REPUBLIC OF RWANDA

MINISTRY OF HEALTH

Rwanda Health Resource Tracking

Output Report

Expenditure FY 2013/14 and Budget FY 2014/15

Published in September 2016

Contents

Acronyms:

AIDS	: Acquired Immune Deficiency Syndrome
B	: Billions
CBHI	: Community Based Health Insurance
CHAI	: Clinton Health Access Initiative
CHUB	: Centre Hospitalier Universitaire de Butare
CHUK	: Centre Hospitalier Universitaire de Kigali
CS	: Corporate Services
CSO	: Civil Society Organization
DH	: District Hospital
EGPAF	: Elizabeth Glaser Pediatric AIDS Foundation
ESR	: Epidemic Surveillance and Response
FBO	: Faith Based Organization
FY	: Fiscal Year
GoR	: Government of Rwanda
HC	: Health Center
HRH	: Human Resource for Health
HMIS	: Health Management Information System
HRTT	: Health Resource Tracking Tool
JSI	: John Snow, Inc.
MCCH	: Maternal, Child and Community Health
MH	: Mental Health
MINECOFIN	: Ministry of Finance
MoH	: Ministry of Health
MOPD	: Malaria and Other Parasitic Diseases
MPPD	: Medical Procurement and Production Division
MRC	: Medical Research Center
MTEF	: Medium Term Expenditure Framework
MTI	: Medical Technology and Infrastructure
NGOs	: Non-Government Organization
NCBT	: National Center for Blood Transfusion
NCC	: National Child Council
NCD	: Non Communicable Diseases
NHA	: National Health Account
NRL	: National Reference Laboratory
NSPs	: National Strategic Plans
PBF	: Performance Based Financing

PEPFAR	: U.S. President's Emergency Plan for AIDS Relief
PMEBS	: Planning, Monitoring & Evaluation and Business Strategy
RBC	: Rwanda Biomedical Center
RHCC	: Rwanda Health Communication Center
RWF	: Rwandan Francs
SAMU	: Service d'Assistance Médicale d'Urgence
SOPs	: Standard Operating Procedures
SPIU	: Single Project Implementation Unit
STI	: Sexually Transmitted Infection
SWAP	: Sector Wide Approach
TA	: Technical Assistance
TB	: Tuberculosis
UN	: United Nations
UR	: University of Rwanda
US	: United States
UNAIDS	: Joint United Nations Program on HIV/AIDS
UNFPA	: United Nations Population Fund
UNHCR	: United Nation High Commissioner Refugees
UNICEF	: United Nations International Children's Emergency Fund
VP	: Vaccination Program
WFP	: World Food Program
WHO	: World Health Organization
YOY	: Year Over Year

Foreword

In light of Rwanda's significant progress towards achieving VISION 2020, I have the honor to introduce the output report on the Health Resource Tracking Tool (HRTT), which includes FY 2013/14 expenditures and FY 2014/15 budget. This data is a result of the Round 4 data collection and has been produced to provide a summary of financial flows within the Rwandan health sector. While government spending in health is increasing, external funding is rapidly tightening due to ongoing effects of the international economic recession. Therefore, advances in resource tracking remain paramount in ensuring sustainable health financing.

Motivated by a commitment to universal health coverage, the Ministry of Health outlined in its 2015 Health Sector Policy a pivot towards universal accessibility of equitable, affordable quality health services for all Rwandans. The Ministry therefore aims to strengthen policies, resources, and management mechanisms for both support and delivery, as well as bolster health governance through reporting mechanisms like the HRTT.

The ongoing implementation of HSSP III, which defines and implements strategies to make VISION 2020 and the Health Sector Policy operational, has demonstrated that the Rwandan health care system continues to make remarkable improvements in monitoring and evaluation. To further increase transparency, accountability, and efficiency within the health sector, the Ministry continues to track financial resources through the HRTT at the organization, project and activity levels. The newly revised HRTT, a web-based tool, is used to collect comprehensive expenditure and budget data from all the levels of the public health sector as well as from donors, development partners, and international and local NGOs. In doing so, the tool harmonizes data collection and ensures that the collection is routine, timely, and comprehensive.

The HRTT could not have developed without the enduring support of our development partners. Therefore, I would like to acknowledge and thank all partners especially United States Agency for International Development (USAID), UNAIDS and Rockefeller Foundation, who have contributed directly to the development of the new version of HRTT and other partners who have been integral to the production of this report.

With continued commitment by stakeholders, I am confident that HRTT will continue to improve joint planning between the Ministry and its partners in order to re-align financial flows wherever possible. Increasingly robust monitoring and evaluation, integrated solutions, and well-aligned resource allocations will help bring the Rwanda health sector into a sustainable future.

Dr Patrick NDIMUBANZI
Minister of State in Charge of Public Health and Primary Health Care

1. Introduction

Over the past few years, Rwanda has achieved some of the most significant improvements in health outcomes within the Sub Saharan African region. The progress is largely due to the strong commitment of the Government of Rwanda (GoR) and its development partners. Together, they have developed a comprehensive health sector-financing framework aimed at decreasing donor dependence and increasing domestic resources. For continued progress and effective utilization of resources, the GoR, in 2010, implemented routine tracking of finances throughout the health system using the Health Resource Tracking Tool (HRTT). The key goal of applying the tool is to improve evidence-based decision-making, planning, and overall management performance. It also improves monitoring, transparency, and accountability – essential ingredients for effective governance of the health system – at all levels of the health sector. When combined with epidemiological and population data, information from the HRTT can be used to determine the cost effectiveness of the implemented initiatives as well as to assess if the allocated resources are in alignment with health sector strategies.

The HRTT is used to collect comprehensive expenditure and budget data from all the levels of the public health sector as well as from donors, development partners, and international and local NGOs. As data from health centers, private companies and clinics, public sector (other line ministries), some civil society organizations and faith-based organizations have not been collected in this exercise, henceforth the HRTT does not measure total health budgets or expenditures.

HRTT tracks the resources disbursed by institutions and their allocation to specific projects and programs. Developed within the framework of the GoR fiscal decentralization policy, the HRTT aims to harmonize fiscal planning within health sector priority goals and to track centralized and decentralized resources that could support increased decisions for reallocating resources to higher priorities within the Health sector.

