

# The Struggle for Ownership of Assistance

## *Health and HIV/AIDS in Rwanda*

BY JOHN RWANGOMBWA

RWANDA HAS, in recent years, registered impressive progress against the Millennium Development Goals in its health sector. Whilst the destructive and disruptive effects of the 1994 genocide are still felt in modern-day Rwanda, key performance indicators in the health sector have now recovered to—and are beginning to exceed—their pre-war levels. For example, in 2005, Rwanda's infant mortality rate stood at 86 per 1000 live births—the same level as in 1990. Over the period 2005 to 2008, we have achieved a one-third reduction. Other indicators such as maternal mortality and under-5 mortality are following suit, but further progress is needed. The prevalence of HIV now stands at 3.1 percent of the population: less half the average for Sub-Saharan Africa, though still a significant burden on our population.

As Rwanda recovered and rebuilt its public institutions at the turn of century, national ownership of Rwanda's development vision has never been stronger. This is now characterized by a second-generation Poverty Reduction Strategy, the Economic Development and Poverty Reduction Strategy (EDPRS), from which sector strategies (such as the Health Sector Strategic Plan) cascade. Although Rwanda is undertaking reforms designed to increase its domestic revenue base, we must acknowledge the role that foreign aid will continue to play in the medium term. Official Development



Patients at an HIV clinic in Nyagasambu, Rwanda. The clinic was built with funds from the U.S. global anti-AIDS program, PEPFAR.

Assistance (ODA) totals approximately US\$700 million per year, which finances almost half of the government budget. Additional aid-financed interventions fall outside the budget. The health sector is no exception.

## Government ownership of aid as a prerequisite for sustainable and high quality health care

RECENT IMPROVEMENTS to Rwanda's health care system have focused on providing incentives for delivering quality care at the local level. Inherent to these approaches is the need to promote and adequately finance preventive services, and to reward performance in the provision of health care.

Total health expenditure continues to rise in Rwanda, representing 17.1 per cent of GDP in 2006, up from 6.6 percent in 2003. Government expenditure represents a significant proportion of it, with 18 percent of government expenditure earmarked for the health sector in 2006. These increases have allowed the Rwanda's government to decentralize health services. Block grants to local governments now enable greater flexibility in service provision, responding to local needs and incorporating an element of performance-based financing. This model grants full autonomy to health centers and hospitals, backed by central government support for the planning and operationalization of the approach. Such an approach rewards creativity and results in improved coverage and quality of care at the district and village levels.

Of course, decentralization and performance-based financing of health can only happen if government is able to channel sufficient financial resources to those facilities from which the population should benefit. Whilst ODA to Rwanda's health sector now accounts for approximately 30 percent of all aid, not all of this finds its way into the government structures that have been set up to ensure the equitable and efficient channelling of resources to their intended beneficiaries.

## Direct budget support favored

IN RESPONSE TO LOCAL FINDINGS on bottlenecks in the delivery of aid at the country level, and building on the successes of the Paris High Level Forum on Aid Effectiveness, the Government of Rwanda developed its national aid policy to articulate its preferences in aid modalities and management to promote harmonization, alignment and, ultimately, development results. Our Aid Policy recognizes the need for continued development of national capacities in tandem with the need for a significant shift in the way donors do business in our country. Direct budget support (DBS) is one approach favored by our Aid Policy, as it has been shown to strengthen domestic ownership as well as domestic accountability and transparency—insofar as a greater share of public resources are included in the budget and accounts submitted to Parliament.

Government institutions and donors working in Rwanda's health sector have responded to the principles set out in Rwanda's Aid Policy by invigorating the work of the health sector coordination group and, last year, by setting out the

principles for the operation of a Sector-Wide Approach (Swap) for health in Rwanda, codified in a Memorandum of Understanding. Much has yet to be done, however, if the principles to which we have all subscribed at the international, national and sectoral levels are to be translated into reality.

While some donors have responded by coming on board with sector budget support, and maintaining contributions in the form of general budget support, such assistance only accounts for one third of all aid to Rwanda, and much less in the health sector. Some of our largest donors in volume continue to channel all of their support outside government institutions, relying on non-governmental implementing partners, who bring with them significant costs and reduced levels of accountability to the Rwandan population at large.

Just as participants at the round table on Ownership at the Accra HLF were shocked to learn that a recent *Reality of Aid* report found that less than 26 per cent of global aid is actually available for direction and programming by beneficiary countries because of tying, earmarking and foreign payments to donor-selected suppliers and implementing partners, my colleagues working in Rwanda's health sector continue to grapple with the daily reality of donors' domestic interests.

A sovereign government can only provide adequately for the health care of its people when adequate resources are put at its disposal. In the short- to medium-term, donors will play a huge role in providing these resources responsibly. It can achieve this through the decentralized and performance-based approaches described above, backed with a system of comprehensive health insurance (in Rwanda, the Mutuelle system, which has grown to cover the majority of Rwandans).

In 2005, the Health Sector Support Project 1 (HSSP 1) set the goal to reach 50 percent enrollment in Mutuelles, the community based health insurance (CBHI) program. Within one year, enrollment in some form of insurance became mandatory and enrollment had reached 73 percent; in 2007, enrollment in CBHI stood at 83 percent. CBHIs have led to significant improvements in uptake of health care services.

