II.

The following sections (B.3.6 to B.3.8) also take a cross-cutting perspective. The ToC of the joint health program is assessed (section B.3.6), taking into consideration how the program was implemented. The following section (B.3.7) includes a critical review of the phase-out strategy of the joint health program, while the last section (B.3.8) delivers a critical analysis of how successfully various aid modalities and instruments were brought into action.

3.1 Evolution of Rwandan-German cooperation

Since 2004, GDC support to the health sector gradually aligned itself to the Rwandan national health sector's planning and implementation process in the context of SWAp. In the light of national health sector reform in Rwanda, a joint framework of all German implementing organizations was established in December 2004 to combine the support of all GDC agencies into one program. This framework defined the purpose of cooperation in the health sector to improve the health status of the population, with the ultimate goal of contributing to social and economic development in Rwanda. Three main objectives were set: (1) to enhance poverty-oriented health systems development, (2) to improve all aspects of reproductive health with a focus on family planning, and (3) to foster HRD. These later became the key areas for support and the components of the Rwandan-German Health Program.

Creating a joint framework of the German implementing agencies in the health sector was a step taken by BMZ as a means to alleviate friction among, losses to, and fragmentation of the GDC projects and programs.⁵⁵ The DED and GTZ programs in the former *préfectures* of Byumba and Butare (cf. Chapter B.2.1) had already introduced the joint management of both projects in 2003. Advanced integration and harmonization of GDC interventions also included those of the financial cooperation (KfW) program, HIV-Prevention/Social Marketing II. From 2005 onwards, all former projects and programs were integrated into one joint health program under the emerging SWAp.

In 2007, the first joint program proposal of the implementing organizations was submitted to BMZ. It defined one overall cooperation goal (*the health status of the Rwandan population is improved*) and three component objectives. The indicators for the program objective and some of those for the component objectives (cf. Annex E) were drawn from the monitoring framework, which was established by EDPRS and the first health sector strategic plan (HSSP I 2005 – 2009).

3.2 Adapting to the changing context

The evolution of Rwandan-German cooperation, as presented in the previous section, indicates that GDC adapted its support to the changing context. GDC integrated its various projects and programs successfully as a precondition for aligning its interventions to national priorities in the health sector, as defined by HSSP. These national priorities have been defined as a result of a number of high-level policy processes since 2000 (cf. A.3.1.3).

GDC also adapted its interventions to Rwandan aid policy (GoR, 2006). This translated into a combination of joint financing modalities (SBS) and pooled funding through CDPF with project-based aid. GDC, especially, played a major role in designing SWAp (cf. chapter B.3.3.1).

In using its comparative advantage of long-term experience in decentralized health service delivery (cf. Chapters B.1.1 and B.2.1), GDC intentionally directed its focus on health systems strengthening as a complement to vertical programs. Vertical programs, especially funded by the US Government and GFATM, had become more and more prevalent in terms of aid volume flowing into the health sector (cf. Chapters A.3.1.3 and A.3.2).

The following sections include the different components of the Rwandan-German Health program, implemented during Phase III, and provide more evidence on how GDC adapted its interventions to the changing context.

⁵⁵ As this was a BMZ policy for GDC, worldwide, no special reference has been made to eventual friction, losses, and fragmentation, as far as GDC in Rwanda was concerned.

3.3 Achievements

3.3.1 Sector-wide approach, sector budget support, and capacity development pooled fund

Evolution of the SWAp in Rwanda's health sector

SWAps emerged in the mid-1990s in response to slow progress in human development in several countries, despite large flows of aid (cf. Box 9). In Rwanda, SWAps were fully positioned in seven sectors in 2012, including those important to development (e.g., agriculture, education, and health) (MINECOFIN, 2012a). In the health sector, the National Health Policy (GoR, 2005a) and HSSPs I-III (GoR, 2005b; GoR & MoH, 2009, 2012) provided the overarching policy framework for SWAps. HSSP I (2005–2009) broadly defined the communication and coordination structure through the health sector cluster group, several TWGs, and sub-sector working groups (GoR, 2005a).

Box 9. Sector-wide approach (SWAp)

In response to criticism of traditional project-based aid being too donor-driven, the international development community reformed its methods of aid delivery, resulting in the emergence of SWAp. Under SWAp, funds from DPs contribute directly to the development and implementation of a defined sector policy under a government authority. Key principles of SWAp are: (1) the partner government leads and takes ownership of the sector program and (2) that there is a shared effort by DPs to support the program, including all or a majority share of funding for the sector. Ideally, different aid modalities are combined under SWAp, including joint financing. Consistency between what is planned within-sector (SWAp) and across sectors (PRSP processes) is important (WHO, n.d.).

Following a review of the progress achieved by partners in the harmonization and alignment process within the Rwandan health sector, a number of steps were taken to strengthen SWAp, including the reorganization of TWGs, establishing joint review mechanisms, and developing coordination mechanisms at the district level (Niechzial & Ruginga, 2006). In October 2006, the first joint health sector review (JHSR) was undertaken (IHP+, 2006). In 2007, a Memorandum of Understanding between the

GoR and eight DPs⁵⁶ officially launched the SWAp (GoR & MoH, 2007).

Based on an evaluation of HSSP I, HSSP II (2009–2012) was adopted in late 2008. In 2009, the SWAp structure was reorganized. The health sector working group (HSWG) replaced the former Health Sector Coordination Group and changes in TWGs and WGs were effected. A SWAp manual and a roadmap were developed with the support of GTZ and other DPs (UNICEF, United Kingdom, United States). These documents, which set out institutional procedures for SWAp, were adopted at JHSR (IHP+, 2006). Since 2010, SWAp has been gradually extended to the district level through the establishment of health commissions in each district under the Joint Action Development Forum (JADF). Following a mid-term review of HSSP II in 2011, a draft version of HSSP III was developed in a consultative process, including major health sector stakeholders (MoH, DPs, district administration, professional and civil society associations) in 2012 (IHP+, 2011).

The health SWAp architecture is currently composed of the HSWG as the coordinating body, chaired by the MoH Permanent Secretary and co-chaired by a DP representative with another DP representative as shadow co-chair. Under the HSWG, about 30 TWGs and sub-WGs exist (GoR & MoH, 2012, p. 135), each chaired by a MoH official and co-chaired by a DP representative. Health sector performance is regularly reviewed by DPs and Rwandan partners in the biannual JHSR.

Major DPs in the health sector (i.e., Belgium, GDC, Luxembourg, Switzerland, United Kingdom, and United States) worked through SWAp structures and mechanisms. Only a few DPs, however (i.e., Belgium, GDC, and United Kingdom), are engaged in joint financing modalities (SBS and CDPF). The starting point was a joint mission by GDC and Belgium to design joint financing mechanisms for the health sector, including SBS and CDPF. This set the stage for signing several financing agreements for SBS in the following years between MINECOFIN and different DPs.⁵⁷ Since 2007, SBS has been supported by Belgium, Germany, and United Kingdom with USD 20.68 million, USD 24.27 million, and

⁵⁶ African Development Bank, Belgium, Germany, Switzerland, United Kingdom, United Nations Country Team for Rwanda, United States, and World Bank.

⁵⁷ BTC and DFID in 2007, GDC/KfW in 2009, and BTC in 2010.

USD 16.67 million, respectively (Synergy International Systems, 2013). CDPF was funded by DFID since 2007 (GBP 2 million); by SDC (CHF 1.8 million), GTZ, and KfW since 2009 (EUR 0.6 million); and by BTC since 2009 (EUR 0.5 million).

According to data provided by MINECOFIN, between 2008 and 2012 the share of SBS to the overall health budget amounted to 8.4% (including other ministries in addition to the MoH) and 15.9% of the MoH budget. SBS, as part of overall donor funding, provides a different picture: with 63% of the health sector still funded externally (as at 2010), only 6.25% of all donor funds were channeled through SBS. In the health sector, the US Government was, by far, the major DP, contributing 39% of funds provided

through external assistance (cf. Chapter A.3.2). All contributions from the US Government are provided as off-budget funding.⁵⁸

The development of SWAp in the Rwandan health sector was jointly supported by several DPs, as requested by the GoR in accordance with its aid policy. Joint financing, joint design, review missions, and the shared financing of consultancies and studies, were carried out. Many activities supported by GDC, therefore, were conducted jointly with other DPs, in particular – but not exclusively – with SBS DPs. Table 8 summarizes the major activities to which GDC provided substantial inputs in the form of funding, policy advice, and technical assistance.

Table 8. SWAp and joint financing modalities: Inputs and outputs

Major activities and contribution of GDC	Major jointly achieved outputs
SWAP Development	
Support to the conceptualization and design of SWAp Support to the elaboration and review of HSSP I (2005–09) and HSSP II (2009–2012), Support to the elaboration of HSSP III Active participation and facilitation in HSWG, TWG, and JHSR Support to the development of SWAp in five districts	Establishment of SWAp structures, HSCG/HSWG, TWG, and monitoring and review mechanisms SWAp Memorandum of Understanding SWAp manual and roadmap Development and implementation of HSSP I (2005–2009), HSSP II (2009–2012) and HSSP III Establishment of JADF health commissions
SBS	
Design of SBS Disbursement of SBS: First tranche (EUR 6.0 million) in 2009; second tranche (EUR 3.6 million, including EUR 0.1 million for CDPF) in 2010; third tranche in 2011	Increase of health sector budget and implementation of HSSP II (2009–12)
CDPF	
Conceptualization and design of CDPF Disbursement to CDPF: 2010 (EUR 0.6 million ⁵⁹) Support to external audit of CDPF (2011) Technical assistance to CDPF management (steering committee, SWAp secretariat, SPIU)	Establishment and reinforcement of coordinating units at central level (SWAp secretariat) Ad hoc support of capacity development interventions at district level until 2011 Review of HSSP I and development of HSSP II Implementation of elements of the HRH strategic plan (2011–16) since 2012

Sources: Project and program reports of implementing organizations to BMZ; timeline (Doc.25) and milestones documentation (Doc.23) by GIZ Health Program.

Theory of change

The joint Rwandan-German health program had been part of SWAp since 2005. The intended change, outlined in the joint

health program's ToC (cf. Annex D), is that through support to SWAp and through SBS, coordination and cooperation between GoR and external DPs has improved (outcome). Support to SWAp

⁵⁸ It is interesting to note that the US Government was about to provide SBS to the agricultural sector in 2012, which failed to materialize because of several DPs suspending GBS to GoR in the second half of 2012 (information by the German Embassy in Rwanda). This sheds a different light on the apparent inability of the US Government to provide SBS due to provisions in the Budget and Accounting Act.

⁵⁹ EUR 0.5 million from GTZ and EUR 0.1 million from KfW.

and SBS has also led to improved ownership within the MoH and improved capacities regarding public financial management (outcome). These two outcomes, together with enhanced quality care, contribute to making the health system better respond to the needs of the population, especially the poor. The enhanced quality care (output) results from the strengthening of capacities in the health sector, funded from CDPF. The health status of the population, ultimately, has improved (impact).

Relevance

SBS and pooled financing mechanisms in the context of SWApS are aid modalities that have been strongly enhanced by the aid effectiveness agenda. In light of the Paris Declaration on Aid Effectiveness, GoR endorsed its respective aid policy in 2006 (GoR, 2006). It aims to increase the effectiveness of external assistance to Rwanda and provides a basis on which support can be mobilized. The preferred aid modality of GoR is un-earmarked GBS, followed by SBS. Stand-alone projects should only be considered if they are on budget or, at least, aligned to a national strategic plan. Donor resources should be pooled rather than provided through individual projects (GoR, 2006; GoR & MoH, 2012; G INT SWAp 2).

The BMZ country strategy for Rwanda (BMZ, 2009b) highlights the importance of GBS and SBS and relates them to the following objectives and expectations: support to Rwanda's poverty-oriented development policy through funding and continuous policy dialogue and harmonization of donor procedures through joint financing mechanisms and reduction of transaction costs (BMZ, 2009b, p. 11). Likewise, the BMZ priority strategy for Rwandan-German cooperation in the health sector underlines that GDC is fully integrated into the national planning process, led by HSSP I, HSSP II, and the health SWAp and that it is, thus, in line with the Paris Declaration (Doc.19). Joint financing modalities are seen as appropriate instruments in the context of program-based approaches to promote health sector reform and reduce transaction costs.

Until recently, BMZ very much supported GBS and SBS for Rwanda (G INT GEN 2; INT SWAp 9). In view of accusations by

the United Nations regarding Rwandan support to militia in Eastern Congo, however, BMZ has suspended its planned GBS for 2012/2013 and 2013/2014 (BMZ, 2012a, 2012b). Since GBS also flows to sector ministries, this will affect the health sector budget. As other DPs also have suspended GBS, the aid flow has considerably decreased with unavoidable repercussions on available national budgets (World Bank, 2013). Given these constraints and in recognition of the considerable efforts from the GoR to contribute to regional peace consultations, the German Government has released part of the scheduled GBS for the joint program relating to vocational education (EUR 7 million) and decentralization (EUR 7 million).⁶⁰ The mode of delivery, in fact, has changed from GBS to off-budget project funding. The remaining EUR 7 million remains on hold (Sandner, 2013).

SBS was intended "to expand the total resource envelope available for the poor in the health sector, and hence close the HSSP financing gap [...] by focusing on items in the health budget that address quality health services for the poor and the vulnerable" (Doc.48). The link to the component objective ("The health system responds better to the needs of the population, especially the poor") is evident. The relevance of SBS is evident, as its objectives are aligned with the EDPRS and HSSP. Providing SBS is also in line with the aid effectiveness agenda.

Box 10. Capacity development pooled fund (CDPF)

The Capacity Development Pooled Fund is a co-managed finance pool of the Ministry of Health and DPs (BTC, DFID, GDC, and SDC). The primary aim of the CDPF was to assure effective coordination and to avoid the duplication and overlap of the various efforts of DPs to support capacity building in the health sector in Rwanda. The pooling of resources for technical assistance, including capacity building, has emerged as an aid modality in the joint efforts of DPs and national governments in partner countries to improve aid and development effectiveness, following the Paris Declaration (2005).

CDPF (cf. Box 10) was first conceived as a "transitional mechanism to provide short term capacity development support to operationalize the health SWAp" (Doc.48). The major rationale was to rapidly build up capacity in health planning and management, in order to avoid the risk that investments in the health sector fail to produce sustainable benefits. The establishment of the

⁶⁰ Personal information from the BMZ regional desk.

CDPF was also conceived as a substitute to the accompanying interventions for SBS (INT EXP 10). A more pragmatic rationale for CDPF was to bring other DPs that could not engage in SBS to participate, at least, in pooled funding (INT GEN 4).

Until 2011, the activities of CDPF were conducted in a rather ad hoc manner, without being based on a capacity building needs assessment or a coherent strategy. Strategic objectives were developed as a follow-up to an external audit conducted in 2011 (Doc.50).⁶¹ In its current design, CDPF aims to increase the numbers of trained and equitably distributed staff and to improve the productivity and performance of health workers, as well as the capacity to plan, develop, regulate, and manage HRH (Republic of Rwanda, MoH, & SPIU, 2012). These objectives are aligned to the HRH Strategic Plan (2011–2016).

Technical assistance, combined with pooled funding, is viewed as important by officials in MoH to ensure an effective implementation of national health strategies and guidelines (G INT GEN 3; INT SWAp 4). Some DPs also share this view. Their main argument is that such a mix of approaches can enable GDC and other DPs to transfer experiences from implementation at the district level into the dialogue with Rwandan partners in the TWGs (INT GEN 4; INT SWAp 7).

It can be concluded that GDC support to the SWAp has reflected, to a large extent, the priorities of the German and Rwandan Governments. The same applies to GDC support to joint financing modalities. GDC support in terms of technical assistance has reflected, to a large extent, the priorities of the German Government, since GoR has shown a clear preference for budget support and pooled funding. The aid modalities by GDC have been appropriate to achieve the objectives established, together with its Rwandan partners.

Effectiveness

In the context of SWAp, GDC has followed a multi-level approach. Coordination and policy advice was ensured through the participation of the health sector coordinator in the HSWG, as well as KfW and German Embassy representatives in the Budget

Support Harmonization Group and JBSRs. GIZ-seconded experts also co-chaired and participated in several TWGs and supported the development of national strategies and guidelines. At the district level, technical assistance and training was provided to district and hospital administrators, in addition to health professionals. Furthermore, GTZ/GIZ has supported the plans of district hospitals and administrations with local subsidy agreements.

The following paragraphs provide information on the final status of the indicators relating to the achievement of the component objective (“the health system responds better to the needs of the population, especially the poor”) in the context of support to SWAp (cf. also Annex E).

“The Economic Development and Poverty Reduction Strategy (EDPRS) contains health specific strategies, focusing especially on the access of the poor to health services, and resource allocation on district level is improved” (Doc.26). EDPRS (2008–12) objectives and its flagship programs focus on pro-poor growth and on governance. Health objectives are to maximize preventive health development interventions and build capacity for high-quality and accessible health care services for the entire population, in order to reduce malnutrition, infant and child mortality, and fertility, and to control communicable diseases (Republic of Rwanda, 2007). In EDPRS 2 (2013–18), these health objectives figure less prominently. They are ensconced under fundamental issues aimed to improve quality, demand, and access to health insurance. Improved access is only made explicit in relation to improved health insurance for the poor (GoR & MoH, 2012, p. 80). According to the mid-term review of HSSP, the share of the MoH budget, allocated to the district level, increased from 11% in 2006 to 40% in 2011 (IHP+, 2011).

“The joint financing of the health sector of at least two bilateral development partners continues” (Doc.26). Following the Division of Labor exercise under the leadership of GoR, GDC support has been phased out, including joint financing. Only Belgium is committed to further providing SBS until 2020, after which DFID will phase out its support to the health sector (DFID, 2013). There

⁶¹ While the audit has focused primarily on financial management issues, it serves as an opportunity to reconsider the strategic orientation of CDPF.

is still, however, some uncertainty about this commitment.⁶² Belgium will most probably continue to finance CDPF, together with SDC, but the modalities for the renewal of the grant are not yet finalized. Attracting other major DPs to pooled financing mechanisms has not been successful so far.

“The management capacity of the MoH in health financing is strengthened as a result of at least 90% of all actors in the health sector (2010: 80%) entering into the Health Resource Tracking Tool [HRTT] more complete data on the amount and use of funds and the use of the data base for the annual planning 2012/13” (Doc.26). Information on the number of stakeholders entering data into HRTT is available, but not conclusive to the point that the indicator could be verified. It proved more difficult than expected to have all actors in the health sector providing the required data (HRTT, 2012).⁶³ HRTT did provide data for the annual planning 2013/14. There are indications that the management capacity of MoH has been strengthened. The results from the data collection, however, remain inconclusive.

Sector-wide approach

Between 2004 and 2012, the health SWAp evolved from concept to structured cooperation between MoH and its partners. There is supportive evidence that SWAp is well-established in the context of the Rwandan aid architecture (GoR & MoH, 2012, p. 94). In its entirety, the structure and mechanisms (HSWG, TWG, JHSR) are functional and follow clear and transparent procedures. There is a strong role for GoR to coordinate the dialogue among DPs (INT SWAp 9, 10).

Both Rwandan and German former stakeholders in the program claim that they played a crucial role in the early stages of SWAp development (INT SWAp 16, 19). MoH officials and DP representatives have emphasized that GDC was instrumental in bringing SWAp to life, establishing its framework and procedures, and

consistently advocating for harmonization and alignment (G INT GEN 4; G INT SWAp 1, 6, 7, 8, 13).

The interviews also revealed that some confusion remains with regard to the mandate and role of some TWGs and to the coordinating role of the SWAp secretariat (INT SWAp 6).⁶⁴ Furthermore, the quality and effectiveness of SWAp appeared to depend very much on the strength of the respective TWG. Some TWGs met often, while others did so rarely. Some chairs of TWGs apparently lacked the influence or authority in MoH to enforce decisions. Informal power and communication structures in MoH still play an important role, bypassing TWG mechanisms. In some areas, such as human resources development, dialogue, strategy design, and technical advice took place primarily outside of the formal SWAp framework (G INT GEN 4; INT SWAp 6, 7, 13, 18; INT HRD 21).

With regard to the decentralization of SWAp, MoH officials, GDC staff, and DP representatives at the central level concurred in their assessments that the respective compositions (i.e., the district health management teams (DHMT))⁶⁵ have been created at the district level, but that in many of the districts, they do not yet assume their roles and responsibilities in a sufficiently proactive and committed manner (G INT GEN 4; INT SWAp 3, 5). The JADF and its sub-commission on health appear to operate fairly well, when they are supported either by an active local leader (mayor or vice-mayor) or by a DP working within the district (INT SWAp 6, 7). In those communities supported by GDC, the JADF was viewed more as an opportunity to regularly exchange information on health-related activities in the area than as an avenue for strategic planning and shared resource management (G INT GEN 8, 10, 11).

The improved coordination among the various stakeholders relating to health systems development (comparative case study) has been revealed by health service providers – from the focus

⁶² For the time being, commitments from Belgium for SBS only cover the period 2011–14 (INT SWAp 22).

⁶³ The use of the data base was voluntary and transparent (for all implementation activities). Consequently, certain amounts spent were duplicated, which made their tracing onerous (INT SWAp 16).

⁶⁴ In 2012, DP group continued to give priority to the strengthening of TWG performance, since some TWG members had not responded to the jointly agreed requirements (cf. Minutes of DP group, 2012).

⁶⁵ DHMTs were created in order to formalize existing mechanisms and initiatives for health systems coordination, already implemented in some districts prior to 2012. The major role of DHMT relates to planning and management, supervision, coordination, financial and resource oversight, regulation, and increasing participation of the local community in the delivery and management of health services. The membership is as follows: deputy mayor responsible for social affairs (chairperson), district health unit staff, director of the district hospital, director of pharmacy, director of CBHI, representative of the head of health centers, and a representative of CHWs.

group discussions and interviews held – as being a positive effect of decentralization. DHMTs, however, are not yet in a position to play their role effectively, since they have been provided with GDC advisory support only during the phasing out period in 2012. Interviews conducted in the five districts revealed that DHMTs still require considerable support and guidance in order to operate effectively. Regarding the interface with the JADF, clarification is lacking on their respective competencies, roles, and responsibilities, as well as on the linkage and reporting systems (INT SWAP 1, 4). In addition, informal communication systems within MoH appear sometimes to bypass formal SWAP mechanisms (INT SWAP 4).

Sector budget support

SBS was earmarked to fund key interventions in the health sector. As had been understood by the core DP group, this represented an increase in allocations from the health budget to primary- and secondary-level health care, and figured prominently among performance triggers (INT EXP 6, 10). There is supportive evidence that the share of the health budget allocated to the district level increased from 11% in 2006 to 40% in 2011 (IHP+, 2011). On closer examination of SBS contributions by GDC, it appeared that the first and second tranches (EUR 6.0 million and EUR 3.6 million, respectively) had not flowed into the health budget. This led to an unexpected and considerable delay in the use of the funds, as was disclosed in the report of the Auditor General (GoR & MoH, 2010a), accessed by the GDC in November 2011 (INT EXP 6, 9, 10).⁶⁶ KfW had requested the third tranche to be transferred in October 2011, based on the JHSR. After bilateral discussions between MINECOFIN, MoH, and KfW, a detailed plan for the use of the three tranches of SBS funds was submitted to GDC by MoH. The funds, in fact, had been earmarked for hospital equipment at the district and province levels and health centers (Doc.28). There is some evidence that this actually reflected priority interventions, in accordance with HSSP II (INT EXP 9, 10).

Budget support is expected to provide donors with a greater leverage effect on reform processes by raising policy dialogue

between donors and partner countries to a more strategic level (BMZ, 2008; de Kemp, Faust, & Leiderer, 2011). While this effect does not figure explicitly in the program's ToC, it should be considered as one of the target outcomes from the perspective of DPs. There is some supportive evidence from the interviews that this effect did materialize as was intended. Interviewees among GDC and DP staff, who were engaged in SBS in Rwanda, claimed that they had more leverage from their privileged access to MINECOFIN and as a result of more focused dialogue on health sector performance during JHSR,⁶⁷ which took place twice a year (G INT GEN 4; INT SWAP 12, 16).⁶⁸ Several JHSRs, between 2006 and 2012, included key issues, such as transparency with regard to budget allocation and expenditure, the need to address financial sustainability issues in HF strategies, and the harmonization of data collection and analysis.

Most of MoH officials, who were interviewed, acknowledged the importance of SBS and pooled funding (G INT GEN 3; INT SWAP 4). They also emphasized that project-based, off-budget funding – in combination with technical assistance – should still be viewed as a necessary and complementary modality.

Interviews revealed that opportunities for leveraging policy dialogue were restrained due to SBS constituting a relatively small proportion of aid in the health sector (6.25% in 2010; INT EXP 19; cf. also chapter A.3.2). This made it difficult to position the increase of domestic contribution to the health sector budget as one of the key topics for policy dialogue, as had been intended. DPs also drew attention to the fact that the principal donor in the health sector, the United States, is not only absent from the group of DPs providing SBS, but it also provides nearly 40% of health sector aid, thus comparatively increasing its leverage in terms of policy dialogue (INT EXP 6, 9, 10, 19).

Capacity development pooled fund

The different interpretations among DPs and MoH of the objectives of CDPF have presented challenges to its timely implementation as a joint financing modality, a fact that many of those

⁶⁶ Beyond the fact that these funds may have been frozen in a special account under MINECOFIN, there is no further evidence on the reason for this delay.

⁶⁷ It should be noted that the participation of DPs in the JHSR was not restricted to those contributing through SBS.

⁶⁸ DPs providing SBS and GBS – as did GDC and DFID – had access to the budget support harmonization group and the joint budget support review. There are indications that this setting provided substantial opportunity for policy dialogue (INT EXP 19), but this has not been further explored in the context of this evaluation.

