REPUBLIC OF RWANDA

MINISTRY OF HEALTH
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Rwanda's Performance in Addressing Social Determinants of Health and Intersectoral Action

A Review against the Five Themes of the Rio Political Declaration

World Health Organization

Abbreviations and acronyms

AIDS	Acquired Immunodeficiency Virus
ART	Antiretroviral Treatment
BCC	Behavior Change Communication
CBHI	Community Based Health Insurance
CB-IMCI	Community based Integrated Management of Childhood Illness
CCT	Conditional Cash Transfers
CHUB	Centre Hospitalier Universitaire de Butare
CHUK	Centre Hospitalier Universitaire de Kigali
CHW	Community Health Workers
C-MNH	Community Maternal and Neonatal Health
COPD	Chronic Obstructive Pulmonary Diseases
CRC	Citizen Scorecard
CSO	Civil Society Organizations
DH	District Hospital
DHS	Demographic and Health Survey
DDP	District Development Plan
DIP	Decentralization Implementation Plan
DP	Development Partner
DPCG	Development Partners Coordination Group
DPEM	District Plan to Eliminate Malnutrition
DQA	Data Quality Audit
ECD	Early Childhood Development
EDPRS	Economic Development and Poverty Reduction Strategy
EICV	Integrated Households Living Conditions Survey
FARG	Genocide Survivors Support and Assistance Fund
FBO	Faith Based Organization
FCTC	Framework Convention on Tobacco Control
FGD	Focus Group Discussion
GBS	General Budget Support
GBV	Gender Based Violence
GDP	Gross Domestic Product
GoR	Government of Rwanda
HBCP	Home-Based Care Practitioner Program
HC	Health Centre
HiAP	Health in All Policies
HIV	Human Immunodeficiency Virus
HHs	Households
HMIS	Health Management Information System
HRH	Human Resource for Health
HSWG	Health Sector Working Group
HSSP	Health Sector Strategic Plan
IA	Intersectoral Action
IBBS	Integrated Bio-Behavioral Surveillance Study

ICT	Information and Communication Technologies
IDSR	Integrated Disease Surveillance and Response
IEC	Information, Education, Communication
ILO	International Labor Organization
IOSC	Isange One Stop Center
IPPS	Integrated Payroll and Personnel Information System
JSR	Joint Sector Review
KFH	King Faisal Hospital
LMIS	Logistics Management Information Committee
LODA	Local Entities Development Agency
JADF	Joint Development Action Forum
MDG	Millennium Development Goal
MICS	Multiple Indicator Cluster Survey
MIDIMAR	Ministry of Disaster Management and Refugees
MININFRA	Ministry of Infrastructure
MIGEPROF	Ministry of Gender and Family Promotion
MINAGRI	Ministry of Agriculture
MINALOC	Ministry of Local Government
MINEACOM	Ministry of East African Community, Commerce and Industry
MIFOTRA	Ministry of Public Service and Labor
MINEDUC	Ministry of Education
MYICT	Ministry of Youth and ICT
MINIRENA	Ministry of Natural Resources
MoH	Ministry of Health
MTEF	Mid-Term Expenditure Framework
MTR	Mid-Term Review
MYICT	Ministry of Youth and ICT
NCDs	Non-Communicable Diseases
NGO	Nongovernmental Organization
NHRC	National Health Research Committee
NHRA	National Health Research Agenda
NISR	National Institute of Statistics of Rwanda
NSS	National Statistical System
OOP	Out-of-Pocket
OSH	Occupational Safety and Health
OVC	Orphans and other Vulnerable Children
PBF	Performance Based Financing
PFM	Public Finance Management
PH	Provincial Hospital
PHC	Primary Health Care
PHI	Private Health Insurance
PWD	People with Disability
RPHC	Rwanda Population and Housing Census
PPP	Public Private Partnerships

PWs	Public Works
PRSP	Poverty Reduction Strategy Paper
RAB	Rwanda Agriculture Board
RBC	Rwanda Biomedical Center
RDRC	Rwanda Demobilization and Rehabilitation Commission
RGRC	Rwanda Citizen Report Card
RGS	Rwanda Governance Scorecard
RMH	Rwanda Military Hospital
RMI	Resonance Magnetic Imaging
RNP	Rwanda National Police
RSB	Rwanda Standards Board
RSSB	Rwanda Social Security Board
RTT	Resource Tracking Tool
SACCO	Savings and Credit Cooperatives
SAMU	Service d ’Aide Médicale d’Urgence (Pre-hospital care)
SBS	Sector Budget Support
SDG	Sustainable Development Goal
SDH	Social Determinant of Health
SHI	Social Health Insurance
SISCom	Community Health Management Information System
SoP	Standard Operating Procedures
SPIU	Single Project Implementation Unit
STEPS	WHO STEPwise approach to chronic disease risk factor surveillance
SWAp	Sectorwide Approach
SWG	Sector Working Group
TB	Tuberculosis
THE	Total Health Expenditure
TWG	Technical Working Group
UDHR	Universal Declaration of Human Rights
UHC	Universal Health Coverage
UN	United Nations
UNDP	United Nations Development Program
UNICEF	United Nations International Children's Emergency Fund
UPR	Universal Periodic Report
USA	United States of America
USD	United States Dollar
VAW	Violence Against Women
VUP	Vision 2020 Umurenge Program
WHO/AFRO	World Health Organization, Africa Regional Office
WHO	World Health Organization

Table of Content

List of tables

Foreword

Health is considered as cornerstone of any human development and sustainable socioeconomic transformation of any country. That is why it is easier to understand the reasons why health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

In the past twenty-three years, Rwanda has made tremendous advances across a wide range of domains despite the 1994 Genocide against Tutsis which devastated the country's economy and population, and exacerbated a number of development constraints. The health sector is one domain in which remarkable progress has been made, making the country one of the leading health-sector reformers in Africa. This is because health matters have then been considered in a new light, with emphasis on both quality of life and the determinants of health. This is largely reflected in the Rwanda 2020 Vision whereby, apart from improving the general welfare of the population, improvements in education and health services are prioritized and targeted to build a productive and efficient workforce.

A healthy population is considered as a fundamental resource for the national development. For instance, the Rwanda 2003 Population Policy outlines strategies to manage the population growth, the management of the sustainability of natural resources, food safety, access to primary and secondary education for all children (with a focus on technical and vocational instruction as well as information technology), good governance, equal opportunity, and participation in development by both men and women.

In order to sustain these achievements and continue along the path to address Social Determinants of Health (SDH) in the line with the Universal Health Coverage (UHC) and Sustainable Development Goals (SDGs), the health-related policies in Rwanda will continue to be envisaged in a multisectoral approach targeted at the poorest members of the population to improve quality, and both geographical and financial accessibility to health care services.

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Executive summary

For over a century, Rwanda experienced governance problems which culminated into the Genocide against Tutsi in the 1994. The Post-Genocide Government inherited a country with a situation characterized by lawlessness, insecurity both within and from outside the country, destroyed social and economic infrastructure, dislocated public service systems, displaced and traumatized population, a deeply divided and wounded society, among other things [1]. To address these governance issues, the GoR focused efforts on institutionalization of good governance through a national consultative process that took place between 1998 and 1999. The discussions and debates involved Rwandans from all walks of life, including leadership from the Government, Business Community, Academia and Civil Society. Throughout the consultative process, there was a broad consensus on the necessity for Rwandans to clearly define the future of the country. This process provided the basis upon which the current Rwanda Development Agenda is built [2].

Today, Rwanda is often cited as good example among countries which has been making tremendous progress in improving living conditions of their populations. For instance, Rwanda made significant progress in all the Millennium Development Goals (MDGs), and achieved 7 out of 8 MDGs[3]. Another indicator that shows Rwanda's progress in improving the health status of its population is the substantial increase of life expectancy at birth from 51.2 years in 2002 to 66.7 years in 2016 [4].

These two examples about Rwanda's progress in health development are just examples of many important achievements in the field of health during the past 15 years. To understand the patterns of Rwanda's achievements in health development, it is important to explore how Rwanda addresses the Social Determinants of Health (SDH) particularly those related to routine conditions in which people are born, live and work. It is in this particular context that a case study on Rwanda's Performance in Addressing Social Determinants of Health was conducted by the Rwanda Ministry of Health, with technical and financial support from the World Health Organization (WHO). The overall goal of the exercise was to document Rwanda's recent initiatives that contribute to the advancements of the Rio Political Declaration on Social Determinants of Health.

Using a qualitative approach, this case study describes Rwanda's progress in addressing SDH by comparing the country's situation against the five key themes of the Rio Political Declaration on SDHs. The five key priority areas of action aimed at addressing health inequities include:

(i) Adoption of a better governance for health and development
(ii) Promotion of stakeholders and community participation in policy-making and implementation;
(iii) reorientation of the health sector towards reducing health inequities;
(iv) Strengthening global governance and collaboration
(v) Monitoring progress and increasing accountability.

The major findings are presented under the five key themes are as follows:

- **Adoption of better governance for health and development:** With an urgent need to effectively manage consequences of the Genocide against Tutsis, Rwanda developed and sustained different systems to support governance in all sectors. For the health sector, achievements in the adoption of good governance structures are classified into 4 areas:
  (1) Decentralization of power and finances
  (2) development of pro-poor programs supporting poverty reduction;
  (3) creation of policy, institutional and legal frameworks for the protection of vulnerable populations
  (4) promotion of integration across sectors to improve intersectoral action for health and health equity.
- **Promotion of community participation in policy-making and implementation:** To ensure community participation, the Government decentralized the power to enhance community empowerment and citizen participation; created conducive policy and regulatory frameworks for civil society, private sector and other stakeholders' participation in policy dialogue; and established national and decentralized forums to improve communication between leaders and the population.
- **Reorientation of the health sector towards reducing health inequities:** The reorientation of the health sector was undertaken through major territorial, administrative, and policy reforms done in the post-genocide period. The health system has been reformed and strengthened as follows: (1) the health system has been strengthened to provide basic amenities and services that are fundamental to promoting health; (2) national and sub-national policies have been formulated and implemented to address health inequities, especially the Community Based Health Insurance has been established to ensure equitable and affordable access to health services for the general population including the poorest and other most vulnerable groups, resulting in improved health equity and access to health services; (3) the legal and policy framework for the health financing has been established, and mechanisms to protect the population against catastrophic health expenditures are in place; (4) equity was integrated into health systems and programs.
- **Strengthen global governance and collaboration:** The promotion of SDH goes beyond individual country efforts and requires partnership and collaboration in global governance. In this area, Rwanda endorsed a number of initiatives to: (1) accelerate the implementation by the State Parties of the WHO Framework Convention on Tobacco Control (FCTC), (2) implement actions set out in the Political Declaration of the United Nations General Assembly High-Level Meeting on the Prevention and Control Non-Communicable Diseases (2011); and (3) to ensure the compliance and implementation of the International Health Regulations (2005).
- **Monitoring the progress to increase accountability:** On top of promoting the monitoring of processes to increase accountability across the board, the GoR created monitoring systems and mechanisms (creation of M&E system across sectors and districts, and the creation of the National Institution of Statistics of Rwanda) to ensure evidence-based policy making and

strategic planning. In the framework of Rio Declaration, Rwanda is achieving the following:(1) generation of health and SDH data related to relevant indicators disaggregated by prioritized stratifiers in WHO databases to improve global visibility of health inequities through global e-platforms and publications. (2) health and SDH monitoring systems have been implemented to improve monitoring of health inequalities. (3) the legal framework for health research and evaluations of actions on the SDH has been put in place; and (4) important instruments have been put in place to guarantee public access to information related to SDHs. As detailed in the next sections of this document, Rwanda has made important efforts to address Social Determinants of Health (SDH). This resulted in great health outcomes and socioeconomic gains for Rwanda citizens. However, there are still persistent and emerging challenges in addressing SDH, including demographic pressure, persistent extreme poverty despite significant progress in its reduction, very small and overexploited land, high dependency on rainfall, effects of climate change, including challenges in the health sector resulting from the reduction of external funding, then posing sustainability issues that might also impact on the sustainability of outcomes already achieved to address SDHs.

I. Introduction

1.1. Background

The World Health Organization (WHO) defines health as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity [5]. This definition implies that one's health status goes beyond his or her physical and mental health and encompasses the social environment he or she lives in.

The adoption of this definition in 1946 paved the way to a broader consideration of health in its other key aspects. For instance, the Universal Declaration of Human Rights (art. 25) adopted two years later (1948) stated that health is part of the right to an adequate standard of living [6]. The right to health was further clarified by the 1966 International Covenant on Economic, Social and Cultural Rights. It states that the right to health includes "underlying determinants of health", mainly access to safe drinking water and adequate sanitation, safe food, adequate nutrition and housing, healthy working and environmental conditions, health-related education and information, as well as gender equality (Couzos Thiele, 2007).

As a result of the above development, several other international treaties, conventions and declarations have put health at the centre of human development. For example, the 1978 "Alma-Ata Declaration on Primary Health Care and Health for All", highlighted the need to strengthen health equity by addressing social conditions through intersectoral programs. Furthermore, systematic analyses conducted in the 1990s on the impact of social conditions, found that dominant technology driven and better health care services alone cannot generate major population health outcomes. The Analyses concluded that social conditions shape health inequities and recommended that to achieve health equity implied working to reduce gaps in health between privileged and disadvantaged social groups [8].

The need to reduce health inequities was further reiterated by the Rio Political Declaration that was adopted by WHO Member States at the World Conference on Social Determinants of Health in October 2011 in Rio de Janeiro, Brazil. This declaration sets out actions to address health inequities in five areas: 1) to adopt better governance for health and development; 2) to promote participation in policy-making and implementation; 3) to further reorient the health sector towards reducing health inequities; 4) to strengthen global governance and collaboration, and; 5) to monitor and increase accountability[9].

Most of social determinants of health were addressed in the 8 Millennium Development Goals (2000-2015) as one of the most important international commitment to ensure global and equitable development for all. In Rwanda, most of the targets defined in the framework of MDGs have been achieved. However, issues and challenges related to persisting extreme poverty remain with their consequences and will be addressed through the 17 new global goals set and agreed upon in 2015 (Sustainable Development Goals, SDGs: 2015-2030) to eradicate extreme poverty and ensure sustainable development.

These declarations are very important and are the expression of international solidarity. Once adopted, Member States committed to provide progress reports and/or to be assessed on progress made in achieving their commitments. As a Member State of the World Health Assembly and the United Nations, Rwanda has not only endorsed all WHO conventions and declarations, it has also made a global commitment to provide regular reports and updates on the progress made in implementation of provisions set out in the different declarations.

It is in this context that the Rwanda Ministry of Health and the WHO Rwanda Office agreed to document initiatives designed and implemented by Rwanda to advance the Rio Political Declaration on Social Determinants of Health and the Sustainable Development Goals.

1.2.Objectives

The overall objective of this documentation was to showcase Rwanda's recent initiatives that contribute to the advancements of Rio Political Declaration on Social Determinants of Health.

1.3.Rwandan context

The history of Rwanda is strongly marked by the 1994 Genocide against Tutsis, which devastated the Rwanda's economy and population. As a consequence, the population socio-economic issues were seen in a new light, with emphasis on both the quality of life and population growth. Based on the Rwanda Vision 2020, a National Population Policy was developed and issued to all development partners in 2003. This Policy emphasized the pressing need to improve the quality of life by providing strategies to affect both demographic (fertility, mortality) and socio-economic factors. The Policy advocated for slow population growth, sustainable management of natural resources, food safety, access to primary and secondary education for all children (focusing on technical and vocational training as well as information technology), good governance, equal opportunity, and participation in development by both men and women [10].

Due to the ambitious reforms undertaken coupled with home grown solutions implemented by the Government of Rwanda (GoR) for the last 20 years; the country has registered tremendous achievements across many areas[11]. In terms of health and socioeconomic indicators, it is noteworthy that Rwanda was one of the few countries in the region that had almost achieved all the Millennium Development Goals (MGDs) in 2015[3].

Table 1: Rwanda's progress in achieving MDGs

	Goals	Status
1	Eradicate Extreme Poverty and Hunger (Met and exceeded for Extreme Poverty. Challenge remains on Stunting at 38% vs. 24.5% target and poverty at 39.1% vs. 30.2% target)	Partially met
2	Achieve Universal Primary Education	Met
3	Promote Gender Equality and Empower Women	Met
4	Reduce Child Mortality	Met
5	Improve Maternal Health	Met
6	Combat HIV/AIDS. Malaria and Other Diseases	Met
7	Ensure Environmental Sustainability	Met

There are many key drivers for all these achievements. On MDG Goal 1, the key drivers include a high economic growth rates experienced by Rwanda since 2000, and a strong implementation of pro-poor policies and strategies put forward in Rwanda's Vision 2020 and the Economic Development and Poverty Reduction Strategy (EDPRS III). The achievement of MDG2 was mainly driven by the remarkable rise in education enrolment supported by the Government program of "fee-free education" up to the first 9 years of school with 6 of those years being mandatory primary schooling years. Later, the fee-free education was extended to cover 12 years of basic education, thereby including the entire secondary school cycle.