To date, there have been five rounds of the HRTT and the following information has been collected[1]:

- Round 1: Expenditure data for FY 2009/10 and Budget data for FY 2010/11
- Round 2: Expenditure data for FY 2010/11 and Budget data for FY 2011/12
- Round 3: Expenditure data for FY 2011/12 and Budget data for FY 2012/13
- Round 4: Expenditure data for FY 2013/14 and Budget data for FY 2014/15

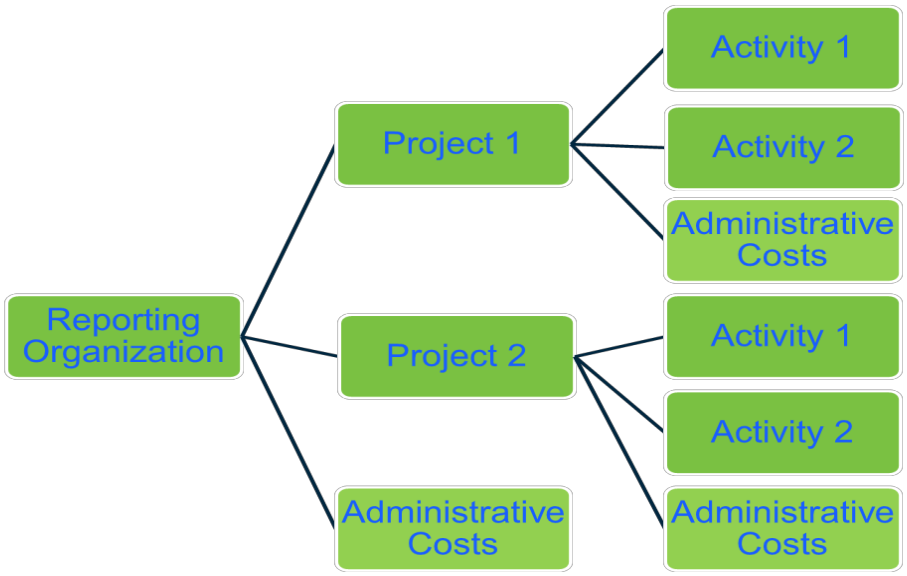
This report describes the methodology applied in Round Four to collect and analyze the HRTT data and to present key findings. Data collection was comprised of two key categories: **FY 2013/14 expenditures** and **FY 2014/15 budget.** Expenditures imply actual spending of the institution during the specified fiscal year, whereas budgets imply planned expenditure. Note that budgets are not always officially approved when data is collected; therefore, forecasts are provided by the institutions.

The chart below summarizes the HRTT structure that provides an organized framework containing detailed categorizations for each of the three reporting levels: reporting institutions, projects, and activities.

[1] Prior to Round 4, HRTT data was collected in US dollars. Refer to Annex 3 for the exchange rates used to convert the previous data into RWF.

- The **reporting institutions** are expected to provide all the data captured in the HRTT, including project and activity levels
- At the **project level**, data on the funds that have been disbursed or are expected to be disbursed are captured
- Expenditure data is collected at the **activity level** by each implementer, and is disaggregated by the following:
    - **"Activity purpose(s)"** describes all the purposes or the goal of an activity, e.g., malaria treatment – each activity should have one activity purpose
    - **"Inputs"** or cost categories are provided by breaking down budgets and expenditures by specific cost inputs
    - **"Location"** identifies the percentage of spending at the central vs. district level, based on the intended beneficiaries
    - **"Beneficiaries**" are the groups benefiting from the activities

HRTT Structure



For more details on the HRTT structure, please see Annex 2.

2. Overview of HRTT Data Collection, Cleaning, and Analysis Process

The expenditure data collection process for the FY 2013/14 and the FY 2014/15 budget was led by the Directorate General of Planning, Health Financing and Information System within the MoH. The process was initiated by a one-week training organized for all the reporting institutions in October 2015. The training was intended to serve as a refresher course and capacity transfer activity for reporting institutions. In the near future, these trained reporters should be able to regularly enter the required information with ease. During the training, all the reporters had the opportunity to practice data entry, under the supervision of the HRTT team. Following the training, the reporting institutions were supported individually to finalize data entry. As was the case with previous rounds of data collection, the HRTT team reviewed all the submissions and followed up with the reporters in case of

errors or incomplete data. The reporting institutions were generally responsive to the requests by the HRTT team during the data cleaning process.

The following data was collected by all reporting institutions.

- Projects
- Activities
    - Purpose
    - Inputs
    - Location
    - Beneficiaries
- Funding sources
- Implementers of health activities

Data quality has always been a key priority during the HRTT data collection process. To ensure high quality, the team worked with each of the institutions, providing individual support to reporters from the start of data collection. The strategy permitted monitoring data quality from the start of data collection and provided immediate intervention when reporters were unclear about the data entering or when mistakes were made.

In 2014, the HRTT was revised to update and redesign the classification tree and to improve the flexibility and user-friendliness of the tool. However, reporting institutions are still facing some difficulty in reporting and aligning their budget and expenditure activities with the structure of the tool. To mitigate these challenges, SOPs (Standard Operating Procedures) and procedure manuals are needed. The SOPs will also help harmonize the nomenclature and provide details on the current HRTT classification tree.

A total of 128 active health sector institutions reported to the HRTT for Round 4 (for the complete list of reporting institutions, please see Annex 1). The overall response rate for this round was 91% as 128 out of 140 institutions expected to report.

The data collection process was followed by data cleaning. Each institution received support for ensuring the correctness of the data entered into the tool. The HRTT team then analyzed the data to estimate the disbursements received, spending, allocations, and budget.

This report is a generalized analysis of the FY 2013/14 expenditure and FY 2014/15 budgets. Further analysis can be generated on request, including detailed levels of analysis of specific programs.

3. Institutional Health Spending Analysis

This section contains estimates of institutional health budgets and expenditures by reporting institutions, financing agents, implementing agents, MTEF programs and sub programs, geographic location, and inputs (cost categories).

3.1 Year over Year Institutional Spending Trends

Since multiple rounds of data collection have been conducted, this section analyzes the key trends. As more rounds of data collection are added, institutional absorptive capacity and the changes in budgets and expenditures over the years can be estimated.