DPs interviewed stressed (INT SWAp 1, 5, 8, 13; INT GEN 4; INT EXP 10). While some DPs favored a flexible financing modality, in addition to SBS and project-based aid, others emphasized clear orientation towards capacity development, mainly due to the lengthy process of agreeing on common procedures and on DPs tending to micromanage the direction of CDPF (Doc.53).

Some evidence can be provided with regard to the contribution of CDPF to capacity development during the first phase. While CDPF was used to finance the evaluation of HSSP I and the development of HSSP II, the latter national plans constituted a key element in SWAp and the development of a unified approach towards strategic health management. This is, therefore, an indirect but important contribution to capacity development in the sector. Since capacity development activities were backed in an ad hoc manner and without a common strategic framework, it can be concluded that capacities – for example, of CBHI managers at the district level or of specific target groups in district hospitals⁶⁹ – indeed, have been developed and strengthened. There is, however, a lack of evidence of how these capacities have been utilized.

Subsequent to the reorientation of its support in 2011, CDPF focused on the long-term training of health staff, particularly with regard to secondary health care. In compliance with the HRH Strategic Plan, the new three-year work plan (2011–2014) includes, among other development interventions, nursing and midwifery training and an upgrade of the program, a physician assistant program at the Kigali Health Institute, a hospital management program, and the training of biomedical technicians (Republic of Rwanda et al., 2012). The programs were implemented in November 2011 and, as the relevant results will be available only in December 2014, their effectiveness could not be included in the evaluation.

The role of CDPF as a joint financing modality weakened when, in 2012, a major US-funded initiative to support HRH development in Rwanda was launched and required coordination with CDPF (Doc.53) between the United States Government and GDC

representatives, including the CDPF Steering Committee. It was not possible, however, to pool the US funds with those of the CDPF-contributing DPs and ensure joint planning and budgeting procedures. To the extent possible, effort was made to ensure complementarity. In comparison, CDPF funds are modest, when compared to the US funds for the HRH program (USD 20–25 million per annum) (INT DP 1).

In conclusion, SWAp structures and mechanisms, on a national basis, are operating effectively at varying degrees with regard to TWGs. GDC's support to make these structures and mechanisms functional has been effective, as has been evidenced from those TWGs where GDC has played a leading role. SWAp, at the decentralized level, is yet to operate smoothly, given that GDC support could have been more effective by a later phasing out period of Rwandan-German cooperation in the health sector. SBS could not be fully explored as an aid modality due to a limited leverage effect and a lack of coherence among contributing DPs. So far, basket funding (CDPF) has helped strengthen institutional capacities in the health sector only to a moderate extent. GDC has been effective in operationalizing CDPF and in strengthening its strategic orientation.

Efficiency

While the inputs provided by GDC for the implementation of SWAp – in combination with joint financing modalities (SBS and CDPF) – can be identified, the outputs and outcomes were achieved jointly (i.e., with Rwandan partners and other DPs). An attempt to measure cost-effectiveness by relating GDC inputs to shared outputs and outcomes, therefore, is not pertinent. This also applies to the assessment of SBS performance and its flows into the overall sector budget.

As far as the GDC contribution to SBS is concerned, the disbursement procedure has proved to be efficient, given that the three tranches (2009, 2010, and 2011) were transferred on schedule. The procedure for transferring these funds to the health budget, however, was inefficient (cf. the respective paragraph under 'effectiveness'). There have been other similar instances of delays

⁶⁹ Funds from CDPF were used to cover financial gaps with regard to capacity development activities, scheduled in annual work plans, at the district and hospital levels. This was based on proposals made by districts and hospitals (Doc.53).

with regard to SBS funding, as experienced by Belgium and United Kingdom (INT EXP 20).

There has been apparent inefficiency in the use of CDPF funds (Doc.50), which were used – without adhering to strategic guidelines – for non-core and ad hoc activities, as well as their being under-used. In response to audit recommendations (Doc.50), CDPF now has been placed under the responsibility of SPIU in MoH.

A common measure used to assess the efficiency of SBS or pooled funding modalities is the extent to which they have contributed to reduce transaction costs for recipient governments and DPs. The interviews have indicated that transaction costs were reduced for Rwandan officials in MoH (INT SWAp 13, 14) – especially after the establishment of SPIU – but that they did not substantially decrease from the perspective of GDC staff (G INT GEN 2). In the case of CDPF, an increase of workload and coordination activities, especially for DPs, was observed.

In conclusion, there were deficiencies in terms of SBS and basket funding (CDPF). Transaction costs could be only partially reduced.

Sustainability

The rationale for a review of the sustainability of GDC support to SWAp, SBS, and CDPF is not because Rwandan-German cooperation is ending as a result of its high-level ownership and sustainability in terms of GDC aid to the health sector, which are being achieved. It is because of the GoR's commitment to the aid-effectiveness agenda. In accordance with Rwanda's aid policy and Division of Labor, MINECOFIN's view was that donor support should be equally distributed among EDPRS sectors. As the health sector has benefitted from substantial support from DPs in previous years, the priorities were set by the GoR in order to fill the gaps in other sectors. Support to productive sectors needed to sustain economic growth which, in turn, would strengthen the health sector. MINECOFIN, therefore, was confident that the health sector would cope with the termination of GDC support (G INT SWAp 2).

Current and former MoH officials who were interviewed, see a major opportunity to sustain GDC support in SWAp, SBS, and CDPF, given that GoR – not a DP or GDC – owns SWAp. Because of GDC alignment to the priorities of GoR, officials anticipate that the strategies developed with GDC support will continue operating. The same interviewees, however, highlighted the fact that the hole left by German support to SBS and CDPF would need to be filled by domestic and external resources. At the same time, technical assistance – particularly in the areas of HF and health technology management – still would be needed in the short term (G INT GEN 3; G INT SWAp 1, 3). Regarding health technology management, MoH officials and DPs expect serious funding gaps to occur after the phase-out of GDC in terms of maintenance, repairs, and the procurement of spare parts (INT SWAp 3, 7, 10). The training of biomedical technicians, co-financed by CDPF and Belgium, therefore, is highly welcome under the umbrella of the HRH program. To date, their number is still limited and technical assistance to develop systems operations between the district and the central levels remains critical (INT HRD 5; INT SWAp 7).

At the district level, the main risk to continuing GDC support to SWAp relates to consolidation of performance. According to interviewees in the district administration, the structures and mechanisms to implement national strategies are in place, but the resources are lacking for capacity building and supervision of health facilities and staff. The mobilization of resources from other stakeholders at the district level was seen as a challenge (INT HRD 8; G INT GEN 8, 10, 11).

In view of the high-level ownership by GoR and the functionality of SWAp structures and mechanisms established, the prospects for the sustainability of health program achievements in various areas can be rated as satisfactory. Despite this, there are indications that SWAp-dynamics have further lost momentum in the first half of 2013 (INT DP 1; INT EXP 20; INT SWAp 21). DP interviewees consider this to be because key DP staff members have left Rwanda. The HSWG, as one of the key forums for SWAp, apparently does not succeed in organizing its work effectively. The fact that the JHSR is not taking place in April 2013 can also indicate

that the SWAp process has become less vital. It is also obvious that the US-funded HRH program is implemented primarily through project-based aid, in lieu of CDPF. There are indications that bilateral cooperation between GoR and the United States has taken the lead, to the detriment of the SWAp process.

As illustrated by the financial gap analysis HSSP III (GoR & MoH, 2012, p. 121), the challenge remains that the health sector still very much depends on external support. While the US Government has further strengthened its role as the major donor in the health sector, its funding is declining. With LuxDev having retreated from the health sector in 2013, and with DFID having phased out its support, only Belgium has announced its long-term commitment. As far as SBS is concerned, however, Belgium's commitment only will cover the period 2011–14. There is some indication that MINECOFIN will respond to this challenge with a new Division of Labor policy (GoR & MINECOFIN, 2013), given that the new players, France and China, will provide support to the health sector for the actual EDPRS period (2013–18). There is a possibility that DPs joining the health sector will display a level of commitment which, hopefully, will contribute to revitalizing the SWAp dynamic.

3.3.2 Component 1: Health financing

Two health reforms, designed to overcome the under-utilization and low quality of services in Rwanda, have sparked special interest in the international development community (cf. Logie, Rowson, & Ndagije, 2008; Musango, Doetinchem, & Carrin, 2009; Saksena, Antunes, Xu, Musango, & Carrin, 2010): a country-wide CBHI (cf. Box 11) and a PBF of health providers (cf. Box 12). Both reforms originate from small-scale projects in the resource-poor, post-conflict environment that followed the 1994 genocide, and have been accompanied and shaped by German cooperation over a period of several years.

Health financing in the Rwandan health system

CBHI

When international emergency assistance was phased out, following the 1994 genocide, user fees for health services were reintroduced in Rwanda in 1996 (INT HF 32; cf. Soeters et al., 2005). As a consequence, the use of health services dropped to 0.25 consultations per capita per annum by 1999 (INT RP 1; cf. also Schneider, 2005). To reduce the catastrophic costs resulting from out-of-pocket payments for health services, GoR and some NGOs locally piloted three CBHI schemes in 1999 (cf. Binagwaho, Hartwig, Ingeri, & Makaka, 2012) (cf. Box 11). The key evolutionary stages of CBHI since then have been its scaling up, nationally, in 2004, accompanied by a policy (MoH, 2004), the development of a legal framework, backed by law in 2007 (GoR, 2008a), and the issuance of a new policy in 2010 (MoH, 2010a).

Box 11. Community-based health insurance (CBHI)

Health insurance, in general, can be defined as “a contract between the insured and the insurer to the effect that in the case of specified events (determined in the insurance contract) occurring, the insurer will pay compensation either to the insured person or to the health service provider” (WHO, n.d.). Rwanda's current CBHI (*mutuelles de santé*)⁷⁰ is based on a form of health insurance, referred to as social security, “whereby, in principle, society's risks are pooled, with contributions by individuals usually dependent on their capacity to pay” (WHO, n.d.).

In its current form, CBHI is organized to correspond with both administrative entities (sector, district, and national levels⁷¹) and care levels (health centers, district hospitals, and referral hospitals) (cf. MoH, 2012b). Premiums are collected from CBHI members (approximately 70% of the CBHI budget) at health centers (sector level) and pooled with subsidies from GoR (approximately 13%), DPs (approximately 9%), and private employers (approximately 8%) (all percentages for 2006, taken from GoR & MoH, 2008). These funds reimburse health centers for services delivered to CBHI members. The sector risk pool is reinsured by larger risk pools at the district and national levels. The pools at the sector level cover about 15,000 members each, and a district pool (30 in total) covers about 300,000 inhabitants

⁷⁰ For the sake of clarity, it should be noted that the use of “community-based” could be somewhat misleading. Some scholars consider either non-governmental ownership of a scheme or voluntary enrolment of members as definitional preconditions to qualify as “community-based” (cf. Bennet, 2004; Ekman, 2004; Robyn, Sauerborn, & Bärnighausen, 2013). Although both aspects do not apply in the Rwandan context, following the scheme's evolution, this report refers to the Rwandan insurance as CBHI, commonly and officially used in Rwanda.

⁷¹ The current administration system of the Republic of Rwanda is structured (from the largest to the smallest) by provinces, districts (the main decentralized governance unit), sectors, cells, and villages (cf. MINALOC, 2011).

(cf. MoH, 2010b). The CBHI policy of 2010 (MoH, 2010a) replaced the capitation system (1,000 RWF per person⁷² per annum; a co-payment [*ticket modérateur*] of 200 RWF at the point of use (i.e., at a health facility) by a contribution system. This was based on socioeconomic stratification, ranging from full government substitution for the poorest up to 7,000 RWF, plus co-payments for the more wealthy. Membership in an insurance has been mandatory by law in Rwanda since 2007 (GoR, 2008a).

PBF

PBF started out as a geographically specific pilot between 2002 and 2005 (MoH, 2008), and has been rolled out nationwide since 2005 (cf. Basinga et al., 2011; Soeters et al., 2005) (cf. Box 12). While PBF encompasses all care levels, only the administrative model for district hospitals is presented here (cf. Rusa, Schneidman, Fritsche, & Musango, 2009) because Germany, as sole DP under the Division of Labor concept of GoR, has supported PBF in the district hospital of Ruhengeri.⁷³ PBF budgets for hospitals are estimated, based on an annual value of approximately USD 600 per bed. Each quarter, a team from a peer hospital (often comprising MoH and DP representatives) evaluates the hospital's performance against a checklist of 51 indicators. The percentage of the prospective budget disbursed as an incentive is contingent on the degree of indicator achievement. Both the area (administration, quality assurance, or clinical activities) and quality of performance enter the calculation as weights. An invoice, approved by a district steering committee (under supervision of the Rwandan Ministry of Local Administration, Community Development and Social Affairs, MINALOC), is subsequently sent to the purchaser (MoH) to pay the performance fee (through MINECOFIN) to the district hospital which may decide on how to use these revenues.

Box 12. Performance-based financing (PBF)

Performance-based financing – sometimes referred to as Pay for Performance, output-based aid, or Performance-Based Payment – can generally be defined as the “transfer of money or material goods conditional on taking a measurable action or achieving a predetermined performance target” (Eichler & Levine, 2009, p. 6). PBF in Rwanda (also known as *approche contractuelle*) aims to overcome under-utilization and poor coverage of health services (cf. Rusa et al., 2009). MoH introduced financial incentives for health service providers to improve their performance on a defined set of services, quantitatively and qualitatively, and their management of services and systems (MoH, 2009a). PBF thus tackles the supply side of the health system.

Both CBHI and PBF should be considered as flagships among the Rwandan health reforms, pursued at a high pace and with strong political commitment. In absolute terms, the funds, transferred through PBF, totaled USD 5.7 million in 2006,⁷⁴ peaking at USD 11.8 million in 2007 (WHO, 2009b, p. 114). The 2006 National Health Accounts (GoR & MoH, 2008, p. 15) estimated that CBHI contributed about USD 15.3 million to total health expenditure. These figures highlight the centrality of both programs for Rwandan HF, given a total public health expenditure of approximately USD 58 million in 2006 (cf. GoR & MoH, 2008, p. xvi).

The component of health financing in the Rwandan-German health program

Theory of change

The overall goal of the program's HF component aimed to increase the responsiveness of the Rwandan health system, especially towards the poor (cf. program progress reports, 2008 – 2012). With regard to CBHI, the goal indicator was to increase the percentage of the population covered by insurance from 60% in 2008 to 100% in 2012 (cf. Annex E). The second target was to introduce PBF in at least 50% of the district hospitals from 2008 to 2010, which was replaced by the goal to develop adjusted PBF criteria for the newly designed structure of province hospitals in 2012.

⁷² Although the premiums under the capitation system had to be paid individually, membership in the insurance was family-based (cf. GoR, 2008a: Article 5; MoH, 2004, p. 7).

⁷³ On a policy level, however, Germany supported PBF per se. For PBF regarding CHWs, cf. MoH (2009b) and Mugeni, Ngabo, and Humuza (2011); for the application at health centers, cf. e.g., Meessen et al. (2006).

⁷⁴ Of these USD 5.7 million, 20% was allocated to PBF in district hospitals (USD 1.15 million). The largest financial contributor was GoR with about 46%, followed by Belgium (32%) and United States (22%). The World Bank contributed 13% of the USD 2.96 million disbursed through PBF to health centers (GoR: 85%; Belgium: 2%). PBF for CHWs was solely paid by GoR (USD 1.61 million) (WHO, 2009b, p. 114).

The general ToC (cf. Annex D) for HF stipulated that technical and financial inputs to the central units for CBHI and PBF at MoH and the respective decentralized implementing entities on district and sector levels (multi-level approach) strengthen the capacities to manage and expand these schemes (output). The effective steering should lead to increasing financial accessibility (through CBHI) to sufficient high-quality health services (through PBF) and foster management capacities and additional revenues at the health facilities (both schemes), resulting in increased pro-poor responsiveness of the health system (outcome). Ultimately, the population's health status is, thereby, improved (impact).

More precisely, the CBHI strand in the program's ToC assumes that in the framework of a multi-level approach, policy and technical advice (inputs) to the MoH unit for CBHI lead to sufficiently harmonized strategies and available funds. This proximal output enables CBHI units at MoH to effectively manage the insurance scheme, resulting in a higher pro-poor responsiveness of the Rwandan health system (outcome). This logic is paralleled at the district level: technical support (inputs) facilitates the management of CBHI by the respective authorities and staff in the program area (output), leading to the same outcome.

The PBF strand largely adheres to a similar logic: policy and technical advice (input) to the MoH unit for PBF lead to suitable PBF strategies. The implementation of these strategies at the level of health facilities leads to proper performance evaluations, which trigger a higher motivation of staff (output) and finally causes an improvement in the structural quality of health services, leading to a higher pro-poor responsiveness of the Rwandan health system (outcome). At the decentralized level, GDC was solely responsible for paying the incentives for Ruhengeri district hospital from 2007 until mid-2011, which led – adhering to the same logic – to an improvement of service quality at the hospital.⁷⁵

Implementation

German cooperation has accompanied CBHI since its rollout in 2005 as co-chair of the mutuelles working group with technical advice and workshops to coordinate donor activities (Doc.39). Major inputs by GDC to support the Health Financing Unit at MoH and its subordinate unit, the Cellule Technique d'Appui aux Mutuelles de Santé (CTAMS), in the last years comprise the piloting of management software at the district level (Doc.43), supporting MoH to elaborate a CBHI procedure manual, and train CBHI managers, accordingly, implementing a financing mechanism to balance the different CBHI district pools and to improve the data situation on CBHI by operationalizing HRTT (cf. Doc.28; MoH, 2012b). In addition, GDC organized different CBHI policy dialogues, conferences, and workshops, and already had advocated a contribution system, based on stratified CBHI premiums (INT EXP 16). In cooperation with MINALOC, GDC has since supported the Ubudehe⁷⁶ assessment and database, which serves as the basis for such an income-based stratification since the capitation system was abolished in 2010 (MoH, 2010a). At the district and sector levels of the program area, GDC – mostly through national district technical advisors – has offered support to CBHI staff and members of the steering committees by offering training and assistance on issues, such as planning, management, finance, supervision, sensitizing, monitoring, and evaluation. This has facilitated the coordination between District Health Units, district hospitals, and JADF, thus strengthening the district health system (Doc.40; Doc.43; GIZ & KfW, 2012).

Although not explicitly embedded in the program's log frame (cf. Doc.44; Doc.45), the so-called social funds (*fonds d'équité*), established by GDC in the program area in 2007, constituted a HF mechanism that closely related to CBHI. These funds subsidized costs related to medical treatment, at the hospital level, not covered by CBHI, such as transport, drugs, or food. In addition, the funds bore the CBHI premiums for patients who could not afford them. Eligible for these services were those deemed economically vulnerable by local staff (INT HF 33, 34).

⁷⁵ Most of the evidence presented here is based on accounts on the situation in Ruhengeri and, therefore, has the status of a case study not necessarily generalizable to PBF on other care levels or district hospitals. Interviews suggest that the complex PBF procedures slightly varied between district hospitals (INT EXP 20; INT HRD EH 8).

⁷⁶ Ubudehe is a participatory poverty assessment approach, which is applied first in the PRSP process (RGB, 2012). Presently, Ubudehe serves to identify beneficiaries of Rwanda's social protection programs, such as Vision 2020 and CBHI (Ruberangayo, Ayebare, & de Bex, 2011). The six ordinal Ubudehe categories comprise (cf. GoR, 2002): (1) those in abject poverty (*umutindinyakujya*), (2) the very poor (*umutindi*), (3) the poor (*umukene*), (4) the resourceful poor (*umukene wifashije*), (5) the food rich (*umukungu*), and (6) the money rich (*umukire*). CBHI premiums are stratified along these categories since the CBHI policy of 2010.

About 1,300 people benefited from social funds in the years 2008 and 2009 before the CBHI policy reform of 2010 (Doc.27).

At the decentralized level, GDC provided training to PBF data collectors and evaluators (Doc.40), as well as to district staff (Doc.28), and participated in the quarterly peer evaluations of hospitals. Furthermore, GDC was the only DP under the Division of Labor policy to sign and carry out a local subsidy contract to directly finance PBF in the district hospital of Ruhengeri. Some GDC members have, based on experiences from Ruhengeri, seriously questioned the relevance and effectiveness of PBF and have published critical accounts on it after they had left Rwanda (e.g. Kalk, 2008; Kalk, 2011; Kalk, Paul, & Grabosch, 2010). Diverging views between some (former) GDC staff members and GoR have thus, at times, burdened the otherwise constructive spirit of Rwandan-German cooperation (INT EXP 15, 20; INT SWAP 19). Between 2007 until mid-2011, GTZ/GIZ disbursed approximately EUR 500,000 as PBF incentives in Ruhengeri (DEval estimation, based on data provided by GIZ). At the central level, technical assistance for PBF was directed to the responsible MoH unit, the *Cellule d'Appui à l'Approche Contractuelle*. GDC participated in different policy dialogues and workshops on the development of PBF indicators, with linkage to quality management of health services (Doc.43). GTZ/GIZ also co-chaired the technical working group on HF under the SWAp and was highly appreciated by other members for its technical expertise and for the experiences shared from the districts in this forum (INT SWAP 8, 16, 19, 22; Doc.39; Doc.43).

Relevance

The Rwandan strategic priorities for HF specified in the 2009 HF policy aim to “ensure that quality essential health services and particularly MDG-related interventions are financially accessible to the whole population in an equitable, efficient and sustainable manner under a results-based financing framework” (MoH, 2009c, p. 18). GoR incorporated CBHI and PBF into its first HSSP for the years 2005 to 2009 (GoR, 2005b), as well as in its successor for the period 2009 to 2012 (GoR & MoH, 2009). These strategic plans align to EDPRS (GoR, 2007) and Vision 2020 (GoR & MINECOFIN, 2000).

International priority areas for BMZ are health systems strengthening through the implementation of solidarity-based HF mechanisms (BMZ, 2009e, p. 18) and the establishment and reform of social security systems (BMZ, 2009f, p. 17). The human-rights-based health concept of BMZ (BMZ, 2009a) emphasizes four core elements, namely, (1) availability, (2) accessibility, (3) acceptability, and (4) quality. As CBHI and PBF (mainly) target the improving financial accessibility and service quality, respectively, CBHI and PBF conform to both Rwandan and German priorities. In addition, CBHI and PBF contribute especially to MDGs 1, 4, and 5, which BMZ and GoR are committed to achieve. Due to this high level of alignment to Rwandan and German priorities on the one hand, and HF to the larger Rwandan policy framework on the other, ownership among the partner organizations for, and relevance of, the HF objectives was high (INT HF 3, 4; G INT HF 1, 2).

The strong political will and high pace with which GoR pursued the implementation of CBHI and PBF has been so hasty at times that decentralized structures were overstrained (INT EXP 16; MoH, 2008). The design of the German program as a multi-level approach, ranging from policy advice at the central level to capacity development for decentralized structures, paired with financial contributions to the PBF system, has been a good choice to tackle this challenge. Accompanying both reforms on various levels has helped the German cooperation to share experiences from the districts at the central TWG level (Doc.43).

While German support to CBHI and PBF has been fully in line with Rwandan strategic priorities, there is some controversy about setting up and financing the social funds (INT HF 1). GDC representatives and the staff at hospitals benefiting from the social funds described them as important for financial management because providers faced high uncovered costs for treating the poorest (INT HF 6, 17, 21, 22, 33, 34; G INT HF 10, 16, 17). Government interviewees and one other DP, however, did not share this perception and were rather dismissive (INT HF 2, 26; G INT GEN 13). The social funds have been relevant by alleviating the negative consequences for the poorest struggling to pay CBHI fees and, thus, have contributed to health equity (INT HF 33, 34;

INT HRD DW 1; INT InD DW 31; comparative case study; Doc.43), but have done so by creating new, non-aligned structures that are less endorsed under Rwandan aid policy (GoR, 2006).

Concluding, CBHI and PBF both align to high-level (Vision 2020, EDPRS) and sector (HSSP) objectives on the Rwandan side, as well as to BMZ priorities (human-rights-based health concept, health systems strengthening, and social security systems) on the German side. The design of the program as a multi-level approach (policy advice at MoH and support of district structures) was highly relevant to patch “weak spots” at the district level due to the high pace of implementation. GDC social funds were not relevant in their design by creating non-aligned, parallel structures, but targeted a highly relevant and complementary goal for CBHI to ensure health equity before the policy reform of 2010. The HF component was, thus, overall highly relevant, considering its goals and design.

Effectiveness

HF in Rwanda is broadly viewed as a success story (cf. Logie et al., 2008). It is difficult, however, to attribute results to GDC due to confounding influences in a SWAp environment. In the following, the contributions of German support to reach the overall outcome for PBF and CBHI (increased pro-poor responsiveness of the Rwandan health system) are presented.

CBHI

According to a number of interviews, the inputs of GDC as co-chair of TWG (HF) at the central level contributed to improved coordination, information sharing, and joint implementation of HF issues between MoH and DPs (INT HF 4, 22, 25, 27, 37; G INT HF 2, 10, 13, 16, 24; INT SWAP 8, 16, 19, 22). This lends plausibility to the fact that policy advice and technical support to the unit responsible for the community-based health insurance (CBHI) at MoH contributed to the provision and usage of harmonized strategies and resources. Strengthening this argument is the fact that German moderation led to GFATM disbursements of about USD 34 million, which has been crucial to reach CBHI coverage today and to subsidize the indigenous (INT HF 0, 13, 34; G INT HF 29; Kalk, Groos, Karasi, & Girrbaach, 2010). Focus-group discussions

and interviews at the district level have supported this notion. CBHI key informants self-assessed their capacities as sufficient to follow the MoH design and reported positive feedback from clients and community representatives in the CBHI steering committees on this matter (comparative case study). It should be mentioned, however, that the support for applying to GFATM was provided through the German BACKUP Initiative, a BMZ help desk (implemented by GIZ) created exclusively for countries seeking GFATM support. The grants, therefore, represent an example of successful technical advice towards effective fundraising rather than a monetary input to the program. The approval by the GFATM was exceptional because Rwanda was, at that time, one out of only three grantees for health systems strengthening (cf. Kalk, Groos, et al., 2010).