Table 2 Rwanda's progress in achieving MDGs1-2

	Baseline (2000)	MDG Targets (2015)	Actual (2015)
MDG 1: Goal 1: Eradicate Extreme Poverty and Hunger			
Goal 1: Eradicate Extreme Poverty and Hunger	60.4%	30.2%	39.1%
Percentage of Population below the Extreme Poverty Line	40%	20%	16.3%
Percentage of underweight children under five years.	24.3%	12.2%	9%
Percentage of under five children stunted	42.6%	24.5%	38%
Percentage of under five children wasted	6.8%	2%	2%
Goal 2: Achieve Universal Primary Education			
Net Enrolment Rate (Primary)	72.6%	100%	96.9%

Source: NISR; Rwanda Statistical Yearbook, 2016

The achievement of MDG 3, policies and law reforms to promote gender equality were very crucial. In the first place, laws discriminating women were abolished (e.g. The 2003 Constitution provides for at least 30% of seats to women in parliament and other decision-making positions. In 2016, 64% of seats in the Chamber of Deputies were occupied by women.

This percentage was 38% in the Senate ([12]. In the Government, 40% of Ministers are women. Currently women in Rwanda have rights to property and inheritance. In addition, there were many other initiatives established to fight against Gender Based Violence (e.g. Isange One Stop Centres) through providing integrated comprehensive response, care and support services to girls and boys, women and men victims of Gender Based Violence (GBV) or child abuse. Another notable achievement was women empowerment through many economic empowerment programmes meant to boost their access to financial services. This was implemented through Women Guarantee Fund and entrepreneurship program. It is also worth to mention institutional mechanisms that were established to enhance gender accountability: Ministry of Gender and Family Promotion, the Gender Monitoring Office, the National Women Council etc. were also instrumental.

Table 3 Rwanda's progress in achieving MDG 3

	Baseline (2000)	MDG Targets	Actual (2014)
MDG 3: Goal 3: Promote Gender Equality and Empower Women			
Ratio of Girls to Boys in Primary School	1.00	1.00	1.03
Ratio of Girls to Boys in Secondary School	0.51	1.00	1.12
Share of women in waged employment in the non-agricultural Sector	7.6%	50%	27.3%

Source: NISR: Integrated Household Survey on Living Conditions (EICV4) 2013/14

As regards to the MDG 4 and 5, the direct key drivers for MDG 4 include improvements in vaccination coverage with the proportion of children fully vaccinated increasing from 75% (2006) to 93% in 2015, and currently, over 95% of children are vaccinated against measles. For the MDG 5, it has been driven by the increase in the percentage of deliveries assisted by skilled health care providers from 39% (2006) to 91% in 2015.

Table 4 Rwanda's progress in achieving MDG 5

	Baseline (2000)	MDG Target	Actual 2015
MDG 4: Reduce Child Mortality			
Under Five Mortality per 1,000 live births	196.2	50.1	50
Infant Mortality per 1,000 live births	107	35	32
Goal 5: Improve Maternal Health			
Maternal Mortality Ratio – deaths per 100,000 live births	1076	268	210

Source: NISR: DHS 2014/15

The MDG 6 was driven by increased several initiatives including free access to ARTs to reach universal access, prevention of mother to child transmission (covered under the Community Health Insurance Scheme), providing pregnant women and children under 5 with free treated bed nets. Other initiatives involved facilitating access to antiretroviral treatment for all HIV/AIDS patients and multisectoral collaboration especially with FBOs, Civil Society Organizations including associations of people living with HIV and AIDS.

Lastly, the MDG7 was essentially driven by the establishment of institutions to closely monitor and champion environment protection and management e.g. Rwanda Environment Management Authority (REMA). Laws and policies determining the use and management of land, preserving wetlands and forests have been passed. Non-biodegradable plastic bags have been banned, while the protection of river banks and lake shores was ensured. Robust tree plantation programs and rainwater harvesting in public and private institutions projects have been implemented.

Table 5 Rwanda's progress in achieving MDGs 6-7

	Baseline (2000)	MDG Target	Actual
MDG 6: Combat HIV/AIDS. Malaria and Other Diseases			
HIV prevalence rate amongst women 15-49 & men 15-54	N/A	1%	3%
Malaria Proportional Mortality over 5 years of age	15.9%	N/A	4.1% (2011)
Proportion of children under five sleeping under an insecticide-treated bed net	5%	N/A	84.8%
Goal 7: Ensure Environmental Sustainability			
Proportion of population using an improved drinking water source	64.1%	82%	84.5%
Proportion of population using an improved sanitation facility	51.5%	74.5%	83.4%

Source: NISR. DHS 2014/15

By achieving most MDGs, Rwanda made commendable progress in addressing social determinants of health. Considering the tremendous achievements on MDGs, and their role in addressing the Social Determinants of Health, it is important to document the progress achieved, identify strengths and weaknesses and share the experiences and lessons of Rwanda with other countries in similar settings.

1.4.Methods

To document Rwanda's progress in addressing Social Determinants of Health, we compared Rwanda's situation against the five key themes of the Rio Political Declaration on SDHs. A qualitative approach was utilized to capture and analyse data on recent, diverse and multiple initiatives or tools demonstrating Rwanda's progress vis-à-vis the Rio Declaration themes. The data collection process was done in two main steps.

The first step consisted of desk and literature reviews of all actions currently undertaken by the health sector and stakeholders in the field of social determinants of health. The review targeted existing guiding documents, mainly policies, regulations and strategies put in place by the health and other sectors to address the social determinants of health including published researches, and peer reviewed papers, and institutional/administrative reports.

The second part involved discussions and semi-structured face-to-face interviews with different stakeholders, in the institutions involved in the formulation and/or implementation of strategies and actions related to Social Determinants of Health, and interviews were organized with the persons responsible for implementation of those strategies and actions.

The aim of interviews was to have a better understanding of how initiatives are coordinated among different stakeholders, to identify the best practices and innovations, to collect opinions related to challenges, constraints and opportunities, and proposed solutions.

Interviews were conducted among stakeholders identified at the Central and Decentralized levels. At the Central Level, interviews focused on how policies are designed whereas discussions at the decentralized level focused on the involvement of the Local Government in designing and implementing policies related to Social Determinants of Health.

At central level, Ministries and other Government Institutions were selected according to their role and responsibilities in designing and implementing the main components of Social Determinants of Health. The table below shows the Ministries and Government Institutions consulted and their association to the SDH.

For the recruitment of participants, the non-probability, judgemental or purposive sampling method has been applied. Ministries and other Government Institutions at central and decentralized levels were selected according to their role and responsibilities in designing and implementing policies to address Social Determinants of Health. At central level, a total of nine ministries and 7 public institutions implementing actions on SDHs have been included in the exercise and 26 persons participated in the interviews. One planned ministry was not able to participate in the assessment, due to unavailability of their representatives.

Table 6: Institutions visited at central level

Institution	Name of the policy (year developed)	Policy intent/Social Determinant related actions
• **Ministry of Health** • **Rwanda Biomedical Centre (RBC)**	• Rwanda's Health Sector Policy (2015) • Rwanda's Health Sector Policy (2005) • Rwanda's Third Health Sector Strategic Plan 2012-2018 (HSSP-III) • Rwanda's Second Health Sector Strategic Plan 2009-2012 (HSSP-II) • Rwanda's First Health Sector Strategic Plan 2005-2009 (HSSP-I) • The Rwanda National Food and Nutrition Policy (2014)	• Health System • Nutrition
• **Ministry of Agriculture** • **Rwanda Agricultural Board (RAB)**	• Environmental and Social Management Guideline for Agriculture Projects (2016) • National Agricultural Extension Strategy (2009) • Strategic Plan for Agricultural Transformation in Rwanda-Phase I (2005) • Strategic Plan for the Transformation of Agriculture in Rwanda – Phase II (2009) • Strategic Plan for the Transformation of Agriculture in Rwanda – Phase III (2014)	• Food and Nutrition • Social Protection
Ministry of Gender and Family Promotion	• Early Childhood Development Policy (2016) • National Policy for Orphans and Other Vulnerable Children (2003) • National Policy for Family Promotion (2005) • National Integrated Child Rights Policy (2011) • National Gender Policy (2010) • National Policy against Gender-Based Violence (2011)	• Gender promotion • Early childhood development • Family and child promotion • Women empowerment
Ministry of Education	• Education Sector Policy (2003) • National School Health Policy (2014) • Girls 'Education Policy (2008) • Integrated Early Childhood Development Strategic Plan 2011/12 – 2015/16(2011) • National School Health Strategic Plan 2013/14 – 2017/18(2014) • School Health Minimum Package (2014) • Adult Education Policy (2014)	• Primary education • School health • Adult literacy • Girls and Women education • Special needs education

	• Skills Area and Numbers of Priority Skills Required Across Rwanda-Five Year Program for Priority Skills Development to Deliver EDPRS II (2013 - 2018) • Special Needs Education Policy (2007)	
• **Ministry of Labor and Public Service** • **Rwanda Social Security Board**	• National Employment Policy (2007) • Occupational Safety and Health (2014) • National Policy on Elimination of Child Labor (2013) • Ministerial Order relating to maternity leave benefits scheme (2016) • Policy Framework for Rwanda's Civil Service Reform (2002) • Law governing the organization of Pension Schemes (2015) • Law Regulating Labor in Rwanda (2009)	• Occupational health and safety • Child labor and social protection • Employment policies and strategies
• **Ministry of Local Government** • **Districts** • **Local administrative entities Development Agency (LODA)**	• Decentralization Implementation Plan (DIP)2011-2015(2011) • National Decentralization Policy (2012) • National Decentralization Policy (2001) • National Strategy for Community Development and Local Economic Development (2013-2018) • Updated Version of the National Human Settlement Policy in Rwanda (2009) • Implementation of Rural Settlement Policy (2010) • Labor Intensive Public Works Strategy (LIPWS) • District Action Plans to Eliminate Malnutrition (DPEM) • Joint Action Development Forum District Levels (JADF)	• Social Protection • Local economic development • Good Governance and Decentralization • Health Insurance
Ministry of Disaster Management and Refugees	• The National Disaster Management Policy (2012) • Basic Housing Construction Instructions for Protection Against Natural and Manmade Disasters in Rural Areas (2012)	• Natural and Manmade disasters • Management of Disasters
Ministry of Finance and Economic Planning	• Economic Development and Poverty Reduction Strategy II (2013-2018)	• Poverty reduction
• **Ministry of Infrastructure** • **Water and Sanitation Corporation (WASAC)** • **Energy Utility Corporation Limited (EUCL)**	• National Policy and Strategy for Water Supply and Sanitation Services (2010) • National Sanitation Policy (2016) • National Sanitation Policy Implementation Strategy (2016) • National Sanitation Policy Implementation Strategy (2016) • National Sanitation Supply Policy (2016) • National Water Supply Policy (2016)	• Water and Sanitation • Urbanization • Energy • Transport • Housing • Health Insurance

• **Rwanda Housing Authority (RHA)**	• National Water Supply Policy Implementation Strategy (2016) • Water and Sanitation Sector Strategic Plan 2013/14-2017/18(2013) • Electricity Law Rwanda (2010) • Rwanda Energy Policy (2015) • Energy Sector Strategic Plan (2015) • Rural Electrification Strategy (2016) • The Urbanization and Rural Settlement Sector Strategic Plan (2013-18) • National Land Policy • National Housing Policy • Construction Industry Policy • National Urbanization Policy • National Investment Strategy • Law Governing Urban Planning and Building in Rwanda • Law Governing Human Habitation in Rwanda • Law Governing Land in Rwanda • National Land Use and Development Master Plan (2011) • The Kigali City Master Plan (2013) • Local Physical Plans Detailed Plans • Implementation Orders of the Law Governing Urban Planning and Building in Rwanda.	• Universal Health Coverage and Equity • Social Protection
• **Ministry of Natural Resources** • **Rwanda Environment Management Agency**	• Rwanda Environmental Policy 2003 • Green Growth and Climate Resilience Strategy • Environment Sub-Sector Strategic Plan 2010 – 2015 • Baseline Climate Change Vulnerability Index for Rwanda (2015) • Rwanda Environmental Education for Sustainable Development Strategy a Strategy and Action Plan for 2010-2015(2010)	• Environment • Land, Water and Sanitation
National Institute of Statistics of Rwanda (NISR)	• Reports of National Surveys • National Statistical Year Booklets	• Indicators of Social Determinants of Health

At decentralized level, consultations were organized with the District Authorities. Nine (9) districts over 30 were included in the exercise: 2 districts per province (4 provinces) and one district in Kigali City. Except in the Nyarugenge district (Kigali City) were an interview was organized with 3 representatives, focus group discussions were organized in provinces, and most of time the Vice-Mayor in charge of Social Affairs was the lead, and a total of 30 officers participated in the exercise (an average of 3 participants per district). Two criteria were used to select participating districts. One of them was the proximity, where neighbouring districts were not selected. Also, districts that were previously visited during the Mid-Term Review of the Health Sector Strategic Plan were not considered because most of their situation was reflected in the mid-review report. The table below shows the Districts visited by Province.

Table 7: Districts visited at the decentralized level

Province /Kigali City	Districts
Kigali City	Nyarugenge
Northern Province	Gicumbi Rulindo
Southern Province	Ruhango Nyaruguru
Eastern Province	Nyagatare Kayonza
Western Province	Nyabihu Karongi

1.5.Data analysis

All data and information collected throughout face-to-face interviews and desk and literature reviews were analysed using a thematic analysis approach and were grouped under the five key themes of the Rio Political Declaration on SDHs.

1.6.Presentation of findings

For the purpose of this documentation, findings are organized under each of the five key areas of action of the Rio Declaration. Before the presentation of the Rwandan achievements, a summary of topics under each theme are presented. Rwanda actions under each of the Rio Declaration themes are further categorized, grouping similar types of activities being undertaken.

II. RWANDA'S ACTIONS ACROSS THE FIVE RIO DECLARATION THEMES

2.1. Rio Declaration Theme 1: Better governance for health and development

Governance is "the system of values, policies and institutions by which a society manages its economic, political and social affairs through interactions between the State, Civil Society and the Private Sector, defining how the society organizes itself to make and implement decisions to achieve mutual understanding, agreement and action"[13]. Governance is also concerned with mechanisms and processes for citizens and groups to articulate their interests mediate their differences and exercise their legal rights and obligations. Good governance is then characterized by participation, rule of law, transparency, responsiveness, consensus oriented, equity and inclusiveness, and effectiveness and efficiency[12]. Good governance has 8 major characteristics. It is participatory, consensus oriented, accountable, transparent, responsive, effective and efficient, equitable and inclusive and follows the rule of law. It assures that corruption is minimized, the views of minorities are taken into account and that the voices of the most vulnerable in society are heard in decision-making[14].

For Rwanda, "Good Governance is the exercise of economic, political and administrative authority to manage a country's affairs at all levels, comprising the mechanisms, processes, and institutions through which that authority is directed"[15]. Good governance attributes state capability, accountability, responsiveness, inclusiveness, fairness and legitimacy all of them required to promote development, human rights, justice and peace[15]

The United Nations Development Programme (UNDP) five principles of good governance include: legitimacy and voice (participation and consensus orientation), direction (strategic vision), performance (responsiveness, and effectiveness and efficiency), accountability (and transparency), and fairness (equity and inclusiveness, and rule of law) [15].

In 2000, the country commenced the development phase by launching many reforms supported by strategic policy frameworks that cater for effective oversight, coalition-building, provision of appropriate regulations and incentives while paying attention to system-design and accountability. One of the most important reforms undertaken in the 2000s was the decentralization of government. The overall objective of decentralization process was to deepen and sustain grassroots-based democratic governance and promote equitable local development by enhancing citizen participation and strengthening the local government system, while maintaining effective functional and mutually accountable linkages between central and local Governments entities.

The following specific objectives were also pursued through decentralization:

- To enhance and sustain citizens' participation in initiating, making, implementing, monitoring and evaluating decisions and plans that affect them by transferring power, authority and resources from central to local government and lower levels, and ensuring that all levels have adequate capacities and motivations to promote genuine participation.
- To promote and entrench a culture of accountability and transparency in governance and service delivery by strengthening national and local accountability mechanisms to make them more relevant, credible, conducive, supportive/attractive to all citizens, leaders and non-state entities.
- To fast-track and sustain equitable local economic development as a basis for enhancing local fiscal autonomy, employment and poverty reduction, by empowering local communities and local governments to explore and utilize local potentials, prioritize and proactively engage in economic transformation activities at local, national and regional levels, and ensure fiscal discipline.
- To enhance effectiveness and efficiency in the planning, monitoring, and delivery of services by promoting joint development planning between central and local governments and ensuring that service delivery responsibilities and corresponding public expenditure are undertaken at the lowest levels possible.
- To consolidate national unity and identity (Ubunyarwanda) by fostering, enhancing and sustaining the spirit of reconciliation, social cohesion and common belonging as a nation hence ensuring lasting peace and security as well as community of purpose for sustainable national development.
- To build and consolidate volunteerism, community work and self-reliance based on cultural and other values of collective responsibility, personal worth and productive involvement.
- To fast-track and translate the regional integration agenda into politically meaningful, economically fruitful venture for Rwandans in all corners of the country, and as a strong anchor for national stability, peace and unity.

In the health sector, governance is also seen as an essential approach for the health systems to achieve the provision of essential public health services and functions. For this reason, several successive reforms (health policies, strategies and decentralization policy) have been put in place to institutionalize good governance in the Health system and improve service delivery while strengthening linkages and interactions between citizens as services users, the state and health service providers. Efforts made by Rwanda in health Governance are in line which what is recommended by WHO: responsiveness and accountability; an open and transparent policy dialogue; participatory engagement of citizens; and operational capacity of government to plan, manage, and regulate policy and service delivery [16][17].