Figure 3.1 Institutional Spending Trends

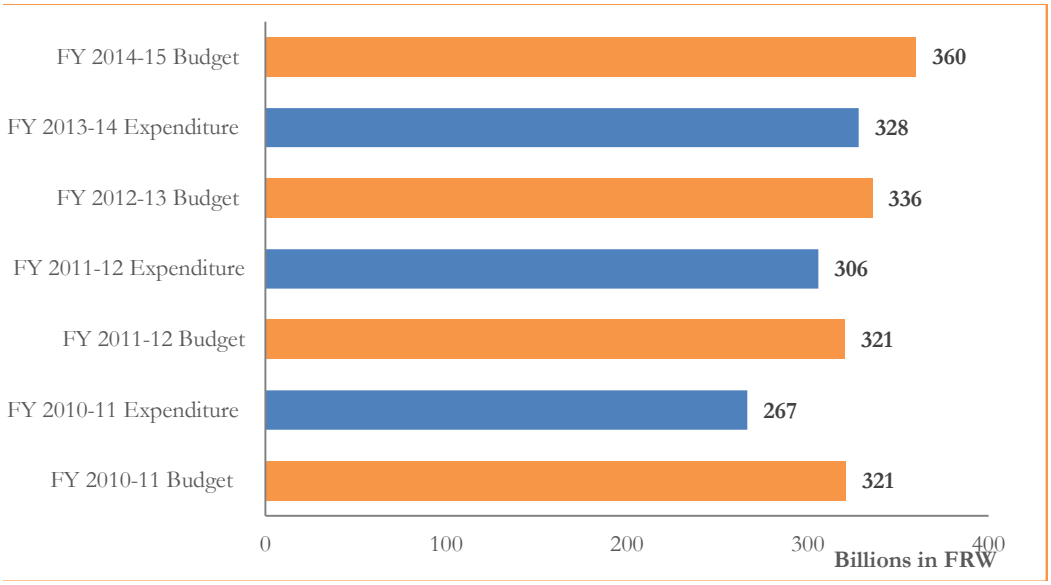


Figure 3.1 illustrates institutional health spending trends in Rwanda. Although the current HRTT data does not have information on FY 2012/2013 expenditure, the estimates show that the total institutional health spending in FY 2013/14 increased by 23%, from RWF 267 billion in FY 2010/11 to RWF 328 billion in FY 2013/14.

Figure 3.2 YOY Expenditure Trends by Funding Sources

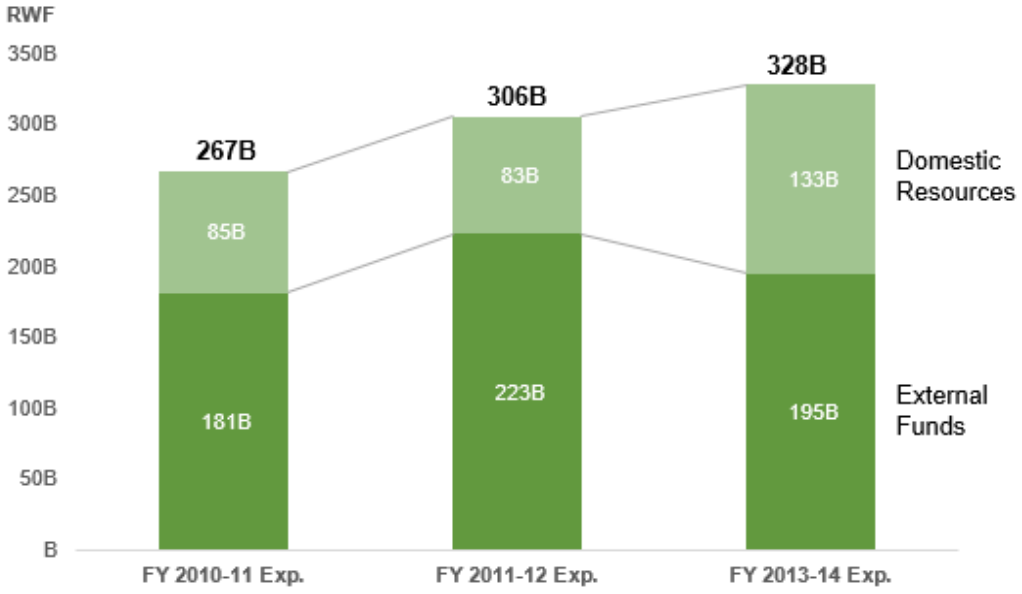


Figure 3.2 shows the trends in institutional reporting vis-à-vis the financing sources in Rwanda. The term 'financing sources' refers to the entities or revenues streams that fund health projects and activities.

Figure 3.3 YOY Expenditure Trends by Detailed Funding Sources

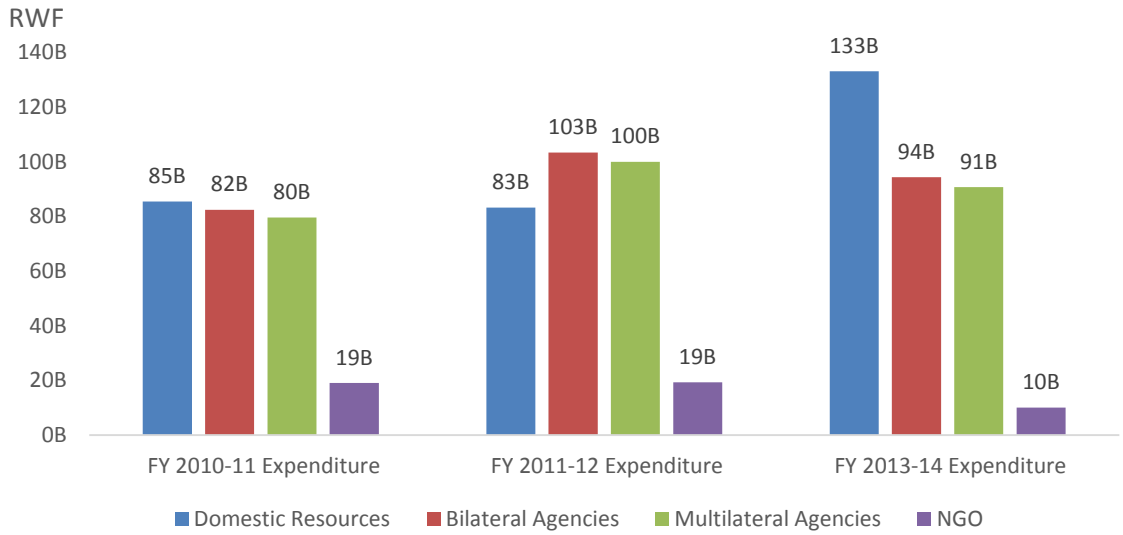


Figure 3.3 shows the funding trend of the four key financing sources in Rwanda. FY2013/14 shows there is a decline in external sources, e.g. multilateral and bilateral funding and NGOs, and an increase in domestic resources, e.g. the central government and internally generated revenues. Development partners have cut budgets and expenditures and, in some cases, halted support.

