Joint Health Sector Support III c : lessons learned and recommendations for the new programme

RWA1509911

September 2019

Belgian development agency

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1 Evolutions in the policy dialogue and technical assistance

1.1 Joint Sector Review

The Joint Sector Review (JSR) was held consistently twice per year throughout the JHSS implementation period, once to review the previous year (around October/November of the calendar year; the Backward Looking JSR) and once to look at the year ahead (around May/June of the calendar year; the Forward Looking JSR). These meetings have had a fixed agenda set by MINECOFIN that contains financial reporting and projecting, performance measurement using a fixed basket of indicators and forward planning and progress against previous JSR recommendations.

All Development Partners are present during these presentations by the Ministry of Health and are invited to comment. Although some improvement has been observed over the last two years, meeting materials were in general distributed to partners only a few days before the review allowing only scant and cursory comments. However, with the establishment of a core group of DPs and MoH officers (planning department) that was made responsible for the organisation of the review as well as the Health Sector Working Group (see later), the meeting shifted markedly from a foremost procedural gathering to discussion about contents. The priority indicators are now discussed in depth and recommendations are duly updated.

In the last two to three years, under the leadership of the Permanent Secretary of MoH, the JSR and HSWG have been held in close proximity and this has been at the basis of the mutual improvement of both meetings. It has enabled to link technical issues brought up by the Technical Working Groups in the HSWG with performance and budgetary processes. Although the discussion of these links still needs further improvement and although the discussions are mostly about cost and cost effectiveness (Value for Money), accountability and compliance, there is a real potential to shift towards scenario planning that includes allocative efficiencies (not only doing the right things but doing them in the right combination). Good examples are the recently developed scenarios for health financing, the Demographic Dividend potential and the Family Planning business case, soon to be followed by the business case for MCCH as pursued by UNICEF.

1.2 Health Sector Working Group

As mentioned, the Health Sector Working Group in tandem with the JSR has provided the Development Partners with an ever-increasing quality of the sector dialogue that allows now to pinpoint assistance of partners (technical and financial) with a realistic agenda driven by the Ministry of Health. Quality improvement of this meeting was especially enhanced in the year 2018 when a retreat for both the HSWG and JSR was held outside Kigali that reduced the focus of the meeting to a few priority issues that were discussed in depth giving enough time to go into technical details and an exchange of ideas on content of the government programmes. The input of Technical Working Groups into the HSWG, which should form the basis for discussions, were until then predominantly procedural, because every single TWG was expected to report and therefore the reports were reduced to listings of activities without much discussion on the rationale. The widely differing performance of the TWGs did aggravate the lack of

discussion. Choosing only specific topics forced the TWGs to focus and gave the HSWG more direction and sense of belonging of the partners. This notwithstanding, not all TWGs are fully operational and some don't meet or meet very irregularly. The structure of the TWGs has been reviewed in the HSWG in the past year (2018/19) and brought in line with the 4th Health Sector Strategic Plan (2018-2024). The existence of topical TWGs has, however, the risk of compartmentalisation and losing sight of the inherent links between the groups (e.g. the direct links between health finances and staff projections). The HSWG still needs to develop mechanisms to coordinate and link the TWGs and their reporting (connecting the dots), possibly through expanding from vertical technical issues (e.g. the malaria programme) into a health system strengthening approach with life cycle planning and Universal Health Coverage as priority binding frameworks (e.g. developing first line health services including PPPs).

Another improvement developed was the combination with field visits (that have become part of the jointly monitored priority indicators of the JSR) that have been conducted immediately before the JSR or HSWG meetings. This provided both government and development partners with a reality check that pervades the technical discussions.

1.3 Joint Field Visits

As mentioned above, joint field visits have contributed a lot to the enrichment specifically of the HSWG. They were structurally reinstituted in 2016, when the priority indicator (of the JSR list of 10 high level indicators) for DP participation was changed from district videoconference meetings to the percentages of recommendations from field visits that were followed up. This coincided with a change of Minister and Permanent Secretary at MoH and in analysis this has been decisive for the renewed success of organising field visits (and thus allowing DPs to have a hands-on experience of health service delivery in Rwanda). Furthermore, connecting the focal topics to be handled in the HSWG (see above) with the focus of the field visits has deepened strategic discussions in the sector dialogue.

All field visits hitherto have been conducted in rural areas, despite the growing request from DPs to organise an urban visit as they believe priorities and challenges in urban areas might be considerably different from those in rural areas, both in terms of disease patterns (epidemiology transition) and health service delivery structures (involvement of private sector). This deserves some attention in the future.