Through the implementation of the Decentralization Policy, Rwanda has registered four big achievements that cover critical elements of better governance as stated in the Rio Political Declaration on SDH. The four main achievements are:

- Decentralization of power and finances
- Development of pro-poor programs supporting poverty reduction.
- Creation of policy, institutional and legal frameworks for the protection of vulnerable populations.
- Promotion of integration across sectors to improve intersectoral action for health and health equity.

2.1.1. Decentralization of power and finances

The Decentralization is the transfer of responsibilities, authority, functions, as well as power and appropriate resources, to district and sub-district levels. This can take three forms:

- **Deconcentration which** is the transfer of functions and resources to lower level units of the same administrative system;
- **devolution** is the transfer of some powers and authority, functions and resources by legal and constitutional provisions to the lower levels;
- **delegation** that is the transfer of functions and resources to a subordinate authority with the capacity to act on the behalf of the superior authority without a formal transfer of authority in the same structure[18].

The Decentralization Policy was first adopted in 2000 with the aim to promote good governance, service delivery, and national development and objectives to: (1) to enhance and sustain citizens' participation; (2) to promote and entrench a culture of accountability and transparency in governance and service delivery; (3) to fast-track and sustain equitable local economic development; (4) to enhance effectiveness and efficiency in the planning, monitoring, and delivery of services; (5) to consolidate national unity and identity (ubunyarwanda); (6) to build and consolidate volunteerism, community work and self-reliance[18].

Its implementation was divided in 3 phases (Decentralization Implementation Plans, DIPs). During the first phase (2000-2005), decentralization helped us democratize leadership and create platforms for nurturing leaders, mostly women and youth, In the second phase (2005-2010), strong reforms have undertaken: local government structures have been set up, with performance innovations put in place (Imihigo, performance contracts) and platforms for community mobilization, accountability and participation were created. A territorial restructuring reduced considerably the number of administrative entities from 11 to 4 provinces and the Kigali City, 106 to 30 districts, etc. in order to make them more functional.

With the Decentralization policy, and the Law Nº 87/2013 of 11/09/2013 determining the organisation and functioning of decentralized administrative entities, Districts became full Local Governments and took over many of the former responsibilities of central and provincial levels. Central government remains responsible for formulating national policy, ensuring national security, and creating an enabling environment for civil society and the private sector.

In accordance with the same law, the Village as the basic unit for mobilisation and interaction of the population. The Village is an entity in which the population participates directly to their development. The Village is governed by a village council. These territorial reforms deepened the decentralization process by enhancing effectiveness and efficiency in service delivery to communities; improved people participation in finding solutions for issues affecting them and enhanced leadership accountability.

Local government is now responsible for: identifying community needs; deciding priorities; making and formulating local policy; implementing national policies; and using resources efficiently. Significantly, local government is responsible for promoting the participation of individuals, households and communities in decision-making. Local communities are represented at local government level through District Councils, Sector Councils, Cell Councils, and Village Councils.

2.1.2. Pro-poor programs for poverty reduction

2.1.2.1. Background

The first Poverty Reduction Strategy Paper (2002-2006) clearly described Rwanda's extreme poverty after the 1994 Genocide against Tutsis as the outcome of both economic and historical factors. To respond to this challenge, the Rwanda Vision 2020 was developed, with an aim to become a middle income nation with a healthier, educated and generally more prosperous population, by 2020 [19]. To achieve this goal, Vision 2020 has been translated into action by a series of medium-term strategic plans: the Poverty Reduction Strategy Paper (PRSP) was developed in 2001 and covered the period 2002-2006; the first Economic Development and Poverty Reduction Strategy (EDPRS) covering the period 2008-2012-and the EDPRS 2 currently under implementation since 2013 to 2018 [20].

2.1.2.2. Pro-poor social protection programs: Achievements

Along with implementation of the Decentralization policy to strengthen good governance, Rwanda developed strategies to reduce poverty and accelerate the socio-economic development. In this regard, a Poverty Reduction Strategy Paper, PRSP, was developed and implemented (2002-2006), with emphasis to manage the transition from emergency relief and rehabilitation (reconstruction) to the development phase. Six broad priority areas identified for action included rural development

and agricultural transformation, human development, economic infrastructure, governance, private sector development and institutional capacity-building [21].

Despite strong economic growth, poverty fell during the PRSP period by only 2.2 percentage points. More than half of the population continued to live below the national poverty line. Extreme poverty, defined as the income required to provide food requirements of 2,100 calories per day, fell by 4.2 percentage points between 2001 and 2005, but still afflicted more than one third of the population, while income inequality as measured by the Gini coefficient, rose from 0.51 to 0.52[22], [23].

In terms of non-income poverty, the PRSP was much more successful. Infant, under-five and maternal mortalities all decreased by 20-30%. Progress continued under EDPRS and by 2012 the associated health MDG targets for 2015 had already been achieved or were on track. Access to education has improved with the implementation of the nine-year basic education program while completion rates have also increased significantly for both boys (79%) and girls (82%) by 2012. [24].

Due to the low performance of PRSP to reduce the poverty, EDPRS 1 (2008-2012) was developed and marked a distinct change in the approach to development. A key conclusion of the PRSP experience was that the social sectors (particularly health and education) had been well addressed, but the real economy i.e. the sectors dealing with the production of goods and services and actions to reduce the poverty, had not. Priority was, therefore, given to accelerating growth, creating employment and generating exports. These were to be catalyzed through public investment in infrastructure, and through regulatory reforms. They were intended to reduce the costs and risks of doing business and to create an attractive environment for private sector investment and activity[21].

From the review of Rwanda's socio-economic performance (DHS 2005, EICV 2006) together with the lessons from the PRSP, a new strategy, Economic Development and Poverty Reduction Strategy (EDPRS 2007-2012) was developed with four priorities: (1) Increase economic growth by investing in infrastructure; promoting skills development and the Service Sector; (2) Slow down population growth through reducing infant mortality; family planning and education outreach programmes; (3) Tackle extreme poverty through improved food security and targeted schemes of job creation and social protection; (4) Ensure greater efficiency in poverty reduction through better policy implementation which includes enhanced coordination[20].

Effective implementation of EDPRS 1 resulted in reductions in poverty between 2006 and 2012, with over one million Rwandans being lifted out of poverty. Income inequality as measured by the Gini coefficient decreased from 0.51 in 2000 to 0.49 in 2011[20]. Reduced poverty and income inequality demonstrate that an increasing number of Rwandans are benefitting from their country's economic progress[25].

Based on lessons learnt from PRSP and EDPRS 1, EDPRS 2 (2013-2018) puts an emphasis on enhanced linkages of social protection programs, with a particular attention to increasing graduation from extreme poverty. Four priority interventions are leading the social protection strategy in EDPRS 2:

- Priority 1: Integrated Approach to Land Use and Human Settlements.
- Priority 2: Increase the Productivity of Agriculture by building on the sector's comparative Advantage;
- Priority 3: Enable Graduation from Extreme Poverty by monitoring graduation through a database across social protection programs,
- Priority 4: Connect Rural Communities to Economic Opportunity through Improved Infrastructure.

The National Social Protection Strategy was updated in 2014 to align with the EDPRS2 and to take into account the findings on poverty and on social protection coverage from the results of the EICV3 (2010) survey. The updated social protection strategy ensures that all poor and vulnerable men, women and children are guaranteed a minimum standard of living and access to core public services. Those who can work are provided with the opportunities for escaping poverty, and as a result an increasing number of people are able to access risk sharing mechanisms that protect them from crises and shocks [26]. Social protection programs contribute to reduce poverty and vulnerability and promote equitable growth, by establishing a social protection system that tackles poverty, inequality, and improves access to essential services and social insurance'[26]. Social protection programs target the poorest categories and most vulnerable groups of the population: (1) extremely poor households; (2) Vulnerable survivors of the Genocide against Tutsi; (3) Vulnerable People with disability; (4) Historically marginalized people; (5) Elderly; (6) Orphans and vulnerable children. They intended to be:

- **Protective:** providing essential support to those living in poverty
- **Preventative:** providing a safety-net to those in danger of falling into poverty
- **Promotive:** supporting people to pull themselves out of poverty graduate and
- **Transformative:** aims to improve the social status and rights of the marginalized.

The implementation of core social protection programmes was coordinated by the Ministry of Local Government (MINALOC) but several complementary programs and initiatives are delivered by other ministries. MINALOC is responsible for the three components of the VUP (Vision 2020 Umurenge Programme): (a) Direct Support to assist those who are not able to work (b) Public Works to provide jobs to poor persons who are able to work and the Financial Services to provide small

loans for small income generating projects. Social protection programs include the Genocide Survivors Support and Assistance Fund (FARG), the Rwanda Demobilisation and Reintegration Commission (RDRC), health insurance schemes and many other social assistance schemes like those targeting marginalized and other vulnerable groups (orphans).

Key initiatives administered by other ministries include the "Girinka Munyarwanda" One Cow per Poor Family' programme and its Rural Sector Support Project by Ministry of Agriculture. The program was set up with the central aim of reducing child malnutrition rates and increasing household incomes of poor farmers. These goals were to be achieved through increased access to, and consumption of milk, by providing poor households with a heifer.

One Cow brings nutrition, sustenance and employment, providing a stable income for a family and is a source of soil nutrients via manure to assist small scale cropping activity. By December 2016, more than 203,000 families had benefited from the program. However, many more families, some of the Rwanda's most poor still eagerly await to receive the many benefits the program can bring.

Another very important social protection program is the "Ubudehe program, Community assistance program" that targets the poorest category of the population. The Ministry of Health and the Ministry of Gender and Family Promotion provide subsidised subscriptions for community-based health insurance (CBHI) and in-kind social care services.

These non-contributory programmes form the basis of Rwanda's essential package of social transfers as advocated by the United Nations' Social Protection Floor initiative, which aims to ensure that countries worldwide can guarantee a minimum level of income security and access to vital social sector services for all citizens. Besides these non-contributory measures, Rwanda also has a limited system of contributory social protection mechanisms that enable people in formal employment to access medical care including pension scheme for the elderly [27].

The prioritization of social protection in the Vision 2020, and in the midterm strategic plans (PRSP and EDPRS 1&2) has contributed to the Rwanda's progress in implementing strategies that protect vulnerable populations.

Notable achievements of social protection programs in Rwanda are to have put in place policies and institutional framework and mechanisms to identity and follow-up on vulnerable populations.

- The "*Ubudehe Database*" was created in 2001 and is regularly updated. The database facilitates planning of interventions meant for the poor and vulnerable population groups and it is based on evidence and accurate data.
- Pro-poor and social protection programs have been making a significant impact in improving living conditions of people supported. According to the NISR, from 2000 to 2011, one million people in Rwanda have lifted themselves out of extreme poverty, capitalizing on a rapidly integrated development programs, including social protection nets. In addition, social protection programs have contributed to the improvement of access to different services[28].

- Health insurance is another very important component of social protection mainly its part, the community-based health insurance. Over 85% of Rwandans are covered by a health insurance scheme and they include the poorest groups All people in extreme poverty, currently estimated at 16% of the population, are supported by the Government to have access to healthcare services through health insurance, and other social services. In the framework of education for all, their basic needs are covered to allow them access free education up to the secondary school (Nine and Twelve basic education programs).
- As a result of Social protection interventions, EICV4 (2013/2014 indicates that 42.7% (21% of households eligible for social protection programs in Ubudehe category 1, 13% of category 2 participated in VUP (Vision 2020 Umurenge), and 8.9% of category 3 were enrolled in social protection programs. The cause of low participation is that all sectors were not yet participating in the program and the funds available were not sufficient.
- Within the VUP program, beneficiaries of direct support are mostly elderly or people with disabilities (72% and 42% respectively). Finally, heads of households participating are Males (74.5%) and Females (24.5%). Apart from VUP, 14% other households reported to access public income support from other sources (old age pension; genocide survivor support; demobilization and reinsertion support, health and education payments, food relief).

2.1.2.3. Challenges

While Rwanda is commended for the design and implementation of pro-poor programs, there are still challenges, especially in scaling up and ensuring full coverage of people.

- Extreme Poverty rate is still high, and is currently estimated at about 16.3% [27].
- Most of social protection programs are still largely depending on external funding. This constitutes a threat to their scale-up and future sustainability.

- Some 82% (EICV 4, 2013/14) of the country's workforce is in the agricultural sector, which has long been the engine of the economy. As agriculture is not yet modernized, any dysfunction of

rainfalls disturbs the agricultural productivity, with huge consequences on living conditions of households. This becomes more complicated for households already in social protection programs. They generally invest in farming as follows:

Table 8: Main use of VUP Public Works transfers

Main use	Participant households (%)
Farm / animals	16.6
House construction / improvement	16
Education/health	11.7
Business	2.2
Consumption (excl. food/clothes)	10.3
Consumption (food clothes)	38.9
Other	4.3
Total	100

Table 9: Main use of VUP Direct Support

Main use	Participant households (%)
Farm/animals	24
House construction / improvement	17.7
Education / health	4.7
Business	1.3
Consumption (excl. food / clothes)	7.6
Consumption (food clothes)	37
Other	7.8
Total	100

Another challenge that is hindering social protection programs in Rwanda is the population growth that is not in line with the economic growth. The annual population growth is estimated at 2.6 percent, and the Population density stands at 467 people/km2. This gap between economic growth and population growth remains important, and the rapid increase of the population may impair the socio-economic achievements of the last 15 years[29].

2.1.3. Institutionalization of frameworks to cater for the rights of vulnerable populations

2.1.3.1. Background

The 1994 Genocide against Tutsis left behind many vulnerable populations such as widows and widowers, refugees and displaced people, elderly persons, prisoners, orphans including vulnerable children, people with disability, people living HIV and AIDS, etc. For instance, 85,000 child-headed households were left as well as a high proportion of households headed by women (34% in 1996) and by female widows (21% in 1996). While prisoners and widow-headed households were often amongst the poorer households, the high proportion of female household heads had also presented a challenge to the traditional gender roles in Rwanda [19]. To counter the effects of Genocide, the GoR, devised important legal and institutional frameworks in an effort to manage the burden of issues that were encountered by vulnerable populations. The frameworks are regularly updated based on emerging needs particularly those related to social protection. Below is a description of achievements registered in institutionalizing frameworks and mechanisms catering for the protection and rights of vulnerable groups.

2.1.3.2. Achievements in protecting and ensuring rights of vulnerable populations

2.1.3.2.1. Protection of women and children

In the aftermath of the 1994 Genocide against Tutsis, women took up new roles as heads of households and engaged in rebuilding the country along with others. Since then, Rwanda recognized that recovery and development would only succeed with women playing a central role. Gender equality, women empowerment and child protection became a cornerstone of the Government of Rwanda's development strategy and a proven source of development progress. The greatest achievement since 1994 in women and child protection has been taking the women of Rwanda from being desperate victims to leading actors in the reconstruction and development of the country.

Key drivers of Rwanda's achievements in gender equality, women empowerment and child protection, have been made possible by a strong political will from the highest level which resulted in the creation of a legal framework and institutional mechanisms for the advancement of women and child protection.

a. Legal and policy framework for women and child protection

- The Constitution of the Republic of Rwanda of 2003 Revised in 2015 enshrines the principles of gender equality and women's rights and provides for the minimum 30% quota for women in all decision-making positions.
- LAW Nº32/2016 OF 28/08/2016 Governs Persons and Family as well as relations between persons.
- Law N° 59/2008 on the Prevention and Punishment of Gender-Based Violence (GBV) punishes marital rape and addresses GBV in all its forms.
- Law N°54/2011 of 14/12/2011 relating to the rights and the protection of the child: Guarantees the rights and protection of all children against abuse.
- Law N° 43/2013 of 16/06/2013 Governing Land in Rwanda: Guarantees Women equal rights with Men on Land access, ownership and utilization.
- Law Nº27/2016 of 08/07/2016 Governing Matrimonial Regimes, donations and successions governs matrimonial regimes, donations granted or received within a family and successions.
- Law N° 13/2009 of 27/05/2009 Regulating Labour in Rwanda: Provides for equal opportunities and equal pay for women and men, and prohibits sexual harassment in the workplace.
- Organic law N° 10/20/2013/OL of 11/07/2013 Governing Political Parties and Politicians: Prohibits any form of discrimination based on gender, sex, race and religion in political parties.
- Organic Budget Law N° 12/2013, Instituting Gender Responsive Budgeting: Enforces accountability measures for Gender sensitive resource allocation across sectors programs and projects through Gender Budget Statements; a mandatory annex of the Budget Framework Paper submitted to both chambers of Parliament.
- Organic Law N° 01/2012/OL of 02/05/2012 instituting the Penal Code represses crimes related to the sale of children, child prostitution and child pornography.
- Law No 32/2016 of 28/08/2016 Governing Persons and Family Governs natural persons and family as well as relations between persons.
- Law N°003/2016 of 30/03/2016 Establishing and Governing Maternity Leave Benefits Scheme establishes and governs maternity leave benefits scheme.

b. Institutional Mechanisms for the Advancement of Women and Child Protection

The political will for ensuring gender equality, the advancement of women and children in Rwanda is demonstrated by a strong institutional framework that has been established, which include: Ministry of Gender and Family Promotion (MIGEPROF), Gender Monitoring Office (GMO), National Women Council (NWC) and Forum for Women Parliamentarians (FFRP), and the National Commission for Children (NCC).