Domestic Resources have increased from RWF 85 billion in FY 2010/11 to RWF 133 billion in FY 2013/14, an average increase of 12% YOY. This demonstrates that this financing source will become an increasingly important component of resource mobilization. In FY2013/14, there was an increase in reporting from the decentralized level, including the administrative districts and district hospitals, which partly reflects also on the increase in domestic resources reported by the HRTT over time.

On the other hand, there has been a reduction in funds from bilateral and multilateral agencies in the same period. The expenditure contribution of international NGOs has progressively declined from RWF 19 billion in FY 2010/11 to RWF 10 billion FY 2013/14, an average decline of 19% YOY.

3.2 Institutional Spending by Reporting Institution

Most reporting institutions include government organizations, donors, and other development partners active in the health sector during that period. The reporting institutions were financing agents and/or implementing agents.

Figure 3.4: FY 2013/14 Expenditure by Reporting Institution

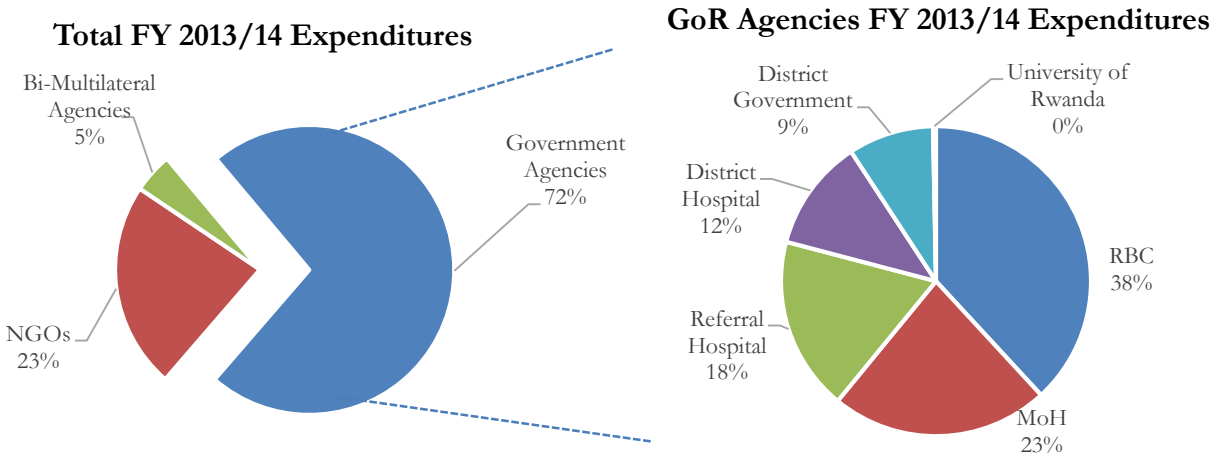


Figure 3.4 shows the 2013/14 expenditure by reporting institution. The GoR agencies reported a significant amount of the expenditures at 72%, followed by NGOs at 23%. Bilateral and multilateral agencies combined reported 5% of the total amount of institutional health spending. Among the government institutions that reported, the majority (79%) of their total reported expenditure is under the spending responsibility of the central government (RBC, MoH and referral hospitals), while 21% is managed at the district level (administrative districts and district hospitals). Health facilities reported 30% of the total GoR spending with 18% and 12% from referral hospitals and district hospitals, respectively.

Figure 3.5: 2013/14 Expenditure and 2014/15 Budget by Reporting Institution

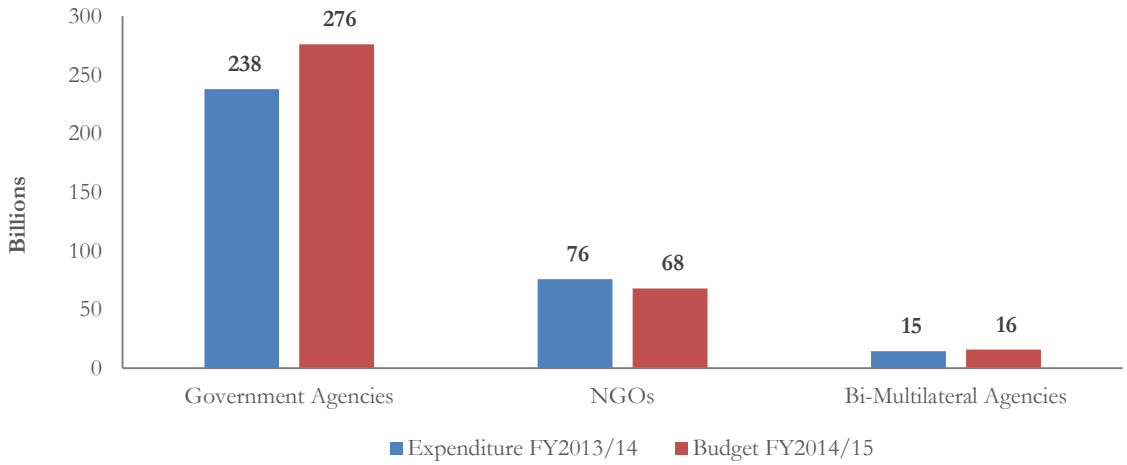


Figure 3.5 shows expenditure and budget by reporting institution. GoR agencies are planned to increase from RWF 238 billion to 276 billion, an increase of 16%.

3.3 Institutional Spending by Funding Source

In this section, expenditures and budgets are broken down based on funding source. The first part details on budget, off budget and internally generated revenues. The second part details the financing agents.