1.4 Technical Working Groups

The structure of the Technical Working Groups is in line with the prevailing Health Sector Support Plans (HSSP III, and a slightly changed structure for HSSP IV). This has resulted in a mix of programme related groups (e.g. MCCH) and system-oriented groups (e.g. Human Resources). The TWGs are rather vertically organised around singular issues for policy and strategy formulation. They are the platforms on which the GoR and DPs work together on technical issues. However, because of the paucity of partners in the sector (a result of a strict division of labour approach pursued by government) membership of these TWG often have a core of 'usual suspects', i.e. personalities that are often the same sitting on different TWGs; Enabel has been a member of 7 different TWGs (out of the total of 12) and co-chaired three TWG under

the HSS pillar of HSSP III (i.e. Planning, Health Financing & Information systems, Quality & Standards, and Mental Health).

Hitherto the binding/lead TWG has been the Planning, Health Financing and Information Systems TWG (that was co-chaired by Enabel in 2017) under chairmanship of the Director General Planning of the MoH. Terms of Reference instruct that TWGs should meet once a month and report to the HSWG on a quarterly basis. In reality, depending on prevailing issues and pre-occupations of DP members in the sector, TWGs might be more or less active (the performance is a mixed bag with some TWGs showing no discernible activity at all). The existence of a core team, see above under HSWG, might be a way to address frequency of meetings and reporting to the HSWG enforcing compliance and accuracy but to date the core team has mainly been composed of DPs and only really led and supported by 1 technical person on the MoH side (under the guidance of DG Planning).

Connecting subject contents and interlinkages between the different TWGs (e.g. the way that health financing affects access to service (packages) that relates to available infrastructure and human resources, etc.) will need more thought in the future. Some concepts around which a holistic policy and strategy environment could gel have already been mentioned, in particular a life cycle approach, scenario planning, and the dimensions of UHC, but a clear focus of stewardship to capitalise on the potential synergy that exists between the TWGs is necessary. Although the Planning, Health Financing and Information Systems (PHFIS) TWG was tasked to oversee these linkages, this has not always led to comprehensive reporting to the HSWG because of the varying quality of TWGs. The HSWG under the preparatory purview of the PHFIS TWG, has therefore been hampered in developing a comprehensive overview of the sector's development. Through its oversight on ongoing missions, (operational) studies, etc. the Research & Knowledge Management TWG might be another option. Because, as earlier mentioned, actual active membership of the TWGs often falls to a core group of personalities from the government and DPs, some solutions might be found there, giving the DPs a more active role in the agenda setting (cave ownership).

By virtue of being represented in 7 TWGs Enabel has been in a privileged position and as one of the few DPs has been able to develop a unique 'helicopter view' of the sector and could be pivotal in moving the coherence of the sector further, notwithstanding the reduced focus of the Belgian sector assistance moving forward.

1.5 Use of consultancy budget

The use of the JHSS consultancy budget under the "régie" modality that was fully under the control of the team of JHSS advisors for the Sector Budget Support programme (as a complementary resource to the BS disbursements and TA) has been instrumental in creating trust with the partner by providing flexible funding and somehow steer the policy dialogue by carefully selecting activities, research, consultancy work to be supported (with due regard for ownership of GoR partners and DPs). More specifically the following activities shave been supported under the current phase of JHSS:

- Sponsorship of 38 community health workers' participation in the International Conference on Family Planning 2018

- Consultancy for the development of a Business case for investments in Family planning 2018
- Formulation Health Financing Strategic Plan 2018-2024
- Venue and catering for field visits, HSWG and JSR from 2016-2018
- Sponsorship towards other conferences in the health sector 2018-2019
- Consultancy for the analysis of out-of-pocket and catastrophic health expenditure 2019

2 Lessons for the future health portfolio

2.1 Budget Support as a modality in a Sector-Wide Approach context

In the last five years of the JHSS programme, Belgium was the only DP using the sector budget support modality in the Health sector. As an aid instrument it served the aid effectiveness criteria and a holistic approach to the health sector development/reform. Indispensable elements for sector budget support – in essence input financing where the donor is taking largest investment risk – are the policy dialogue on the health sector's strategic framework and direction, sector performance on key indicators and accountability for expenditures; hence the addition of Technical Experts in the areas of PFM and Public Health.

As illustrated above (HSWG and JSR processes) this dialogue has improved markedly since the arrival of the outgoing JHSS experts in December 2013 (PFM) and May 2015 (Public Health). The Enabel JHSS team has played a facilitating role by active participation and facilitation of JSR and SWG meetings and their participation in a large number of TWGs.