- The Ministry of Gender and Family Promotion (MIGEPROF) ensure strategic coordination of policy implementation in the area of gender, family, women's empowerment and children's issues. It plays a leading role in the implementation of Gender Agenda. Under the lead of this ministry, the following policies have been formulated: National Policy for family promotion, National gender policy and strategy, National GBV policy, Early Childhood Development Policy, National Policy for OVC, Integrated Child Rights Policy, etc.
- Gender Monitoring Office (GMO) monitor gender mainstreaming and the fight against Gender Based Violence in public, private, civil society and religious institutions to achieve gender equality in Rwanda. It organizes, mobilizes and advocates for women participation in National Development. In 2015-16, GMO conducted assessment in the public, private and civil society institutions to explore to which extent gender equality and fighting Gender Based Violence are reflected in programs and planned interventions/activities.
- National Women Council (NWC) is responsible for building women's capacity and ensures their participation in national Development through advocacy and Social mobilisation. One important intervention of NWC is the financial support of 135 women cooperatives across the country and the support of the Parent's evening forum
- Forum for Women Parliamentarians (FFRP) oversees and advocates for the enactment of Gender sensitive laws.
- National Commission for Children (NCC) is responsible for the monitoring, promotion and protection of the rights of children in Rwanda. It has a special mandate to ensure the realization of the rights and freedoms of Rwanda's children, particularly those that are vulnerable in society.

2.1.3.2.2. Protection of refugees and other disasters victims

Rwanda started experiencing ethnic-based hostility from 1959. The Rwanda post-colonial history has been marked by experiences of refugees. The hostilities forced thousands of its population to seek asylum in different countries across the region. The 1994 Genocide against Tutsis that cast a dark shadow over the country saw millions of Rwandans scattered across the world, especially in Africa. In addition, Rwanda also hosts refugees from neighbouring countries, mainly the Democratic Republic of the Congo and Burundi.

However, the Government of National Unity that was established after the 1994 Genocide against Tutsis invested considerable efforts in re-establishing peace and security, enforcing unity and reconciliation, as well as restoring social cohesion to ensure that all circumstances led to massive exile of Rwandans are eliminated. To sustain these efforts, the GoR established legal, policy and institutional frameworks and mechanisms to protect refugees.

a. Legal and policy frameworks for the protection of refugees and other disasters victims

- Law N° 12/2014 of 09/05/2014 This Law governs refugees and asylum seekers in Rwanda.
- Law N°41/2015 of 29/08/2015 establishes disaster management in Rwanda.
- Ministerial instruction N°02-2016 of 01-06-2016 determines the management of refugees and refugee camps.
- The National Disaster Management Policy establishes the guiding principles and architecture for disaster management in Rwanda by presenting the institutional structures, roles, responsibilities, authorities and key processes required to achieve a coordinated, coherent and consistent approach. The policy provides overarching frameworks for decision-making and coordination across disaster management sectors and actors, including government ministries, civil society organizations, international organizations and the private sector.
- National Contingency Matrix Plan gives general guidance on response mechanisms and operations during emergencies, responsibilities, roles of partnering institutions. It identifies and clarifies roles and responsibilities of the internal and external stakeholders throughout the entire cycle of disaster management.

b. Institutional mechanisms for the protection of refugees and other disasters victims

At the national level, the formulation and coordination of policies for disasters management (DM) and refugee affairs policies is the responsibility of the Ministry of Disaster Management and Refugee Affairs. A comprehensive implementation of these policies is done through a national and decentralized collaboration with a broad range of actors from the government, the civil society and the development and humanitarian community. The institutional framework for Disaster Management and refugee affairs is composed of the following body:

At the national level, there are four leading committees:

- **National Disaster Management Executive Committee (NDMEC)** is the highest DM decision-making body, sits at the Central Government level and is chaired by the Minster responsible for Disaster Management. NDMEC is responsible for the overall national coordination and makes decisions on national DM issues, especially during emergencies. In case of a major emergency, the NDMEC is the main advisory committee to government role in conducting the response.
- **National Disaster Management Technical Committee (NDMTC)** is composed of Focal Points from Line Ministries and Institutions members of the NDMEC. It is responsible for advising the NDMEC on the planning and implementation of interventions for disaster management.
- **National Platform for Disaster Risk Reduction (NPDRR)** is composed of line Ministry focal points for disaster management and all organisations playing a significant role in Disaster Management. The NPDRR is chaired by MIDIMAR and co-chaired by the United Nations Resident Coordinator.

- **The UN/MIDIMAR Joint Intervention Management Committee** is joint coordination mechanism to facilitate the effective and efficient collaboration between MIDIMAR and the United Nations in Rwanda. The Joint Intervention Management Committee is chaired by the Minister of Disaster Management and Refugee Affairs and co-chaired by the representative of the United Nations in Rwanda.

At the decentralized level, the disaster management is coordinated as follows:

- **District Disaster Management Committees (DDMC)** is set up in each district of Rwanda. Work in close collaboration with the relevant Local Government structures and Stakeholders in their respective areas.
- **Sector Disaster Management Committees (SDMC)** play an important role in the community by carrying out Disaster Management activities, mobilizing communities in the identification of causes of their vulnerability to risks and implementation of the risk reduction programmes.

2.1.3.2.3. Protection of Persons with Disabilities

Rwanda has ratified both the UN Convention on Rights of Persons with Disabilities (UNCRPD) and its optional protocol. From there, the Government is a clearly committed to engage constructively on issues of disability. It is in this move that legal and institutional instruments have been established to ensure the protection of people with disabilities.

a. Legal and policy mechanisms to protect Persons with Disabilities

- Law N° 01/2007 of 20/01/2007 protects disabled persons in general;
- Law N°02/2007 of 20/01/2007 protects, particularly, former combatants who were disabled during the war;
- Ministerial Order N° 010/07.01 of 12/10/2007 provides for the regulation of the federation, associations and centres responsible for the welfare of persons with disabilities.
- Presidential Order N° 37/01 of 14/7/2009 ratified the agreement establishing the African Rehabilitation Institute, adopted in Addis Ababa, Ethiopia on 15 July 1985; and entrusted the Minister of Health and the Minister of Foreign Affairs and Cooperation with its implementation.
- Ministerial Order N° 01/2009 of 19/6/2009 Determines the Modalities of Facilitating Persons with Disabilities to Practice and Follow Cultural, Entertainment and Sports Activities.
- Law N°03/2011 of 10/02/2011 establishes and determines the responsibilities, organization and functioning of the national council of persons with disabilities.
- Disability Mainstreaming Guidelines propose practical steps of mainstreaming disability in various areas of life.

- National Council of Persons with Disabilities (NCPD) Strategic Plan and Its Operational Plan for the Implementation set out the objectives and strategies for the period 2013-2018.

b. Institution framework for the protection of persons with disability

The National Council of Persons with Disabilities was created by the Constitution of June 3, 2003 as amended to date, and was established by the Law N°03/2011 of 10/02/2011 determining its responsibilities, organization and functioning. It is a public and independent institution with legal personality and both financial and administrative autonomy. It is a forum for advocacy and social mobilization on issues affecting persons with disabilities in order to build their capacity and ensure their participation in national development. The Council assist the Government to implement programs and policies that benefit to persons with disabilities.

2.1.3.2.4. Protection of rights of other vulnerable populations

a. Legal and policy frameworks

The GoR established different mechanisms meant to ensure the enjoyment of fundamental human rights secured by the Constitution and other national and applicable international human rights laws. Rwanda's Constitution dedicates forty-one (41) Articles to establishing and ensuring fundamental human rights and freedoms. The commitment to realise those fundamental rights is stated in the Country's Vision 2020 and Economic Development Poverty Reduction Strategy 2 (EDPRS II) which form the baseline for every government policy and program.

Improvements in the law and practice relating to access to justice; human rights, freedom of expression and association; promoting gender equality, among others, led to significant transformation of the human rights situation in Rwanda over a decade. Rwanda has registered some key improvements, globally in these and more areas.

b. Institutional frameworks

To ensure the enforcement of laws meant for the protection of human rights in Rwanda, the GoR established many institutions dedicated to the monitoring and reporting on the implementation and compliance with human and fundamental rights in Rwanda. These institutions include:

- **National Commission for Human Rights (NCHR)** was created in 1999, and is a constitutional body provided for by Article 177 of the Rwandan Constitution. It is an independent institution responsible for the promotion and protection of human rights in Rwanda. A new Law No 19/2013 of 25/03/2013 determines the mission, organisation and functioning of the NCHRi which re-affirms the independence and autonomy of the NCHR in performing its functions. That law requires the NCHR to present reports of its activities only to the Parliament for consideration. A key mandate of the NCHR is education and sensitization of the population on their human rights.

- **The Office of the Ombudsman** is established by the Constitution of 2003 as amended to date. In 2013, additional powers were granted to the Office which included expanded authority to investigate human reported rights violations. It now has the mandate to act as a link between the citizen, public, and private institutions and to investigate complaints of injustice, corruption and related offences in public and private entities. The Office of the Ombudsman also receives complaints from individuals and associations regarding the behaviour of civil servants. It is empowered to report on unlawful acts, investigate and initiate prosecutions against corrupt actors. Annually, the Office of the Ombudsman organizes a national campaign commonly known as "Anti-corruption week" and a second week focusing on fighting against injustice. During those campaign weeks, the Office increases awareness of its mandate and existing reporting structures in communities across the country. Individual and collective complaints related to corruption and unfair practices by civil servants are also received during those weeks.
- **The Rwanda Governance Board (RGB)** is a public institution established by law No 41/2011 of 30/09/2011. It was formed from the merging of Rwanda Governance Advisory Council (RGAC) and the National Decentralization Implementation Secretariat (NDIS). RGB's core mission is to promote the principles of good governance and decentralization, conduct research and policy analysis related to governance, monitor the practices of good governance, coordinate and support media sector development and enhance citizen participation among others. In the fulfilment of its mandate, RGB conducts regular research on the impact and perception of Government services among the public.
- **Parliamentary Committees on Human Rights:** The Parliament of Rwanda has also two specific committees in charge of human rights. The Committee on Unity, Human Rights and Fight against Genocide which is in the Chamber of Deputies, and the Committee on Social Affairs and Human Rights and Petitions which is in the Senate. Apart from receiving individual complaints on human rights, both committees are responsible of all issues relating to harmonization of Rwandan laws and international conventions on human rights ratified by Rwanda, and they examine the functioning of the structures of administration that have relationship with respect of human rights; unity and reconciliation of Rwandans.
- **Rwanda Correctional Service (RCS)** was created in 2011 from the merger of the former National Prisons Service (NPS) and the Executive Secretariat of National Committee of Community Services "Travaux d'Intérêt Général" which operates (TIG) as an alternative penalty to imprisonment. It is an institution that rehabilitates convicts to become responsible citizens following their time served, rather than being a punishment-oriented body. Since its establishment in July 2011, RCS designs proper correctional regimes including the promotion of justice, through aligning with international standards, and proper coordination with other justice sector institutions to prepare for the effective reintegration of inmates back into society.

2.1.4. Integration across sectors to improve intersectoral action for health and health equity

In Rwanda, like in other countries, the key drivers of health inequities include education, globalization, employment and working conditions, food security, water and sanitation, healthcare services, housing, income and its distribution, unplanned urbanization social exclusion, etc. Those drivers, commonly known as social determinants of health, are outside the control of the health sector and then, health issues cannot be solved exclusively by actions of the health sector.

In Rwanda, SDH are addressed through multisectoral actions and are implemented by more than one sector. One of Rwanda's key achievements in addressing drivers of health inequities has been the creation of national clusters responsible for ensuring joint planning, monitoring, and evaluation of crosscutting interventions. This approach is highly recommended in EDPRS 2 implementation to manage coordination and collaboration issues that were encountered in the implementation of the first two medium-term strategic plans (PRSP and EDPRS1) to implementation of Vision 2020.

The Government created four ministerial clusters to maximize intersectoral collaboration among different sectors:

- **The Social Cluster** is responsible for the coordination of social affairs interventions planning and implementation.
- **The Economic Cluster** is responsible for streamlining joint actions and programs contributing directly to the economic development. These include Agriculture and Animal Resources; Trade, Industry and Tourism; Infrastructure; Improved Settlement; Private Sector Development, Cooperatives and Investment; Forestry, Environment and Natural Resources; Information and Communication Technology
- **Governance Cluster** coordinates joint efforts to promote Good Governance, citizen mobilization; adoption of laws to promote youth and gender development, security and sovereignty, foreign affairs and cooperation, non-government organization (NGO), civil society and media development.
- **Justice Cluster is mandated to foster** Justice in general and, in particular, streamline efforts to fight against Genocide**,** injustices and corruption, as well as promoting the respect for Human Rights.

With the intention to maximize the integration and collaboration among different sectors, the Government of Rwanda reviewed its annual planning and monitoring processes and included in a new system of annual joint performance contracts (known as Imihigo in Kinyarwanda), whereby each concerned stakeholder in a cluster is given tasks to perform and report on quarterly and jointly. The joint performance contract approach started July 2015 is now praised for its capacity to boost intersectoral consultations and collaboration in the planning, implementation, and reporting on achievements of joint interventions/programs.

For instance, in the fiscal year July 2016-June 2017, seven sectors had joint performance contracts: agriculture, energy, export, job creation, service delivery, social protection, and urbanisation.

The social cluster is mainly implementing the Joint Performance contract in social protection programs. Districts, different Ministries and Institutions under social cluster coordination are working together to the achieve two outcomes: (1) Increased coverage of social protection programmes to the extreme poor and vulnerable, and (2) Accelerated and Sustainable Graduation out of poverty.

The table below highlights one example of integration and collaboration efforts in the implementation of Rwanda Joint Action Plan for the Elimination of Malnutrition (JAPEM), developed to operationalize the Food and Nutrition Policy; and the implementation of the community-based health insurance.

Table 10 Integration in the implementation of Rwanda Joint Action Plan for the Elimination of Malnutrition

Output	Indicators	Activities to deliver the output and responsible
Joint action plan to eliminate malnutrition implemented	**Indicator:** Number of cows distributed by end June 2017 **Target**: 34,777 Cows	**MINALOC AND DISTRICTS** • Identification of "Girinka" (One cow per poor family) beneficiaries • Preparation of tender document for Heifer to be purchased • Mobilize different partners' groups mobilized to support Girinka program • Organize Girinka week and pass on events **MINAGRI (RAB)** • Elaboration of technical specification for Heifer to be purchased • Technical assistance of heifers' selection and laboratory test • Monitoring and evaluation of "Girinka" program at decentralization level.
	Indicator: Number children benefiting from one cup of milk program at school **Target:** 85,282 Children	**MINAGRI DISTRICTS** • Ensure the supply of milk to schools • Upscale the program from 112 to 128 schools • Linking 7 Milk Collection Centers (MCCs) to 7 schools • Use milk zone to supply milk to schools in Bugesera, Kigali, Burera and Nyanza. **MINEDUC** • Ensure that milk provided is consumed by targeted children. **MINAGRI & MINEDUC** • Joint follow up with MINAGRI and MINEDUC milk supply to the schools
	Number of under-five children with acute and chronic malnutrition supported.	**MINALOC DISTRICTS** • Conduct beneficiaries target. • Provide milk to under 5 children with acute and chronic malnutrition. • Mobilize citizen to fight malnutrition. • Coordinate and monitor the implementation of JAPEM 2016-2017
	Functional distribution system of fortified blended food to targeted beneficiaries (children under 2 years old, lactating and	**MINALOC (LODA)** • UBUDEHE Category 1 is designed and approved. **MIGEPROF** • Assist in identifying beneficiaries (children under 2 years old, lactating and pregnant mothers in UBUDEHE Category 1) is designed and approved.

	pregnant mothers in UBUDEHE Category 1)	**MINISANTE** • Purchase and distribute Fortified blend food (FBF) • Screen malnourished children.
	1,500 MT of bio-fortified beans produced	**MINAGRI (RAB) Harvest plus** • To avail timely basic seeds • To increase the number of multipliers from 70 to 100. • Follow up multiplication process • Provide technical support **DISTRICTS** • Farmers mobilization • Selection of beneficiaries
	Number of households with kitchen garden (Cumulative)	**MINAGRI (RAB)** • Provide improved seeds and technical support to needy HHs. **MINALOC & DISTRICTS** • Mobilize households for kitchen gardens establishment. • Kitchen garden awareness and monitoring **MINAGRI (RAB)** • Training of farmers through Farmer Field school • Joint follow up with Districts kitchen garden establishment • Provide technical support
School feeding program in 12YBE schools reinforced.	Number of Students in 12YBE fed at school	**MINEDUC, MINALOC Districts** • Organize mobilization campaigns on school feeding program **MINEDUC Districts** • Organize mobilization to school feeding program • Screen most vulnerable students to be supported • Provide subsidy to most vulnerable students • Monitor the school feeding program
Community-Based Health Insurance Strengthened.	Proportion of people covered under Community Based Health Insurance Scheme (CBHI).	**MINALOC** • Mobilize the citizen to participate in the community-based health insurance. **MINISANTE MINECOFIN** • Transfer to RSSB annual CBHI subscription for indigents as per RSSB request.

	MINISANTE • Ensure the quality of health services. **MINECOFIN** • Ensure adequate PFM mechanism, • Train mobilization committee's members.