The extent to which these contributions have led to a more effective management of CBHI by MoH could not be scrutinized in detail due to the difficulty of tracing decision-making processes *ex post*. The evidence regarding increased pro-poor responsiveness to the health system, however, suggests that antecedent outputs were predominantly generated as postulated by ToC. As of the end of 2011, the nationwide insurance covered 91% of the population (MoH CBHI database; data provided by GIZ), rising from a coverage of 7% in 2003 (MoH, 2010a, p. 6). The average utilization rate of health services was at approximately 0.83 consultations per capita (MoH, 2011a, p. 53) compared to 0.25 in 1999 (cf. Schneider, 2005). Several studies support these findings (Binagwaho et al., 2012; Lu et al., 2012; Saksena et al., 2010; Shimeles, 2010) and strongly support the assumptions underlying CBHI that pre-payments and risk pooling effectively reduce catastrophic costs from out-of-pocket payments and increase service utilization in Rwanda.

Focus-group discussions revealed a generally high satisfaction of end users with CBHI services and management, as well as the successful reduction of financial access barriers of visiting health centers and access to higher care levels (comparative case study). The hypothesized revenue generated at health facilities has been supported for the old (Schneider & Hanson, 2006) and current CBHI systems. Health professionals reported that the

increased financial autonomy of their facilities has led to better staff recruitment, training, and drug procurement, relative to the needs of their catchment area (comparative case study). The study found, however, that delays in CBHI reimbursements from higher-level pools, at times, have restricted this financial autonomy (comparative case study).

The enrolment and utilization rates, however, are lower among the poorest. Binagwaho et al. (2012) state that these rates have not changed substantially between the 2005 and 2010 DHS rounds. There is, furthermore, consistent evidence that catastrophic health spending is higher and service utilization is lower among the poor (Lu et al., 2012; Shimeles, 2010).⁷⁷ These findings about the limited equity of CBHI are supported by the comparative case study: end users complained about misclassification into Ubudehe categories, leading to unaffordable CBHI premiums and co-payments on the one hand, and possibly a decline of trust in the insurance scheme on the other (cf. Schneider, 2005). Respondents (independent of “German districts” or comparison districts) consistently complained about the affordability of CBHI due to the payment modalities. The three core problems mentioned were (1) the number of installments (one before a reform in July 2011, two afterwards), (2) the need to enroll the entire family, and (3) the need to wait one month after payment until health services can be claimed. Because these payment modalities are deliberately imposed by MoH policies to avoid high-risk CBHI pools through adverse selection (Binagwaho et al., 2012), a solution to balance the needs of both sides may be hard to establish. Further evidence on this problem stems from focus-group discussions with heads of health centers. They consistently reported that the financial autonomy of health facilities is restricted by the low capacity of those in Ubudehe category 3 to pay the 10% co-payments and additional costs (e.g., food) at district hospitals and the delays of reimbursements from the central level⁷⁸ (comparative case study; INT EXP 3, 16; INT HRD DW 3, 8).

The Rwandan-German program is fully aligned to the Rwandan goal for global health insurance coverage (i.e., 100%), which has not yet been met (91% at end of 2011). The evaluation team considers this as mere formal under-achievement, given the tremendous success of the overall CBHI developments since the national scale-up in 2005. In May 2012, the indicators were reset to 90% (cf. Annex E) and HSSP, for the period 2012 until 2018, does not target universal coverage either (cf. GoR & MoH, 2012). Regarding health equity, the available evidence points to the conclusion that financial access barriers have been reduced: financial access has, since the policy reform of 2010, improved for the poorest (Ubudehe categories 1 and 2 are now fully subsidized). But those in category 3 sometimes face hardship to cover out-of-pocket payments at the district hospitals (especially the 10% co-payment). This indicates that access barriers have been pushed to higher Ubudehe categories and care levels.

Social funds

Several interviewees inferred that the limited equity of the CBHI approach until 2010 *ex post*, highlights the relevance and effectiveness of the social funds (cf. INT EXP 3; INT InD DW 31). A key finding from the comparative case study is that the social funds have provided a visible value addition to supporting economically vulnerable people to access health services that has not been found in other districts. This complementarity to the (then) existing CBHI design (cf. Doc.43) especially underscores the significance of social funds to reach the component's goal.

PBF

While it is documented that GDC actively participated in technical working groups (INT EXP 20; INT SWAP 8, 16, 19, 22), GDC cannot be counted among the lead donors regarding PBF. PBF guidelines for district hospitals and CHWs feature the role of certain DPs, with the exception of Germany (MoH, 2008, 2009b). The biggest contributors are GoR, followed by BTC, World Bank, and US-financed NGOs (WHO, 2009b, pp. 114 – 115). The self-reported German purpose of PBF was to place stronger emphasis on assessing service quality with the PBF indicator

⁷⁷ The studies by Saksena et al. (2010) and Sekabaraga, Soucat, Diop, and Martin (2011) conclude the opposite, but they can be considered as methodologically weaker (cf. Binagwaho et al., 2012).

⁷⁸ The introduction of roaming in 2010 further aggravated this problem. Invoices from health centers for roaming patients are processed at the central level and, hence, further delay reimbursements due to higher administrative efforts.

system (INT EXP 20). Several interviews have suggested that CBHI received more emphasis than PBF from GDC in terms of HF (INT HF 1, 2, 3, 4). Regarding decentralized support to PBF, GDC contributed to the training of PBF evaluators and data managers, participated in peer reviews of hospitals (Doc.40; GIZ & KfW, 2012), and disbursed approximately EUR 500,000 as performance incentives to Ruhengeri hospital between 2007 and 2011 (DEval estimation, based on data provided by GIZ). Ruhengeri hospital has made far-reaching administrative changes (Doc.9). While the PBF evaluation system was not well understood and accepted by hospital staff at the time of its introduction in 2008 (Doc.38), the comparative case study sheds light on the most recent perceptions. Focus group discussants at hospitals and district resource persons (including those of Ruhengeri) acknowledged the alignment of PBF to the district performance contract system (*imihigo*). The respondents questioned whether the indicator system, in fact, validly measures what it is supposed to measure. The targets set by PBF indicators often were perceived as being too rigid and, at times, unattainable (cf. also INT HRD HM 15). Health staff, nevertheless, self-reported higher motivation for their work due to the PBF system (cf. also INT HRD HM 6; INT RP 15). These self-assessments do not, however, allow for determining whether this effect is attributable to the setting of incentives or whether it can be attributed to a general increase in remuneration (cf. also INT RP 13, 14).⁷⁹

Two core assumptions underlie the PBF evaluation system: (1) low motivation of health professionals is the main impediment to high-quality services – as opposed to other resource constraints – which (2) can be overcome by incentives. The risks postulated in the literature are that financial incentives (by definition *extrinsically* motivating) may crowd out *intrinsic* motivation and lead to “gaming” (i.e., manipulating the system to achieve a desired outcome, for example, by skimping on quality) (cf., e.g. Gorter et al., 2013; Grittner, 2013; Oxman & Fretheim, 2009). Evidence on the first assumption is mixed (INT HRD DW 7; INT EXP 2, 18; INT InD 31; Paul, 2009) and, hence, inconclusive.

Regarding the second assumption, the negative effects of PBF in Ruhengeri, such as crowding out and gaming, have been consistently reported and researched (INT InD 31; INT EXP 5; Kalk, 2011; Kalk, Paul, et al., 2010; Paul, 2009) and they pose a threat to the improvement of the structural quality of health services – usually under-researched (cf. INT HF 24 and Ireland, Paul, & Dujardin, 2011). While these experiences in Ruhengeri also have led GDC to more strongly focus its support on the HF component of CBHI (INT EXP 5, 16, 20), it is unclear if these effects prevail today. The nationwide PBF rollout has been conducted in a standardized manner, thus lending plausibility to the assumption that other district hospitals have faced similar problems.

Undoubtedly, it can be concluded from interviews, reports, and studies that PBF has induced positive changes: quality and quantity of services have increased (INT G10, 16, 22, 24, 25, 27; INT HF 3; Sherry, Bauhoff, & Mohanan, 2013); health staff self-reported increased productivity and less absenteeism; and internal communication and supervision have improved (Kalk, Paul, et al., 2010; comparative case study; Paul, 2009). According to the PBF indicator score, the overall performance of Ruhengeri hospital rose from 78% in 2008 to 84% in 2010 (data provided by GIZ).

In addition to the improvement of the structural quality of health services, it is assumed that PBF has increased capacities to manage for results and autonomy at the provider level. Focus group discussions suggested that end users reported that they were treated with more respect at health facilities since the introduction of PBF (improved client satisfaction can be seen as indicator for service responsiveness; cf. Kruk & Freedman, 2008), and health professionals reported that due to improved supervision, management can tailor the facilities’ services more closely to client needs (comparative case study). The same key interviewees voiced two major risks: (1) PBF may exacerbate inequities between health providers because the inflexible indicator system will favor well-capacitated over resource-poor facilities in the long run.⁸⁰ (2) a majority of respondents considered their work

⁷⁹ Several reviews concluded that PBF (and results-based approaches in the health context, in general) are still not well researched (Fretheim, Witter, Lindahl, & Olsen, 2012; Gorter, Ir, & Meessen, 2013; Grittner, 2013; Oxman & Fretheim, 2009), making it impossible to scrutinize this link in ToC, based on evidence for other contexts.

⁸⁰ According to MoH, weak performance areas in one year determine the goals set for the next year and, hence, allow for some flexibility by taking into consideration the differences in available resources between hospitals. As this information became available during a discussion of the draft version of this report, it was unfortunately impossible to corroborate these strategic deliberations and their results empirically in this evaluation.

environment suffered from problems not tackled by PBF, such as high turnover rates and lack of equipment. The raised use of health services (through CBHI and PBF), especially, has markedly increased workload and the strain on hospital capacities, and as a result, other resource constraints may become the bottleneck to high-quality health services.

Assessing the effectiveness of the HF component against the formal component goal (“PBF introduced in at least 50 % of the District Hospitals”; replaced in 2010 by “develop adjusted PBF criteria for the newly designed structure of province hospitals”⁸¹) does not make sense. Both indicators were taken from the national Rwandan strategy and exclusively assess a status rather than the component’s performance (for a comprehensive overview of the program indicators, cf. Annex E).

Summing up, while 50 % of the district hospitals have, nationwide, implemented PBF and the national insurance coverage rate is beyond 90 %, the component’s goal indicators may allow to formally conclude that the program has been a success, but they are too coarse-grained to exhaustively represent the narrative on the component’s goals. The extent to which these goals were reached requires more elaboration. The upward tendency in CBHI coverage rates illustrates a highly positive development towards a responsive health system. The assessment of health equity, the second aspect of the component goal, shows that financial access barriers have been reduced for the poorest, but that catastrophic costs related to treatment and CBHI fees have been pushed to higher care and income levels. Before their phase-out in 2010, GDC social funds had helped to bolster these costs in the program area and, hence, had been an effective tool to increase financial accessibility and the utilization of services. The evidence confirms that PBF does increase service orientation and the outputs of health professionals, but it also suggests that negative motivational side-effects and resource constraints are real and may constrain overall effectiveness.

Efficiency

Between 2008 and 2012, GDC provided a total financial input of EUR 2.24 million for HF, allocating EUR 0.74 million to MoH at the central level and EUR 1.50 million to partner districts (Doc.24). This was supplemented by staff inputs in the form of one international technical assistant and three national technical advisors covering the five program districts.⁸²

Performance-based financing

Efficiency considerations are at the heart of PBF because this approach has been developed to overcome weaknesses in the input-output relationship of input-based financing approaches (cf. Paul, 2009). Systematic reviews by Gorter et al. (2013) and Oxman and Fretheim (2009) conclude, however, that efficiency is among the least researched aspects of PBF. The methodological challenge for assessing efficiency in the PBF framework is to put into relation all costs, including those for administration and verification of service provision (i.e. enforcing the contract; cf. Gorter et al., 2013), as well as the hidden costs due to gaming and the general changes in the management and performance environment.

The mid-term review of HSSP I (GoR, 2008b, p. 22) concluded that PBF imposed substantial costs in terms of financing (approximately USD 1 per person per annum, according to an MoH projection, even rising to USD 3), as well as the time needed for supervision, evaluation, and accounting. The data collection process for the audit and verification of health provider statements, especially, appeared to be too centralized and, hence, inefficient (WHO, 2009b, p. 127). An estimate provided by Kalk (2011) of approximately 50 % for PBF’s overhead costs of PBF in areas with difficult geographic access seemed too high when it was compared to the latest figure available to the evaluation team – which dated back to 2007 – indicating a justifiable amount of 20 %. With regard to the district level, the delay for reimbursements to providers often totaled arrears of up to three months in 2007 (GoR, 2008b, p. 21). A resource person roughly estimated the time needed to fulfill all PBF indicators per staff

⁸¹ The first indicator has been achieved; the second has not. The reason provided by GIZ is that delays in the development of a legal framework for provincial hospitals has made reviewing the indicators impossible (Doc.28). See also the annex on the program’s indicators, Annex E.

⁸² In addition, there has been one CIM-integrated expert at the MoH SWAp Coordination Unit. This advisor, however, was not primarily related to HF.

member – based on an average work week – to be around three to four hours per staff member per diem in 2008, suggesting the need to raise the staff level by approximately 50 % to compensate for the increased workload (Doc.9). This non-generable example calculation illustrates some of the hidden costs of PBF. Costs for logistics and peer evaluators from other hospitals, MoH, or DPs are additional.

Even if the available evidence on the efficiency of the Rwandan PBF approach in district hospitals is scarce, the arguments presented raise the question whether such a resource-intense procedure as PBF is (yet) sufficiently efficient to overcome the problem of low human resources it was designed to address in the first place. Alternative approaches to increase the motivation of staff, such as generally increasing health professional salaries without tying them to performance should be scrutinized.

CBHI

BMZ policy on social security (BMZ, 2009c) considers efficiency as one performance criterion for social security systems, such as CBHI (cf. also Robyn et al., 2013). One sub-dimension is *targeting efficiency*; that is, the extent to which those people who are contributing and, hence, foreseen to profit, actually profit from services. The high CBHI enrolment rates indicate a high targeting efficiency – especially given the fact that a review article found the average coverage rate of other insurance schemes in low-income countries to be around 10 % (Ekman, 2004, p. 253). One consistent finding of the comparative case study, however, lends support to the notion that misclassification of Ubudehe categories (which determine CBHI premiums and co-payments) is seen as a frequent problem by CBHI members and staff, indicating further untapped potential to increase the targeting efficiency of the Rwandan CBHI.

The second sub-dimension of efficiency for social security systems refers to *transfer efficiency*. If administration and transaction costs are high, only a small percentage of the means pooled for risk protection actually reach designated recipients (low

transfer efficiency).⁸³ A review of HF in 2008 showed that the HF system is highly inefficient, due to its fragmented nature, and it cites the introduction of social health insurance in the Republic of Korea as an example that overall administrative costs can be reduced to less than 10 % (WHO, 2009b). Given the introduction of new policies and subsequent changes, the expenditures for CBHI running costs in Fiscal Year 2011/12 of 15.27 % (MoH, 2012b) indicate that Rwanda is on its way to increase the transfer efficiency of CBHI. Interviews with resource persons at the district level, however, indicated that timely reimbursements are a challenge – especially for district hospitals. This results in the need to pre-finance running costs by hospital management, which may – according to one interview – amount to between RWF 1.5 and 2 million.

Summing up, systemic challenges for efficiency relate to the fragmentation of the Rwandan HF system and the – at times – long delay to reimburse district structures from the central level. Efficiency considerations for PBF can hardly be exhaustive due to a lack of specialized research quantifying costs for the resource-intense underlying processes (planning, verification, and accounting) and negative side-effects, such as gaming. The available figures point to sufficient efficiency when measured by the percentage for overhead costs (production efficiency). It is impossible to pursue discussions on allocation efficiency, as the viability of alternative approaches (general increase of salaries, non-monetary approaches) has not been ruled out. The high coverage rates of CBHI and the policy reform of 2010 (both supported by German contributions) indicate that target efficiency is high and improvements regarding transfer efficiency are gaining ground.

Sustainability

Regarding CBHI, the principle of risk pooling is a key to financial sustainability. The larger the group of insured, the better the risk pooling, and thus the lower the risk for the individual member (GTZ, 2005). From a policy perspective, the Rwandan system has various assets. The legal obligation to insure (GoR, 2008a) and

⁸³ Because the social funds constituted a mechanism outside the GoR-owned financing system, BMZ rationale does not apply to them. The social funds were judged as rather efficient, however, due to the results generated with small inputs (INT EXP 16). The funds necessary to subsidize treatment-related costs for about 1,300 people per annum were estimated at around EUR 40,000 (cf. Doc.27), indicating high production efficiency.

the high coverage of CBHI may promote risk pooling across all economic strata and, hence, limit adverse selection, leading to high risk pools. In addition, the new CBHI policy (MoH, 2010a) has laid the foundation to overcome regressive capitation towards more equity.

From an empirical perspective, the financial sustainability of CBHI is still a challenge. The Rwandan insurance system is fragmented. About 91% of the Rwandan population benefits from a health insurance; CBHI encompasses 85%, while the balance falls to insurances for public servants and army members. While there are now mechanisms to cross-subsidize the national CBHI risk pool from these resources and external funds (MoH, 2010b), the functionality of these mechanisms is not sufficient: the national pooling risk still amounted to a deficit of RWF 247 million and a gap of RWF 306 million at the district level in Fiscal Year 2011/2012. The sector level, however, covered all expenses (provider bills, running costs, and the transfer of 45% of collected premiums at the district level) (MoH, 2012b). Further problems, identified in the situational analysis from HSSP III (IHP+, 2012), are the lack of staff and management capacities at the Health Financing Unit at MoH and at the decentralized level, as well as the need for a system to horizontally balance inequities between poor and rich districts or sections. One might add that the newly introduced roaming could aggravate this problem.

While households financed 70% of CBHI in 2006 (donors: 13%, government: 9%, private firms: 8%; GoR & MoH, 2008), the current share funded by premiums and co-payments totaled 60% of the CBHI funds for Fiscal Year 2011/2012 (government: 21%, GFATM: 11%; other: 8%) (MoH, 2012b). These unresolved issues and the continuing substantial share of investments by DPs and GoR (the GoR share also includes DP support as budget support) illustrate the need for continued, predictable external assistance to the Rwandan social security system (cf. IHP+, 2012) and demonstrate the current low financial sustainability of the CBHI system.

Regarding the equity funds set up by GDC in the program to support the poorest – omitted by the CBHI approach – sustainability

has been low. Equity funds have not been introduced as self-sustaining structures, but were created with the primary purpose of mitigating equity problems. GDC, in any event, discussed an incremental hand-over strategy in 2010, at the district level with JADF, to implement income-generating activities for poor strata and assist districts to budget social funds into their strategic plans (Doc.27; cf. also B.3.7). The comparative case study, however, has shown that the Common Development Fund⁸⁴ has partly taken over the operation of the equity funds, but that it does not have sufficient means to fill all previous gaps.

A recent systematic review of PBF in the health sector has found that sustainability is – next to efficiency – one of the least researched aspects of results-based financing (Gorter et al., 2013; Oxman & Fretheim, 2009, came to a similar conclusion). This hampers the assessment of the financial sustainability of PBF, based on previous experiences.

The cessation of German support for the PBF scheme in Ruhengeri hospital in mid-2011 resulted in financial losses for hospital staff (INT EXP 20). Given the fact that PBF payments represented, on average, up to 45% or more of their monthly salary (WHO, 2009b, pp. 119 – 120) (and this external assistance was intended to fill the motivational gap for high-quality services), the sustainability of the results achieved through PBF in Ruhengeri should be cautiously considered. Regarding the phase out of German support, hospital staff and the management have reported problems in keeping PBF operational and, in general, it has reduced the means to organize activities, such as equipment maintenance and staff recruiting – they did not, however, self-report to be suffering from reduced motivation or performance (comparative case study; INT RP 30).

Paradoxically, the largest risk for sustaining the effects of PBF might stem from the incredible success of another health sector reform. Due to the increased coverage and utilization of CBHI, health professionals are burdened with even higher workloads (comparative case study, cf. also Paul, 2009). The complex and resource-intensive evaluation and verification process, furthermore, still needs external resources – 40% of the PBF budget in Fiscal

⁸⁴ The Common Development Fund (CDF) is government owned (through MINALOC) and aims to support development at the decentralized level (MINALOC, 2008).

Year 2011/2012 (MoH, 2012a, p. 58). PBF related to HIV/AIDS and tuberculosis is, especially, highly funded from external resources (cf. IHP+, 2012). PBF may stabilize human resources and maximize efficiency, but it can neither fill the staffing gaps nor can it offer a solution to the inequality among facilities.

In conclusion, the gathered evidence suggests that sustainability should be considered as the “weak spot” among the DAC criteria due to the high dependency of the Rwandan health sector on external funds, and it should be deemed yet to be low. Recent policy and legal reform (partly with GDC contributions), however, paired with a large share of household-generated funds, promise a positive trend towards the sustainability of CBHI in the long run. GDC social funds have proved rather unsustainable. Not designed to last as self-sustaining structures, their operation has been taken up by Rwandan structures, but it has left gaps. Given that German support to PBF at the district level has led to setbacks in maintenance and recruitment, the German contribution to PBF has been rather unsustainable.

3.3.3 Component 2: Sexual and reproductive health

Sexual and reproductive health in the Rwandan health system

High population density, strong population growth, and the incidence of HIV and STIs determine the Rwandan strategy of SRH and family planning. On the one hand, population growth can be considered as one of the main challenges in the course of economic, social, and environmental development with regard to the availability of arable land, natural resources, and food security, since more than 80% of the population rely on subsistence farming as their main source of income (Sommers & Uvin, 2011). On the other hand, family planning has been a sensitive topic in Rwanda after millions of Rwandans lost family members and friends in the course of the civil war and genocide (Muhoza et al., 2013; Schindler & Brück, 2011; Solo, 2008). Accordingly, family planning had not been a priority in the Rwandan health strategy before it became more relevant from 2000 to 2005, when an increase of the overall fertility rate from 5.8 to 6.1 was found in the DHSs (NISR & ORC Macro, 2006). At the same time, emphasis on HIV control strategies had risen, since prevalence rates

had increased with the incidence of civil war and had remained at high levels until 2005, when HIV prevalence stabilized at 3% of the overall population.

Today, the promotion and improvement of SRH has become a core strategic issue within the Rwandan health architecture. Reproductive health, family planning, and maternal and child health are related to the majority of essential targets in EDPRS, Vision 2020, and MDGs. Maternal health focuses on decreasing maternal morbidity and mortality. Family planning is another top priority in Rwanda in order to reach the ambitious target set for fertility reduction. Moreover, the SRH strategy includes areas, such as STIs, HIV/AIDS, and tuberculosis prevention and control. In this regard, SRH refers to some of the main challenges in the Rwandan health system and is highly relevant to improve social and economic development.

The objectives and strategies of SRH in Rwanda were outlined by GoR in HSSP I, II, and III (GoR, 2005b; GoR & MoH, 2009, 2012). Within the SWAp architecture, joint efforts in SRH aim to reduce the rate of morbidity, infant mortality, and maternal mortality by improving access to quality care of reproductive health and promoting equality and equity among women and men (GoR, 2005a). With regard to HIV and STIs, it aims to reduce transmission rates and mitigate the personal effects of HIV. Six priority areas for reproductive health were formulated in HSSP I, including (1) safe motherhood and infant health, (2) family planning, (3) prevention of and care for HIV and STIs, (4) adolescent reproductive health, (5) prevention of and care as a result of sexual violence, (6) social change for the empowerment of women (GoR, 2005b). The multi-sectoral approach, proposed in HSSP I, included the integration of the six priority areas, efficient monitoring and evaluation systems, gender equality and human rights, and a reinforcement of the entire health system for an improved delivery of treatment for people living with HIV. HSSP II put further emphasis on SRH, including family planning and maternal and child health as top priorities (GoR & MoH, 2009). These priorities are also highlighted in the Rwandan EDPRS, which claims to target population growth, infant mortality, and family planning through the improvement of the quality of health

care and education outreach, particularly for girls (GoR & MoH, 2007; MINECOFIN, 2011a).

The component of sexual and reproductive health in the Rwandan-German health program

Theory of change

The SRH priority areas outlined in HSSP I and presented above became the main intervention strands of the Rwandan-German cooperation under the umbrella of the SRH component (Annex D). The overall component objective was to contribute to the improvement of all aspects of SRH and family planning (impact) (Doc.45). SRH interventions thereby focused explicitly on the impact indicators of the overall program, including the total fertility rate, HIV/AIDS prevalence rate, and infant mortality rate (cf. Annex E).

At the national level, GDC focused on the support of national guidelines and strategies, especially with regard to fertility, HIV/AIDS, and mother and child health (inputs), in order to contribute to the overall component objective. The interventions aimed to support the implementation process (outputs) towards the improvement of coordination and organization of curative and preventive SRH services (outcome) (cf. Annex D).

At the decentralized level, GDC focused on the technical and financial support of district health facilities and community health systems strengthening with regard to fertility, HIV/AIDS, and mother and child health, as well as tuberculosis, malaria, and tropical diseases (inputs). Moreover, strategies on the prevention of and the response to gender-based violence were supported. Another prominent intervention strand in terms of SRH was support to the national program of contraceptive social marketing through the private sector. In the later phase of cooperation, special emphasis was placed on adolescent SRH. All SRH interventions at the district level focused on the provision of services in public health facilities and throughout communities (output) in order to increase service utilization (outcome) (Annex D). Since 2004, the main component indicators at the outcome level were the overall contraceptive prevalence rate (CPR),

user rates of male condoms, especially among youth, as well as knowledge of target groups on SRH and HIV/AIDS (Annex E).