## The persistence of donor earmarking: threat or opportunity?

PRACTITIONERS OF BOTH MEDICINE and public finance share a first common principle: "Do no harm." In the face of massive increases in public resources for health care in developing countries in recent years, many practitioners of both disciplines have begun to talk of the potential distortionary effects of donor earmarking and the so-called "vertical funds" that have now found their place in development cooperation at the country level. If some researchers and policymakers are to be believed, the massive influx of finance—much of it in the form of ODA—earmarked for specific diseases or interventions has the potential to undermine the sustainable development of the very country systems that need to be built up to respond to a population's health care needs over the long term.

Rwanda is no exception to the phenomenon of donor earmarking. Figure 1 shows almost two-thirds of donor resources to the health sector in 2006 were earmarked for interventions

related to specific diseases, with HIV/AIDS absorbing the greatest share of these resources. In 2006, approximately US\$ 200 million were allocated to the health sector (more than \$20 per capita) corresponding to about 7.5 percent of GNP. Two-thirds of this accumulated budget was financed off-budget by development partners, and more than half of it was earmarked for projects and programmes on HIV/AIDS control. On the positive side, some of these funds are “re-integrated” into the overall health care system through cross-subsidy effects (e.g. the medical doctor hired through HIV/AIDS earmarked funds carrying out consultation and treatment for all kinds of patients coming to the hospital).

While HIV/AIDS prevention and treatment is an important cornerstone of Rwanda’s EDPRS, the eradication and treatment of life-threatening diseases in Rwanda—as in any country—depends on a more holistic health infrastructure, characterized by trained professionals, high-quality clinical facilities, and affordable access. Indeed, the Government of Rwanda has built successful partnerships with the providers of assistance to the sector, such as the Global Fund for Aids, Tuberculosis and Malaria, to ensure that their assistance is situated within the government’s plan to transform the Rwandan health sector as a whole, not limited only to single types of disease or treatment. For example, the upgrading of health centers and laboratories financed by donor resources, is approached in a manner that not only allows those facilities to cater better to the prevention and treatment of a subset of diseases, but provides higher-grade public health facilities for the use of the local population as a whole.

As policymakers, we need to be cautious about earmarked aid, but above all, we need to recognise the importance of dialogue between the beneficiaries of assistance and its

providers. Where a population—and its government—is able to exert strong ownership of a country’s development agenda, donors should align their assistance to country systems and plans, and participate in common dialogue at the country level, focused on joint and shared development results.

## From Paris to Accra and beyond: localizing the debate

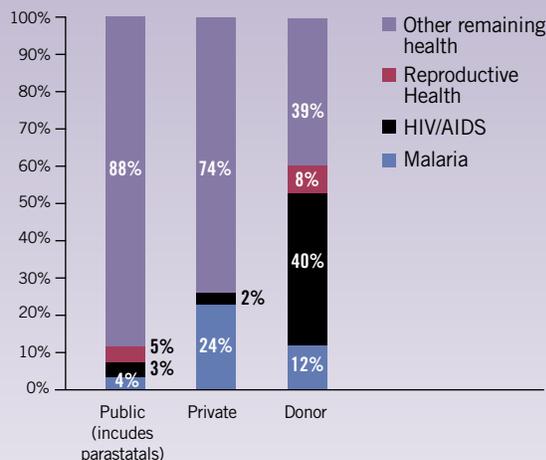
THE ACCRA HIGH LEVEL FORUM, and more specifically the at-times-tense negotiations of its outcome document, provide us with a strong platform from which to continue our dialogue on aid and its effectiveness at the country level. Rwanda’s experiences in the health sector give us one concrete starting point for this work. Just as the Accra discussions focused on the necessity of using country systems for financial management and procurement, Rwanda’s government looks forward to partnering with donors to ensure that their plans to use national systems are concrete and transparent, and are felt by the beneficiaries of the public services we are trying to reform.

In a similar vein, we eagerly await the concrete recommendations of the OECD-DAC Working Party on Aid Effectiveness regarding the implementation of a division of labor among all donors at the country level. This issue has been discussed in our Development Partners Coordination Group, and the experience of Rwanda’s health sector highlights the fragmentation in the delivery of aid. No fewer than 16 bilateral and multilateral agencies provide assistance to the health sector in Rwanda, exacerbating the scope for duplication, and adding to transaction costs in the form of parallel analytic works, missions, and meetings with government officials.

Lastly, we must not forget that we—developing country governments—are the drivers of our own development. The Accra Agenda for Action is clear on the need for developing countries to step up capacity-development efforts. Rwanda has come a long way in developing its capacities in the last decade, both in the form of systems, institutional and human capacities. Last year for example, Rwanda met its 2010 target for the quality of Public Financial Management (PFM) systems as envisaged by the Paris Declaration. We must not be afraid to continue setting ambitious targets for ourselves and sharing those with our development partners in an open, transparent and mutually accountable manner.

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**FIGURE 1: EARMARKING OF DONOR RESOURCES TO RWANDA'S HEALTH SECTOR IN 2006**



Source: Government of Rwanda