As stated in the above-table, there is a clear intersectoral action approach in addressing the malnutrition through the Joint Action Plan for the Elimination of Malnutrition (JAPEM) and in implementing CBHI program. For the JAPEM, the intersectoral approach is described as follows:

- **MINALOC** ensures the coordination of the implementation (including sensitization of the population on nutrition and Hygiene) and Monitoring and Evaluation of the plan at central, and district levels
- **MOH** coordinates the implementation of nutrition activities related to prevention and treatment/ rehabilitation as well as technical support to other sectors
- **MIGEPROF with the National Women Council (NWC)** ensures the implementation of the plan at household level; focusing on supporting home production of nutritious foods, healthy preparation and monitoring of food intake for under five children and pregnant women
- **MINAGRI** ensures food security and family production of nutritious foods like establishment of kitchen gardens and small animal rearing and sufficient foods at household level and with the help of Farmer's Promoters.
- **MINEDUC** ensures sensitization of good nutrition at schools, focusing on school feeding and nutrition education in schools.
- **MIDIMAR** ensures coordination and sensitization on good nutritious in the refugee camps.

To step up intersectoral actions in the eradication of malnutrition, a National Nutrition and Food Program Coordination Secretariat was recently created to ensure collaboration among stakeholders involved in the fight against malnutrition in Rwanda.

As regards to CBHI implementation, the joint intersectoral is done as follows:

- MINALOC coordinates with decentralized government entities for the mobilization of citizen to participate and adhere to the community-based health insurance.
- MINECOFIN and RSSB is coordinate the collection of CBHI premiums and CBHI financial management
- MINISANTE ensure the quality of healthcare services for CBHI members

2.2.Rio Declaration Theme 2: Participation in policy-making

2.2.1. Background

Citizens or community participation in policy making and implementation is part of good governance and concerns the engagement of individuals and communities in decision-making and implementation about things that affect their lives [30]. Widespread community participation improves the sense of ownership of the policy process among ordinary citizens and government, as well as ensures the quality of the policy produced. It also provides people with the opportunity to influence decisions that affect their lives and strengthens participatory democracy including improving the quality of governance by allowing citizens to demand greater transparency and accountability from the authorities [31].

Before 1994 Genocide against Tutsi, the governance structure was very hierarchical, centralised and authoritarian. Then after the Genocide against Tutsi, the governance system and decision-making processes came into question, and it was clear that change was needed. In 1999, plans for democratic decentralisation began to be implemented. The decentralisation process was intended to reduce poverty through improved standards of governance and better accountability of the government to its people. The ultimate goal was to increase the voice of the population in government and to make it more responsive to people's needs.

As a result of the promotion of good governance principles, decision-making powers have now been decentralized and devolved from the central government level down to district and community levels. Many legal and policy frameworks, as well as institutional mechanisms were also developed to facilitate and boost effective community participation in policy and decision making. The achievement of the GoR can be summarized in the following three key components:

- Decentralization of power to enhance community empowerment and citizen participation;
- Creation of conducive policy and regulatory frameworks for civil society, private sector and other stakeholders' participation in policy dialogue;
- Translation of culturally owned practices into social development programs and strategies to improve communication between leaders and the population;

2.2.2. Achievements in the promotion of participation in policy-making

2.2.2.1. Decentralization of power to enhance community empowerment and citizen participation

The post-genocide government vowed to decentralize power as a way of consolidating participatory governance and fast-tracking citizen-centred development. This orientation was inspired by the fundamental principles of human rights, dignity, freedom and development that had been violated until 1994. Further, the decentralization of power was intended to enhance accountable governance through promotion of citizen participation and mobilization for delivery of development, strengthening public accountability and improving service delivery [2], [20].

The determination to enhance citizen engagement in decision-making and service delivery has been translated into action by the Community Development Policy adopted by the GoR in 2001 and amended in 2008. This policy envisages a community that is organised, self-motivated, hardworking, forward-looking, and has the ability to exploit local potential with innovations geared towards sustainable development. It hence identifies the Village (Umudugudu) as the core formal community and focus of the policy; and aims at effective and sustainable participation of the community in its own development, so as to achieve poverty reduction and self-reliance based on the sustainable exploitation of available resources[32]. The review of a range of government reports, and consultation with a number of relevant institutions found that significant achievements have been realized in decision making participation as summarized below.

- The GoR has made impressive progress in putting in place legal and policy frameworks, as well as institutional and policy reforms that reinforce the role of districts in the local development. The Ministry of Local Government coordinates the overall compliance with decentralization policy and laws. Districts, as local government, coordinate the implementation of the decentralization policy and ensure community engaging and participation.
- Decentralization policy has been enhanced and people's participation in electing their leadership has been increasing constantly.
- The law governing decentralized entities has been revised to clearly define responsibilities of the local entities.
- Rwanda Decentralization strategic framework was also revised and harmonized with EDPRS 2 priorities.The Cell, an administrative entity which is closest to the community, is now staffed with two permanent staff (Executive Secretary and a Socioeconomic Development Officer).
- In 2011, participation in electing members of the parliament and local leaders reached 96%. The general average of citizen participation in Umuganda has reached over 78.1%.
- Governance month has been introduced for the local leaders to directly interact with citizens and address some of their issues.

2.2.2.2. Creation of policy and regulatory frameworks for civil society, private sector and other stakeholders' participation in policy dialogue

GoR recognizes civil society organizations (CSOs), non-government organizations (NGOs) and the Private Sector as key partners in the national development[2], [20]. CSOs and NGOs participate in a wide range of sectors such as human rights, accountable governance, social protection, peace and reconciliation, community development and empowerment.

To streamline efforts and contributions of NGOs and CSOs to the Rwanda's socioeconomic development, the GoR created the following legal, policy and institutional frameworks:

2.2.2.2.1. Relevant national-level laws and regulations affecting civil society include

- Organic Law 55/2008 of 10/09/2008 Governing Non-Governmental Organizations;
- Law Number 04/2012 of 17/02/2012 Governing the Organization and Functioning of National Non-Governmental Organizations;
- Law Number 05/2012 of 17/02/2012 Governing the Organization and Functioning of International Non-Governmental Organizations; and
- Law Number 06/2012 of 17/02/2012 Governing the Organization and Functioning of Religious-Based Organizations.
- Ministerial order Nº 001/07.01 OF 14/01/2013 Determining Additional Requirements for the Registration of Religious-based Organizations.
- Organic Law N° 10/2013/0L of 11/07/2013 Governing Political Organizations and Politicians.

2.2.2.2.2. Institutional and policy mechanisms supporting the coordination of CSOs

- The overall national coordination of CSOs is done by Rwanda Governance Board (RGB), an autonomous body with the mandate to monitor service delivery by the private sector, to register non-governmental organisations (NGOs) and civil society organizations (CSOs) facilitate them in the implementation of their interventions.
- The Joint Sector Review (JSR) is also another participatory forum that brings together stakeholders across each sector, including government, private sector, CSOs, and donor institutions.
- At the decentralized level, the action of CSOs and NGOs is coordinated through the Joint Action Development Forum (JADF), a framework established in 2007 by the Ministerial Instructions No. 04/07 of 15/07/2007 to serve as a consultative forum for District Development Stakeholders (CSOs, NGOs, Development Partners, Private and Public Sectors and Local Government). JADF operates in all the 30 Districts where at every District there is a Permanent Officer in charge of day to day operations of JADF. In the beginning, JADF operational framework was chaired by the Vice Mayor in charge of Finance and Economic Development but with time as JADF evolved in its operations at District level, members decided to elect any competent member to Chair JADF outside of the District administration and influence. Many District JADFs Committees are chaired by officials from different NGOs/CSOs operating in those Districts.

2.2.2.2.3. Private Sector Engagement (PSE)

The Private Sector has been the backbone of the creation of Rwanda's impressive economic growth over the last ten years. Privatization and the creation of Rwanda Development Board (RDB) have been very essential in engaging with the private sector across all sectors to fast-track Rwanda's economic growth and development.

RDB has the mandate to transform Rwanda into a dynamic global hub for business, investment, and innovation by fast tracking economic development in Rwanda and by enabling Private Sector growth. Its scope of our work includes all aspects related to the development of the private sector. This involves working with and addressing the needs of companies of all sizes and both local and foreign investors.

In 1999, the Rwanda Private Sector Federation (PSF) was founded as the Private Sector's counterpart and umbrella organization in the Private Public Partnership (PPP) framework in Rwanda. It replaced the former Rwanda Chamber of Commerce and Industry. PSF promotes and represents the interests of the Rwandan business community. It groups 9 professional chambers. It was established in December 1999. The foundation of PSF has ensured a stronger voice on sectoral matters; stronger capacity to provide sector specific services; and easier and more effective consultation with a more holistic and less fragmented view of industries. Beyond a strong brand and membership base, PSF pioneered Business Development Services (BDS), registered wins in advocacy and played a strong national and regional role.

The participation of the private sector in the Health Sector is set out in EDPRS2 and provided for in the Health Sector Strategic Plan. The private sector is also consulted through all processes of annual planning and participates in the provision of curative healthcare services through a number of private clinics, polyclinics, dispensaries and hospitals operational, especially in urban areas although limited in number. Through Public Private Partnership (PPP) mechanism, up to 409 health posts have been created in remote places, where no health centres exist and the process is on-going. The private sector is also involved in promotion and social marketing of different medical products widely used for disease prevention (condoms) and treatment (e.g., oral rehydration solution) including distribution of pharmaceutical products.

The MOH is promoting partnership with private investors in the local production of medicines and other commodities. Private sector is already involved in the teaching of health professionals (Faculty of medicine, Nursing schools, Allied health science schools, specialized clinics, and partnerships are being built to strengthen existing health facilities (King Faysal Hospital).

The Private Sector is currently engaged in fighting of malnutrition where a Fortified Blended Foods (FBF) project is operational in Rwanda and is producing the complementary food for children, pregnant and lactating women. This project is partnering with Government of Rwanda, where the beneficiaries from categories 1 of Ubudehe are receiving the fortified food free of charges (government have already subsidized). With regard to SDH, the Private Sector engagement is still low, but, Private sector is solicited to implement policies that address production, import and distribution of unhealthy products: manufacture of tobacco products; sugar; fast food and junk foods; alcohol; automobiles; and prevention of advertisement of health damaging products.

Private sector is requested to promote healthy policies like safety programs in factories and agriculture, accident reduction in vehicle transportation, tobacco reduction, the promotion of generic drugs, and the promotion of essential drug lists". Already, the law on tobacco control has been promulgated. Rwanda Standards Board has been established and has in charge of control of the quality of food production and importation, while several other regulations on substance abuse have been enacted.

2.2.2.2.4. Establishment of national and decentralized forums to improve communication between leaders and the population

On top of CSOs and private sector engagement, the GoR implements other national and decentralized forums meant to boost citizen participation. The following are key forums that give citizens and leaders to come together and discuss national and local issues: the National Dialogue Council, election of local authorities, media coverage, visits of the President of the Republic and other high level authorities (Ministers, Parliamentarians) to the population.

2.2.2.2.5. National level forums

- **National Umushyikirano Council ("Inama y'Igihugu y'Umushyikirano")**: In Kinyarwanda, "Umushyikirano" means a consultative meeting where participants are able to exchange ideas, share experiences and question each other. This forum is governed by the Rwandan Constitution (article 140). It is convened every year, and is chaired by the President of the Republic. It provides all Rwandans with the opportunity to ask questions directly to their leaders. Participants debate issues relating to the state of the nation, the state of local government and national unity. There is an annual theme for each Umushyikirano. The event is attended by members of the Cabinet and Parliament, representatives of the Rwandan community abroad, Local Government, media, the diplomatic community and others invited by the Head of State. It is a leading example of participatory and inclusive governance. It directly engages citizens with their leaders, and Rwandans are part of the decision making that affects their lives. Finally, it is a forum for Rwandans to hold State officials accountable.

- **Visits of the President of the Republic to the Population:** Presidential visits to Districts are mostly appreciated by the population, where the President of the Republic gives citizens the opportunities to ask questions and raise their concerns, mainly those that have not been solved by the Local Government, and many of them relate to health. Due to lack of time, all the questions raised by the population that are not immediately addressed by the President, the team accompanying him documents the issues and forward them to the concerned institutions with clear action-points for implementation. At district level, solutions to questions raised by the population are part of the District performance contracts and implemented accordingly, while regular progress are submitted to the President's Office.

- **Commissions in the National Parliament** hold public hearings on the legislation under review, and both Deputies and Senators have increasingly sought constituent views during their visits to the field. The **Parliament Social Affairs Commission** is in charge of monitoring social activities including health. Every year, the Commission organizes field visits to monitor implementation of social services, and social service delivery at district level. During their visits in districts, among other matters, they collect opinions and demands from citizens and ensure that they have been taken into account by concerned ministries. Most of time this is made in coordination with the National Human Rights Commission.
- In the Cabinet, every Minister has a District as his/her **constituency**, follows up and monitor activities carried out by the District through regular visits and identify different problems and challenges faced by the district and reports directly to the Cabinet.
- **Councils for special categories of the population:** to ensure social inclusiveness and equity, there are different councils where specific needs are discussed and channelled for the appropriate decisions and national advocacy. These councils include National Women Council, National Youth Council and National Council of People with Disabilities.
- **The media coverage:**
    - **Press Conferences**: The President of Republic and other Cabinet Members hold a monthly press conference where media ask different questions related to the problems faced by the community, as well as clarifications on Cabinet Decisions. Regular press conferences are also organized between media and different ministries, including the Minister of Health.
    - **Radio remains** Rwanda's most popular media source that covers almost the entire nation. The number of radio stations increased from one 2 radio stations in 1994 to over 30 radio stations currently; including community radio stations that play a great role in increasing the flow of information and feedback between policy-makers and the community.
- **Good Governance Surveys** are conducted annually measure the population satisfaction about service delivery. The large part of these surveys is conducted by Rwanda Governance Board: The Rwanda Citizen Report Cards, the Rwanda Governance Scorecards, the Rwanda Civil Society Development Barometer, and the Rwanda Media Barometer. Two additional annual assessments are conducted by the Ministry of Local Government: Social Sector Assessment, and Service Delivery Assessment.

2.2.2.2.6. Decentralized forums

At decentralized level, several mechanisms have been institutionalized to promote and strengthen citizen participation and accountability links between the population and Local Government.

- **Governance month** (Ukwezi kw'Imiyoborere) consists in a full month of awareness campaign where local authorities meet the population in villages to discuss about good governance, community development and others population issues.
- Community w**eekly outreach meetings** with Local Government: Every Wednesday, local authorities organize outreach meetings at village level. During those meetings,

socioeconomic topics such as Health Insurance coverage, Hygiene and sanitation, Nutrition and family planning etc. are included on the agenda.

- **The Parents' evening forum (Umugoroba w'Ababyeyi) i**s a forum in which Families (both men and women) come together at the village level to discuss and solve problems and challenges in families and in the village. In many occasions, these forums discuss and solve domestic conflicts. They also discuss available opportunities strategies to effectively develop their community or village[33].
- This forum contributes positively to health as they are discussing issues pertaining to social, health, and economic development including resolving family conflicts, promoting family planning and adolescents' reproductive health, Fighting and preventing Gender Based Violence; Protecting and providing good care for their children; fight against malnutrition, promotion of hygiene and sanitation, strengthening social cohesion and solidarity, discuss on income generation projects etc.
- **Umuganda** (Monthly community works): is organized every last Saturday of each month. The population at each village meet in a pre-defined place to execute community works, mainly the maintenance of local roads, construction of classrooms, construction of a public offices, fighting soil erosion, construction of a house for poor families, etc. After works, a meeting is organized and the population discuss about problems that the village is facing. Umuganda promotes community involvement and strengthens cohesion between community members of different background and levels. It also promotes volunteerism and strengthens ownership of socioeconomic development. Also, Umuganda is an opportunity for the population to access authorities and articulate their needs and voice opinions on various issues. The meeting after Umuganda, known as "Inteko y'Abaturage" in Kinyawanda (Assembly of the Population) takes decision on all issues pertaining to the welfare of the Village. Umuganda is a good opportunity for health promotion and behaviour change communication where the messages regarding malaria prevention, hygiene and sanitation, Community Based Health Insurance adherence, fight against malnutrition etc… are provided. Umuganda is also an effective channel of communication between the Government entities and the population. Most of announcements and communications requiring a national dissemination use Umuganda events to spread the messages across the country at once.
- **Accountability day** is organized at the end of every quarter and is dedicated to the presentation of the progress achieved in the implementation of the District performance contract. During the meeting, the population ask questions and provides its opinions.
- **The weekly District authorities' outreach** (Wednesday): this day is already institutionalized. District, Sector and cell authorities meet the population every Wednesday. They discuss on the district development issues, and problems that are faced by the population, including health. Meanwhile the population is invited to propose possible solutions to problems raised during the meeting.
- During the **District annual exhibitions**, the District authorities are in contact with the population and they discuss on how their activities may be improved. Exhibitors also receive different advices from the visitors, on how to improve their production in order

to increase their income, have better access to social services and improve their living conditions.

- In addition to the above forums which are implemented across all Districts, some have established different initiatives that facilitate community participation. For example, The "Malayika Mulinzi" (Guardian Angel) in Musanze District calls upon citizens to take care of orphans and other vulnerable children in the community; the "Ijisho ry'Umuturanyi"(Neighbour's eye) initiative consist in community sensitization to report drug dealers, etc.

2.2.2.3. Institutionalization on traditional volunteerism initiatives as home-grown solutions to accelerate community development.