Implementation

Between 2004 and 2012, GDC contributed to SRH at the national and decentralized levels. At the national level, technical support to strategies and national plans was provided through TWGs with regard to family planning, adolescent SRH, and gender-based violence. In all three working groups, GDC sometimes held the position of co-chairs. Moreover, GDC contributed actively to the Country Coordinating Mechanism. In addition to the interventions in the program's ToC, joint proposals to GFATM for different grants for HIV, tuberculosis, and malaria were supported. Between 2004 and 2012, 19 proposals were developed, mainly through support of the BACKUP Initiative, a project funded by BMZ (Doc.21). The German contribution to the GFATM and the BACKUP Initiative, however, is beyond the scope of this evaluation and is, therefore, not part of the following analysis.

At the decentralized level, GDC continued its long-lasting support to various levels of the Rwandan health district, including activities at referral hospitals, district hospitals, health centers, and communities. The main approach concentrated on the training of health personnel, with emphasis on service delivery through DED/GIZ development workers and an integrated expert from CIM, who worked on relevant SRH topics, such as neonatal services and mother and child health. In the areas of adolescent SRH and gender based violence, GDC provided support to the multi-sectoral efforts through DED/GIZ development workers in Musanze, Huye, Nyaruguru, and Gisagara. In 2011, the advisors were replaced by national technical assistants, supported by German short-term consultants until the phase-out. The technical assistants worked with youth centers, peer educators, and the private sector.

Box 13. Community health workers (CHWs)

The concept of CHWs is to render basic health services to the community. CHWs are indigenous members of the community where they work. In most countries, CHWs are selected by the communities with clearly defined roles and responsibilities. CHWs are supported by the health system, but are not necessarily part of its organization, and have a shorter period of training than professional workers (Lehmann & Sanders, 2007). In Rwanda, CHWs are meant to close the gap between the demand of the communities for health services and the limited capacities of the Rwandan HRH (Mugeni et al., 2011). Today, Rwanda has more than 45,000 village-based CHWs who also provide SRH and family planning services (MoH, 2012c).

With support from GDC, family planning services were extended to the health center and community level. Permanent staff was employed by health centers and activities were coordinated with the Rwandan strategy relating to CHWs (cf. Box 13). GDC supported CHWs in order to establish linkages and complementarities between GDC funding areas, such as adolescent sexual reproductive health and gender-based violence, and Rwandan strategies at the community level. Some CHWs also provide family planning services, including the provision of contraceptives (IHP+, 2011).

Box 14. Peer educators

Peer educators are part of the community-based health system. The concept of peer education is to establish community-based distribution networks of basic health care and youth-friendly services in SRH. In Rwanda, young educators are selected by local health centers and trained in SRH and communication methods. Teams of always one female and one male educator are formed and supervised by the health centers in order to bring information about SRH services to peers in the community. Peer education therefore, uses participatory methods, such as sport events and theaters.

GDC also supported the national concept of peer educators (cf. Box 14), a strategy that raised considerable attention with regard to service provision at the community level (Doc.43). In total, more than 1600 peer educators were trained in the GDC target districts (GIZ & KfW, 2012). For this, the GIZ training manual on adolescent SRH was used as a national reference document. In this regard, peer educators complemented the strategy for social marketing, which involves the provision of services, such as the distribution of contraceptives through the private sector at local shops, kiosks, and health centers.

Box 15. Social marketing

Social marketing in health is the application of marketing strategies to promote public health and behavior change. The approach uses commercial marketing techniques to promote public goods, such as reproductive health and related behavior (e.g., prevention of pregnancies or STIs). With regard to pharmaceuticals, social marketing over-brands generic products in order to match cultural values and aesthetic standards of the local target population. Subsidizing products, such as contraceptives, is used to meet the ability to pay among low-income populations, thus bridging the gap between free-of-charge drugs in public sectors and commercial pharmaceutical prices. Social marketing uses commercial and NGO distribution channels as an alternative source to public sector service provision. Depending on the product, this can be circuitous for pharmaceuticals (hormonal products) or trade channels for fast-moving consumer goods (condoms). Besides promoting its branded products through diverse media, social marketing also applies state-of-the-art communication methods to influence consumers' knowledge, attitudes, and behavior through "generic communication".

One of the most prominent strategies in the component of SRH was support of private sector social marketing (cf. Box 15) through the international NGO, Population Services International (Rwanda). In Phases II and III (1996–2012), social marketing was supported through the financial cooperation of KfW with an overall investment of EUR 14.4 million, of which 43% (EUR 6.25 million) was spent in the SWAp period. Since the late 1990s, there has been a shift from social marketing, with emphasis on HIV prevention, to a wider approach at the nexus of PHC and HIV/AIDS. Financial support was provided to subsidize contraceptive methods, create and market contraceptive brands, establish and expand the private sector distribution network, conduct promotional activities, carry out consumer studies, train health personal, and cover overhead costs. The GDC approach to social marketing aimed to improve the access to contraceptives through modern marketing methods, in order to change the attitudes and behavior of the Rwandan population.

As SRH covers some core aspects of the Rwandan health system, including vertical programs, such as HIV control, various other actors are contributing to this component, including relevant support to national plans (Joint United Nations Program on HIV/AIDS (UNAIDS), USAID), social marketing (GFATM), and adolescent SRH (United Nations Fund for Population Activities (UNFPA), Family Health International) between 2004 and 2012 (INT SRH 26, 27, 28, 30, 32, G INT SRH 4, 23).

Relevance

High population density, together with high fertility rates and a still critical level of infant and maternal mortality, underpinned a high overall relevance of interventions regarding SRH and family planning at the time of program development. The component of SRH, thus, was set up as a comprehensive strategy aligned to Rwandan and German sector strategies on general health- and human-rights-based principles (BMZ, 2009a, 2013; GoR, 2005a; GoR & MINECOFIN, 2000).

Together with DPs, GDC contributed to the national strategy on family planning, including guidelines on how to integrate it into general health care services and how to create linkages of partnerships among public and private health care providers (G INT SRH 3, G INT SRH 1, INT SRH 26, G INT SRH 31). Finally, a National Policy on Family Planning (2006 – 10) was developed and implemented. In the course of this process, family planning became a key priority in the Rwandan health strategy and has maintained its relevance, as highlighted in the latest Family Planning Strategic Plan 2012 – 16 (MoH, 2012c). During the implementation process, GDC contributed visibly to the integration of family planning at the community level through youth centers, peer educators, schools, and universities (Westhoff, 2013). While it had still been a neglected topic in the national Poverty Reduction Strategy, it became a prominent element in its follow-up strategy (EDPRS), raising awareness between family planning and the incidence of poverty, as well as linkages between it and the HIV/AIDS response.

At the same time, HIV control became an important strategy, in accordance with Rwandan and German health priorities (BMZ, 2009a, 2012c; Doc.45; GoR, 2005a). At the national level, GDC contribution focused on the support of TWGs, through which three National Strategic Plans on HIV/AIDS have been developed between 2001 and 2012 (G INT SRH 3, G INT SRH 1, INT SRH 26, G INT SRH 31). The contribution to the national plans was also supported by other relevant strategies, such as the AIDS Poverty Impact Reviews, which had been conducted throughout all sectors in 2007 and had led to intensive consultation and the full integration of HIV/AIDS strategies to EDPRS and Vision

2020. The priority setting in the course of EDPRS also led to the integration of the former SRH vertical programs, family planning, and HIV prevention, which constituted the main pillars of the SRH component within the joint health program. Between these pillars, there has been a general priority shift from GDC strategies from HIV prevention towards SRH and, in particular, family planning due to promising epidemiological data, new forms of treatment (e.g., ART), and the availability of funds from relevant vertical HIV/AIDS programs.

With regard to the high percentage of young people in Rwanda and the importance of this population segment for socioeconomic and demographic development, adolescents have become an important target group in terms of SRH. At the policy level, GDC contributed to Rwanda's first National Policy and a National Strategic Plan for Adolescent Sexual and Reproductive Health and Rights (2011 – 2015). GDC, therefore, supported MoH in co-chairing the 2010-established TWG on adolescent SRH, which involved the challenging task of coordinating various ministries, including those of health, youth, family promotion, and gender. The policy and plan were agreed by all TWG partners (G INT SRH 1, 7, 10, 14, 18, 21, 23, 26), with GDC providing technical support and awareness-raising. In addition, GDC helped produce a national adolescent SRH training manual for health care providers, as well as supported national technical assistants and PSI at the decentralized level. The adolescent SRH strategy is of high relevance from a health and human rights perspective, since it includes a number of gender-sensitive and age-specific targets. The contribution is also significant as conflicting positions (e.g., the Catholic Church and traditional leaders) were taken into account. National media campaigns highlighted the strong commitment of GoR to adolescent SRH strategies (Westhoff, 2013).

Another area challenging the health status of the Rwandan population, socioeconomic development, and human-rights' norms is gender-based violence, which increased dramatically in the course of the post-conflict phase and is still a threatening issue today (IHP+, 2011). As a consequence, it became a prominent topic in a multi-sectoral working group, supported by GDC. Gender-based violence is a cross-cutting issue also concerning

other ministries, such as the Ministries of Education, Youth and Sports, Family and Gender, Interior, and Justice. Even though gender-based violence has not been investigated in detail within the consolidation phase of this evaluation, it can be stated that a multi-sectoral policy on gender-based violence was released in 2011 to which GDC contributed through awareness-raising and information at the decentralized and central levels. The 2011 Mid-Term Review, however, has revealed that gender-based violence is still not a priority intervention at the decentralized level (IHP+, 2011).

To achieve the objectives formulated in SRH, the policy framework of HSSPs I and II highlights the role of access to quality health products, such as modern contraceptives. While the utilization of services has remarkably increased over the last decade, studies still point to an unmet demand by people who have limited access to quality health care services (Solo, 2008). In the GDC's initial programs on HIV prevention and social marketing, the target groups were the sexually active. Special emphasis was placed on most-at-risk groups, such as truckers, the armed forces, and commercial sex workers. During the course of "PHC and HIV/AIDS Control I and II", the focus had also been on the rural population and women at a reproductive age before focusing more on adolescents.

In order to increase the coverage of service provision and to reduce disparities with regard to access to health services, GDC supported the public and private sector strategies. The current Strategic Plan on Family Planning (2012–16) underpins the relevance of this strategy, highlighting the objective to further improve family planning service delivery systems within the public and private sectors (MoH, 2012c). MoH, therefore, intends to increase private sector involvement, in order to increase the use of and the access to family planning services as a sustainable funding alternative to the significantly increasing costs of contraceptives. While it was envisaged that 60% of all contraceptives be provided by the private sector by 2015, the rate for 2012 it is estimated to be below 5%, pointing to enormous challenges for private sector development in the next years (MoH, 2012c). The latest Strategic Plan on Family Planning approves a

comprehensive private sector strategy for social marketing and an analysis of contraceptive coverage for the *mutelles* and private health insurance.

To conclude, GDC support to SRH has reflected the priorities of and was fully aligned with the objectives set by the Rwandan and German Governments in terms of general health and human rights-based principles. The strong alignment of GDC support to national priorities and the consideration of the prevalent country characteristics led to a high acceptance of the priorities and interventions of GDC by partner organizations and target groups. Its multi-level approach and focus on both the public and private sectors were appropriate to reach the respective target groups and achieve established objectives. However, technical and financial support to the private sector fell short with regard to the provision of contraception and information services in a sector environment where MoH still needed to play a crucial role. Further strengthening of the private sector would have met the priorities of the GoR and helped to reduce the costs to the public sector.

Effectiveness

The overall effectiveness of GDC contribution to SRH relies on joint efforts on national and decentralized levels. At the national level, GDC support to TWGs contributed to the development and implementation of key policies and plans supporting the effectiveness of activities relating to health districts (G INT SRH 3, G INT SRH 1, INT SRH 26, G INT SRH 31). Topics such as adolescent SRH and gender-based violence were included in the agenda, with a raising of awareness at the decentralized level (S EH 21).

At the decentralized level, GDC contributed to health service delivery by significantly improving (1) antenatal care, (2) clinic-based deliveries and post-natal care, (3) HIV testing and counseling (including voluntary counseling and testing), (4) coverage of antiretroviral treatment, and (5) treatment of tuberculosis (Abbott & Rwirahira, 2012; GoR & MoH, 2011a; IHP+, 2011; NISR, MoH, & ICF International, 2012). Other health areas which were supported and had improved during this period were

(6) linkages between tuberculosis and HIV prevention programs and (7) malaria prevalence control (IHP+, 2011; NISR, MoH, & ICF Macro, 2009). A substantial extension of health services delivery, in general, was repeatedly mentioned by the respondents of the comparative case study across all investigated care levels. Applying a comparative perspective among districts detected no significant differences between the “German districts” and comparison districts. Moreover, remaining shortcomings could be detected in the intensity and coverage of the service provision. Although 98% of women now use antenatal care services, only one third attends four counseling sessions, as recommended by WHO (NISR et al., 2012). User rates for postnatal care are promising, but the difference between rural and urban areas remains striking (NISR et al., 2012). HIV testing, a component indicator between 2004 – 07, has significantly increased through GDC support towards voluntary counseling, testing, and the use of Personal Interest Tests (GoR & MoH, 2011a).

Since 2004, GDC followed an integrated approach in terms of tuberculosis and HIV control, which became relevant during the course of its engagement in the Country Coordinating Mechanism. It was GDC initiative which led to the concept of the first tuberculosis control project to be successfully submitted to GFATM, with a budget of USD 11 million. GDC’s involvement in linking the HIV and tuberculosis programs contributed to a high rate of 97% of suspected tuberculosis cases being tested for HIV; 84% of HIV-positive persons, eligible for treatment, were covered by antiretroviral treatment in 2010 (IHP+, 2011). With regard to family planning, geographic access to basic services has improved in the last five years (comparative case study), permanent staff responsible for family planning are employed at the district health facilities, and the number of qualified nurses has increased (GoR & MoH, 2006a, 2011a, 2011c).

The GDC approach to social marketing focused on cooperation with the private sector to extend coverage of distribution networks through commercial wholesaler and retail points throughout Rwanda. One indicator, relevant to assess the effectiveness of social marketing, was the market share of products distributed

by the private and public sectors. Market share, therefore, is used as a proxy to the coverage of social marketing through the private sector. In 2010, the public and private actors had an equal market share of 50% in the provision of male condoms (NISR et al., 2012). At the same time, however, the majority of women (90%) obtained modern contraceptives from public institutions (Westhoff, 2013). The latter is partially explained by the fact that Rwandan women prefer injections for family planning, which still can be obtained through public health centers. This implies a substantial role of the private sector with regard to male condoms, but a very limited overall role, as commented by MoH (MoH, 2012c). The current Family Planning Strategic Plan now sets a priority on continuing to increase the market share of the private sector, in order to develop a sustainable family planning program that can focus on the overall population, especially in rural communities and including the most at-risk groups that are often not reached (MoH, 2012c). Truck drivers and prostitutes are less likely to be reached through CHWs, peer educators, and public health facilities and, therefore, rely more heavily on retailers. The strengthening of private sector social marketing is also relevant, as the costs for contraceptives are expected to increase, calling for more sustainable commercial marketing channels.

Service utilization, nevertheless, consistently has increased due to the efforts of GDC. Joint efforts of MoH and DPs led to an increase in (1) the modern contraceptive prevalence rate, (2) condom usage, (3) knowledge on family planning and HIV/AIDS, especially among youth, and (4) changed attitudes, (e.g., decreased number of wanted children) (Doc.28; GoR & MoH, 2010b, 2011a; NISR et al., 2012).

In order to investigate the success of a family planning program and its effectiveness on fertility, the level of the current use of contraceptive methods is a key indicator. Between 2005 and 2010, the component indicator of the modern contraceptive prevalence rate⁸⁵ among married women (15 – 49 years) increased significantly from 10% (NISR & ORC Macro, 2006) to 45% (NISR et al., 2012). In addition, 6% of women in this age category used traditional contraceptive methods, an overall contraceptive

⁸⁵ In line with DHS definition, modern contraception includes female sterilization, male sterilization, pill, IUD, injections, implants, male condom, female condom, diaphragm foam or jelly, lactational amenorrhea method, and emergency contraception (NISR et al., 2012).

prevalence rate of 52% (NISR et al., 2012). In this age cohort, injections were the preferred contraceptive method (26%), followed by the pill (7%), and implants (6%). The use of male condoms by men attributed to only 1.8%. This very low share can be explained by the limited importance of condoms for the prevention of STIs among married couples and is hardly comparable to the group of unmarried couples. In 2010, the component indicator of the condom usage rate among youth (15–24 years) at last sexual intercourse was met and reached 42% for females and 66% for males, a significant increase compared to 25% for females and 39% for males in 2005 (NISR et al., 2012; NISR & ORC Macro, 2006). In this time period, the uptake of male condoms for this target group was largely driven by social marketing campaigns and innovative distribution channels, such as condom dispensing machines in the health districts (INT EXP 6).

Coverage of service utilization, however, is still not universal and there is further unmet demand for the various modern contraceptives, including male condoms (Abbott & Rwirahira, 2012). In addition, the latest DHS round recorded high regional differences in terms of access and usage of modern contraceptives (NISR et al., 2012). One significant barrier is the access to health facilities in Rwanda's hilly terrain where population is dispersed. Limited access to contraceptives and information was also detected for the GDC target group of adolescents (Binagwaho, 2009). This still holds in 2013, as confirmed by the results of the comparative case study. For the overall population, the incidence of poverty is the main access constraint, as shown by Sommers (2012), which poses considerable challenges to low-income groups, such as truck drivers and prostitutes (both high-risk target groups for GDC with regard to HIV prevention). The use of condoms increases with education and in urban areas (NISR et al., 2012). This was confirmed by a secondary 2010 DHS data analysis, which detected a positive and significant correlation between education and the adoption of modern contraceptives, implying a mixed scenario with regard to health equity. The unmet demand for family planning among married women, nevertheless, has declined significantly from 38% to 19% between 2005 and 2010 (NISR et al., 2012).

Besides service utilization, the GDC approach to social marketing has placed strong emphasis on information campaigns. These provide information on family planning and on the prevention of STIs and HIV. While knowledge of modern contraception with regard to family planning is nearly universal in Rwanda today, knowledge of HIV/AIDS varies more strongly according to background characteristics. The 2010 DHS revealed that only 56% of women and 52% of men age 15–49 had comprehensive knowledge⁸⁶ on HIV/AIDS (NISR et al., 2012). This share has varied little since the 2005 DHS survey, which found comparable rates (NISR & ORC Macro, 2006). In spite of the impressive success of the national social marketing program in extending access to contraceptives, the effectiveness of information campaigns on STIs and HIV/AIDS has been found rather limited, especially in relation to rural communities in remote areas (comparative case study). Youth, especially, are inadequately aware of public information campaigns, but have knowledge from their peers on where to get contraceptives in their communities. This finding has been confirmed by a secondary data analysis of the 2010 DHS, which demonstrated the limited effectiveness of media with regard to knowledge, and stronger relevance of peer groups. Limited effects of radio, television, and newspaper campaigns were also found by Muhoza et al. (2013). The current policy on family planning, therefore, proposes a fundamental shift in the distribution philosophy to make better use of existing networks of CHWs and peer educators and intensify the provision of contraceptives and information at the community level (MoH, 2012c).

Finally, a secondary data analysis of the 2010 DHS found social marketing to have an equitable effect on middle and upper wealth categories, as no significant differences in the use of modern contraceptives exist among the top four wealth quintiles. The lowest quintile, however, had significantly lower adoption rates, implying that access to services for the poor was limited due availability or price. These findings support the health care utilization challenges, identified by Abbott and Rwirahira (2012) and the National Institute of Statistics of Rwanda (2012), including (1) rural-urban disparities with regard to access, usage,

⁸⁶ People are considered to have comprehensive knowledge about HIV/AIDS when "they know that both condom use and limiting sex partners to one uninfected person are HIV and AIDS prevention methods, they are aware that a healthy-looking person can have HIV, and they reject the two most common local misconceptions, HIV transmission by mosquito bite and by sharing food" (NISR et al., 2012, p. 181).

and knowledge, (2) socioeconomic differences, especially by wealth and education, and (3) a relatively high unmet need for family planning, especially for the unmarried.

To conclude, the main objectives and targets for SRH have been achieved. GDC, therefore, has contributed effectively to health service delivery through both technical and financial assistance. Relevant programs have been supported and linkages between different actors (public and private) and intervention areas (e.g., HIV prevention and tuberculosis) were established. At the national level, TWGs have been functional and have provided policies and plans appropriate to achieve the objectives set at national and decentralized levels. GDC has contributed effectively through agenda setting and technical inputs (e.g., adolescent SRH). The financial and technical contribution of GDC to social marketing has been effective in order to reach the established targets and objectives. Not all topics addressed by the TWG, however, have reached decentralized levels to an adequate extent (e.g., gender-based violence prevention). While most outcome indicators have been reached, geographic and socioeconomic differences remain with regard to access to quality health services. Moreover, the role of the private sector with regard to the provision of contraceptives is very limited, which weakens the potential for the joint effectiveness of the public and private sectors.

Efficiency

Within the consolidation phase of this evaluation, no rigorous efficiency analysis could be conducted for the interventions in the SRH component, given the thematic priorities set by the stakeholders involved and the data at hand. The following paragraphs, therefore, only provide some general findings which could be used as a starting point for further investigation.

The SRH strategy was fully integrated into national frameworks, preventing parallel structures and excessive costs to the extent possible. GDC efforts of harmonization and alignment were recognized by the national authorities and other DPs. In the context of SWAp, government systems were used and supported, which is likely to have reduced overall transaction costs.

In combined efforts with all DPs, most of the program's performance indicators were achieved on time; achievements often exceeded established targets. The GDC multi-level approach of working at the ministry and all care levels contributed to well-adapted interventions and feedback loops between national and decentralized levels.

At the community level, GDC contribution focused on coordination, training, and strategic support to the capacities of and interaction between health centers, secondary health posts, CHWs and peer educators. The underlying strategy was to provide effective health care services at limited cost to a low-income population and under the limited capacities of public district health facilities. The comparative case study found that this approach contributed significantly to service provision at the community level. Between 2008 and 2010, 11 development workers were involved, who later handed over their activities to national technical assistants. Besides support to the public sector, avenues within the private sector were taken, providing EUR 3.25 million from KfW for contraceptives and medical equipment between 2008 and 2012.

Sustainability

At the national level, important policies and plans were approved and are now being implemented. Continued policy dialogue is guaranteed through TWGs embedded in SWAp. Technical assistance has contributed to the operation of TWGs and has largely been taken over by partner institutions (INT SRH 17, 19, 12). Moreover, HSSP III recognizes SRH as a key component in future Rwandan health strategies, underlining strong political support by the Ministry (GoR & MoH, 2012). This political and strategic scenario is, therefore, significantly important to enable the continuation of the development of SRH in the Rwandan health system. Future effectiveness will depend on the ownership of MoH and DPs to continue the dynamics created through the long-term contributions of GDC in this area. While overall ownership of MoH can be considered as high, the processes will require the continuous momentum of all partners through TWGs.

At the decentralized level, the total number of qualified staff working in family planning, gender-based violence, and adolescent SRH was continuously increased in all health facilities (cf. comparative case study). This enabled health facilities to continuously extend service provision and access to care. Rural-urban differences remain, nevertheless, including technical performance of staff and modern equipment, and not all necessary health care services are provided equally across the country (IHP+, 2011).

DED/GIZ development workers have supported the health district facilities with a number of long-term staff in relevant SRH areas, such as neonatal hospital services and maternal and child health. Even though development workers have contributed to the education of health professionals through the provision of training at the respective care levels, daily routine and workload drove some development workers into a gap-bridging role and prevented the development of health professionals to some extent. In addition, overall staff fluctuation implicated the sustainability of capacity development. Limited technical performance of health professionals also was found in the HSSP II Mid-Term Review (IHP+, 2011). In order to continue the training of health professionals in future, GDC managed to transfer the activities previously implemented by development workers to Rwandan national technical assistants. The national assistants continued to provide support with regard to adolescent SRH, gender-based violence, and HIV/AIDS, working together with youth centers, peer educators, and the private sector in social marketing. However, at the end of the data collection stage of the evaluation, it remained unclear whether or not the national technical assistants had been absorbed into the Rwandan health sector and whether or not they remained in their positions, which is doubtful given the high staff turnover rates in the Rwandan health system.

The GDC strategy for social marketing was carried out through the private sector over the entire period. In early 2012, the international NGO, Population Services International, transferred some responsibilities and activities relating to social marketing to the national NGO, Society for Family Health. Even though the

transfer of responsibilities to the Society for Family Health was not directly supported by GDC, due to the timing at the end of Rwandan-German cooperation in health, it can be perceived as a relevant milestone towards the sustainability of family planning and social marketing in Rwanda (INT EXP 10). Previously, the involvement of national stakeholders had been low (Solo, 2008); thus, the Society for Family Health will complement and continue the approach established by PSI. Although both organizations receive additional funding from GFATM and the President's Emergency Plan for AIDS Relief, short-term financial gaps may occur as a result of the cessation of financial support to social marketing by KfW – a challenge to the future strategies of the young national NGO Society for Family Health. Potential gaps have been recognized by MoH, which has committed to engage more strongly in social marketing, subsequent to GDC support (Doc.28). Concrete financial commitment from MoH, however, could not be confirmed at the time of the data collection (INT EXP 15); it can, nevertheless, be seen as an enhancing factor for social marketing in Rwanda (INT EXP 10). No clear Division of Labor between the public and private sectors has been proposed, however, which would have been instrumental to the sustainable development of the private sector and commercial social marketing strategies in Rwanda, outlined in the latest Family Planning Strategic Plan (MoH, 2012c).