Figure 3.6: 2013/14 Expenditure by On Budget, Off Budget & Internally Generated Revenues

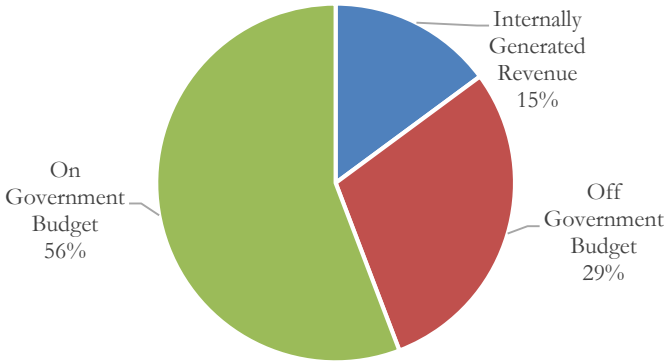
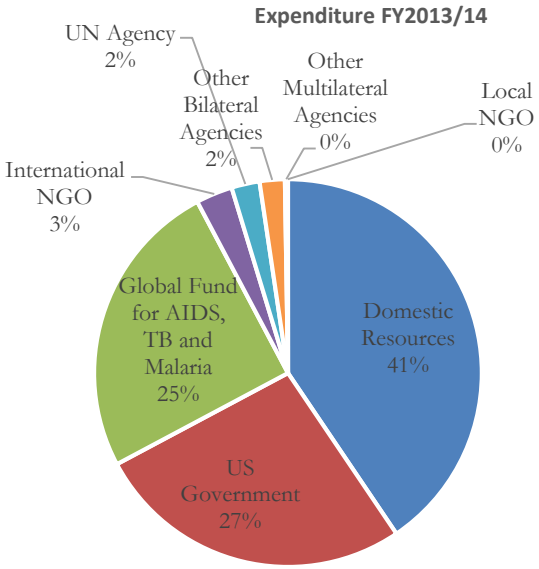
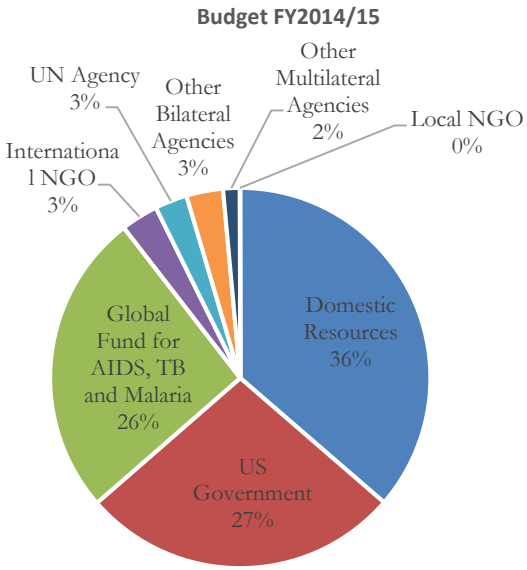


Figure 3.6 illustrates the proportion of on-budget funding (56%), including GoR revenues such as those generated from taxation, loans, grants, donations, and development partner contributions through general and sector budget support. The off-budget proportion (29%) reflects other sources of funds allocated that are reported in the development budget (may be earmarked), but not reported into the financial law. Internal generated revenues comprise funds reported by institutions - from income generated activities, reimbursement from health insurances (Public and private), Co-payment and Out of pocket expenditures.

The proportion of funds on government budget was 56% in FY 2013/14 – 29% was off-budget, while the remaining 15% was internally generated revenues by government institutions.

Figure 3.7: FY 2013/14 Expenditure by Funding Source
Figure 3.8: FY 2014/15 Budget by Funding Source





Figures 3.7 and 3.8 illustrate the key financing sources for health programs/projects in Rwanda. The key financing sources, for both the expenditure and budget data, were the Domestic Resources, US Government, and Global Fund. Together, they contribute about three-fourths of the funds flow into the sector. Domestic Resources are leading the funding sources with RWF 133 billion, followed by US Government with RWF 88 billion and Global Fund on the third position with RWF 82 billion. US Government and Global Fund for AIDS, TB and Malaria have planned a budget of RWF 98 billion (accounting for 27% of the total FY 2014/15) and RWF 93 billion (accounting for 26% of the total FY 2014/15 budget) respectively, whereas the Domestic Resources budget is RWF 131 billion or 36%.

Figure 3.9: FY 2013/14 Expenditure and FY 2014/15 Budget by Top 12 Funding Sources

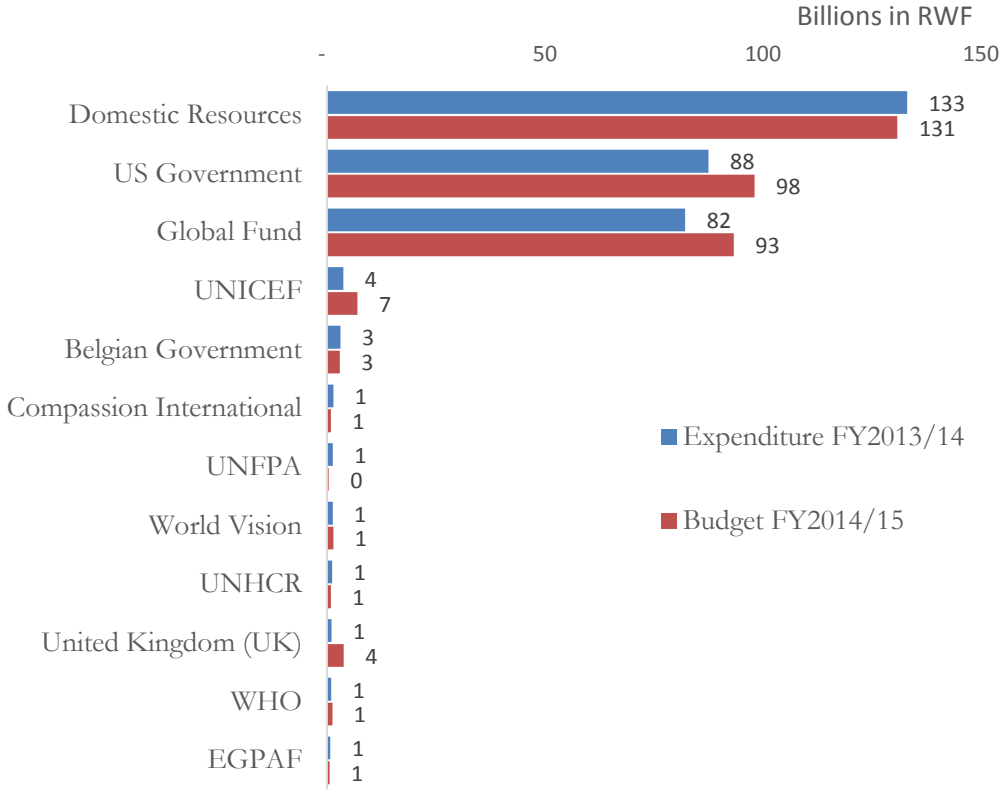


Figure 3.9 further illustrates the top 12 financing sources of health activities in Rwanda. The Domestic Resources, US government and the Global fund account for the top funding sources of health activities in Rwanda.