In addition to modern institutions, African countries use traditional good practices drawn from their culture to solve their problems, mainly at village level. The relevance of traditional methods is progressively gaining an audience among policy makers. As example, in 2004, the United Nations Economic Commission for Africa (UNECA) organized a forum which discussed governance in Africa, including the role of traditional systems of governance in the modern culture acknowledging the increasing reality of synergy between the traditional and the modern context. Traditional mechanisms are rooted in symbolism which not only ensures that the whole community participates, but also ultimately emphasizes the notion of local ownership ([34]

In the Rwandan traditional, several positive practices were rooted in the culture and history. They served to construct a strong culture from which the Rwandan population evolved without divisions or internal conflicts across centuries.

To rebuild the shared national unity and identity after the 1994 Genocide against Tutsi, the GoR drew on aspects of Rwandan culture and traditional practices to enrich and adapt its development programs to the country's needs and context. Home grown solutions are culturally owned practices, adapted and translated into development programs. The most important home-grown solutions include:

- **"Abunzi"** (Mediators): They were men known within their communities for personal integrity who were asked to intervene in the event of conflict, to settle disputes and also to reconcile the conflicting parties and restore harmony within the affected community;

- **"Gacaca"** (traditional community court): small clearing where a community would traditionally meet to discuss issues of concern. People known for their integrity (elders and leaders) in the village ("inyangamugayo") were requested to facilitate a discussion about a dispute between 2 parties. Any member of the community is allowed to participate actively. Afterwards, the inyangamugayo proposes a solution to the problem discussed. In 2002, "Gacaca" courts were revived as a way to process the millions of criminal cases that arose following the genocide. Contemporary Gacaca draws inspiration from the traditional model by replicating a local community-based justice system with the aim of restoring the social fabric of society. In total, 1,958,634 genocide related cases were tried through Gacaca.
- **"Itorero"** (Civic education): a cultural school created for young people where Rwandans would learn language, patriotism, social relations, sports, dancing, songs and defence.

2.3. Rio Declaration Theme 3: Health Sector Reform to Reduce Health Inequities

In a move to reorient the health sector towards reducing health inequities, Rwanda performed four important reorientations:

- Decentralization of healthcare services up to the community level
- Major Investments in Universal Health Coverage
- Promotion of integration of interventions and programs
- Establishment of strong regulations and policies for the protection of the population

2.3.1. Decentralization of healthcare services up to the community level

In line with different reforms undertaken after the 1994 Genocide against Tutsis to improve service delivery across all sectors in Rwanda, the Health system has also been reorganized to align with the new territorial administration that was reorganized to allow the implementation of the Decentralization Policy. In addition, the reorganization of the health system was undertaken to ensure universal demand and access to affordable quality services, and to encourage and value community inputs; to identify health priorities and needs expressed by the population, with focus on wellbeing of individuals and communities, especially women and children; and fosters equity, inclusion and integration of marginalized groups.

The health system reorganization aligning it with the decentralization programs allowed achieving very impressive progress. The number of health centres trebled, 14 new hospitals were constructed, and a strong Community Health Workers' system was established. With 3 CHWs in each village, there are now 45,516 CHWs deployed in the community across the country.

At the Cell level, health posts have been recently as a second layer supplement the community health system. So far, 501 have been built in places located too far from health centres and are operational. Along with the community health system, health posts contributed to bringing health services closer to the population.

There is now at least one Health Centre established at each Sector. This increased the number of health centres from 186 in 1994 to 504 currently. There is also at least one District Hospital in each District (36 district hospitals). At the same time, a Provincial Hospital has been established in each Province (4 provincial hospitals) and 7 Referral Hospitals established at the National level. Currently, the total number of hospitals is 48, from 34 in 1994.

Health centres and district hospitals have been extended and designed in the way to host all essential integrated services to be provided to the population in accordance with defined packages. In Rwanda, health centres look like small hospitals. Similarly, district hospitals and their package have been extended and provided with more capacity (equipment) in maternal health, neonatology and emergency services. Provincial Hospitals have been designed to provide some tertiary care so as to reduce the burden and workload that was observed in the national referral hospitals.

Investments made in construction of new health facilities and the decentralization healthcare services improved geographic accessibility. This average time to access the closest health facility was reduced from 95 minutes in 2006, to 61.4 minutes in 2011, and to 56.5 minutes in 2014. For the next years, the goal is to build more health posts and continue cutting down the average time used to reach a health facility.

2.3.2. Major Investments in UHC

Rwanda has built a remarkable system for universal health insurance coverage to both the segments of its population employed in the rural and informal sectors and the segments employed in the formal sector. This system has improved dramatically with the emergence and extension of the health insurance system. Under the CBHI scheme, the GoR assist the vulnerable people who are not able to pay for themselves by paying premiums and co-pay for them at points of care.

Improvements registered in the geographical coverage pushed the government to further establish other mechanisms that effectively support and ensure universal health coverage. Key mechanisms established are: a functioning health financing system, creation of a pre-hospital care system, and the increase of a competent healthcare workforce.

2.3.2.1. Health financing system

Over the last 15 years, Rwanda has developed a comprehensive financing framework with two main channels for financing, one from the supply side, transfers from the treasury to districts and health facilities (Performance Based Financing) and one from the demand side, the insurance system (CBHI). These mechanisms have permitted to attain important achievements such as reduction of unmet needs, increased consumption of health care, decreased incidence (risk) of catastrophic expenditures and decreased inequality in consumption of health care. This was facilitated by political commitment and the issuance of a legal framework which makes health insurance compulsory for all Rwandans.

Government spending on health has surpassed the 15% required under the Abuja Declaration showing high commitment and support to the development of the sector financing within the Country limited resources. In the 2015/2016 Fiscal Year, it was 16.52% of the Total Government spending [35]. Risk pooling has been greatly improved as a result of the extension of CBHI schemes which allow the majority of the population access to healthcare services and drugs. Social and private health insurances now cover approximately over 4/5 of the population.

2.3.2.1.1. Health insurances

- Rwanda is already advanced in implementing Health Insurance and risks pooling systems, which attained a coverage of about 90% of the population in 2016 (MoH and RSSB reports of 2015/16). There are 4 public health insurance schemes: (1) Health insurance for civil servants in the public sector, managed in RSSB; (2) Health insurance for the Security Organs; (3) Private Health insurance; (4) Community based health insurance (CBHI).
- Health insurance coverage that was very high as 90% in 2011, but dropped considerably to attain 72% in 2012-13 and 2013-14, at the time CBHI Policy changed to increase the contributions of subscribers. During the periods 2016-2017, CBHI adherence increased 84%. When considering the Quintiles, EICV4 (2013-14) showed that only 59.6% households belonging to Q1 were insured. This proportion was 65.2% for Q2, 72.2% for Q3, 75.7% for Q4, and 82.8% for Q5. As the percentage of CBHI started to increase again, these figures may have changed.
- The GoR has scaled up CBHI nationwide. The scheme has succeeded in establishing a functional affordable health insurance system for households operating in the informal sector. It is a success story in health insurance design and implementation as the coverage is among the highest in the world.
- The scheme benefits from a strong public financial support to allow the informal sector population to access the essential healthcare package provided at all levels in an equitable manner, including full subsidization of 16 per cent of the population with low income.

2.3.2.1.2. Performance Based Financing (PBF)

- After improvement in geographic accessibility through the decentralization of healthcare services up to the community level; and the improvement of financial accessibility to healthcare services through the introduction of CBHI, the GoR introduced the Performance Based Financing (PBF) program to improve the quality of healthcare services. The PBF program was intended to increase the quantity and the quality of health services provided, as well as to Increase health worker motivation.
- In Rwanda, PBF program has been a powerful financial instrument for enhancing the performance of the health system as well as the quality of healthcare services. It is associated with the increase of healthcare services utilization that increased from 0.33 (2003), 0.81 (2009), 0.94 (2013); 1.1 (2014) visits per inhabitant, and 1.25 in 2015[36].

2.3.2.1.3. Creation of the pre-hospital care system

In 2007, the GoR continued its efforts to further deepen access to healthcare services and created an emergency medical service unit (SAMU) with 2 levels of intervention: primary intervention from site to hospital and secondary intervention from lower health facility to higher health facility or vice versa.

Ground ambulances increased from 97 in 2007 to 225 in 2014. The district hospital ambulances are managed and repaired by the district hospitals. Maintenance plans and schedules for ambulances exist and there are contracts with specific garages for repair and maintenance. For pre-hospital ambulances, initially there were 4 sites that were reduced to 3 in the city of Kigali. 9 different sites have been created resulting in decreased response time from more than 18 minutes to 12 minutes on average.

At Headquarters site, there are 2 ambulances available 24 hours a day. A toll-free call centre (912) was established in 2009 operating 7/24 and initially most of the cases involved road traffic accidents. By 2012, ambulances started receiving calls beyond road traffic accidents. SAMU started with 12 personnel and now has 62 at Headquarters. For capacity building, there are courses on basic lifesaving skills, medical dispatch and continuous professional development (in cardiac support, learning from case management at SAMU, etc.) and planned continuous professional development with the Department of Injury. In 2013, ambulance attendants were trained (2 nurses and 2 drivers for hospitals and 1 nurse and 1 driver for health centres) in a first aid course by the Rwanda Red Cross trainers.

SAMU has undertaken international interventions where Rwandese were involved in incidents and has strengthened collaboration with other sectors, particularly that of Defence sector. Multi-stakeholder collaboration is in place through the Steering Committee for Disaster Management and there is direct collaboration with the Rwanda Air force for air ambulance (standby team with helicopter to provide air ambulance when necessary) and the Rwanda Marines with boat ambulance (procured and stationed on Lake Kivu at Kibuye marines). Regarding funding of SAMU, salaries of staff are paid by the GoR while SAMU services are paid either through health insurance payments, or out of pocket (for patients not insured). The tariff is set by MOH and is based on distance and consumables use. SAMU contributed to the decrease of maternal and child mortality rate, where the ambulances are called by Community Health Workers to intervene if there is an emergency for pregnant women and she is taken from home to the health facility.

2.3.2.1.4. Increase of a competent healthcare workforce

A number of policy and planning documents are relevant to and inform the HRH sustainability plan. These include:

- Rwanda Vision 2020
- Rwanda Aid Policy, 2006
- Economic Development and Poverty Reduction Strategy (EDPRS), 2013-2018
- Rwanda HRH Policy, 2015
- Health Sector Strategic Plan – 2012 – 2018
- HRH Strategic Plan 2011-2016

Table 11 Document that inform the HRH sustainability plan

National Policy/Plan	Directions of policy/plan related to HRH sustainability
Vision 2020	**Pillar:** Comprehensive human resources development, encompassing education, health, and ICT skills aimed at public sector, private sector and civil society. To be integrated with demographic, health and gender issues"
Economic Development and Poverty Reduction Strategy (EDPRS), 2013-2018	**Foundational issues**: Demographic issues: Food security and malnutrition. Quality, demand and accessibility of primary health care. Consolidating decentralization.
Rwanda HRH policy	**Policy Objectives** • To improve the production of HRH by strengthening education and training • To improve the equitable recruitment and deployment of Human Resources for health system • To strengthen attraction, motivation and retention of available health professionals for increased universal access to health services
Health Sector Strategic Plan – 2012 – 2018	**Priority** "Improve quantity and quality of Human Resources for Health (planning, quality, management"
HRH Strategic Plan 2011-2016	All aspects are relevant

Rwanda has a shortage of Health professional's vis- a-vis to the WHO standards. For example, the expected number of health professionals per population are 1/10.000 (Medical doctor), 1/1000 (for nurse), 1/1000 (Midwife) and (1/1000 (lab technician). But the current situation shows that the health professional available per population are, 1/10,055 (Medical Doctor), 1/1142 (nurse) 1/4037 midwife and 1/10500 (Lab technician)[37].

To manage all issues that were prevalent in the human resources for health (HRH), the MOH adopted its first HRH Policy in 201 and revised in 2015 and the Strategic Plan to guide the planning, management and development of HRH in Rwanda. The first HRH policy and strategic plan clearly state Rwanda's vision in the improvements of HRH.

In the same move to improve skills competence and skills of the health workforce, the curriculum for medical school, nursing and midwifery school and for allied health professional have been reviewed, and postgraduate trainings in all fields have been introduced. These important reforms

and investments undertaken to improve HRH have greatly improved the status of HRH in Rwanda.

Table 12: Ratio-Medical Professionals

HRH Indicator	2011	2014	2015
Doctor/population ratio	1/16,001	1/10,739	1 / 10,055
Nurse/population ratio	1/1,291	1/1,142	1 / 1,142
Midwife/population ratio	1/66,749	1 / 4037	1 / 4,037

2.3.3. Promotion of integration of interventions and programs

In Rwanda, there is a strong political and institutional orientation towards integration of planning and implementation of interventions and programs. For the health sector, integrated services delivery has been defined as one of values and guiding principles of the Rwanda's Health Sector Policy.

The Rwanda health system is now aligned with national goals, among which Vision 2020 and EDPRS overarching goal of poverty alleviation. It leverages and builds on existing assets in terms of infrastructures and human resources, but also on cultural values and institutional bodies. It develops and strengthens decentralized services whenever possible while remaining coordinated. All sectors of the Rwandan population are actively involved, including the private sector and civil society.

The integration of interventions across the entire health system has been facilitated by the merger of all diseases vertical programs under one institution: The Rwanda Biomedical Centre (RBC). This institution was established in 2011, with the mandate to coordinate the technical implementation of all health programs in Rwanda, and serve as technical advisory body for the MoH.

RBC merged over ten disease and health programs related agencies to eliminate duplication of work, increase output and improve efficiency in services delivery. The merged agencies are: National AIDS Commission CNLS); the Centre for Treatment and Research on AIDS, Malaria, Tuberculosis and other epidemics (TRAC Plus); National Medical Referral Laboratory (NRL); National Centre for Blood Transfusion (NCBT); the Procurement agency for medical equipment, drugs and supplies (CAMERWA); Pharmaceutical Laboratory of Rwanda (LABOPHAR); Central workshop and maintenance (ACM); Rwanda Health Communication Centre (RHCC); Expanded Program of Immunization (EPI); Psychosocial consultation services (SCPS); Mental Health Program, and the Non-Communicable Diseases.

Thanks to these reforms, many achievements in terms of integration can be highlighted.

- The effective integration of the planning and implementation of Infectious diseases programs increased the knowledge, behaviours and practices towards specific infectious diseases prevention methods for general and key populations,
- It increased the demand and use of health services for infectious diseases, provided and improved early detection, diagnosis, confirmation, care and treatment of infectious diseases in the general and targeted populations,
- It set foundations to regulate emerging and re-emerging infectious diseases control measures.
- Mental health services have also been integrated into all health facilities of the national system and mental health problems are managed at the community level.
- Community health services have integrated into the community development services and administrative structures. Integrating community health services at every level has been very important as it improved the quality of services for the clients by reducing missed opportunities that often resulted from vertical programs.
- In terms of Partnership and Coordination structures, an institutional framework has been put in place to strengthen intersectoral collaboration at the central, intermediary and peripheral levels of the health system. The Joint Action Development Forum (JADF) coordinates local development interventions, and specifically for health interventions, ensures that all stakeholders fulfil their responsibilities and are accountable within the Sector wide approach (SWAp) at decentralized level and facilitates involvement of private health care providers.
- Different structures have been created to ensure the involvement of all health stakeholders:
- The Health Sector Working Group (HSWG) comprising representatives from the health sector, DPs, and CSO improves the coordination of activities and harmonization of procedures of both the GoR and Development Partners (DPs), in order to increase effectiveness and efficiency of aid in the health sector and to ensure better alignment of DPs behind the Health Sector Strategic Plan (HSSP), with an enshrined principle of mutual accountability.
- Technical working groups (TWGs) are operational entities where technical and policy issues are discussed by staff of MoH with representatives of DPs, NGOs, FBOs, and CSOs. TWGs operate under the authority of the HSWG. The objective of the TWGs is to support and advise the MOH in the implementation of subsector strategies and policies and develop relevant guidelines and tools to be used by the implementing agencies.
- The Single Project Implementation Unit (SPIU) was created to reduce the number of separate projects and the administrative burden of the MOH in managing and reporting on the various projects with off-budget resources.

2.3.4. Regulations and policies for the protection of the population

To ensure the protection of the population, the Rwanda Health Policy promotes "People-centred services" as one of the three value and principles that have to guide all interventions for the population in Rwanda. According to this value and principle, the health system ensures universal demand and access to affordable quality services; encourages and values community inputs to identify health priorities and needs expressed by the population; and fosters equity and inclusion and integrates marginalized groups by focusing on the well-being of individuals and communities, and more specifically of women and children.

The existence of professional health bodies helps the MOH to better organise the medical, dental, pharmaceutical, nursing and paramedical professions. The reinforcement of their structures will allow them to better understand their role, most notably in: the recognition of qualifications, the registration of diplomas, the management of problems relating to professional ethics, and the elaboration and revision of professional classifications according to qualification and specialisation. Equally, they must support the MOH in the accreditation of services and the certification of professionals.

2.4. Rio Declaration Theme 4: Global Governance and Collaboration

Thakur and Weiss define, Global governance as the complex of formal and informal institutions, mechanisms, relationships, and processes between and among states, markets, citizens and organizations, both inter- and non-governmental, through which collective interests on the global plane are articulated, rights and obligations are established, and differences are mediated.

For the World Commission on the Social Dimensions of Globalization (WCSDG) global governance is "the system of rules and institutions established by the international community and private actors to manage political, economic and social affairs" (ILO 2004, p. 75). Therefore, global governance for health concerns (a) any institutions and practices of global governance which affect the determinants of health and (b) institutions and practices of global governance specifically created to address health determinants and outcomes. (WHO, 2007: Commission on SDH: Globalization, Global Governance for Health and SDH: A review of linkages and agenda for action).