To conclude, there is high potential for the sustainable achievements of SRH due to the recognition that it is a key priority in the future health sector strategy of Rwanda. The technical performance of health professionals, however, is still limited and there are considerable geographic and socioeconomic differences with regard to access and the use of health services, which pose considerable challenge to this sustainability.

3.3.4 Component 3: Human resources development

Human resources development in the Rwandan health system

Human resources are a core element of all health systems and are essential to guarantee the availability and quality of health services. WHO recommends that for African countries to meet the health-related MDGs, the population should be covered by

a minimum of 0.2 medical doctors and 2.3 nurses and midwives per 1,000 people (AHWO, 2009). The 2006 World Health Report identifies 57 countries facing a critical health workforce shortage, among them Rwanda, because of weak strategies and regulatory frameworks, poor quality of pre- and in-service training, low salaries of health staff, together with difficult living conditions and internal and external migration (AHWO, 2009; WHO, 2006).

In 2005, Rwanda had not yet recovered from the enormous loss of qualified health professionals, who had either been killed during the genocide or had fled the country. Building on HSSP I (2005–2009) and the first HRH Strategic Plan (2006–2010), HSSP II (2009–2012) set more emphasis on improving the quality of trained professionals and their distribution throughout the country (GoR & MoH, 2009). GoR embarked on promoting and supporting pre-service education; strengthening the capacity of training institutions; scaling up the number of CHWs; regulating and decentralizing wages through personnel transfers to the districts and health facilities; and developing incentives for improved work outputs through the PBF-system. In addition, between 2005 and 2012, in-service training of health professionals was considerably expanded and developed by several training institutions in the country, including the Faculty of Medicine at the National University of Rwanda, Kigali Health Institute, and the School of Public Health.⁸⁷

The Faculty of Medicine at the National University of Rwanda⁸⁸ was established in 1963 and reopened in 1997 after the genocide, with the mandate to provide medical education programs for all medical and allied professions in Rwanda. The number of enrolled students has increased from 239 in 1997 to 545 in 2004 and has, more or less since, kept the same level. Graduates of the six-year degree program must undertake one year of internship before registering as general practitioners.

The Faculty of Medicine of the National University of Rwanda and its supervision fall under the responsibility of the Ministry of Education. The primary role of MoH was to define the human

resources needs (Bail & Kantengwa, 2006). In reality, the respective roles and responsibilities of both Ministries in this area have not been always clear. The internship program was originally initiated by MoH in 2003. While the program first included four hospitals,⁸⁹ it was later extended to other hospitals. The implementation of the internship program faced several difficulties, as stated by interviewed interns, former partners, and development workers (INT RP 12, 23; INT HRD DW 5). It was obviously quite a contentious issue: *“We (the MoH) wanted them (the interns) to be in the hospitals all the time; they wanted money”* (INT 30).

Tensions eventuated between MoH and the Ministry of Education (INT RP 12; INT RP 23). Management of the internship program was soon transferred to the Ministry of Education until 2010. In 2010, the internship program was restructured by ministerial decree and it again fell under MoH. Since the restructure, medical students study for six years and, after graduating, undertake a year of clinical internship. The interns work and are trained in 18 selected district hospitals that are considered appropriate by MoH.

The School of Public Health was established in 2000 in Butare and then was transferred to Kigali in 2005. It provides training to national and regional health professionals in support of national and regional health plans and conducts applied research. A large number of health professionals working for MoH, mainly at the central and district levels, have benefited from these programs.

The HSSP II Mid-Term Review in 2011 revealed that substantial efforts had been made by GoR to improve coverage for the health workforce. While the national targets set for the overall ratio of doctors and nurses to the population had been met and surpassed, a severe shortage of qualified midwives persisted. Despite impressive improvements, Rwanda still has fallen short of the standards recommended by WHO for African countries (i.e., a minimum of 1 medical doctor per 5,000 population and 2.3 nurses and midwives per 1,000 population (AHWO, 2009).

⁸⁷ Regarding the development of medical education in Rwanda, cf. (AHWO (2009); Bail and Kantengwa (2006); GoR and MoH (2011)).

⁸⁸ For the National University of Rwanda, Faculty of Medicine, please refer to: www.sph.nur.ac.rw.

⁸⁹ University Hospital Centers of Kigali and Butare, Kanombe Military Hospital, King Faysal Hospital, and Ruhengeri Hospital.

Table 9. Evolution of health workforce density between 2005 and 2011

	2005	2008	2011
Doctor/population ratio	1/50,000	1/33,000	1/17,240
Nurse/population ratio	1/3,900	1/1,700	1/1,294
Midwife/population ratio	Not available	1/100,000	1/66,749

Source: IHP+ (2011).

In response to these challenges, a new HRH Strategic Plan (2011–2016) was developed in 2011 that set a strong focus on increasing the quantity of skilled nurses, midwives, and specialist physicians and on improving the quality of pre-service and post-graduate training (GoR & MoH, 2011c). This plan is currently being implemented with substantial financial support from the US Government and the technical support of several US universities to the above-mentioned Rwandan training institutions (G INT GEN 4; INT HRD 21).

In 2012, a ministerial order was issued to determine the modalities for the posting of medical staff in the health sector. According to this decree, medical doctors are now assigned by MoH to district hospitals. District hospitals can now recruit medical doctors and pay them from the hospital or DP budget, but they are required to submit a request for non-objection to the Minister (Art. 2 and Art. 4 of the ministerial order; Official Gazette 25 of 18.06.2012).

The component of human resources development in the Rwandan-German health program

Theory of change

In 2007, the first joint program proposal of German implementing organizations was submitted to BMZ. The objective of the HRD development component was defined as “Increasingly well trained health professionals are available for the Rwandan population”. While HRD is composed of three sub-components: (1) medical education, (2) hospital management, and (3) health technology management, four indicators were formulated and adapted between 2007 and 2012.⁹⁰ Three of these indicators were related to the sub-component, Medical Education.

The intension, outlined in the joint health program’s framework, was to enhance the capacities of MoH to enable it to manage (coordinate and organize) human resources and the competencies of health service providers – through technical and financial assistance – to enable qualitative services to patients. As a result, increasingly well trained health professionals are now available (output). This adds to the improved quality management of health facilities, maintenance of equipment, and the provision of medical services (outputs) to the health system, focusing on the needs and priorities of the Rwandan population, in particular, the poor (outcome). The health status of the population, ultimately, has improved (impact).

Implementation

Between 2000 and 2012, 19 development workers provided assistance to medical education in several specialities and training fields at the National University of Rwanda medical faculty, the University Teaching Hospital in Butare, and the district hospital of Ruhengeri. Their main scope of work was the practical training of interns and doctors, including clinical practice. Virtually all those development workers interviewed emphasized that it was not possible or that it proved very difficult to prioritize their main activities, given that practical training went hand in hand with clinical practice.

At the district level, hospital management had been an integral part of the PHC projects implemented by GTZ and DED since the beginning of the 1980s. Support to MoH began in 2004. In collaboration with BTC, GTZ/GIZ supported the development of a training manual on hospital management. At the decentralized level, GTZ/GIZ financed short-term courses and workshops on

⁹⁰ An overview of indicators and their adjustment in the course of program implementation is documented in Annex E.

management issues. GTZ/GIZ technical advisors also gave advice to district hospitals on how to develop strategic and operational plans, based on national guidelines.

Between 2005 and 2012, InWEnt financed the 12-month training of 17 Rwandans in the international leadership program (ILT) on hospital management at the University of Neu-Ulm in Germany. This was in addition to backstopping and training the trainers on their return to Rwanda (Doc.55). Between 2003 and 2005, InWEnt supported the School of Public Health to develop a training manual for district health managers. Cooperation with the School of Public Health continued until 2008 and a prototype for a district health management course was developed (InWEnt project reports; INT HRD 20).

InWEnt also organized various regional training workshops and several electronic learning courses, in which more than 100 Rwandan health professionals participated. These included a variety of topics, ranging from health management and HF to HIV and AIDS and human rights and health (Doc.55).

Systematic activities in the sub-component of health technology management began in 2007/2008. Mainly through SANIPLAN, a German consulting firm sub-contracted by GTZ/GIZ, GDC provided technical assistance at the central and district levels. At the central level, a TWG on geographic access and health technology management was established in 2009. GDC contributed to the development of national policy, relating to engineering and maintenance, and to standards for health facilities infrastructure and equipment. In addition, GDC developed an in-service training program for district hospital technicians on maintenance repair, and provided repair tools and equipment to the maintenance units in the district hospitals (Doc.22).

KfW supported the HRD component by financing the purchase of medical equipment for Butare's University Teaching Hospital in Butare, Ruhengeri's hospital, and 25 health centers in the five districts of Huye, Gisagara, Nyaruguru, Musanze and Gicumbi.⁹¹

HRD was very active, with many DPs involved. Partnerships between international NGOs, international universities, and Rwandan medical training institutions were also forged (Viankandondera, 2012). Most DPs were involved in medical education, some in hospital management, and very few in health technology management and maintenance.

Relevance

In view of the continuing severe shortage of health professionals at all levels and the need to invest in the development of a qualified health workforce and the operation of support systems, GDC interventions in the HRD component were highly relevant to the program objective. In the absence of a qualified workforce, health providers, and facilities, it would have been difficult to offer services and respond to the needs of poor population groups (INT EXP 1, 3).

In accordance with its PRSP and EDPRS, GoR placed strong focus on all HSSPs on HRD in the health sector, in order to achieve the health-related MDGs, specifically by prioritizing the expansion of medical education and by strengthening of training institution capacities. These priorities evolved between 2006 and 2012 – from investment in general medical and nursing education to bridging specific gaps (medical specialists, midwives), but formal medical education continues to be a high priority (INT GEN 13; GoR & MoH, 2006a, 2011c).

Hospital management should be viewed in the context of health systems strengthening and decentralization, which were also among the priorities of GoR as of 2005. In comparison, health technology management and maintenance had received far less attention until 2009, when the development of a maintenance framework for medical equipment was included in HSSP II (GoR & MoH, 2009). The draft HSSP III (2012 – 2018) gives significantly more importance to health technology management by defining health infrastructure development, including maintenance, as a core element of the health support system (GoR & MoH, 2012, p. 66).

⁹¹ This intervention included medical, laboratory, educational, and other equipment for a total of EUR 400,000 (Doc.47). A limited amount of medical equipment was also provided by GTZ and DED.

Likewise, BMZ considers HRD (including the training of health professionals) and regulatory policy and legal frameworks to be a high priority, as stated in its health sector strategy (BMZ, 2009d). In this context, a limited posting of German health workers was considered helpful in preventing the continuing chronic shortfall of trained health workers in some regions (BMZ, 2009d, p. 18). In accordance with its human rights-based approach to health, BMZ also considers quality care, respect for confidentiality, and non-discriminatory treatment as important aspects of professional health training (BMZ, 2009a).

Formal medical education continues to be a high priority on the MoH agenda, but priorities between 2006 and 2012 have moved from focusing on training general practitioners to training specialists (INT GEN 13; GoR & MoH, 2006a, 2011c). This is evident in the last HRH Strategic Plan (2011–2016).

The ILT program in hospital management has been in line with GoR priorities to strengthen health systems by improving management of health facilities. HSSP 1 (2005–09) aimed to “increase the number of those trained in management skills and public health” (GoR, 2005b).

According to ILT alumni, ILT training was relevant to sector needs and their own training requirements. From the perspective of most alumni, hospitals in Rwanda – since 2000 – were managed in a “traditional” way by doctors with no background in hospital management. *“The hospitals were – and still are – mainly managed by doctors who do not have any hospital management skills. They manage hospitals in a traditional way”* (INT 31). Alumni referred to severe gaps in strategic and operational planning, human resources, services organization, patient flow, finance, and drugs management. The ILT was significantly appreciated by MoH partners (INT RP 33; INT GEN 13) and, from the perspectives of managers of INWent and GTZ, it was adequate (INT EXP 4; INT RP 34). The hospital management segment of the course was developed to fit the needs in the African health systems context (INT HRD HM 1).

With regard to medical education, nearly all interviewed development workers acknowledged the importance of individual knowledge transfer to develop the capacity of Rwandan medical students and doctors. They emphasized the importance of practical training for interns. Similarly, interviewed Rwandan partners, former interns, and doctors who were trained by development workers, acknowledged the importance of individual knowledge transfer.

Overall, Rwandan interviewees appreciated the experience, clinical knowledge, and the ability of development workers to adapt to a resource-challenged setting. Not all of their expectations, however, have been met, since not all development workers fit the required profile. It has not been easy for DED to recruit candidates with significant background experience, communication skills, adaptability to a resource-challenged situation, and willingness to work for much lower remuneration than in Germany (INT HRD DW 2; INT EXP 5, 11).

GDC partners at the central and district levels appreciated the training development they received on maintenance and health technology management, and considered them to be highly relevant to their needs, especially since very few other stakeholders were engaged in this area (INT HRD 5, 9, 11; G INT HRD 14). The equipment financed by KfW was also considered adequate and useful, although some concerns with regard to their maintenance and the availability of spare parts were expressed (G INT HRD 14, Comparative Case Study). This had been, apparently, a wide-spread challenge experienced not only by GDC, but also by other DPs, since maintenance clauses had not been included in contracts between MoH and supply companies. MoH has since recognized the problem and intends to include these clauses in the future (INT HRD 5).

At the onset of the MDGs in 2000, maternal and child mortality rates – in comparison with other countries in East and Central Africa – were very high in Rwanda (cf. chapter B.3.1). The decision to support medical specializations, such as pediatrics and

gynecology, and build the capacities of Rwandan physicians to treat the most common diseases and health conditions was an appropriate response towards fulfilling the needs of the Rwandan people, especially women and children.

In summary, medical education and hospital management have reflected the priorities of the Rwandan and German Governments. GDC partners at the central and district levels also have confirmed the relevance of these as HRD efforts to strengthen the health sector. There is conclusive evidence that the capacity development interventions with regard to medical education and hospital management have responded to the needs of the beneficiary groups (health professionals and hospital managers).

Effectiveness

The following paragraphs provide information on the final status of the indicators (cf. also Annex E) relating to the achievement of the component objective (“Increasingly well-trained health professionals are available for the Rwandan population”) in the context of support to HRD (Doc.28; GoR & MoH, 2011a, 2011c).

*“The number of interns increased from 80 in 2010 to 110 at the end of 2012”*⁹² (Doc.26). The number of students entering the faculty of medicine was 53 in 2005 and 107 in 2012, with a peak of 135 in 2008.

In 2010, 99 students graduated from the faculty of medicine after their internship year. In 2012, 79 students (63 males and 16 females) completed their internship year. GDC contributed to the training of 438 interns between 2005 and 2012, and between 2004 and 2010, 600 general physicians graduated from the National University of Rwanda faculty of medicine. This means that approximately more than two thirds of all graduates were trained by DED development workers.⁹³

“98% of the medical doctors who graduated from the internship program by the end of 2011 are deployed in public health facilities until December 2012 at the latest.” In 2011, there were 470 Rwandan generalist practitioners, of which 80% were working in district hospitals. No comprehensive information on the professional career of interns after graduation is yet available.⁹⁴ GDC has provided limited input to the policies of HRD through the TWG on human resources.

“The number of local medical specialists increased to 135 in 2012 and at least each Provincial hospital gets one specialist until the end of 2012” (Doc.26). By the end of June 2012, there was 15,540 staff in public health facilities in Rwanda, including 132 specialist doctors, of which 80% worked in the four referral hospitals.⁹⁵ GDC has supported the training of 52 junior doctors between 2005 and 2011.

*“100% of health personnel in the 5 supported Districts participate in continuing job education at least once a year”*⁹⁶ (Doc.26). In the districts supported by GDC, 100% of the health workforce has received in-service training in family planning, maternal and child health, gender-based violence, CBHI, or PBF. GDC has contributed to training through various development interventions (technical assistance, workshops, and local subsidies for training, conducted by districts).

Hospital management

In June 2013, 10 of the 17 ILT alumni were still working in the public health sector in Rwanda. Nine alumni had been promoted to better positions, but for 7 of them, it was only possible after completing further studies. This was due to the fact that the ILT certificate was not recognized in Rwanda as a postgraduate degree. The Neu-Ulm University of applied sciences took the initiative to provide an opportunity to nine ILT alumni from Rwanda to complete their studies⁹⁷ at Mzumbe University in

⁹² The indicator is not specific, as it is not clear whether it relates to enrolment or to graduation.

⁹³ GDC certainly contributed significantly to increase the availability of well-trained medical doctors in Rwanda. The period interns spent with DED/GIZ doctors, however, was short (three months) in comparison to the length of the medical studies (six years). In quantitative terms, therefore, DED support was – over the whole period – one contribution among many others. GDC contribution, however, was particular in the sense that no other DP systematically supported the internship program over a longer period.

⁹⁴ Interviews conducted with former interns in June 2013 provided the following scenario: of 12 interviewees, 10 were stationed after their internship to a district hospital. Most of them remained in this position for at least two years. Two of the interns did not continue with clinical practice, but began work in public health or research.

⁹⁵ Up-to-date information on the number of specialists working in provincial hospitals is not available.

⁹⁶ This indicator is not appropriate to assess the outcome of capacity development interventions supported by GDC, as it only covers the number of staff participating in training development interventions.

⁹⁷ They were given the opportunity to obtain the MBA in two months instead of two years, as their ILT credits were taken into consideration.

Tanzania. ILT alumni were able to transfer, in different ways, the acquired skills and knowledge, depending on their workplace.⁹⁸ All alumni interviewed stated that the knowledge and skills that they acquired did apply to various areas within hospital management,⁹⁹ and that they were able to transfer this knowledge within their working environment through individual knowledge transfer projects that were built into the ILT course program.

The knowledge transfer projects in the workplace improved many areas of hospital management, which improved the quality of care in several hospitals. Interviewees added, however, that there were barriers to the delivery of improved hospital management and healthcare: staff members, at times, were opposed to change and continued operating as usual; resistance continued as a result of personal vested interests within the old system (INT HRD HM 4, 10, 11, 13); there was little motivation to accept change, given the lack of understanding of its importance; and some projects could not be implemented due to the lack of equipment (INT HRD HM 5, 7, 13). The positive effects that were identified, therefore, were achieved at an individual level, while at an organizational level, it very much depended on the alumni's working environment and the acceptance by their colleagues and superiors.

In 2007, on the initiative of the Minister, MoH created a new in-house task force on hospital management, which included four ILT alumni. Its main role was to support administrative staff in Rwandan district hospitals to improve hospital management. With each member being assigned to one of the four regions in the country, they carried out capacity building activities (e.g., strategic planning and quality management) (INT HRD HM 3, 2, 12; INT RP 33) and, with GIZ assistance, together produced a training manual on hospital management. This was then used for short-term hospital management courses in all districts. Despite the manual being in use as it was developed, it took longer than expected to produce a final version.¹⁰⁰ Other ILT alumni, working

in hospitals, stated that the members of the task force played an important role in the training of district health staff and that they appreciated their endeavors, although they acknowledged that many gaps remain (INT HRD HM 7, 8, 10, 13). GDC and DP managers also appreciated the efforts of the task force and sometimes collaborated with them. Reference was made by managers to the fact that the team's work, at times, created serious conflict within the Decentralization and Clinical Services Departments and personal conflict between those in charge of them. Task force members sometimes were overloaded by ad hoc activities (INT EXP 5; INT RP 34; INT SWAP 6). As of June 2013, they are still part of the team. Responsibility for the task force within MoH eventually changed¹⁰¹ and the team is currently accountable to hospital accreditation (INT HRD HM 2, 12, 33).

Medical education

Interviews conducted with former Rwandan interns give qualitative evidence that the training provided by development workers has resulted in the transfer of knowledge and skills, which in turn, has contributed to improved quality of care within their most recent workplace. With the exception of two interviewees, all (10) expressed positive effects. The skills that were most reported were the ability to diagnose and treat patients accordingly. Apart from clinical expertise, interviewees repeatedly reported that the training had increased their motivation, sense of responsibility, and ability to take charge of patient care. Resident doctors also mentioned that they had learned how to apply new clinical and surgical practices.

From the perspective of the Rwandan doctors and interns, trained by DED/GIZ development workers, various challenges limit their effectiveness as general physicians (INT RP 11; 14; 15; 23; 25; 27; 30): (1) poor working conditions in the district hospitals offered to Rwandan doctors, (2) lack of qualified medical doctors in district hospitals, together with a high turnover rate, (3) low salaries of Rwandan doctors, leading to lack of motivation and

⁹⁸ Directly after the training, 15 of the 17 ILT alumni occupied various positions relating to hospital management in the public health sector: 11 worked in hospitals in various operational positions, such as administrator, procurement officer, internal auditor, or monitoring and evaluation officer. Four alumni worked as hospital managers in the MoH task force.

⁹⁹ Financial management, operational and strategic plans development, human resources management, quality management, material and drugs management, procurement, and data management.

¹⁰⁰ This was due to the fact that the top management in MoH wanted to include new priorities, such as patient-oriented quality management. The training manual was approved by the General Senior Management Meeting of MoH in May 2013. It still requires the signature of the Minister to become effective as an official training document.

¹⁰¹ After two years (2007–09) under the responsibility of the Department of Clinical Services, the Decentralization Department assumed responsibility for the task force from 2009 to 2013. The task force is now, once more, under the responsibility of the Clinical Services Department.

professional commitment, and (4) poor equipment and lack of maintenance.

Of seven development workers interviewed, six provided positive feedback on the overall effectiveness of their work, while one was negative. All mentioned that the training of medical students and interns was effective. Their perception of the key skills that they could transfer concurs with that of the Rwandan interviewees who were, however, more critical with regard to the skills transfer to resident doctors and Rwandan colleagues.

The counterparts of the development workers often were not available, either because there was no one in the position or because they spent part of their working hours as practitioners in private clinics (INT HRD DW 3, 6, 8, 9). Development workers, thus, were sometimes placed into a gap-filling role. Interviews with GDC managers and yearly reports have confirmed this challenge (INT EXP 5, 11; INT HRD DW 8; INT RP 34; yearly reports of DED health coordinators). Interviewees often attributed this issue to weak staff management within hospitals and MoH, as well as the difficult working conditions experienced by Rwandan medical doctors (INT HRD DW 3, 6, 8, 9, 2). Some also referred to a lack of responsibility or sense of medical ethics among Rwandan health professionals (INT HRD DW 2, 7, 8; INT EXP 11):

“Development workers brought with them their medical ethos to Rwanda. Sometimes, they were frustrated, because Rwandan doctors did not show the same ethos and commitment. But one also has to consider the working conditions of Rwandan doctors. Even in Germany, doctors do not live from idealism.” (INT HRD DW 2); *“Many Rwandan physicians still lack empathy, the self-understanding that because one is a doctor, one has to take care of the patients. Responsibility and ethics hardly exist* (INT HRD DW 8).”

Development workers reported that the flow of patients increased during their presence. Once patients became aware of the services (e.g., treatment of complicated gynecological conditions, premature births, epilepsy) that were provided in hospitals, they travelled great distances to access them. Likewise, the number of surgical interventions at Butare’s University Teaching

Hospital increased with the presence of German development workers (cf. interviews and reports of development workers). Interviews and program documents also provide evidence of the contribution made by development workers to the development and provision of new services (e.g., neonatology in Ruhengeri and neurological services in Butare), which is a positive unintended output.

The implementation of the internship program was faced with several difficulties due to the conflicting expectations of medical students and MoH. The initiative, nevertheless, was put into practice and the training of interns took place from 2004 in not only Butare and Ruhengeri, where the development workers were located, but also in three hospitals in Kigali. Reviews of the medical instruction and feedback from interviews conducted during the evaluation mission, reveal that at the national level, management, supervision, and monitoring mechanisms for the internship program had remained weak over the period (Adamczick, 2011; Bail & Kantengwa, 2006).

Many development workers created teaching material or gave inputs to the curriculum. The inputs, however, were not systematically embedded in the national curriculum (Adamczick, 2011). During the last phase of the joint program, in particular, several of the workers provided inputs to national medical treatment guidelines or protocols; for example, on the treatment of fistula and neurological conditions (INT HRD 22, 18; reports of development workers).

It can be concluded that the objective of the HRD component in the joint Rwandan-German health program was achieved: *“Increasingly well trained health professionals are available for the Rwandan population.”* DED/GIZ support and the ILT program in hospital management helped to increase the number of Rwandan health professionals, strengthened their skills and knowledge, and improved the quality of care in Rwandan hospitals.

Interviews with former interns and doctors, who were trained by development workers, have confirmed that the skills they acquired assisted them in diagnosing diseases and treating

patients. Apart from clinical knowledge and skills, the training increased their motivation, sense of responsibility, and ability to take charge of their patients. These skills were a very important asset for the graduate doctors. Despite some challenges, they could apply them in a district hospital setting, benefitting the Rwandan population, particularly women and children. The challenges related to poor working conditions in district hospitals to where Rwandan doctors were assigned, including the lack of qualified medical doctors, a high turnover rate, poor equipment, and weak maintenance. These factors persisted for some years throughout the country, impacting the motivation of Rwandan doctors to remain in district hospitals. The gap-filling role of DED/GIZ development workers, therefore, should be seen – in the first instance – as a system-imminent challenge and not as a direct unintended effect of GDC support.

On their return to Rwanda, ILT alumni were able to improve various aspects of hospital management within their workplace. The evaluation indicates that many of their transfer activities contributed to the positive effects on the quality of care. In their efforts, however, alumni were faced with a number of challenges, including resistance by staff to innovation and a continuing lack of autonomy by hospitals with regard to human resources management. Scaling-up was achieved through the establishment of the task force and the country-wide training of hospital administrators. The continuing high turnover rate of administrative staff, nevertheless, limited the effectiveness of these short-term, in-service training activities. The creation of the training manual on hospital management, which involved the members of the task force, took a long time and its validation is pending.