While a SWAp also considers a common agenda between partners, this was less so in Rwanda over the period of the programme. The division of labour instigated by the government of Rwanda in 2010 (leading to the exit of key partners from the health sector by 2013) narrowed the number of external DPs considerably down. And although the Rwandese health budget leans importantly on external finances, most donors do earmark (as opposed to budget support). De facto the US government and the Global Fund are major contributors to the national health budget. The fact that a large portion of the US funds remain off-budget and input of the private sector is not always clear, does make estimations difficult although the government has tried to get a grip on this by reinstating the Health Resource Tracking Tool in 2016, which follows budgets and expenditures from all sources down to the activity level.

Concerning the dialogue, the earmarking by other DPs and special interest NGOs has to some extent led to sometimes conflicting interests (e.g. US government's approach to reproductive health) that reduces ownership (by the Rwandese government) and harmonisation between DPs. It will be important to monitor these sensitive areas for the benefit of developing health systems especially where it concerns the new Belgian portfolio that will focus on MCCH and SRH services. Although the emphasis of the new programme (in its Result-Based Financing component at national level) will shift to output financing, dialogue remains paramount to assess and assist value for money.

2.2 Portfolio approach (JHSS-CDPF-UB)

The judgement of the JHSS experts on the intended complementarity of the different elements of the Belgian portfolio is somehow harsher. The promise of internal synergy of the portfolio fell short because of a few reasons:

- The Capacity Development Pooled Fund (supported under the ICP 2011-2014) intended to be a flexible fund that would support capacity building in all its aspects to support the Health Sector Strategic Plan of the MoH. However, with the emergence of the division of labour the number of partners in the fund was reduced (KfW, GiZ and DfID left the sector in 2013) and the 'pooled' fund was since then only fed by Belgium, making it a single donor fund. Interest of government waned after the funds dried up and pursuing accountability became a difficult process with only Belgium baring the full responsibility and interest.
- In 2013 the Steering Committee of the CDPF (chaired by the PS) decided to allocate the full budget of the fund towards the training of several cadres of health staff, most prominently the upgrading of nurses. This in effect removed the flexibility utility of the fund making it de facto a human resource training project that was limited in reacting on emerging/innovative needs for capacity building. This certainly added to waning interest of the government in keeping the fund revolving.
- The Ubuzima Burambye (UB) programme was very ambitious in its set-up and scope of work and operationalised in the National Execution (NEX) modality requiring full attention of the managing experts. Though the large thematic scope of UB (i.e. leadership & governance, quality of care, urban health, maintenance of equipment and infrastructure…) promised to offer complementarity to the JHSS approach, in practice, this led to compartmentalisation of the portfolio without much capitalising on opportunities to learn and exchange. The last two years saw some improvements of coordination with regular health team meetings (between the UB and the JHSS/CDPF team) and this has certainly helped in a coherent development of the new portfolio that is commencing in 2019/20.

2.3 Recommendations for the new Health portfolio

Enabel's new health portfolio will have two components, a Result-Based Financing component that will support the national sector plan and a district level operational component that will be aimed at innovation and learning from experience to inter alia inform the sector dialogue. Both components will have a clear focus on Maternal, Child & Community Health and Sexual & Reproductive Health, which offers a huge advantage for facilitating the operationalization of a true programme approach. Circular synergy is thus created: Lessons learned at operational level can be scaled up in national plans to improve outputs and outcomes that are part of the RBF pre-defined results package. Although the financing modality of the RBF (output financing) is the virtual opposite of SBS (input financing) some important lessons can be learned from the current health portfolio especially regarding the sector dialogue between partners:

- Ensure coherence between the two components both internally to Enabel as well as externally to partners to create clear visibility of the Belgian input.

- It is recommended to have some discretionary Enabel funds to facilitate the dialogue as this will increase the visibility, credibility and commitment of the accompanying TA.
- Although the scope of the future portfolio will be reduced from the previous one, we recommend to remain active in the TWGs structures and core groups (both systems and technical TWGs) to retain a strategic oversight on developments within the sector to be able to pre-empt and interact with changes with special attention to important linkages and correlations between TWGs. Further details on this are provided in the JHSS-RBF handover note.
- The RBF programme will need close discussion with government and appropriate technical assistance at the national level to ensure the veracity of measurements (of results) as elaborated in the programme document. Further development of relations with RBC regarding these specific aspects need to be pursued. Knowledge management has hitherto been fragmented between the MoH and the RBC. The future Enabel portfolio will be in a privileged position to provide assistance to align and create robust resource bases.