With regards to the Rio Declaration, it urges Countries to strengthen international collaboration and address social determinants of health through:

- Building capacity of national governments by providing resources, training and expertise to advance health equities.
- Fostering North-South and South-South collaboration by building capacity and providing technical expertise, and sharing promising and best practices on initiatives advancing health equities.
- Preventing and controlling non-communicable diseases through the health equity lens.
- Providing support to the WHO in its leadership role of global health governance.
- Rwanda's key achievements in strengthening global governance and collaboration include

- The promotion of health regulation in regional integration and international collaboration
- Establishment National Aid Policy (2006) and development cooperation architecture
- Investment in the prevention and Control of NCDs (2011)
- Regular reports on international commitments
- Participation in peace keeping missions

2.4.1. The promotion of health regulation in regional integration and international collaboration

In line with Global governance, the GoR encourages regional and international cooperation; and has adopted an active policy of orienting its various socioeconomic activities towards regional integration of and international cooperation.

Under this orientation, the Ministry of health has put in place all regulations and public health mechanisms to align with International health regulations (IHR) designed under the authority of WHO for the following public health issues: national legislation, policy and financing;- coordination, communication and advocacy related to IHR; surveillance for early detection, rapid response capacity and preparedness and response plan for public health emergencies; risk communication to inform the population during public health emergencies; human resources capacity to implement IHR; laboratory capacity to test, diagnose and confirm public health threats; and specific mechanisms to detect and respond to different public health events: points of entry, zoonotic events, food safety, chemical events and radiation emergencies.

2.4.2. Establishment of National Aid Policy and Development Cooperation Architecture

Since 1994, Official Development Assistance (ODA) to Rwanda has played and continues to play an important role in supporting national efforts on development of poverty reduction. The nature of ODA has evolved considerably since then, shifting from one largely characterized as humanitarian mainly delivered by NGOs to the one characterized as development focus with majority of ODA now delivered through the GoR. Today, ODA in Rwanda complements domestic resources in supporting national priorities as articulated in Rwanda's EDPRS.

In 2005, Rwanda signed the Paris Declaration on Aid Effectiveness along with its Bilateral and Multilateral Development Partners, with the aim of stimulating increased efficiency and efficacy in the provision and management of external aid.

The National Aid Policy was developed in 2006 in the context of the Declaration, and sets ambitious goals that respond to Rwanda's situation and needs. It is the outcome of extensive consultation with stakeholders from across the GoR, DPs organisations, CSO and the Private Sector, and acts as a guiding framework for the management of aid in Rwanda.

The Rwanda Aid Policy requires a Donor Performance Assessment Framework (DPAF) as a part of a mutual review process designed to strengthen mutual accountability at the country level, drawn from international and national agreements on the quality of development assistance to Rwanda. The DPAF reviews the performance of bilateral and multilateral DPs against a set of established indicators on the quality and volume of Development Assistance to Rwanda.

The primary forum for dialogue around the DPAF is the Development Partners Coordination Group (DPCG), recognising that the DPAF aims to be inclusive, bringing together all donors and all aid modalities.

2.4.3. Investment in the prevention and Control of Non-Communicable Diseases

For a long period, the management of NCDs in Rwanda had been considered as a treatment reserved to special settings and most of the time available at the tertiary level in the healthcare system. This was partly due to the low capability of decentralized level to detect and diagnose NCDs. As a consequence, the majority of NCDs cases were referred to the tertiary level and some patients often failed to seek care because they cannot afford the service at tertiary level.

Today, non-communicable diseases are taking more importance in the epidemiological spectrum and they are responsible for the double of the burden of disease that is taking place in country. The number of deaths caused by NCDs is increasing and accounted for 35% of mortality in 2015 (MoH: Annual Health Statistical Booklet, 2015); with cardiovascular diseases, injuries and physical trauma and asthma emerging among the top 10 causes of mortality.

Given this epidemiological situation of NCDs in Rwanda, taking into account the Political Declaration of the High Level Meeting on the prevention and control of NCDs (2011), the action Plan for the Global Strategy for the Prevention and Control of NCDs (2008-2013), and the Global strategy on diet, physical activity and health, and the Global strategy to reduce the harmful use of alcohol the GoR put in place institutional and policy mechanisms to control and manage NCDs in Rwanda.

2.4.3.1. Institutional framework

- In 2011, a Division with a mandate to coordinate actions for the control and management of NCDs in Rwanda has been established in RBC. The establishment of a NCDs Division has allowed decentralizing the management of NCDs.
- The decentralization of NCDs management has already started with District Hospitals (DHs). In each District Hospital, there are staffs trained on adequate management and proper follow-up of NCDs cases. So far, each DH has a team of at least 3 people taking care of NCDs patients. This has solved the issue of lack of services near the population. The aim is to further decentralize the management of NCDs up to the community level.
- As patients are still coming at the advanced stage of the disease, multidisciplinary teams for palliative care have been established in all DHs to take care of those patients with complications and those approaching the end of their life; Pain assessment and management was included to ensure that basic palliative care is provided to all in need.
- Various medicines to treat NCDs have been included on the list of essential medicines and are covered by health insurances, including community-based health insurance. The current list includes medicines to treat the following categories of NCDs: Cardiovascular diseases, Chronic respiratory diseases, Anti-diabetics, and Cancer drugs
- In order to improve the access to NCDs medication, especially the most expensive like cancer drugs, efforts are being made to engage industries and other stakeholders to reduce the cost of these drugs and make them affordable mostly for those using "CBHI".

2.4.3.2. Legal and policy frameworks

A legal and policy framework for NCDs prevention has been established. A policy has been developed, and a ministerial instruction guiding health facilities in the early detection of risk factors and of symptoms has been issued. This helps in the early detection of risk factors of NCDs.

- The Law n°03/2011 of 10/02/2011 determines responsibilities, organization and functioning of the National Council of Persons with Disabilities (NCPD);
- Ministerial Order determining the medical services provided at each level of health facilities
- Law governing narcotic drugs, psychotropic substances and precursors in Rwanda N°03/2012 of 15/02/2012;
- Law No 8/2013 of 01/03/2013 relating to the control of tobacco;
- National protocols and guidelines for NCDs management have been developed and disseminated in Health Facilities.
- The capacity for diagnosis and treatment has been increased at referral hospitals by equipping them with MRI and CT scans. Dialysis centres have been created at CHUB, CHUK, RMH, KFH, Gisenyi Hospital and Gihundwe Hospital. A memorandum of Understanding has been signed with Team Heart to build a centre of excellence for cardiac surgery, a cancer centre of excellence has been created in Butaro district Hospital and its capacity is being built in terms of human resources for the management of cancers.
- The 1st cancer centre with radiotherapy is under development at Rwanda Military Hospital (RMH) and will be launched in April 2018.

- HPV vaccine to prevent cervical cancer has been introduced where young girls between 12-15 years are vaccinated, with coverage of 99%.
- Through advocacy, Health Insurances have accepted to include regular medical check-up in the packages they cover. For the CBHI, the community check-up for NCDs risk factors was also launched in 2014.
- Palliative care and end of life care have been decentralized to community level through the creation of the Home-Based Care Practitioner Program (HBCP) in Rwanda. The program support patients with advanced diseases and their families. Home based care practitioners provide the education about NCDs risk factors at community level contributing to the prevention of NCDs and they also help with the civil registration which is going to help with data that are going to support the country for future planning.
- To improve the capacity to provide in-country specialized healthcare service and conduct research on non-communicable diseases, the Government started, since 2015, a six-year plan to upgrade the capacity of 7 District Hospitals to the level of Provincial and Referral Hospitals to allow them to care of cases requiring specialized care. The upgrade of these hospitals consists in providing them with specialized equipment and medical specialists. Three District Hospitals (Kibuye, Kibungo and Ruhengeri) are being upgraded to the level of Referral Hospitals, while 4 other District Hospitals are being upgraded to the level of Provincial Hospitals (Rwamagana, Bushenge, Ruhango, and Kinihira). The process to equip these hospitals has already started. Kibuye and Kibungo Referral Hospitals have already been equipped with CT-Scan Machines, and Medical Specialist who graduate are directly appointed in these hospitals.
- A National HRH program has been created to allow training specialized health professionals (doctors and nurses) in Rwanda and is contributing to the increase of the medical specialists and specialized nurses to be deployed in referral and provincial hospitals.
- A big number of NCDs are the result of four particular behaviors: tobacco use, physical inactivity, unhealthy diet, and the harmful use of alcohol and other substances. Through different channels, the population is sensitized to prevent NCDs by avoiding the above-mentioned risky behaviors. The sensitization focuses on reducing the exposure to the major risk factors and benefits of early consultation and diagnosis.
- The awareness activities are regularly conducted to improve the general knowledge about the prevention of NCDs risk factors and early detection. The sensitization is done using different communication channels:
    - **In Health Facilities**: sensitization for healthy pregnancy: good nutrition, avoiding alcohol and toxin,
    - **Mass sports** for the general population and weekly sports for public servants
    - In Kigali City, two Sunday of each month are dedicated as a “car free day” for physical activities in which no car is allowed to circulate in main roads of the Capital in order to motivate physical activities including walking and jogging in capital roads and to reduce air pollution due to cars emission. This initiative is being expanded to other provinces out of Kigali City.

- **Mass Media:** on Radio Rwanda, topics on NCDs are regularly discussed in a weekly program supported by the Rwanda Biomedical Center.
- **Events and Days to mark NCDs:** Days such as the Diabetes Day, Cancer Day etc. are celebrated annually in Rwanda and, at every occasion, different sensitization activities, including the screening for different NCDs, are organized.
- **Community outreach events:** Messages on NCDs are integrated into other key health messages and are disseminated during the community outreach events regularly conducted at the Village level. During these events keys messages like health eating, physical exercising, and early screening are given.

2.4.3.3. Mental Health Services

To deal with aftermath of the 1994 Genocide against Tutsis, the GoR devised a number of strategies to assist those presenting mental health problems with particular attention to those resulting from the genocide

- Treatment of patients with mental health issues has effectively been decentralized, as all Hospitals are now staffed with at least one psychiatric or mental health nurse.
- To ensure this capacity is maintained, two general practitioners and two general nurses from each district hospital are trained each year in psychiatric care.
- The decentralization of mental health services improved the geographic accessibility and reduced transfers to mental health reference structures.
- During the annual commemoration of the Genocide against Tutsis, Health Centers and District hospitals work with the community members to coordinate patient care during this time.

2.4.4. Participation in peace keeping missions

Since 2004, Rwanda has risen to become one of the top providers of peacekeepers for both UN and AU missions. The Rwanda Defense Forces (RDF) are particularly valued due to their training, discipline, professionalism, the development ethos they bring to deployments, and the growing number of women among those trained and deployed.

Rwanda's participation in Peace Support Operations is mainly motivated by the need to take its international responsibility as an active member of the international community. RDF has so far participated in different initiatives designed to bring about peaceful settlement of disputes and resolution of conflicts. These Peace support initiatives fall in areas of: peace-keeping, preventive diplomacy, peace-making and peace-building.

As a matter of policy, Rwanda considers her involvement in peace support operations not limited to the deployment of troops. The involvement could also take the form of providing good offices, specialist support or facilities.

2.4.5. Regular reports on international commitments

As Global transparency and accountability are concerned, Rwanda has committed to regularly report on human rights indicators through different reports. In this move, Rwanda has established

an institutional framework that monitors and facilitates the implementation of human rights obligations. These institutions include but not limited to: National Human Rights Commission; The Office of the Ombudsman; National Commission for Children; Gender Monitoring Office; NCPD; Rwanda Governance Board; National Commission for the Fight against Genocide; Parliamentary Committees on Human Rights.

A National Treaty Body Reporting Taskforce has also been established to prepare reports on all Regional and International Instruments, Conventions, Protocols and Agreements that Rwanda has committed to regularly report on.

Since 2011, the GoR accepted to be reviewed by the Human Rights Council under what is called Universal Periodic Review (UPR) regarding human rights records. This report demonstrates the progress made in the implementation of those recommendations while recognising that there is always more to be done. The Universal Periodic Review serves as tool to assess the Government's performance on her obligations to Rwandans. The UPR for Rwanda was undertaken in 2016. The following are other international conventions, declarations, and treaties regularly reported on by Rwanda.

- International Covenant on Civil and Political Rights (ICCPR)
- International Covenant on Economic, Social and Cultural Rights (ICESCR)
- Convention against Torture (CAT)
- International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (CMW)
- International Convention on the Elimination of All Forms of Racial Discrimination (CERD)
- Convention on the Rights of the Child (CRC)
- Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)
- Convention on the Rights of Persons with Disabilities (CRPD)
- African Charter on Human and People's Rights (ACHPR)
- African Charter on Democracy, Election and Governance (ACDEG)
- African Charter on the Right of the Welfare of the Child (ACRWC)

Still in line with international collaboration, a Centre of Excellence for Health Systems Strengthening has been established at the University of Rwanda/School of Public Health with the aim of strengthening the health systems in the country. The centre performs and develops research agenda for health system strengthening and universal health coverage. The centre also contributes to capacity building at national and regional level in the field of designing and studying health system strengthening approaches.
The centre also is facilitating many countries which come to learn about the best practices in Rwanda's health systems, especially in the areas of Community Health, PBF, and Health Insurance.

2.5. Rio Declaration Theme 5: To monitor progress and increase accountability

The Monitoring of the Social Determinants Health is crucial to strengthen accountability, transparency, and the implementation and evaluation of prioritised interventions. Rwanda's achievements in addressing SDH would not have been possible without strong political will and commitment to monitor progress on actions undertaken in different sectors. The idea to strengthen monitoring and evaluation systems came as one of lessons learnt from the implementation of the Rwanda PRSP (2002-2006).

At this end of this strategy, it was noted that all monitoring and evaluations mechanisms were still rudimentary, donors-driven, and very fragmented. With the second poverty reduction strategy, the first EDPRS (2008-2012), Rwanda started establishing national and sub-national M&E mechanisms to inform evidence-based planning and implementation in all sectors, as well as to monitor progress and increase accountability. The following are key achievements registered in the area of M&E and in line with Rio Declaration recommendations:

- Establishment of systems to collect and disseminate national and sub-national statistical data
- The promotion of research for evidence-based measures on the social well-being;
- Establishment of mechanisms that ensure accountability across sectors
- Strengthen intersectoral mechanisms to address health inequities

2.5.1. Systems to collect and disseminate national and sub-national statistical data

Weaknesses that were observed in the M&E systems of the Rwanda PRSP (2002-2006) forced the GoR to establish institutional and legal frameworks for statistical activities in Rwanda. Actually, this First National Mid-Term Strategy (PRSP) did not have comprehensive statistical data collection frameworks to inform the M&E System. This is why the next national mid-term strategies, EDPRS I (2007-2012) and EDPRS II (2013-2018) were elaborated with a greater emphasis on strengthening M&E Systems.

In addition, with the decentralization process started in 2006 and in line with the Vision 2020 and EDPRS, Sector Strategic Plans (SSP) and District Development Plans (DDP) that were developed since then integrated an important component of monitoring and evaluation.

The development of M&E systems started with the development of mid-term strategies, the most important being EDPRS, for which a national matrix for M&E was created in 2008. After this, the next step was for each sector to have its own sector strategic plan, and to create a sector M&E matrix of indicators to measure its performance against the EDPRS goals. The same process was repeated in districts for their District Development Plans, to ensure their alignment to EDPRS at sector and district levels. The creation of M&E system across sectors and districts highlighted the need for a centralized data collection centre for all statistics on Rwanda. It is in this context that the NISR was established by the Law N° 09/2005 of 14/07/2005.

The Institute was given the following responsibilities:

- To define and ensure the respect of standards and methodologies applied by the national statistical system;
- To conduct national census and other national surveys;
- To advise and train the personnel of the national statistical activities;
- To coordinate and gather statistical information and methodologies of particular sectorial departments in charge of statistical activities in the country;
- To disseminate the official statistical data whether the one publicized by the institute or the data bearing its visa;
- To coordinate the activities of the national statistical system;
- To advise state institutions regarding the development of the national statistical system;
- To encourage the public to participate in statistical activities and learn how to use the census and surveys results;
- To prepare the national program of the statistical system;
- The 2005 law was repealed in 2013, and has been replaced by the Organic Law Nº05/2013/OL of 16/06/2013 on the Organisation of Statistical Activities in Rwanda. This new law has clarified all aspects involved in statistical systems in Rwanda and made mandatory the dissemination of statistical data. It also recommends the organization of a national census every 10 years.
- The creation of M&E systems to monitor the progress and evaluation of outcomes and impacts of development initiatives such as the Vision 2020 Programme, the EDPRS, SSP and DDP resulted in an unprecedented increase in demand for statistics as policy makers and other stakeholders seek information on national development.
- To respond to this need, the NISR prepares and publishes an Annual Statistical Year Book, which is a compendium of statistical information dealing with a wide range of development – pertinent topics. As such, this book is designed to serve as a standard summary of statistics on the social, political and economic situation. This book consists in a standard summary of statistics on the social, political and economic situation of Rwanda. The aim of which is to serve as convenient volume for statistical reference and as a guide to other statistical publication and sources of Rwanda. It serves as convenient volume for statistical reference and as a guide to other statistical publication and sources.
- The Statistical Year Book provide data on Gender; Health and Nutrition; Education; Environment; Agriculture; Water and Energy Production; Transportation and Communication; Travel and Tourism; Income, Expenditure and Wealth; Price Indexes; Banking, Insurance and Finance; Business Enterprises and Foreign Trade; and finally, Law Enforcement, Courts and Order.