Efficiency

Hospital management

The efficiency of the ILT course program on hospital management was assessed following a comparative approach of the cost of the ILT program for each participant against the cost of similar training courses on hospital management. It was not possible, unfortunately, to gain access to the relevant data on the course offered by the School of Public Health. A comparison,

nevertheless, was made against the cost for the two-year Master of Business Administration (MBA) course in healthcare management, offered by Mzumbe University in Tanzania.¹⁰²

Total ILT direct expenditures amounted to EUR 5.65 million with a large portion of the budget spent on the training in Germany. Costs during the second phase amounted to EUR 4.23 million and represented 75% of total ILT direct costs. The direct outlays during the first phase for the selection of participants and the German course in Africa represented 16% of total ILT direct expenditure. The third phase, consisting of the transfer of projects in the respective countries of ILT participants, accounted for 9% of total ILT direct expenditure. Together with administrative fees, the total amount for all ILTs (ILT 1–ILT 6) increased to EUR 9.74 million. For 124 ILT participants during the second phase, the average total amount per participant was estimated at EUR 78.56 thousand.

Based on the average cost of African participants, the total expenditure for 17 participants from Rwanda amounted to EUR 1.34 million. The average fee per participant for the two-year MBA course in healthcare management, offered by the Mzumbe University in Tanzania, is estimated at EUR 12,000 (INT HRD HM 1) and, thus, is significantly lower than the cost of the program in Germany. The content of the MBA course was developed by applying the experience gained from the ILT program and offering a Master's degree, which the ILT program did not. Assuming that an MBA in healthcare management could have been offered in Rwanda at similar cost, the opportunity costs would also have been reduced. Participants, however, would not have benefitted from the experience gained in German hospitals.

With regard to the time invested in the training activity, the interviewed ILT alumni were quite critical. They felt that the time spent to learn German was too long and that the level acquired was insufficient to enable them to study or understand their colleagues during vocational training. Moreover, there would be no subsequent opportunity to use the language. If the ILT course had been conducted in English, the costs could substantially have

¹⁰² This comparison is valid, despite the differences between the ILT and MBA courses: ILT intends to enable participants to design projects for knowledge transfer, which are not a part of the curriculum of the MBA course. The MBA course, nevertheless, provides a degree, which the ILT does not.

been reduced. Another independent evaluation came to a similar conclusion (Doc.46).

Medical education

For this evaluation, the DEval team has refrained from conducting a cost-benefit analysis of DED support to the training of interns and junior doctors. Overall, development workers have calculated that the relationship between the effort invested in their work compared to the benefits has been appropriate (cf. survey results and interviews). Most development workers stated that their jobs were very demanding and at times exhausting, but that in retrospect, they feel that it had been worth it. Their assessment related to the work environment, the availability of counterparts, and their own expectations. With regard to those former interns who were interviewed, several explicitly expressed that the length of time the medical studies took to complete was not adequately reflected in the salaries they received following graduation (INT RP 13; 14; 23; 36).

Sustainability

GDC support has had a long-term positive effect on the mindset of medical students trained by development workers. There is sufficient evidence that – apart from clinical knowledge and skills – the training has increased motivation, a sense of responsibility, and the ability to take charge of patients. In the absence of comprehensive quantitative information, the brain drain (i.e., migration of skilled health professionals to other countries) in Rwanda is not a challenge – 15 of the 17 alumni have remained in the country.

Although turnover of staff has been a challenge, the services that have been developed over the years, with DED support from development workers, are still in operation; this is particularly apparent in the Ruhengeri hospital. Maintenance of equipment has been, over the same period, a serious strain and it continues to threaten the sustainability of services in all hospitals (comparative case study).

The continuation of internship training has proved to be a long-lasting positive and systems-building effect of GDC support. Despite the reform of 2010, however, organizational challenges remain, particularly with regard to the capacity of district hospitals to provide adequate training conditions and intern supervision. The sustainability of the medical health care course also will depend on the capacity of those Rwandan institutions that are involved to address and resolve current management challenges. In addition, the potential of ILT alumni – be it at the task force or district level – to contribute their experiences to the training course is, largely, still untapped.

A potential boost towards sustainability would be the political will of GoR to continue investing in HRH and the use of external resources to achieve this objective. GoR now places a priority on the training of specialist physicians. Questions remain regarding the subsequent long-term engagement of these specialists in public and district hospitals. Interviews held with former interns and doctors, who were trained by development workers, indicate that the country's internal skills drain (i.e., migration of physicians to the private sector or to administration positions) may very well constitute a serious challenge. For many of those interviewed, the ideal workplace in the future is neither in a district nor in a public hospital. Rwandan district hospitals, therefore, will most likely continue to be dependent on a revolving workforce of well-trained generalist practitioners if working conditions in the public health sector do not substantially improve. The continuation of a practice-oriented internship program, therefore, will play an important role in the training of generalist practitioners.

3.4 Impact

The overall program objective was the improvement of the health status of the Rwandan population. Three component objectives were set in order to contribute to this overall goal. The component of health financing aimed to increase the access to services in a financially sustainable manner. The component of sexual and reproductive health focused on targets set for reproductive health and family planning. Human resources development

provided support to service provision and the qualification of health personnel. While the GDC contributions to the single component objectives have increased effectiveness at the output and outcome levels, the combined efforts of the three components constitute the overall program impact (Annex D).

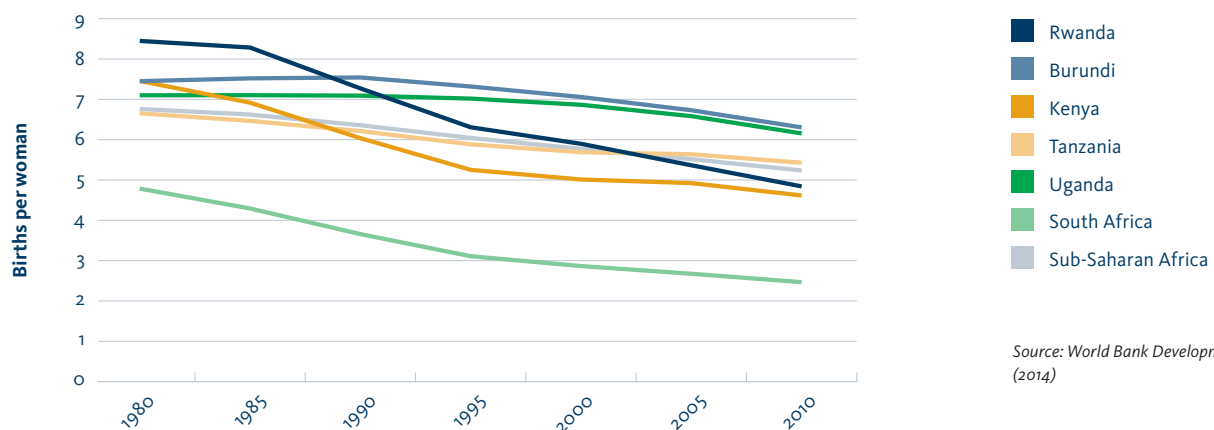
In accordance with the proposed analytical framework, relevant impact indicators refer to the health status of the Rwandan population, including changes in terms of mortality and morbidity, health inequity, risk protection, and fertility (cf. chapter A.2.1). The central unit of investigation, therefore, remains at the population level. To assess the achievement of program objectives, the analysis has focused on the changes relating to client-centered strategic objectives, as outlined in HSSP II, including (1) family planning, mother and child health, and reproductive health; (2) health promotion and prevention of disease; and (3) treatment and control of disease (GoR & MoH, 2009). In alignment with Rwandan priorities and in accordance with the GDC approach to health systems strengthening, three main program indicators have been drawn from EDPRS, in line with the above-mentioned strategic objectives of HSSP II, which include total fertility rate, infant mortality, and HIV prevalence. All components effectively have contributed to the improvement of these broader development goals, in line with the single component objectives that were monitored by component-specific output and outcome indicators, introduced in Chapters B.3.3.1–3.3.4 (cf. also Annex E).

The complexity of the SWAp environment has posed substantial strain on the impact assessment. By applying a contribution analysis, plausibility links could be established on the basis of the program's intervention logic. The analysis also considered confounding factors and alternative explanations to the extent possible. It, however, focused on the plausible links to relevant impacts and excluded the assessment of the strength of the effects in relation to other partners involved.

Family planning, mother and child health, and reproductive health

The main GDC-supported family-oriented services include family planning, mother and child health, and reproductive health. Intervention has relied primarily on preventive and promotional activities, as well as the management of neonatal and childhood illnesses. The aim of this intervention strand is to empower the community through information, education, and other strategies and to provide access to basic health care services.

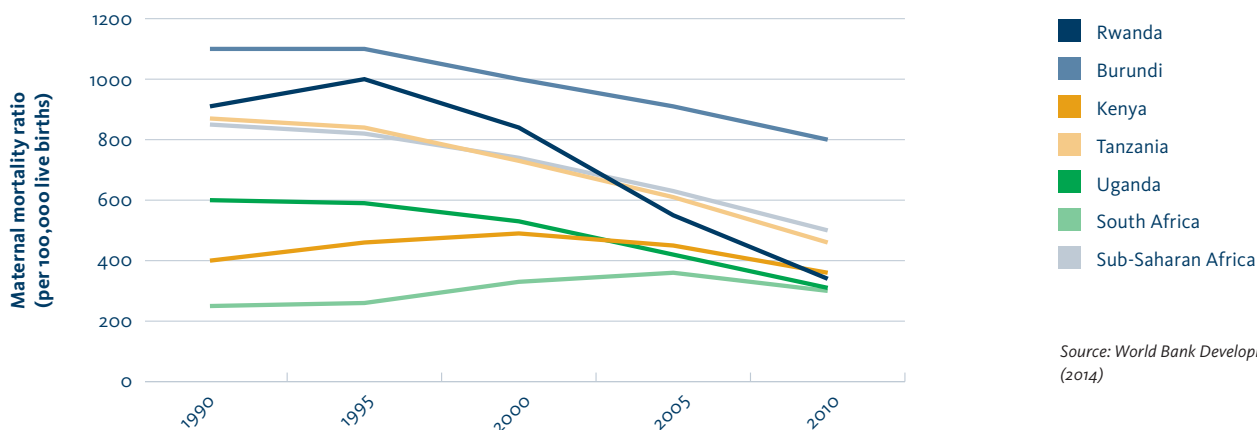
Within the SWAp period, Rwanda has made impressive progress with regard to family planning and SRH. Since 2005, the program indicator of the total fertility rate decreased from 6.1 to 4.6 children per woman in 2010 (NISR et al., 2012; NISR & ORC Macro, 2006). The use of World Bank data has allowed for a regional comparison, which demonstrates that Rwanda has reduced its fertility rate at a much faster pace than other countries in the East African Community (Figure 10). This decline is undoubtedly related to the rapid increase in married women's uptake of modern contraception, to which GDC has contributed, as outlined in Chapter B.3.3.3. Rural-urban disparities remain, however, with rural women having higher fertility rates than their urban counterparts. With regard to family planning, support to social marketing through the private sector has been the most important strategy at the community level. In addition, GDC has assisted the public sector to increase the technical capacities and human resources of health centers, CHWs, and peer educators and to expand the linkages to the activities of the private sector. Results from a secondary 2010 DHS data analysis also have highlighted the influence of some social determinants of health, including education, economic development, and modern lifestyle.

Figure 10: Total fertility rate (births per woman)

In spite of the noteworthy success, regional, socioeconomic, and age-specific differences remain. First, the total fertility rate is higher in rural areas compared to the rates in more urban areas. Second, the total fertility rate remains higher for the less educated and low-income categories (NISR et al., 2012). Third, teenage fertility declined at a slower rate and young motherhood remains more common in rural areas. Investigating the nexus between fertility and modern contraceptives has revealed that the urban poor and the rural population reflect the highest fertility, the lowest contraceptive prevalence rate, and the greatest unmet needs for family planning (NISR et al., 2012). While trends indicate an overall improvement of the total fertility rate, health inequity is still prevalent. Although the GDC focus on the rural population and adolescents could have been expected to reduce inequity, an exact calculation of the effect cannot be made with the data available. It does appear that some efforts in this area achieved less impact. The comparative case study found that while young people have access to modern contraceptives, the relevance of information campaigns on family planning continues to be rather limited, especially in rural areas. As information campaigns were a central element of the social marketing strategy, this result is somewhat surprising. The evaluation also found that youth and unmarried women are still under-served in terms of access to modern family planning, also noted in the German-supported districts.

GDC support to maternal and child health has contributed to a decrease in maternal mortality rates, with Rwanda making considerable progress in achieving the MDG target rate of 1,300 per 100,000 live births in 1990 to 325 in 2015 (Abbott & Rwirahira, 2012). By 2010, the maternal mortality rate was 487 (NISR et al., 2012). Figure 11 highlights that Rwanda has reduced, within the last decades, its maternal mortality rate at an extremely fast pace in comparison to other countries in the region. The main reason for this has been due to the increasing number of women giving birth in health care facilities attended by qualified healthcare professionals. GDC has provided assistance to district health facilities and HRD, in particular, through technical and financial support. The improved quality and quantity of services has been confirmed by findings derived from the comparative case study in the four districts. For further improvements in maternal mortality, an increase in the number of facility-based deliveries will be required, women will need to be encouraged to attend antenatal care on a regular basis, and obstetric care will need to be extended.

Figure 11: Maternal mortality ratio (per 100,000 live births)

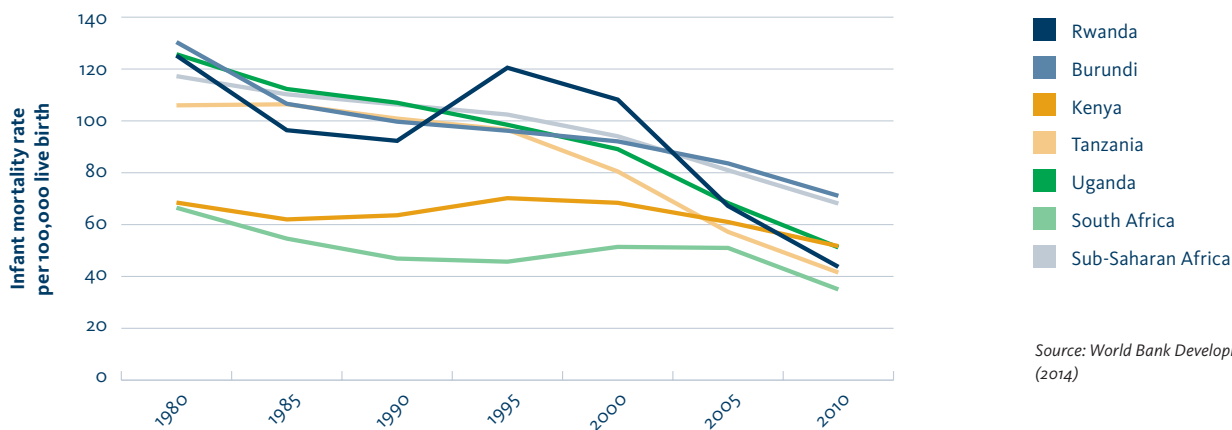


Source: World Bank Development Indicators (2014)

In addition, the under-five child mortality ratio has been reduced from 103 per 1,000 live births in 2008 to 76 per 1,000 live births in 2010 (NISR et al., 2012; NISR et al., 2009). Within the same period, the program indicator of the infant mortality ratio has decreased from 62 per 1,000 to 50 per 1,000 live births, much faster than the Sub-Saharan average (cf. Figure 12). In terms of

child health, Binagwaho et al. (2012) found that CBHI coverage has led to long-term improvements (measured by stunting and mortality). They acknowledge, however, that their results cannot solely explain the drops between DHS 2005 and 2010. They furthermore conclude that more effort will be necessary to cut stunting prevalence down to the MDG target of 24.5%.

Figure 12: Infant mortality rate (per 1,000 live births)



Source: World Bank Development Indicators (2014)

In the broader context of fertility and mother and child health, chronic malnutrition is a relevant factor. In Rwanda malnutrition has been reduced from 51% in 2005 to 44% of children under five in 2010 (GoR & MoH, 2011a). The nutritional status of the Rwandan population is relevant beyond health and is critical for social and economic development, as outlined in Vision 2020. Stunting and malnutrition, nevertheless, are still endemic for a considerable share of Rwandan women and their children (NISR et al., 2012). Most strikingly, differences among socioeconomic strata are prevalent, given that stunted children are found to be least common among wealthier families (NISR et al., 2012). Strategies on mother and child health, therefore, should be improved and complemented by interventions towards the nutritional status of the population.

Health promotion and prevention of disease

With regard to health promotion and disease prevention, GDC has focused on population-oriented services. Service provision includes periodic outreach to communities and scheduled services at health facilities.

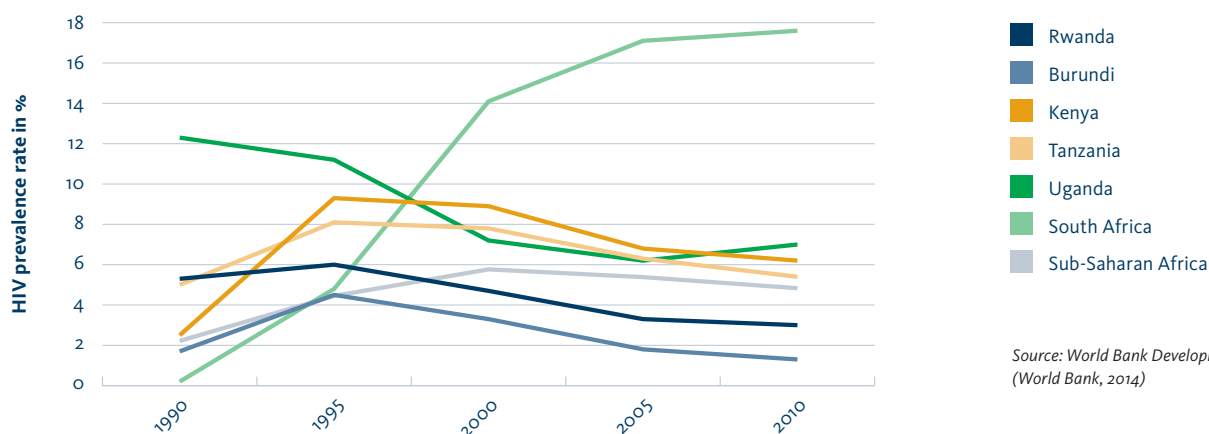
Considerable efforts in health promotion and the prevention of disease have been made in relation to HIV prevention. The approach of GDC to health systems strengthening has been complemented by the activities of other important DPs (e.g., large vertical programs on HIV prevention, implemented by the US Government and multilateral agencies, funded by GFATM; and the President's Emergency Plan for AIDS Relief). GFATM also includes financial contributions from Germany, as one of its largest donors. The two programs have delivered substantial funds, especially for interventions, such as voluntary counseling and testing and antiretroviral treatment.

Since 2000, the Rwandan HIV prevalence has decreased from an estimated 4.7% (World Bank, 2014) to the DHS estimates of

3.0% in 2005 and 2.8% in 2010 (NISR et al., 2012). Due to limited data sources for Rwanda in the late 1990s, some studies have pointed to extremely high national HIV rates of more than 10% in approximately 2000 (UNAIDS & WHO, 2000), which have later been recalculated and adjusted. Despite a limited comparability of the 2000 estimated average and the DHS-based rate for 2005, a remarkable downturn of overall HIV prevalence in this period has been demonstrated by the data sources that were available. Today, Rwanda has one of the lowest HIV prevalence rates in Sub-Saharan Africa. A regional comparison shows a moderate HIV prevalence rate for Rwanda, as illustrated in Figure 13. Women are, in general, more likely to be HIV positive, with 3.7% against 2.2% for men in 2010 (NISR et al., 2012). Due to the response of the national strategy on HIV and the high coverage of antiretroviral treatment, in particular, Rwanda has managed to reduce the number of new HIV infections between 2001 and 2012 by an estimated 55% and AIDS deaths by a remarkable 75% (UNAIDS, 2013).

Although these factors have stabilized the incidence of HIV on the overall population, it has stopped declining and remains extremely high in groups that are most at risk (G INT SRH 6, 28, 30). Voluntary counselling and testing have found that more than 50% of commercial sex workers were HIV positive in 2010 (Rwanda Biomedical Center, 2012). The GDC strategy has had limited effect on the high risk. Moreover, an unintended side effect of social marketing has been identified by the comparative case study in the four districts under study, which was that young adults felt that sex was safe with the use of condoms, leading to increased levels of prostitution among the young who are severely impacted by poverty. Should this trend be perceived as an increase in promiscuity and not as an incidence found in the randomly selected communities for discussion, it could pose an additional challenge to the information and education campaigns at the community level.

Figure 13: Prevalence of HIV (% of population ages 15-49)

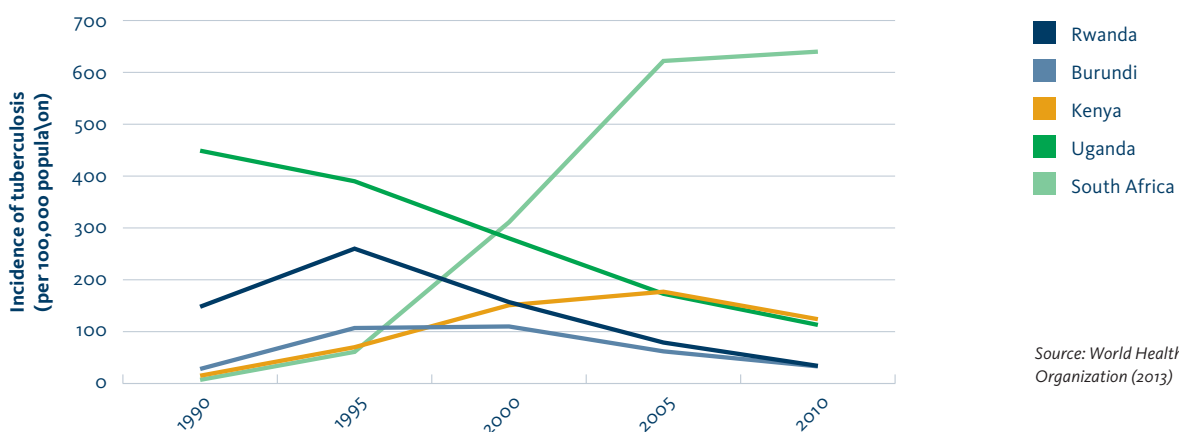


Treatment and control of disease

GDC efforts in the treatment and control of disease encompass all types of curative care that is needed by health care professionals. While some development workers have provided services directly to the population, the main approach focuses on HRD through training and education. Different interventions have been implemented in various healthcare facilities.

In order to assess the impact of treatment and control of disease, information is needed on the state of morbidity and mortality. In Rwanda, malaria remains a main threat to these; it is the main cause of death for children under five years of age and the second main cause for adults, followed by HIV/AIDS (GoR & MoH, 2009). Data from the National Malaria Control Program show that malaria incidence declined by 70% between 2005 and 2010 (NISR et al., 2012). From 2008 to 2010, malaria prevalence decreased from 2.6% to 1.4% for children under five and from 1.4% to 0.7% for women aged 15–49 (NISR et al., 2012). In 2010, malaria was still one of the main causes of outpatient visits to district hospitals, health centers, and CHWs (MoH, 2012d). Within the last few years, GDC has contributed to providing services through technical and financial support to health facilities, medical education, and hospital management.

Besides malaria and HIV/AIDS, tuberculosis and tropical diseases are relevant threats to the health status of the Rwandan population, which can best be addressed through integrated strategies. On this basis, GDC health systems strengthening has focused on integrating tuberculosis and HIV, as well as their co-management. Figure 14 demonstrates a significant decrease, since 1995, in the incidence of tuberculosis in Rwanda. In 2011, 98% of all registered tuberculosis patients were tested for HIV (MoH, 2012d). The overall HIV prevalence of tuberculosis patients was at 28%. These figures illustrate that the majority of interventions at the national and decentralized levels have been successful, as have Rwanda's tuberculosis/HIV policy, HIV counseling and testing, prevention of mother-to-child transmission, delivery of care and treatment of tuberculosis, and universal antiretroviral treatment coverage.

Figure 14: Incidence of tuberculosis (per 100,000 population)

One intervention which has brought considerable attention to improving the treatment and control of disease has been PBF. In 2011, RWF 12 billion was contributed to PBF activities (MoH, 2012d). HIV-related initiatives, alone, accounted for 32% of this total. An assessment of its effectiveness has provided evidence that the performance system has contributed to an increase in the quality and quantity of health care services. There is a risk, however, of undesirable side-effects that cannot be ignored (cf. chapter B.3.3.2). There is insufficient composite evidence to assess the link from the outcome level of PBF to its impact level. A study, based on the 2005 and the 2007/2008 DHS rounds by Sherry et al. (2013), supports the increase in service provision, but failed to detect the effects on health outcomes postulated to be associated with these services. While these findings place in doubt the outcome-impact link of the PBF ToC, it is impossible to rule out all confounding influences. In addition, the results reflect the situation two years previously, when PBF had not yet gained full momentum, and they were, thus, not considered as conclusive evidence. Skiles, Curtis, Basinga, and Angeles (2013) analyzed the same data sets and found that PBF triggers increased service use across all wealth quintiles, refuting the notion that PBF increases inequity, but not confirming that the PBF design is pro-poor. In conclusion, PBF does neither undermine nor support the efforts for equitable access via CBHI.