The US government and the Global Fund increased their planned budgets for the health sector. This could be contradicting and /or misleading and requires caution when comparing expenditures and budgets, as budgets planned do not necessarily represent disbursements. Institutions may have planned budgets that are lower or higher than their levels of expenditure, and the latter being most common.

3.4 Institutional Spending by Implementers

Implementers are organizations that receive funds from financing agents and use them to implement health programs and deliver health services. At times, financing agents may also be implementers of health activities.

Figure 3.10: FY 2013/14 Expenditures by Implementers
Figure 3.11: FY 2014/15 Budgets by Implementers

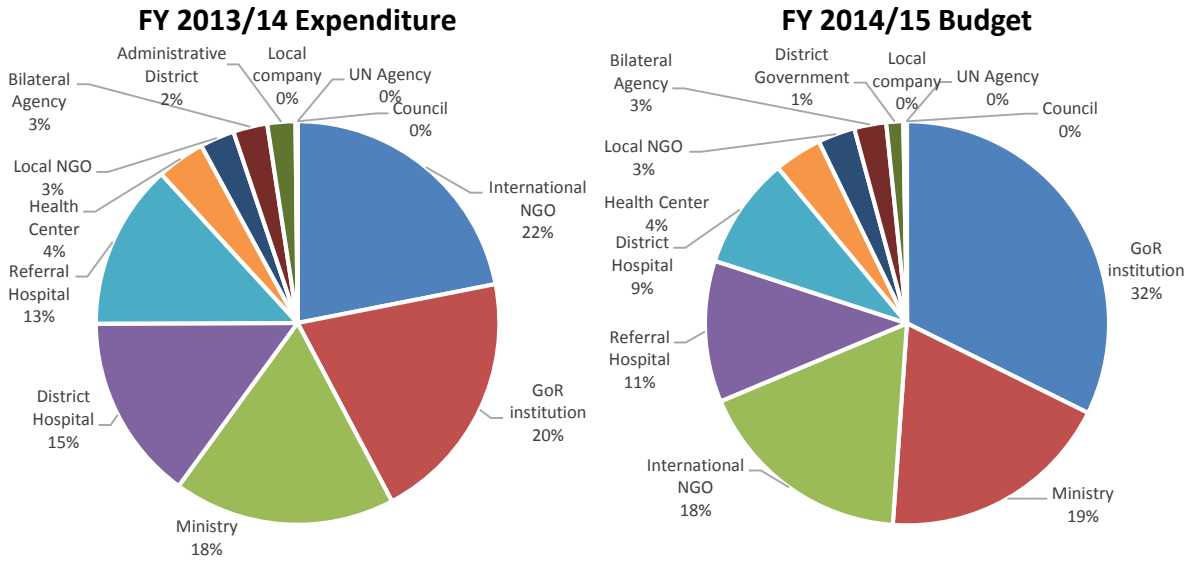
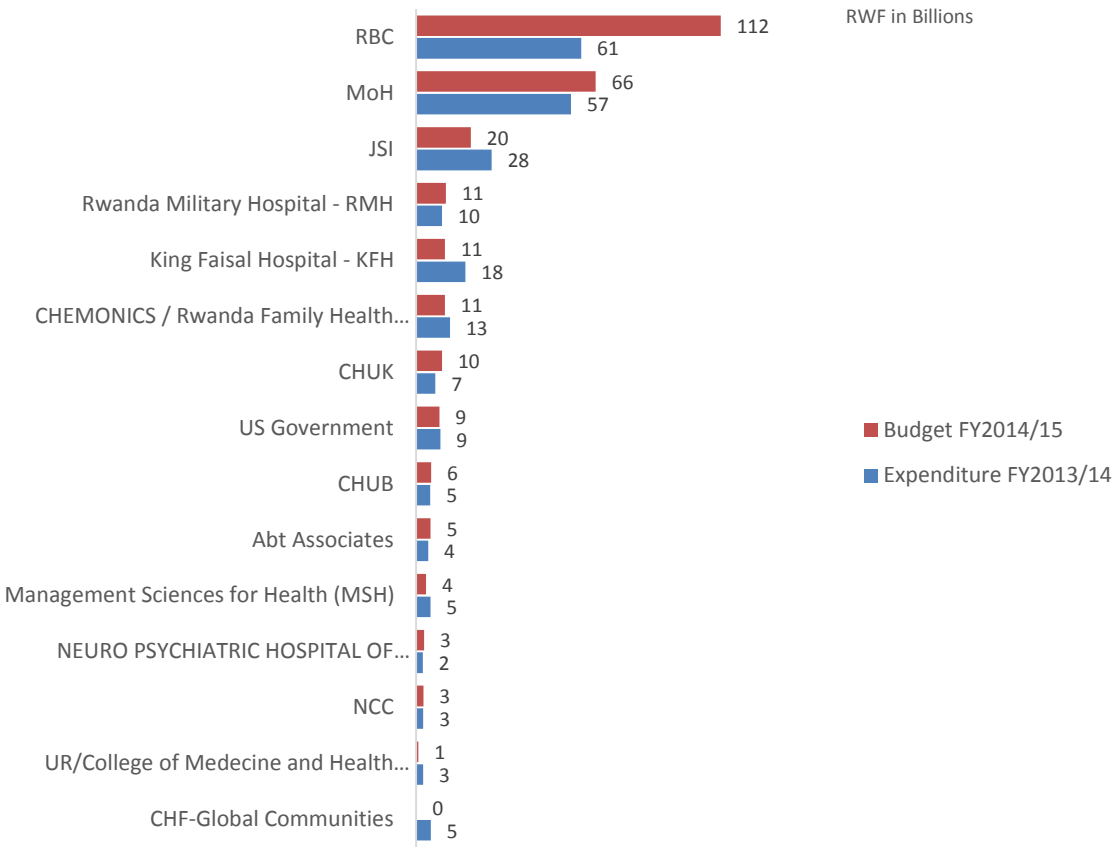


Figure 3.10 shows that expenditures are mostly implemented by international NGOs (22%), GoR institutions, such as RBC, (20%), the MoH (18%), and district and referral hospitals (15%).

A comparison of FY2014/15 budget and FY2013/14 expenditure shows that there was an increase in budgets for the implementation of activities by GoR institutions, rising to 32% from 20%. At the same time, implementation of activities by international NGOs declined to 18% from 22%.