2.5.2. Promotion of research for evidence-based measures on the social well-being

To improve the government and partners' capacity to use evidence-based information for decision making, nationwide surveys are regularly conducted, under the coordination of the National Institute of Statistics of Rwanda (NISR). All these surveys are meant to track the progress being made on national impact indicators. The main surveys regularly conducted include:

- **Integrated Household Living Conditions Survey (IHLCS):** Integrated Household Living Conditions Survey or "Enquête Intégrale sur les Conditions de Vie des ménages" (EICV, or the English acronym IHLCS), is conducted every five years, this data source provides information on changes in the well-being of the population such as poverty, inequality, employment, living conditions, education, health and housing conditions, household consumption, among others.
- **Comprehensive Food Security and Vulnerability Analysis (CFSVA)-2015**: This data source collects indicators on human and social capital, natural capital, physical capital, economic capital and livelihood strategies, food consumption, and health and nutrition
- **Demographic and Health Survey (DHS):** It provides data to monitor the population and health situation in Rwanda. Specifically, the data source collects information on a broad range of demographic, health, and social issues such as household characteristics, maternal and child health, breastfeeding practices, early childhood mortality, maternal mortality, nutritional status of women and young children, fertility levels, marriage, fertility preferences, awareness and use of family planning methods, sexual activity, and awareness and behaviour regarding AIDS and other sexually transmitted infections. The DHS is conducted every 5 years.
- **Population and Housing Census:** Population and Housing Census is the process of systematically obtaining and recording demographic, economic and social data, at a specified time, of the country's population. Compared to other data sources, in which information is collected from only a small sample of the residents, and from that conclusions are reached regarding the general population, the Population and Housing Census gets data from the entire population. The Population and Housing Census are conducted once every ten years.
- **FinScope Survey:** The FinScope data source measure and track the landscape of access to financial services across all the main product categories – transaction banking, savings, credit and insurance, in both the formal and informal sectors- and institutional categories – commercial banks, other regulated institutions, semi-formal non-regulated institutions, including membership-based organizations; and informal or village-based institutions. It also helps in understanding characteristics of those that are financially excluded, segment the market, and identify opportunities for expansion of financial services to the under-served segments of the market. It also contributes to understand the scope of the population of vulnerable poor whose needed financial transactions are too small for any financial institution to provide profitably.
- While national impact indicators are generally tracked through national surveys under frameworks of the Vision 2020 and EDPRS, the outcomes indicators are tracked through routine administrative statistics collected by Management Information Systems of Ministries, Districts and Agencies. These data allow monitoring progresses being in sector strategic plans and district development plans.
- In the Rwanda Health Sector, the following Management Information Systems allow collecting routine data from the community and health facilities. The key Management Information Systems in the Rwanda Health Sector include: Community and facility-based data are collected through the following systems:

- **HMIS (Health Management Information System)** is the primary source of routine data on health services provided through health centres, district hospitals, and referral services. The HMIS was revised in 2011 to collect more data that are relevant. It is built on a web-based platform that facilitates data sharing and use. The completeness of monthly reports is very high. A national data warehouse and dashboard portal has been configured to draw data from the HMIS, SISCom, DHS and other sources.
- **SISCom (Community Health Information System):** This system was established in 2010 and supplies important data on the increasing contributions of community health workers (CHWs) to the provision of health services.
- **Integrated Payroll and Personnel Information System (IPPIS):** This system provides a reliable and comprehensive database for the public service to facilitate manpower planning, eliminate record and payroll fraud, facilitate easy storage, update and retrieve personnel records for administrative and pension processes, and facilitate convenient staff remuneration payment with minimal waste and leakage. IPPIS supports the management of all Civil Service personnel including health sector personnel.
- **Electronic Logistics Management Information system (e-LMIS)**: A computerised system provides data and information on the supply and distribution of medicines and commodities. This system was rolled out in all health facilities and is fully operational at national.
- **Administrative data** sources will provide information on health inventories, supervision, management meetings, logistics management, financial resource flows and expenditures at national and sub-national levels.
- **Vital Registration**: Even if the National Institute of Statistics is not a source of information as such, NISR acts as the custodian of all data from Vital Registrations, surveys and studies, develops and maintain the surveys calendar, and Conduct the general population census. Many efforts are being made to make functional the Vital registration.

2.5.3. Intersectoral collaboration to address health inequities and ensure accountability across sectors

To foster intersectoral collaboration and ensure accountability across sectors, the GoR adopted Result Based Management (RBM) approach to track output indicators across all sectors and districts. This has been customized under what is known as “Imihigo” in Kinyarwanda. Imihigo is as old as pre-colonial Rwanda. Imihigo is a cultural practice in the ancient tradition of Rwanda where an individual would set himself/herself targets to be achieved within a specific period of time and to do so by following some principles and having determination to overcome the possible challenges.

The Imihigo practice was recently reintroduced as a mean of planning, monitoring and evaluation to accelerate the progress towards economic development and poverty reduction. Imihigo has a strong focus on results which makes it an invaluable tool in the planning, accountability and monitoring and evaluation processes. When elaborating its Imihigo or performance contracts, each government administrative entity determines its own objectives (with measurable indicators) taking into account national priorities as highlighted in the International and national strategic documents such as the Vision 2020, EDPRS, Sector Strategic Plans, and District Development Plans (DDPs). The Imihigo, at both planning and reporting phases, are presented to the public for purposes of accountability and transparency.
Ministers, Mayors, Province Governors, and the Private Sector Federation (PSF) annually sign the “imihigo" or performance contracts with H.E the President of the Republic of Rwanda, committing them to achieving the set objectives. Imihigo specifically aim at;

- Speeding up implementation of local and national development agenda;
- Ensuring stakeholder ownership of the development agenda;
- Promoting accountability and transparency;
- Promoting result-oriented performance;
- Instilling innovation and encourage competitiveness;
- Engaging stakeholders (citizens, civil society, donors, private sector, etc.) in policy formulation and evaluation;
- Promoting zeal and determination to achieve set goals;
- Institutionalizing the culture of regular performance evaluation.
- Imihigo is entrenched in the linkage of District plans to National Planning and Budgeting Structures.

On top of Imihigo approach, Rwanda has established other national coordination and M&E systems meant to boost intersectoral collaboration, monitor and evaluate the implementation of all national programs.

Table 13 National Coordination and M&E mechanisms

Role	Organ	Functions
Oversight and Accountability	Senate and Parliament	Oversight of the progress, endorsing plans and budgets, demanding accountability
Strategic Orientation	Cabinet	Approval of financing and implementation plans, strategic guidance
Strategic Monitoring	National Leadership Retreat National Dialogue Council	Annual Monitoring and Accountability
Technical Advise	Development Partners Coordination Group (DPCG)	Technical Advice and support to implementation
National Technical Coordination	Ministry of Finance and Economic Planning	Integrating plans and budgets, Monitoring and evaluating progress across sectors
Sector Coordination	Ministerial Clusters	To coordinate the implementation of Government cross-sectoral programs, monitor and report on progress, discuss and share best practices, identify challenges and put in place measures to ensure they are solved.
Technical Consultations	Sector Working Groups	Forum for engaging all stakeholders, monitoring sector level
Districts coordination	District Councils, Districts Joint Action Development Forums (JADFs)	Forum for engaging all stakeholders, monitoring District level
	Community Outreach through UMUGANDA and Districts administrative organs (e.g. Sectors, Cells, Villages	Citizen Participation and engagement forums

Source: MINECOFIN-SDGs Presentation 2016

III. Discussions and conclusions

The main observation of the review of Rwanda's performance in addressing SDH is that Rwanda has achieved impressive progress on all the key five themes highlighted in the Rio Political Declaration. These achievements are the result of the Government of Rwanda's efforts to institutionalize good governance and the studious implementation of the Rwanda's economic development agenda and strategies.

The vow by the GoR to instill good governance across all sectors was motivated by Rwanda's need to move away from a historically centralized governance model with minimal participation of the population in decision-making affecting their political, economic and social well-being. The promotion of Good Governance was translated into actions by the Decentralization Policy and strategy adopted in 2000, with a vision to empower local communities to determine their own future to achieve good governance.

The implementation of the Decentralization Policy and strategies allowed the effective decentralization of power and finances, through the development of pro-poor programs supporting poverty reduction, the establishment of institutional and legal frameworks for the protection of vulnerable populations, and the integration across sectors to improve intersectoral action for health and health equity.

Another achievement of the Decentralization Policy in Rwanda has been the stimulation and strengthening of participation beneficiaries and stakeholders in policy and decision makers. It all started with the first step of multiple administrative and policy reforms, as well as the reorganization of the entire the territorial Administration.

Secondly, Rwanda drew from its culturally-embedded practices and developed its own ways of promoting comprehensive participation and consultations in policies and implementation. National and decentralized legal and institutional frameworks have then been established and are fully functional at both the national and decentralized level to ensure the participation of all segments of the Rwandan population in policy dialogue and formulation. Community members, children, women, persons with disabilities, and all other vulnerable people have got national and decentralized structures which cater for them and ensure their full participation in policy.

There is now evidence that the GoR's passion to promote good governance through decentralization has improved the efficiency and effectiveness of essential public service delivery. It has also empowered the people of Rwanda to actively participate in the political, social and economic transformation of Rwanda, and has led to an increasing trend towards delegation in the interest of "bottom-up" planning, prioritization and revenue mobilization.

After setting bases for good governance and citizens' increased participation, the GoR had to fight another battle: the economic development and poverty reduction. One of the key tools used by the GoR fight this battle has been the design and rigorous implementation of the National Development agenda: the Rwanda Vision 2020.

The Vision 2020 is a reflection of Rwandans' aspiration and determination to construct a united, democratic and inclusive Rwandan identity, after so many years of authoritarian and exclusivist dispensation. It aims at transforming the country into middle- income nation in which the population is healthier, educated and generally more prosperous.

Vision 2020 has been translated into by 3 medium-term strategies. The first medium-term strategy was elaborated towards the end of the emergency period, when the country was still recovering from the effects of the genocide against Tutsis in 1994. The main concerns were for securing the nation, rebuilding the economy, growing enough food, building roads, providing housing, educating children, providing healthcare and ensuring justice is done.

The second medium-term strategies, the EDPRS I (2008–2012) was elaborated after the country had become a stable nation, and was on the path to achieving better lives for each and every one of its citizens. Great achievements had been registered in human development, particularly in the areas of health and education, as well as in economic governance, through the decentralization of public service delivery and the involvement of the private sector in both decision making and policy implementation. The introduction of the performance-based approach 'Imihigo' allowed local government (districts) to articulate their own objectives which reflect priorities of the local population and develop realistic strategies to achieve these objectives.

The Second EDPRS (2013-2018), currently under implementation was launched in 2013, when the country was faced with new challenges of ensuring greater self-reliance and developing global competitiveness. Conscious of these challenges, we forge ahead knowing that by working together, we always overcome.

EDPRS2 stresses the need for the Private Sector, expected to take the driving seat in Economic Growth and Poverty Reduction, with a greater focus on transforming the Economy, the Private Sector and alleviating constraints to growth of investment. EDPRS 2 also seeks to develop the appropriate skills and competencies to allow people, particularly the youth, to become more productive and competitive to support national ambitions. It again seeks to strengthen the platform for communities to engage decisively and to continue to develop home grown solutions that have been the bedrock of previous success.

For all the three medium-term strategies that have translated Vision 2020 into actions so far, SSP and DDP were elaborated simultaneously to ensure coherence among the national planning documents. They have been developed with a common direction on how each shall contribute to meeting Vision 2020.

As illustration, the Rwanda Health Sector is currently implementing the Health Sector Strategic Plan III (2013-2018) fully aligned with EDPRS 2. We appreciate all three medium-term strategic plans implemented so far, the Rwanda Health Sector has been reoriented to align with the Decentralization Policy and strategies, and to be able to fulfil its mission of serving as a foundation pillar for the Rwanda Economic Development and Poverty Reduction.

3.1. Lessons Learned

From the findings of this documentation exercise, the following lessons can be drawn from the different reports, policies and strategies consulted during the desk review and the discussions with key informants:

- Long term planning frameworks aligned with global objectives and commitment (MDGs, SDGs), pro-poor policies and strategies, use of Home Grown Solutions to implement programs that accelerate socio-economic development yield positive outcomes.
- EDPRS is a good and integrated tool that ensures intersectoral action and collaboration to address SDH. It gives an appropriate monitoring framework for intersectoral action.
- The Decentralization Policy has contributed in empowerment of local authorities, improvement of service delivery and of community participation. The Decentralization and District performance contracts are appropriate instruments that prevent inequalities between districts.
- Performance contracts are important planning tools to ensure equitable local development and equitable implementation of actions to address SDH.
- In Rwanda, poverty is the most important social determinant of ill-health. Addressing poverty means to improve almost all other intermediate SDH.
- Girinka (One cow per poor family) and CBHI have been scored as the most important pro-poor programs impacting on the health status of the population, seconded by VUP program.
- In Rwanda, under EDPRS, there is a clear distribution of roles and responsibilities between sectors with regard to implementation of actions to address SDH.
- There are good social protection programs, but their impact is limited by the number of potential beneficiaries that increases every year due to population growth and limited funds
- Social media can be used to improve communication, to facilitate community participation, community dialogue, and increase connection between population and District authorities. Example is the grouped WhatsApp from the Village committee up to the district.
- Household Performance Contracts, once well monitored, may also improve the health of households.
- Local Community mobilization committees at village level may play an important role to mobilize the populations but also to address the health-related issues like Malnutrition, hygiene and sanitation as well as adherence to CBHI.
- The challenges to addressing SDH include the rapid population growth, the problem of land in a country that depends mostly on subsistence agriculture, the climate change, and financial issues that limit a proportion of the population benefiting from social protection

floors to alleviate the consequences of poverty and limit the sustainability of the Health System.

3.2. Strengths and opportunities to address SDHs

One of the most important strengths and opportunities for the development of Rwanda is the existence of political will and committed leadership observed through the clear long-term vision, policy formulation, integrated planning (EDPRS), inclusive strategies and programs, and the use of culturally drown home solutions to implement different programmes to accelerate the socio-economic development of the country. Rwanda benefits from integrated long-term and midterm planning policy framework: Vision-2020, EDPRS, Sector Policies and Strategies and Operational Plans, DDPs, and there is a functional legal and regulatory framework.

The second advantage is the persisting political stability and security that allow administration and the population to focus on development and wellbeing. Also, the decentralized and administrative system has facilitated the local prioritization and planning, the people cantered policy making, better ownership and a balanced repartition of national resources, resulting in balanced development between districts.

There are mechanisms to ensure good management of resources at central and district levels, fight corruption and promote accountability. Also, mechanisms to ensure the coordination and collaboration of DPs have been put in place and are operational. Mobile phone, social media and internet are developed in Rwanda (70% possession in adults aged 16 years and more). The media is an effective opportunity to channel healthy lifestyles even at community level.

3.3. Summary of Challenges

- **Persistence of high population growth rates**: each year, between 300,000 and 350,000 live births are registered. In 1966, the population was estimated to be 3 million but it is approaching 12 million. Even if the fertility rate continues to reduce, and the population will continue to grow rapidly for at least one generation, as the population is very young.

- **Continuous growing population and its pressure impacts on the land**, already dangerously fragmented, and overexploited, while the majority of the population, living in rural areas, survive from subsistence agriculture. Rwanda is dealing with problems related to deforestation, small and fragmented landholdings, and very small amounts of land available per household and unsustainable land-use management. This has resulted in soil erosion, declining land productivity, and increased vulnerability to different hazards. In Rwanda, there are strong links between Poverty, Food Insecurity, lack of Sustainable Land Management.
- **Climate change**: According to different reports, the average annual T° increased from 18°C in 1970s to 20°C currently. Already, several parts of the country in Eastern and Southern Provinces face recurrent drought periods, while floods and landslides continue to threaten the Western and Northern Provinces, putting populations at higher risk to food insecurity and precipitating them in extreme poverty that some of them had recently graduated from. If it continues like it is, our socioeconomic development pace will be slowed.
- **Currently, the health system is dependant to external funding**, even if it is reducing. This raises the problem of sustainability of the progress already achieved, and to step forward.
- Rwanda has entered the **epidemiological transition,** where we observe increasing burden of NCDs with related risk factors.

3.4. Recommendations

- Due to the predictable impact of climate change, the Government should put in place measures (within the limit of its means) that prevent populations already graduated to relapse in extreme poverty due to consequences of climate change (shocks caused by droughts and floods).
- The Government and Stakeholders to reconsider strategies aimed at better slowing the current population growth, otherwise the current growth rate may impair achievements made in the socioeconomic indicators.
- The Ministry of Health, in collaboration with the Ministry of Finance and Economic Planning, will accelerate the process to identify alternative mechanisms to ensure financial sustainability of the health system, in terms of capacity building and long-term resource sustainability.
- When possible, the Ministry of Health and RSSB shall review the current package of services related to the CBHI, so that CBHI adherents may have access to better health care services.
- There are good social protection programs, but there is a need for the Government to put more efforts to increase the number of beneficiaries which are currently too low.
- At decentralized level, mechanisms should be put in place to foster community mobilization activities like the Parents' Evening Forum that needs to be operationalized and strengthened in all villages.
- Intersectoral collaborations that have been put in place at central level need to be better strengthened and operationalized at district level.

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