To conclude, Rwanda has experienced an impressive improvement in the health status of the population within the last decade. Nearly all national health indicators have improved substantially, which provides a very positive scenario of the current performance of the health sector and brings Rwanda on track to achieve most health-related MDGs prior to 2015. Most of the relevant indicators have improved at a much faster pace than the sub-Saharan average and its neighboring countries. Together with its partners, GDC support to the health sector has contributed to this development to a considerable extent. While the GDC approach of health systems strengthening has been an essential element within the Rwandan health architecture, however, a significant part of this impressive progress has depended, to a large extent, on the financial efforts of some relevant vertical programs with regard to malaria, tuberculosis, and HIV/AIDS prevention. Moreover, the evaluation has found a mixed synopsis with regard to GDC contribution to reduce health disparities in the health status of the population. On the one hand, its multi-level approach has been highly effective with regard to improving overall coverage and access to health services through the support of flagship programs, such as CBHI and PBF. Complementary interventions, such as social funds, have accompanied these larger programs in the transition period towards more poverty-oriented strategies. On the other hand, its

focus on some specific target groups and remote areas has not been sufficient to reduce socioeconomic, age-, gender-specific, and rural-urban disparities in the health status of the Rwandans.

3.5 Coherence, Complementarity and Coordination

GDC contributions to achieve coherence, complementarity, coordination, and harmonization between DPs in the context of the SWAp and joint financing mechanisms

The program was well aligned to the HSSP and worked through the structures and mechanisms of the SWAp (cf. chapter B.3.3.1). GDC contributed continuously to the DP group and the HSWG as main forums for donor coordination. The same has applied to those TWGs that GDC focused its efforts on (cf. Chapter B.3.3.1). GDC has placed special attention on the development and strengthening of SWAp (e.g., through supporting the development of the SWAp-manual and its roadmap and through the initiation of the SWAp task force in 2012). GDC also has directly supported the SWAp coordination unit in MoH with the assistance of an integrated expert (2011–2013).

GDC has been proactive in promoting the idea of a SWAp not only in its entirety, but also on the level of the different components. GTZ/GIZ has co-chaired the TWG on HF in SWAp and was highly appreciated by other members for its technical expertise and the experiences shared from the districts in the forum (INT SWAP 8, 16, 19, 22; Doc.39; Doc.43). Regarding SRH, GDC has focused its contributions on TWG in relation to family planning and adolescent SRH. The TWG on human resources was considered weak by DPs and GDC managers. Dialogue, strategy development, and technical advice mainly took place outside the formal SWAp structure. The HRH strategic plan was formally discussed in TWG, but the main inputs and decisions were made outside the structure (INT EXP 5; G INT GEN 4; INT SWAP 6; INT HRD 21).

Regarding SBS, GDC has placed special effort into harmonizing the contributions by Belgium, United Kingdom, and GDC. The SBS, provided by Belgium and Germany, was jointly designed and

had included pre-requisites for disbursement, performance triggers, and benchmarks (Doc.48). The United Kingdom designed its SBS separately, excluding specific pre-requisites as conditionality for disbursement (DFID, 2008; G INT GEN 4) and it released funds before the pre-requisites for the SBS, provided by Germany and Belgium, had been fulfilled (INT SWAp 4; G INT SWAp 16; INT EXP 6, 10, 16). This lack of coherence and harmonization had negative implications on the ability of the SBS donor group to speak with one voice.

GDC has placed special effort in establishing CDPF, given that it proved to be more cumbersome than had been expected to reach a joint understanding of how to support capacity development most effectively and how to agree on joint procedures. While some DPs viewed the support to CDPF as an entry point for policy dialogue in the sector and for strengthening capacity development and strategy formulation, others saw it as a financing mechanism (INT SWAp 4, 7, 8). At one point, the GDC considered intervening at the level of MoH to secure the continuation of CDPF, since Belgium and the United Kingdom were about to retreat due to the apparently substantial transaction costs (INT EXP 15, 20). GDC also pushed, together with other CDPF partners, for more transparency and efficiency, as reflected in the response and recommendations they presented to MoH subsequent to the publication of the external audit report.

The quality of donor coordination has always had to rely on key representatives of the participating DPs to add enthusiasm and commitment. GDC, through its health sector coordinators, has played an important role in this context, but donor coordination was much weakened when GDC discontinued its contributions during the course of 2013 (INT DP 1; INT EXP 20). Despite the strong ownership of MINECOFIN and MoH, the SWAp process lost momentum (see chapter B.3.3.1), which resulted in JHSR not taking place in April 2013 and HSWG not succeeding in organizing its work in an effective and dynamic manner, among other factors (INT DP 1; INT EXP 20; INT SWAP 21). With a reduced number of DPs in the health sector and an even more dominating role by the US Government, this could indicate that bilateral

cooperation between GoR and the US Government has taken the lead to the detriment of the SWAp process.

Coherence, complementarity, coordination, and harmonization within GDC

There is sufficient evidence to conclude that synergies between technical and financial cooperation have been realized. Coordination and cooperation mechanisms have been developed between both organizations and are functioning well. They have instrumentally tackled the unexpected challenges, (e.g., after it became apparent, in late 2011, that disbursed SBS funds had not been transferred to the health budget (cf. Chapter B.3.3.1)). Although GDC health sector coordinators had technical cooperation background, they were successful in meeting the requirements from technical and financial cooperation.

DED health coordinators¹⁰³ were assigned various tasks, but they did not have steering or staff management responsibility and were dissatisfied with the unclear mandate. At the same time, they felt pressured by the fairly critical perception of their role by development workers. None of the interviewed development workers had considered DED health coordinators to have been an important factor in their work; some, in fact, considered their role as counterproductive (INT HRD DW 6, 8). This perception was not only in parallel to the unclear mandate of coordinators, but also to the fact that they were not medical doctors.¹⁰⁴

Cooperation between DED and GTZ became more profound through the step-by-step process of program development (cf. Chapter B.1.1 and B.2.1). Interviews and reports on the part of development workers have produced evidence of formal coordination mechanisms, including internal team meetings and shared planning sessions having increased over the course of the period. Similarly, development workers became increasingly involved in activities at the national level, such as in the development of treatment guidelines and protocols. Program development also was – from the perspective of development workers and GDC program managers – a difficult integration process. Some of the

development workers having been interviewed emphasized that although personal communication with GIZ program managers was positive, the organizational and hierarchical structures, at times, made cooperation difficult (INT HRD DW 1, 9).

“Personally I had a very good relationship with the GIZ program manager. But formal cooperation with GTZ was often painful and obstructive. We had to beg for money for each and every instrument we needed. One should have given us more freedom to handle” (INT HRD DW 9).

Development workers had understood that they, themselves were to act on their own initiative – as was perceived by others – and were not always willing to take on a subordinate role for the common good of the program (INT HRD DW 1, 6, 8, 9, 10). Furthermore, the development workers in the role of medical doctors were confronted with life and death, on a daily basis, and had to struggle with difficult working conditions in hospitals. Some felt that their own initiatives and commitment were not sufficiently valued, neither by DED nor by GTZ management, and that the structures of both organizations were not adequately flexible (INT EXP 5; INT HRD DW 6, 8, 9). From the perspective of GDC program managers, development workers did not have a common corporate identity, and, therefore, they were unable to critically reflect on their own role in the program (INT SWAP 9). Under these circumstances, it was hard to establish a shared understanding of what capacity development meant in the context of the Rwandan-German health program.

During the course of the program’s development, DED and GTZ signed a cooperation agreement to enhance the coordination and communication process. Those communication processes and the decision-making by the GTZ program management, however, were sometimes perceived as non-transparent by DED staff (INT EXP 5, 11). This experience has been assessed as a learning opportunity to improve the transparency in communications between both organizations (INT EXP 11).

¹⁰³ DED health coordinators were responsible for introducing development workers to their workplace, coordinating their work, ensuring the overall quality of DED contributions, establishing linkages with Rwandan partners and the GTZ/GIZ program management, and appraising new projects.

¹⁰⁴ Medical doctors, used to the hierarchy that exists in German hospitals, found it difficult to accept and recognize the authority and competence of public health specialists.

The merging in 2011 of GTZ, DED, and InWEnt¹⁰⁵ into what became GIZ has made the integration process more challenging. This was more apparent when a number of development workers resigned because of their dissatisfaction with the transition process (INT HRD EH 2).

A cooperation agreement to clarify roles, responsibilities, and procedures between InWEnt and GTZ was put into effect.¹⁰⁶ By and large, collaboration between both organizations has been smooth, but in terms of hospital management, opportunities for coordination and synergy were not grasped. Beyond the involvement of GTZ in proposing ILT course candidates and supporting task force members, there was little substantial relationship between the ILT program and the country-based activities of GTZ in hospital management, given that GTZ was hardly aware of the knowledge transfer projects implemented by alumni (INT EXP 4, 5; INT RP 34). This was primarily due to the fact that GTZ only supported five specific districts from where alumni were absent. More substantial documentation of these projects by ILT alumni, with the support of InWEnt, could have been provided for knowledge sharing and an exchange of lessons learned.

In 2005, a platform between all German governmental agencies and NGOs involved in the health sector was established as the German Country Team Health. In addition to the bilateral development agencies, this new team included the partnership (*Jumelage*) of the German Federal State of Rheinland-Pfalz and Rwanda and NGOs, such as Misereor and Christoffel-Blindenmission. Assessing the effectiveness of the German Country Health Team from a 3C-model perspective would have gone beyond the scope of this evaluation.

3.6 Assessing the theory of change

This section includes the assessment of ToC that reflects the intervention logic of the Rwandan-German health program between 2007 and 2012. The fact that “assessment” differs from “verification” should be emphasized. While the latter refers to the results of implementing ToC (cf. Chapter B 3.3.1–3.3.4), the former relates to the initial ToC. Assessing ToC, however, includes an (eventual) shift of priorities during the course of the implementation process.

The overall ToC and the intervention logic for each component are discussed in Chapter B. 3.3.1–3.3.4. and are presented in detail in Annex D. ToC, therefore, relies on the joint program proposal of KfW, GTZ, DED, and InWEnt. First, the evaluation team reconstructed the ToC, based on the program’s intervention logic. The intervention logic was then adjusted to the analytical framework outlined in Chapter A.2.1. Feedback was gathered from former program staff and ToC was adjusted accordingly without the verification of stakeholders. The underlying ToC, therefore, relies exclusively on the 2007 program proposal. In 2010, some minor adjustments to the program’s intervention logic were made, which are considered in the following analysis.

In order to assess ToC of the Rwandan-German health program, the evaluation team has used the criteria suggested by Connell and Kubisch (1998, p. 3):

1. *“It [the ToC] should be plausible. Do evidence and common sense suggest that the activities, if implemented, will lead to desired outcomes?”*
2. *It should be doable. Will the economic, technical, political, institutional, and human resources be available to carry out the initiative?”*
3. *It should be testable. Is the ToC specific and complete enough for an evaluator to track its progress in credible and useful ways?”*

¹⁰⁵ There are different perceptions on the nature of this merger because it was encouraged by BMZ and because it concerned three organizations differing considerably in terms of size, mandate, and culture.

¹⁰⁶ To be borne in mind is the fact that InWEnt was not decentrally structured as were DED and GTZ, which certainly was not conducive to a smooth coordination process at the country level.

Plausibility

By and large, the evaluation team considers ToC to be plausible. However, the following features lack plausibility:

- Regarding SWAp support, it is not convincing how outcome 5.4.a (“Ownership and public financial management of MoH are improved”) contributes to the achievement of outcome B (“The health system responds better to the needs and priorities of the Rwandan population, especially the poor”). There are missing links which should be made more explicit
- Regarding the HF component, it is not plausible how output 3.3 (“facilities are appropriately evaluated and motivated by PBF system”) leads to outcome 3.4 (“the structural quality of health services is improved”). As elaborated in Chapter B.3.3.2, the current evidence base does not lead to the conclusion that improvements in the quality of services are strictly attributable to external incentives under PBF. ToC, therefore, should represent more explicitly how performance assessments are supposed to trigger motivational mechanisms and behavior change.
- Concerning the SRH component, it is not convincing how output 4.3.b (“The private sector provides workplace programs for members and their families”) contributes to achieve outcome 4.4 (“Target groups benefit from reproductive health and family planning services”). There are missing links that should be made more explicit.
- In relation to the HRD component, it is not plausible how output 6.1 (“Provision of medical equipment to district hospital”) leads to output 5.4 (“Improved medical services are provided by district hospitals”). The provision of medical equipment can lead to improved medical services only if their use and maintenance has been improved.

Doability

By and large, there are sufficient indications that resources were available to carry out the respective activities. The program logic, however, is presented in such a way that implementation arrangements are not always evident. It should also be noted that the decision of GDC to put social funds at the disposal of the health facilities in the five districts it supported indicates

that the intended change regarding improved access to health services through CBHI was not doable to the extent intended.

Testability

In order to allow for ToC to be testable for the purpose of this evaluation, the evaluation team has adjusted it according to its analytical framework (cf. Chapter A.2.1). Despite this important step, there remains considerable paucity in terms of testability due to the program having applied national indicators (HSSP) instead of program-specific indicators. This is pertinent from an alignment perspective, but unsatisfactory from an evaluation standpoint. This has already been highlighted by the project progress review, conducted in 2010, which drew attention to this *“well-known difficulty for programmes that are completely integrated into the partner planning as it is the case for this programme, and as it is desired according to the Paris Declaration. ‘Lower the flag’ is the principle, which means not only the specific German contribution counts, but also the harmonized and aligned contribution of all DP and their different modes of delivery.”* (Doc.45). It is against this background that the evaluation team has opted for a contribution analysis (cf. Chapter A.2.2), in order to assess the GDC contribution in the context of the health SWAp. Despite the use of the contribution analysis, however, the restrictions in terms of testability of ToC could not be overcome (cf. A.2.2 for more details).

Program implementation and adjustment of the theory of change

Priorities have shifted during project implementation, partly leading to the adjustment of ToC. Some elements of ToC have not been implemented as intended.

Decentralization of SWAp was not reflected in the initial 2007 ToC. In the implementation process, it has become more and more apparent that SWAp structures and mechanisms need to be decentralized in order to create ownership among health-related stakeholders at the district level (cf. Chapter B 3.3.1). From 2010 onwards, therefore, the program has placed more emphasis on supporting SWAp-decentralization. This shift of priorities, however, was not made explicit through an adjustment to ToC. This was

the case for adolescent sexual reproductive health, which drew more attention from 2010 onwards on young adults as a target group for the package of SRH-related services.

The decision of GDC to place the social funds at the disposal of the health facilities in the five districts, supported by GDC, was taken during the implementation process. It reflects that the equity issue still deserves special attention, despite the improved CBHI-coverage, since the new CBHI policy that replaced the capitation system with a contribution system, based on socio-economic stratification (cf. chapter B 3.3.2), was only implemented from 2010 onwards.

Activities relating to the technical and logistical advice of district hospitals to provide water, electricity, and biogas (HRD component; processes 5.1) apparently have not been implemented. There is no evidence for the reasons. The same applies to workplace programs (SRH component; output 4.2.b and 4.3.b).

3.7 Phase-out of Rwandan-German cooperation in the health sector

In 2010, GoR proposed a policy on the Division of Labor in line with the 2005 Paris Declaration on Aid Effectiveness. The policy aims to improve aid effectiveness by reducing transaction costs and the fragmentation of the donor landscape, and by focusing on alignment to national priorities and comparative advantages of DPs (GoR & MINECOFIN, 2010). In accordance with this Division of Labor policy, DPs are to concentrate on no more than three sectors. Concrete plans have been developed for each sector and for the DPs by GoR.

For Rwandan-German cooperation, the changed Division of Labor has implied an exit from two sectors (justice and health) and a concentration on three sectors: vocational education, private sector development, youth, and decentralization and governance (GoR & MINECOFIN, 2010). The decision was affirmed by the 2011 bilateral government consultation between Rwanda and Germany (Doc.20). To ensure alignment with national strategies,

a transition period of two years was defined. The exit strategy translated into a roadmap, developed by GDC and MoH, to ensure an effective and sustainable handover to partner institutions and other DPs (Doc.20). As a final step of the phase-out process, the Rwandan and the German Governments agreed to conduct an independent evaluation of Rwandan-German cooperation in the health sector over the period of 30 years (with focus on the period of 2004 – 12), to be carried out by DEval. A joint closing event was conducted in December 2012.

The implementation of the exit strategy began in the first half of 2011, when GDC began scaling down support in some areas. A gradual approach was applied over the transition period. Following a joint review of all implementing agencies of GDC in 2010, milestones were proposed for each component, including the gradual end of support in core intervention areas, such as social marketing and medical education (Doc.29). Other health sector DPs received regular information on the progress of implementing the exit strategy and the main intervention areas that were affected (Doc.20). The initial schedule to coordinate the handover process until the end of 2011, however, was met neither by the Rwandan nor the German Government due to other priorities and time constraints at MoH (Doc.20). During this time, some counterparts felt inadequately informed, leading to misunderstandings over the background of the Division of Labor and its implications at central and decentralized levels (G INT GEN 4; INT SWAp 6; INT SWAp 18).

Although MoH assumed responsibility to lead the handover process, its support was limited (Doc.28). Accordingly, the specification and formulation of handover options were not finalized until April 2012, when GDC formulated an urgent request to MoH to ensure donor coordination. This resulted in intensive consultations between all DPs and Rwandan partners at the national and district levels. In this process, SWAp structures and procedures facilitated consultation, coordination, and mutual agreement among GDC, MoH, and DPs. The joint roadmap was only finalized at a planning workshop in May 2012, during which all DPs presented their planning for subsequent years (Doc.20). With respect to GDC, financial cooperation was supposed to end by August 2012 and technical

cooperation at the end of 2012 (Doc.20). Remaining gaps and needs for actions were discussed in the context of DP meetings and TWGs in order to avoid risks regarding the sustainability of contributions from GDC technical and financial cooperation at the central and decentralized levels (Doc.20).

In view of the strong ownership of GoR and the firm establishment of SWAp structures and mechanisms, the chances for the health program's sustainability in various areas are quite high. The national health sector strategy is fully embedded in the overarching Rwandan policy framework, such as Vision 2020 and EDPRS, important milestones have been reached, and Rwanda is on track to achieve most of the health-related development goals. Moreover, the GDC approach to health systems strengthening has contributed to improve the Rwandan health architecture, including the joint decentralization efforts. In light of these achievements, GoR is confident that the health sector will manage to cope following the end of GDC support (G INT SWAp 2). Two interviewees, however, clearly stated that considering the length of experience and quality of support provided by GDC to the health sector, the German Government should not have been asked to retreat (INT RP 1, 8). These views converge with those of health service providers who were interviewed in June/July 2013 in two of the districts that were supported by GDC. They regretted the retreat of GDC from the health sector and underpinned their arguments by drawing attention to the gaps in the provision of funds and services, which cannot be filled after the GDC phase-out (comparative case study). In this sense, target districts are now facing challenges, such as high staff turnover, difficulty in recruiting qualified health professionals, and reduced capacity to sustain PBF in key district facilities.

In order to attain sustainability in the main former intervention areas of GDC, there are several challenges to be faced. The persistent dependence of the Rwandan health sector on external support can be considered as the main challenge. Other issues relate to the continuation of services and support mechanisms which, so far, had been assured through contributions from GDC. As all these issues have been discussed in detail in Chapters B. 3.3.1–3.3.4, there is no need, in this chapter, to further elaborate on them.

To conclude, while a transition period of over two years was scheduled, for some interventions the phasing-out period has been rather short and, as the transition proceeded hand in hand with the ongoing program cycle, it posed high challenges to the process. Despite the process having been initiated by GoR, its support to the coordination with other DPs and decentralized levels was limited and, to a great extent, was left to GDC. GDC focus on the support of Rwandan strategies and approaches, in line with SWAp, has strengthened the probability that services in the main intervention areas can be sustained after the phase-out. Considering the strong ownership of GoR on the one hand and the SWAp dynamics having lost momentum on the other, the chance for the sustainability of the health program in various areas is moderate to high. This view also reflects the strong reliance of the health sector on external funding.

3.8

Successful and less successful aid modalities and instruments

This section deals, primarily, with the aid modalities and instruments during Phase III of Rwandan-German cooperation in the health sector. However, a highlight on those that prevailed during Phases I and II will put into perspective the changes to the ones emphasized by GDC.

The types, importance, and combination of modalities and instruments changed considerably during the three phases of Rwandan-German cooperation in the health sector. It should be taken into consideration, however, that their spectrum had also changed considerably, having become broader.

During Phase I, technical and personal cooperation were combined (DED). GTZ provided a financial contribution to a project entirely implemented by DED, as it had done in similar projects in Benin and Burkina Faso. This move enhanced cooperation between DED and GTZ and has, thus, become a favorable condition for program development since Phase II. GTZ also implemented a family planning project in close collaboration with KfW, whereby technical and financial cooperation were closely linked from project inception.

Since there was no multi-level approach to guide GDC contributions and the fact that DED development workers had to provide support to hospitals and health centers in seven different prefectures, it was not until the beginning of Phase II when GDC contributions targeted only two prefectures (Butare and Byumba). It was not until 2003, however, that GDC assigned an international long-term expert and combined advisory assistance at the national level with support to implementation at the district level.

During Phase II, financial cooperation was more important, when a country-wide program on contraceptive social marketing was implemented by PSI and financed by KfW. At the same time, and with health becoming a key priority in 2002, GDC began to take on a more program-based approach. The strengthening of cooperation between the organizations within GDC led to a joint program. As of 2005, GDC support has been aligned to national health planning activities in the context of SWAp, with a particular focus on poverty-oriented health systems development.

Regarding Phase III, SWAp, as an aid approach, was a determining pre-condition for the successful combination of aid modalities and instruments that were supported by GDC. Structures and mechanisms were established to coordinate and harmonize the contribution of different DPs in the health sector. GoR took ownership of the process from an early stage, with MINECOFIN taking the lead to align interventions in the health sector with Rwandan development priorities. This is reflected in HSSP, serving as a strategic framework for the development of the health sector, and under EDPRS as the overall development framework. SWAp served as a forum to improve donor coordination. HSWG, together with the various TWGs, provided relevant forums for concept and strategy development and for learning from ongoing implementation experiences.

To explore fully the effectiveness of SWAp in the alignment and harmonization of resources of the various stakeholders at all levels, decentralization was especially important. Creating respective structures and mechanisms at the district level

began only in 2010. Their dynamics, however, have not yet been developed and strengthened in a way to become self-sustaining.

Challenges exist with the coordination and harmonization with other ministries in terms of SWAp; examples relate to the Ministry of Education in terms of medical education and to the Ministry of Local Government in terms of decentralization.

GDC has played a major role in the process of the SWAp design and in establishing and strengthening the different structures and mechanisms. GDC, therefore, has contributed by having recognized the value addition of SWAp to aid effectiveness, in accordance with the priorities of the Rwandan and German Governments and the Paris Declaration.

GDC has underlined the importance of SWAp by engaging in joint financing modalities. SBS can be considered as somewhat successful in terms of channeling funds directly to the national budget, with a special emphasis on allocating a greater proportion of public funds to district health systems strengthening. SBS could have been more successful had all contributing donors (i.e. Belgium, United Kingdom, and GDC) harmonized their procedures towards a joint agreement with GoR. The leverage effect of SBS could have been higher had a more substantial percentage of donor funds been channeled through it. A more efficient procedure for the flow of funds within the government system also could have contributed to making this aid modality more successful.

GDC contributions have benefited from the combination of various aid modalities through SWAp. While GDC has not been one of the major donors in the health sector, according to aid volume (cf. Chapter A.3.2), it has realized an increased leverage effect by combining them. GDC has deliberately focused on health systems strengthening as being complementary to vertical programs, favored by other DPs. GDC, thus, has contributed to redress the balance between vertical and horizontal programs in the health sector.

Basket funding through CDPF was another aid modality that came into play. Its application, so far, is considered as having been less successful, given that the process to establish it with a joint understanding of how to most effectively support capacity development and having joint procedures, proved to be more cumbersome than had been anticipated. The lack of strategic orientation in the first phase of CDPF resulted in funds being dispersed for the emergency funding of capacity development activities rather than for strategic objectives. Transaction costs, perceived as significantly high, led to the near retreat of Belgium and the United Kingdom from participating in CDPF. A strategic intervention from GDC was crucial for CDPF to enable its survival at a difficult period.

During the second stage of CDPF, the HRH strategic plan provided adequate direction for the use of funds. Since implementation of activities is still under way, it would be premature to assess how successful this aid modality has been. Its scope, nevertheless, remains fairly limited, given that the new US Government-funded HRH program has not been integrated into CDPF.

GDC has successfully combined various instruments, such as technical (GIZ) and financial (KfW) cooperation, advisory services from development workers (DED/GIZ), integrated experts (CIM), and human capacity development (DSE/InWEnt/GIZ). This demonstrates that GDC has combined project-based aid with joint financing modalities under a SWAp umbrella.

Technical cooperation has successfully followed the multi-level approach; that is, combining advisory support at national and district levels. The same has applied to capacity building. GDC has thus been able to transfer its experiences from implementation at the district level into its concept and strategy development at the national level, with TWGs playing a major role. Technical cooperation has comprised advisory services by development workers (DED/GIZ) and long-term experts, with the former focusing on the district level and the latter focusing on the national level. GIZ has also seconded national staff as technical advisors to the five districts, supported by GDC. Special

emphasis is placed on the role of health sector coordinators who have played a crucial role in successfully combining various instruments and in transferring their experiences from the program's implementation into sector and policy dialogue.

There is sufficient evidence of the synergy effects from combining various instruments, illustrated by the HRD and SRH components. Advisory support at the national level has contributed to the development of national human resources strategies, including hospital management. The training of specialists was supported in the context of a regional human capacity development program, leading to the establishment of a task force in MoH. Technical advisors were involved at various levels to support the task force members to effectively transfer their skills and knowledge (e.g., through train-the-trainers workshops) on hospital management. Regarding medical education, the work of development workers (DED/GIZ) was supported through financial cooperation to provide the necessary equipment to teaching hospitals.