Figure 3.12: Top Implementers – FY 2013/14 Expenditure and FY 2014/15 Budget

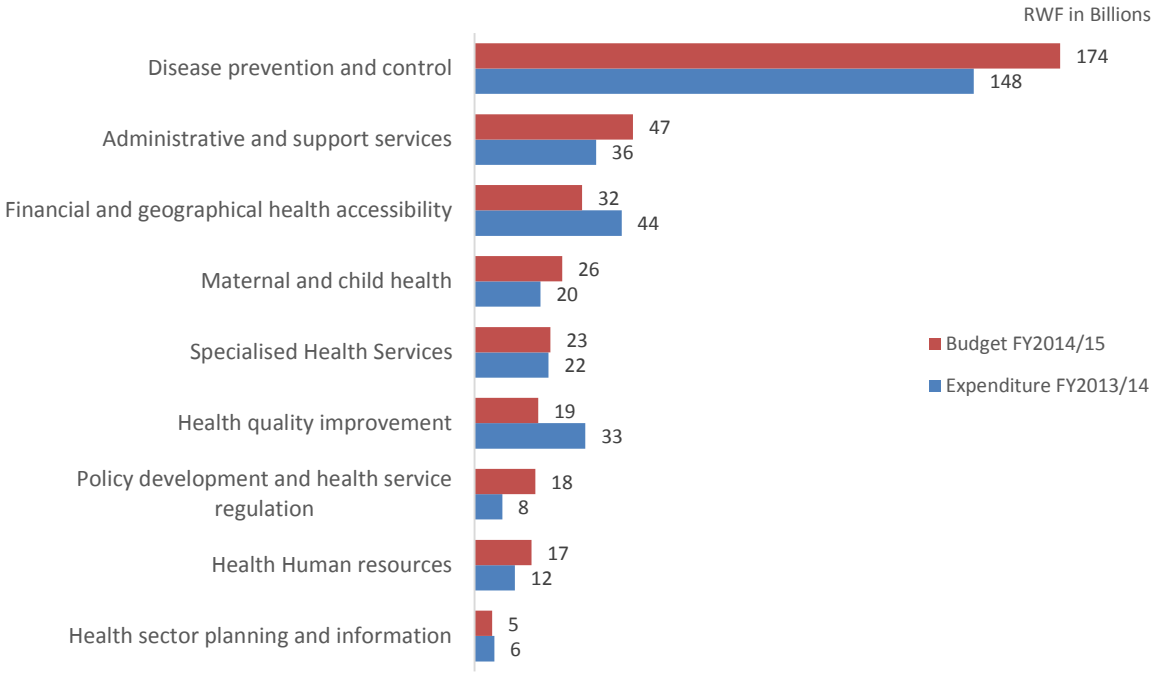


RBC and MoH were the leading implementers in FY 2013/14, implementing RWF 61 billion and RWF 57 billion, respectively. The largest implementer from NGOs was JSI, spending FWF 28 billion. RBC's budget for FY2014/15 is expected to nearly double from RWF 61 billion in FY 2013/14 to RWF 112 billion. This increase is expected with the current transfer of SPIU units to RBC.

3.5 Institutional Spending by MTEF Program and Sub Program

The previous sections illustrated general trends by reporting, financing and implementing agents. In this section, we examine institutional health budgets and expenditures by MTEF Programs and Sub Programs.

Figure 3.13: FY 2013/14 Expenditures and FY 2014/15 Budget by MTEF Program



For FY 2013/14 expenditures, the disease prevention and control sub-program is the largest spending area with approximately RWF 148 billion, representing 53% of the total spending. Funds for disease prevention and control include earmarked transfers to district hospitals and health centers from the Rwandan government.

Overall, expenditures by the MTEF program show a large disproportion in expenditure across the programs, ranging from RWF 148 billion for disease prevention and control to RWF 6 billion for the health sector planning and information. This shows strong commitment to support the priorities of the Rwandan government in disease prevention and control programs.

The MTEF structure (programs and subprograms) has recently been updated by the Ministry of Finance in FY 2013/14. Therefore, comparisons with previous years by MTEF program are not possible.