With regard to the SRH component, advisory support was provided for policy development, as was financial cooperation to contraceptive social marketing. The implementing agency, PSI, was supported by a development worker (DED/GIZ), and development workers (DED/GIZ) also promoted adolescent SRH through advisory services and capacity building at the district level. With regard to SWAp and joint financing modalities, the "integrated expert" (CIM) instrument was effectively used to strengthen the SWAp coordination unit within MoH.



C.

CONCLUSIONS AND RECOMMENDATIONS

1. Conclusions

This section presents the main conclusions that derive from the results of this evaluation. First, concluding remarks include the entire program period of GDC. Second, specific conclusions that have emanated from the SWAp period and the three components, in particular, are also presented.

The conclusions contain ratings of three levels (i.e., “low”, “moderate”, and “high”). Instead of following a scoring system with quantifiable descriptions for each level, the ratings have been gained from the mainly qualitative analysis presented in Part B of this report.

Evolution and adapting to changing contexts

Several instruments and aid modalities have emerged during the course of GDC’s 30 years in the health sector of Rwanda. Throughout this period, there has been a trend from fragmented and decentralized service delivery towards program-based health systems strengthening.

During Phase I, technical cooperation was combined with personal cooperation (DED). This matched similar projects in Benin and Burkina Faso, where GTZ had provided financial contribution to a project entirely implemented by DED. Cooperation between DED and GTZ, thus, was enhanced and was a favorable condition for program development during Phase II. GTZ also jointly implemented a family planning project with KfW, which led to close coordination of technical and financial cooperation from its inception. There was no multi-level approach to guide GDC contributions during that period, and emphasis was placed on providing support at the decentralized level.

With regard to adapting to the changing context, GDC interventions essentially did not alter during Phase I, although the political, economic, and social trends would have suggested the need to adjust to the growing ethnic, social, and political tension. Individual staff, however, adapted project activities accordingly as a means to safeguard their relevance and effectiveness. While

there had been voices within GDC and internationally calling for attention to the sharpening political conflict, GDC misjudged the situation and only reacted at the outbreak of violence in April 1994 by evacuating its German project staff.

While there have been some elements of continuity in GDC assistance during Phase II, the rechanneling of support, in accordance with the changing context following the genocide is considered a dominant characteristic. GDC then began to concentrate its support more intensively on two specific *préfectures*, but it was only in 2003 that GDC started to combine advisory assistance at the national level with support to implementation in the districts. With health becoming a key sector for GDC in Rwanda in 2002 and program development beginning at the same time, GDC consequently evolved to pursue a more program-based approach.

The intensification of cooperation between the different organizations within GDC led to the design of a joint program. Since 2005, GDC support was aligned to the national health planning process in the context of SWAp, with a particular focus on poverty-oriented health systems development. With a long-term commitment to support the health sector in Rwanda, affirmed in 2002, GDC was in a position to begin scaling up innovative initiatives that were fed into national policy development (e.g., CBHI).

The overall financial contribution of GDC over the 30 years has been rather modest, compared to its contribution to other sectors in Rwanda and to that of other donors in the health sector. For most of this period, GDC has focused on technical and personal advisory assistance and project-based financial cooperation. It was only in the last phase of cooperation that the financial volume was significantly increased, with the introduction of joint financing modalities. In response to the aid effectiveness agenda, GDC has engaged in SBS and pooled funding, while other DPs still hesitate to take this step.

Sector-wide approach, sector budget support, and capacity development pooled fund

It can be concluded that GDC support to SWAp and joint financing modalities have reflected, to a large extent, the priorities of the German and Rwandan Governments. Emphasis has been placed on technical and financial cooperation. GDC support, in terms of technical assistance, has reflected the priorities of the German Government to a larger extent, since GoR has given clear preference to budget support and pooled funding.

The aid modalities, supported by GDC, have been appropriate to reach the objectives set by Rwandan and German partners. SWAp structures and mechanisms at the national level have been operating effectively at varying degrees with relation to the various TWGs. GDC efforts in making these structures and mechanisms functional has been highly effective. The SWAp structures and mechanisms at the decentralized level, however, are not yet sufficiently running. Support in this respect could have been more effective, with a later phase-out of Rwandan-German cooperation in the health sector.

The potential of SBS as an aid modality could not be fully applied due to a limited leverage effect and the lack of coherence among contributing DPs. So far, basket funding (CDPF) has contributed – to a moderate extent – to strengthening institutional capacities in the health sector, given that the funds have been spent in an ad hoc manner during the first phase of CDPF. The effectiveness of GDC support in making CDPF operational and in strengthening its strategic direction can be rated as high. There were deficiencies with regard to ‘efficiency’ as far as SBS and basket funding (CDPF) was concerned. Transaction costs could only partly be reduced.

In spite of the high ownership by GoR, the dynamic of SWAp has lost momentum. The same applies to the scope and prospects of joint financing modalities (SBS and basket funding) in a situation where the health sector is still very much dependent on external support.

Health financing

The program’s HF component supported two health reforms that can be considered as flagships among Rwanda’s sector policies: (1) the challenging endeavor to introduce a country-wide community-based health insurance (CBHI) in a low-income country and (2) the establishment of a far-reaching system of PBF (PBF), which seeks to incentivize health professionals to improve their services through reimbursements. The goals and design of the program’s HF component were, overall, highly relevant when measured by the high degree of alignment to Rwandan and German priorities.

Given the impressive trend of increasing coverage rates of the CBHI scheme in Rwanda (currently about 90% of the Rwandan population is covered), the effectiveness of GDC efforts regarding CBHI is rated as high. Efforts directed at the improved health equity of CBHI are rated as moderate to high as the barriers to access to finance have been pushed to higher care levels and to the economically less vulnerable. The evidence gathered confirms that PBF does increase service orientation and the outputs of health professionals, but it also suggests that negative motivational side effects and resource constraints are real. The effectiveness of support to PBF is, thus, rated as moderate. Summarizing these effectiveness appraisals for single HF mechanisms provides an overall effectiveness of the component as moderate to high.

Conclusions on the efficiency of the HF component are limited due to the low availability of items of evidence. Whereas this constraint especially applies to PBF, there are indications of improving efficiency for CBHI. Challenges for the Rwandan HF system constitute the high extent of fragmentation between different mechanisms, such as CBHI and PBF, and the long delays to reimburse district structures, yielding an overall moderate efficiency of the component.

The financial sustainability of CBHI and PBF can be considered as low due to the high dependency on foreign support. While recent policy and legal reforms – partly with GDC contributions – paired

by a large share of household-generated funds are promising for prolonging the positive effects of CBHI in the long run, ending the support to PBF has resulted in financial gaps for the district hospitals under direct support by GDC. The gathered evidence, therefore, suggests that the sustainability of GDC contributions has been low.

Sexual and reproductive health

GDC support to SRH was highly aligned to the objectives and priorities set by the Rwandan and German Governments with regard to global health- and human rights-based principles. The strong alignment of GDC support to national priorities and the consideration of the prevalent country characteristics have led to a high acceptance of the priorities and interventions of GDC by partner organizations and beneficiaries.

In terms of SRH, the GDC multi-level approach at the national and decentralized levels was accompanied by a comprehensive support strategy that focused on the public and private sectors. While the public sector contribution successfully strengthened SRH at the policy level and increased the coverage of professional SRH services throughout the health districts, support to the private sector was bound to social marketing, an approach that contributed to the increase of (1) SRH-related knowledge and (2) and the use of contraceptives throughout the Rwandan population.

At the national level, GDC support to the public sector has contributed to the accentuation of SRH-related topics in TWGs through which relevant policies and plans were provided. GDC has contributed effectively through agenda setting and technical inputs in specific intervention areas, such as adolescent SRH. This strategy has provided an important backbone to interventions at the decentralized level. However, not all topics that were addressed, policy-wise, were adequately addressed and implemented in time at the decentralized level (e.g., gender-based violence).

At the decentralized level, public health centers and secondary health posts have been successfully supported to increase the

number of health care professionals with expertise in SRH. The support to community-based concepts, such as CHWs and peer educators, has been relevant and effective to reach the respective beneficiaries through a suitable strategy to link communities to higher-level services in the health centers and district hospitals. Moreover, the combination of information campaigns with commercial marketing techniques for contraceptives through private sector social marketing has appeared to effectively contribute to awareness raising and attitude and behavior change. In addition, potential synergies between public and private sector support were created at the community level, most notably through linking private sector social marketing and community-based concepts of CHWs and peer educators. Linkages were also created with regard to disease prevention (e.g., HIV/AIDS prevention and tuberculosis).

While the overall GDC strategy to SRH was deemed suitable to reach the respective target groups and objectives set, technical and financial support to the private sector fell short of sufficiently strengthening its role with regard to information services on the one hand and the provision of contraception on the other in a sector environment where MoH still needs to play a crucial role. This is underlined by the continuing limited market share for contraceptives, provided through commercial marketing techniques, and the limited coverage of SRH-related information campaigns in remote areas. Moreover, socioeconomic differences remain with regard to knowledge and service utilization. Further strengthening of the private sector would meet the priorities of GoR and help to reduce the costs for the public sector in the future.

To conclude, the overall effectiveness of GDC support to SRH can be rated as moderate to high. This also holds true with regard to the sustainability of the remarkable achievements. On the one hand, SRH is recognized as a key priority in the future of health sector strategy in Rwanda; on the other hand, it faces persistent future challenges due to the continuing limited technical capacities of health professionals and the considerable disparities with regard to service utilization throughout the population.

Human resources development

The GDC interventions in the HRD component have been highly relevant for the component and program objective. The component has contributed to the national strategy on human resources in health, meeting the priorities of the Rwandan and German Governments and the needs of the Rwandan population.

GDC has contributed in a highly effective manner to increase the number of Rwandan health professionals and to enhance their skills and knowledge. GDC support also has had a long-term positive effect on the mindset of medical students, trained by development workers, and of ILT alumni. Despite the many barriers, they were able to apply their knowledge in their working environment and have contributed to improved quality of care in Rwandan hospitals.

The continuation of the internship program is a long-lasting positive and systems-building effect of GDC support, despite the organizational challenges it still faces. Scaling-up efforts have been achieved with the establishment of the hospital management task force and the country-wide training of hospital administrators.

The efficiency of the ILT intervention was relatively low. The high absolute costs of the ILT course in Germany were also a result of the relatively intensive German language course. The costs could have been substantially reduced had the ILT course been conducted in English, especially since the new language skills were considered insufficient and of low relevance by training participants.

The strong political will of GoR to continue to invest in HRH can be seen as a positive precondition for sustaining the achievements that have resulted from GDC support to HRD. However, maintenance of equipment at health facilities over the years has been a serious challenge and is a persistent risk to the sustainability of services in all hospitals. Similarly, the motivation of Rwandan doctors to remain in the public health sector, particularly at the district level, for a long period of time is quite low.

Impact

In the last decade, Rwandans have experienced a remarkable improvement in their health status and the country is now on track to meet most of the health-related MDGs prior to 2015. GDC, therefore, has contributed to positive changes with regard to mortality and morbidity, risk protection, and fertility reduction. Nearly all national health indicators have improved substantially, making Rwanda one of the top performers in Sub-Saharan Africa.

GDC support to the health sector has contributed to this development to a moderately high extent. On the one hand, GDC has clearly contributed to the improvement of the health status of Rwandans through various interventions in all three components. The multi-level approach of GDC at the national and decentralized levels has proved highly effective with regard to the improvement of overall coverage and access to health services, particularly through CBHI and HRD. Complementary interventions in the districts supported by GDC, such as social funds, have accompanied CBHI in the transition period towards a more poverty-oriented health insurance system. On the other hand, the evaluation finds a mixed scenario with regard to the effectiveness of GDC in reducing health disparities in the health status of the Rwandan population. GDC's resulting effort to focus on some specific target groups and remote areas has been only moderate and, hence, insufficient to reduce socioeconomic, age-specific, and rural-urban disparities in health status. Gender differences remain and strategies, such as gender-based violence, have been only moderately effective at the decentralized level to date.

Moreover, while the GDC approach to health systems strengthening has been an essential element within the Rwandan health architecture, a significant part of the impressive progress has depended on the large financial efforts of some relevant vertical programs relating to malaria, tuberculosis, and HIV/AIDS prevention.

Coordination, coherence, complementarity, harmonization

There is sufficient evidence to suggest that synergies between technical and financial cooperation have been actualized.

Coordination and cooperation mechanisms between both organizations have worked well. Program development has contributed to improved coordination and harmonization between DED and GTZ, but sometimes did prove to be a difficult integration process.

Phase out process

In accordance with the Rwandan policy on the Division of Labor, Germany ceased its support at the end of 2012. Even though a transition period of two years has been scheduled, for some handover processes this time frame was rather short. As this occurred within an ongoing program cycle, it posed high challenges to the organization of the exit strategy. Additional time resources, in accordance with the overall program cycle, would have been useful and should have been negotiated.

Even though the process was initiated by GoR, support to coordination with other DPs and decentralized levels was limited and, to a great extent, left to GDC. It can be concluded that GDC support could have been more effective and sustainable through a prolonged phasing-out period.

Considering the strong ownership of GoR on the one hand and SWAp dynamics having lost momentum on the other, the chances for sustainability of the health program in various areas are moderate to high. The GDC focus on the support of Rwandan strategies and approaches, in line with SWAp, strengthen the probability of services in the main intervention areas being sustained after the phasing-out period. This appreciation also reflects the strong reliance of the health sector on external funding. Key DPs have reduced or will reduce their contributions and not all gaps resulting from the phase out of GDC have been fully closed by national institutions, especially at the decentralized level. With the new Division of Labor policy, however, new DPs have recently started their support to the health sector.

Successful and less successful aid modalities and instruments

GDC has played a prominent role in the design of SWAp and in establishing and strengthening the various structures and mechanisms. GDC has, therefore, contributed to the realization

of value addition of SWAp to bring forward aid effectiveness, in accordance with the priorities of the Rwandan and German Governments and with the Paris Declaration.

Combining various aid modalities through SWAp has proved highly beneficial for GDC contributions to the design and implementation of the joint health program. While GDC has not been one of the major donors in the health sector in terms of aid volume, it has achieved an increased leverage effect by combining them.

GDC has deliberately focused on health systems strengthening (i.e., a horizontal approach for improving the coverage and quality of health services) as being complementary to vertical programs. Vertical programs, especially funded by the US Government and GFATM, had become more and more important in terms of aid volume flowing into the health sector. GDC thus contributed to redress the balance between vertical and horizontal programs.

GDC has successfully combined different instruments, such as technical (GIZ) and financial (KfW) cooperation, advisory services from development workers (DED/GIZ), integrated experts (CIM), and human capacity development (InWEnt/GIZ). There is sufficient evidence of synergy effects from the combination of these instruments.

2. Recommendations

The following recommendations are derived from the conclusions drawn in the previous chapter. They have been formulated against the background of GDC in the health sector having phased out. Some, therefore, are addressed to the MoH in Rwanda with the aim of sustaining the contributions of GDC to health sector development.

Other recommendations are specifically addressed to GDC (i.e., BMZ, GIZ and KfW). Putting them into perspective, one needs to bear in mind that they only reflect the learning experiences

from Rwandan-German cooperation in the health sector. They cannot claim general transferability or applicability. They should, therefore, serve as input for the design, implementation, and phase out of program-based approaches, especially in relation to the health sector, in partner countries with similar conditions to those prevailing in Rwanda. Key characteristics in this respect should be strong government ownership and commitment for health sector development; an enabling environment for socioeconomic development for decent coverage and access to health services; and favorable conditions for decentralized health systems strengthening.

Recommendations relating to aid modalities and instruments that have been applied in the context of Rwandan-German cooperation in the health sector can be relevant to other sectors. What needs to be borne in mind, however, is that configurations of stakeholders vary considerably from one sector to another.

Those recommendations addressed to GDC are, as much as possible, specific to implications for policy development and formulation or for program implementation. The former will be addressed to BMZ, while the latter will be directed to GIZ and/or KfW.

Sector-wide approach, sector budget support, and capacity development pooled fund

MoH

1. The results of the evaluation clearly support further improvement in the overall health status of the Rwandan population, requiring the continuation and intensification of poverty-, gender-, and age-specific interventions in order to tackle inequality and inequity in the course of the current HSSP.

BMZ

2. The evaluation has pointed out that there has been a high leverage effect through the combination of various aid modalities and instruments in the context of SWAp in the health sector. A diversified portfolio of aid modalities and instruments, therefore, has the potential to increase overall effectiveness in the implementation of program-based

approaches. This needs to go hand in hand with sound policy dialogue.

3. To increase the effectiveness of SWAp, not only in the health sector, more emphasis should be placed on improving coherence among DPs, especially with regard to joint financing modalities. In addition, an agreement on the alignment with common procedures has the potential to considerably improve the leverage effect of policy dialogue
4. The evaluation has drawn attention to the challenges relating to a situation where the major DPs in the sector are not the ones in a leading role in SWAp. Future strategies, therefore, should focus more strongly on how to increase the leverage effect through policy dialogue as a means to strengthen the commitment of key DPs to aligning interventions with SWAp. This will certainly require effort from the various DPs in the lead with regard to SWAp, but GDC should explore possibilities to act as broker, which would include using its position in multilateral institutions (e.g., World Bank) to this end.
5. The evaluation has revealed that joint financing of particular intervention areas through basket funding has improved capacity development in the context of the health-SWAp in Rwanda. For future strategies to establish basket funds in relation to program-based approaches in the health sector and beyond, more emphasis should be placed on strategic orientation and joint management as a means to increase the effectiveness, efficiency, and sustainability of developing and strengthening capacities in the respective sector. This requires technical assistance to be available at program inception.
6. More emphasis should be placed on the decentralization of SWAp from program inception, given that core institutional reforms are initiated to allow local actors to participate in the decentralization process. The decentralization process should be supported by capacity building at central and decentralized levels, ideally through pooled funding. While successful support depends critically on the involvement of a number of stakeholders beyond the health sector, the multi-level approach of GDC can provide a sound basis to support the process of decentralization.

GIZ and KfW

7. It is recommended that decentralization of SWAp mechanisms and structures be strengthened at an early stage of the (health) program, provided core institutional reforms have been initiated. The decentralization process should be supported by capacity building at the central and decentralized levels, ideally through pooled funding. While successful support critically depends on the involvement of different stakeholders beyond the health sector, the multi-level approach of GDC can provide a sound basis to support the process of decentralization.

Health financing*MoH*

8. 8Rwandan subscribers to CBHI and those responsible for collecting the premiums at health centers have reported that they perceive the payment modalities of CBHI premiums (e.g., (1) the number of installments, (2) the need to enroll the entire family, and (3) the need to wait one month after payment before health services can be claimed) to be restrictive. While these modalities have been deliberately chosen to demotivate adverse selection, the evaluation team recommends consideration to lower these restrictions to ensure an equitable and consistently high CBHI coverage.
9. To provide an in-depth analysis of the potential of PBF (PBF) in Rwanda, the aspects of effectiveness and efficiency merit further rigorous and methodological research, especially with regard to (1) ruling out alternative explanations, such as a motivational increase by raising health professionals' salaries without performance evaluation and (2) appraising the cost-effectiveness of the burdensome workload.
10. Health professionals have voiced concern that PBF might exacerbate inequities between health providers, given that well-capacitated facilities will expand their head start over resource-poor facilities in the long run by achieving higher PBF returns. In addition, most of those interviewed claimed that their work environment suffered from problems not tackled by PBF (e.g., high turnover rates and lack of equipment). To avoid demotivation and/or manipulation of the system by falsifying achievement due to unrealistic goals and indicators, PBF in Rwanda should intensify capacity development in the facilities and improvements in the physical work environment.
11. Both CBHI and PBF have sought to increase the financial autonomy of health facilities at the sector or district level through reimbursements from the central level. Long delays of transactions, however, often have forced health facilities into pre-financing and endangering the possibility of autonomy. The evaluation team, therefore, recommends that the speeding up of reimbursements to decentralized levels should be tackled.
12. End users and health professionals frequently have reported the miscategorization of CBHI members into *Ubudehe* categories. *Ubudehe* is a participatory poverty assessment to classify the population regarding its economic vulnerability. Because this classification determines eligibility for different governmental social services (among them CBHI membership fees), miscategorization can force the economically vulnerable into catastrophic health expenditures. At the same time, CBHI revenues are lost due to those falsely paying less than required. While the *Ubudehe* classification is under the aegis of the Ministry of Local Government, MoH should advocate a more stringent application of the classification system to safeguard the trust of CBHI subscribers in the equity of the insurance scheme.

BMZ

13. The overall evidence of effects specifically attributable to PBF, their sustainability, and the efficiency of PBF is shaky. Related to the research requisites recommended to MoH for Rwanda, BMZ should support rigorous methodological studies on these aspects in other contexts to critically assess the potential of this approach and broaden the international knowledge base.
14. The existence of a nationwide participatory poverty mapping in Rwanda, stemming from the PRSP process and resulting in the *Ubudehe* categories, has facilitated the transition from a capitation to an income-stratified premium system for CBHI members. Similar categorization systems in other countries

should be incorporated, when designing or supporting equity-oriented social security systems.

GIZ

15. The Rwandan case highlights that social funds guarding insurance schemes can temporarily increase equity. In a period of policy transition from a capitation to a less regressive contribution system, such an approach especially could be applied elsewhere in order to alleviate catastrophic costs for health services affecting the economically vulnerable.
16. The Rwandan case, furthermore, underscores that PBF interventions should not be detached from their context. Human motivation is complex and not solely influenced by financial incentives. To foster intrinsic motivation, PBF as an institutional agreement should not only pay off in terms of money, but also in terms of praise and appreciation. It is, therefore, recommended that future PBF interventions are combined more intrinsically with capacity development for supervision and managerial staff and, at best, with interventions improving the physical work environment. Otherwise the goals and indicators set will be perceived as out of reach and may lead to demotivation or false reporting of goal achievements.

Sexual and reproductive health

MoH

17. The evaluation has provided evidence that the Rwandan-German cooperation has significantly contributed to the improvement of awareness and related behavior with regard to SRH and family planning in Rwanda. The achievements can be assigned to both public and private sector interventions and to their interactions. The evaluation, nevertheless, has found an ongoing limited role of the private sector with regard to the provision of contraceptives and information services. While this is against the priorities of GoR, outlined in the latest Family Planning Strategic Plan, and it increases the burden of rising costs for the public health system, it is critical to further support the private sector in order to increase its market share for contraceptives and to strengthen its overall role in the Rwandan health system. Synergies could be enhanced through potential linkages with the public

health system at the community level (i.e., CHWs and peer educators) and commercial marketing techniques from the private sector. At the policy level, a clarification of roles and responsibilities between private and public actors could enhance coherence and planning capabilities, which is relevant for further donor engagement in private sector support.

18. In spite of the remarkable enhancement of the population's awareness on family planning and HIV/AIDS through large-scale social marketing campaigns, the exposure to knowledge is still not universal and relies on various socioeconomic background characteristics. It is, therefore, recommended that future campaigns should focus more explicitly on specific and disadvantaged target groups, especially in remote areas. Accordingly, synergies between large-scale information campaigns and more specific approaches through the concepts of CHWs and peer educators at the community level should be enhanced.

GIZ and KfW

19. In Rwanda, GDC support was effectively provided to the public and private sectors, especially at the decentralized level where synergies between private-sector-driven social marketing and community-based concepts have been created. However, in light of the ongoing limited role of the private sector with regard to the provision of contraceptives and information, it is recommended that for future social marketing strategies under similar conditions, GDC should place special emphasis on providing advice to clarify the roles and responsibilities between the public and the private sector in order to encourage the potential of commercial marketing techniques and to reduce rising costs for the public health system. At the same time, synergies between the private and public sectors should be enhanced (e.g., through improving the linkages) between private sector distribution networks and community-based concepts, such as CHWs and peer educators.
20. In Rwanda, large-scale information campaigns were supported and led to a remarkable improvement of knowledge and awareness on adolescent SRH, but they have failed to reach more disadvantaged target groups in more remote areas.

In comparable country contexts, where the peer group is the central unit of knowledge transfer, community-oriented concepts, such as peer-educators, should receive further attention. In order to increase overall effectiveness, it is recommended that more specific interventions should focus on key persons within a community to strengthen the multiplier effect of knowledge transfer. Large information campaigns, therefore, should be accompanied by intra-community knowledge transfer at inception. This could also lead to potential synergy effects between the private and public sectors at the community level.

Human resources development

MoH

21. The exit of GDC from the health sector has left a gap in the provision of support to the internship program. It is recommended that, together with DPs, this gap be bridged in order to focus on strengthening the capacities of the district hospitals to train and supervise the interns properly, especially as more district hospitals have been accredited for the medical education of interns in Rwanda. This also requires the joint efforts of MoH and the Ministry of Education to improve the steering and monitoring of the national internship program.
22. The potential of ILT alumni experiences in hospital management should be applied to the medical health care course, implemented in cooperation between the School of Public Health and Yale University.

BMZ

23. In view of the positive Rwandan experience, it is recommended that more substantial support be provided to medical education in partner countries. A strong commitment of the partner country to allocate sufficient financial and human resources to medical education, including the availability of counterparts for development workers, is crucial. Moreover, a combination of individual knowledge transfer and advisory assistance through development workers with other instruments, such as advisory support at the national level and use of basket funding, is recommended in order to increase overall effectiveness of support to HRD.

Phase-out process

BMZ

24. For phase-out processes under similar conditions, relevant stakeholders at the decentralized level should be involved in a strong way, and sufficient human and time resources should be provided in order to guarantee sustainability. GDC should encourage policy dialogue as a means to allow the line ministry to take ownership of the phase-out process. This should be a precondition to guaranteeing the sound management of institutional knowledge.
25. Under similar conditions, time lines should be defined according to the requirements of each component of a program. This will allow for gradual phasing out, instead of the handing over of “the stick” at a certain date. The evaluation team also recommends agreement on the mechanisms to accompany the handover process beyond the exit date in order to safeguard sustainability. This should be based on strategic reflection on achievements with major partner institutions, sharing of lessons learned, and future action.

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