Figure 3.14: FY 2013–14 Expenditures and FY 2014–15 Budgets by MTEF Sub Programs

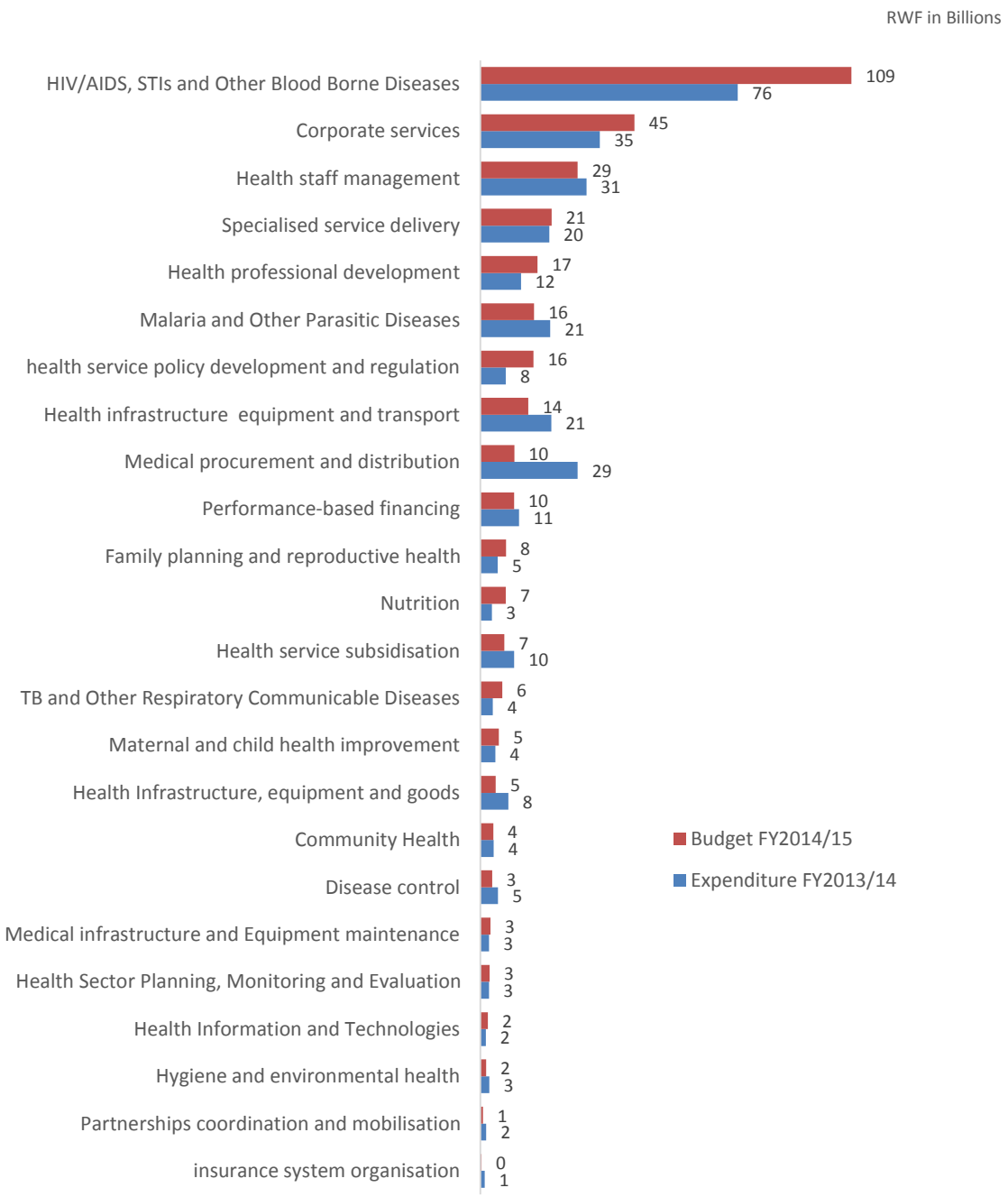


Figure 3.14 shows that HIV/AIDS, STI and blood borne diseases was the largest sub program and is planned to be increased by 43% for the FY2014/15 Budget. The key subprograms that are increasing from FY 2013/14 expenditures to FY 2014/15 Budget are HIV/AIDS, STIs and Other Blood Borne Diseases, Corporate services, Health Service Policy Development and Regulation, and Nutrition. The key subprograms that are declining from FY 2013/14 expenditures to FY 2014/15 Budget are Medical Procurement and Distribution, Health Infrastructure Equipment and Transport, and Malaria and Other Parasitic Diseases.

Figure 3.15: FY 2013–14 Expenditures by MTEF Program and Funding Sources

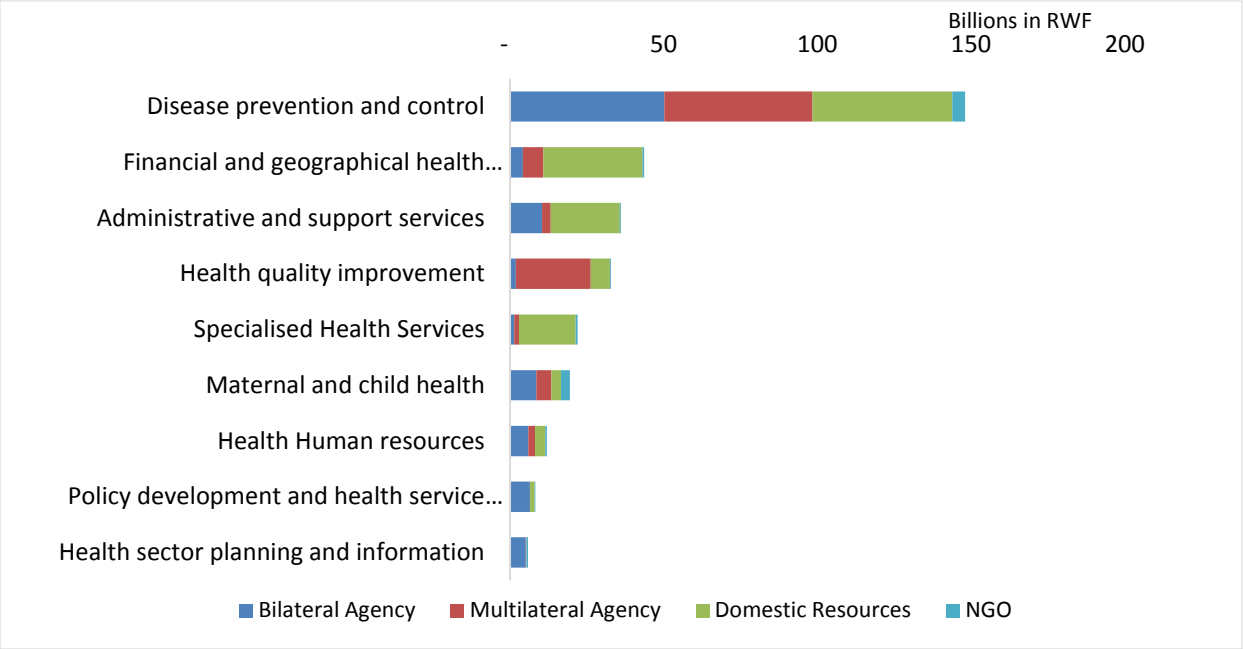


Figure 3.15 displays the MFEF program by funding sources. The majority (67%) of the funding sources for Disease Prevention and Control is provided by external sources comprising multilateral and bilateral agencies. Domestic Resources are mostly spent on disease prevention and control (RWF 45 billion) followed by Financial and geographical health accessibility (RWF 32 billion), Administrative and Support Services (RWF 22.5 billion) and specialized health services (RWF 18 billion).

3.6 Institutional Spending by Location

This section shows where activities are being implemented, national vs district level.

Figure 3.16: FY 2013–14 Expenditures by Location (District vs National)

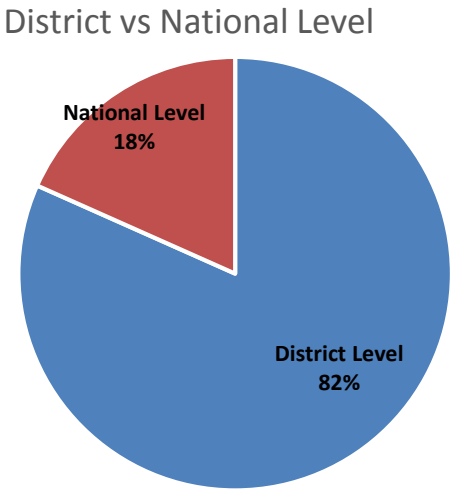


Figure 3.16 shows that the majority of the funds were implemented at the district level (82%).

Figure 3.17: FY 2013/14 Expenditures at National Level vs. District Level by Funding Sources

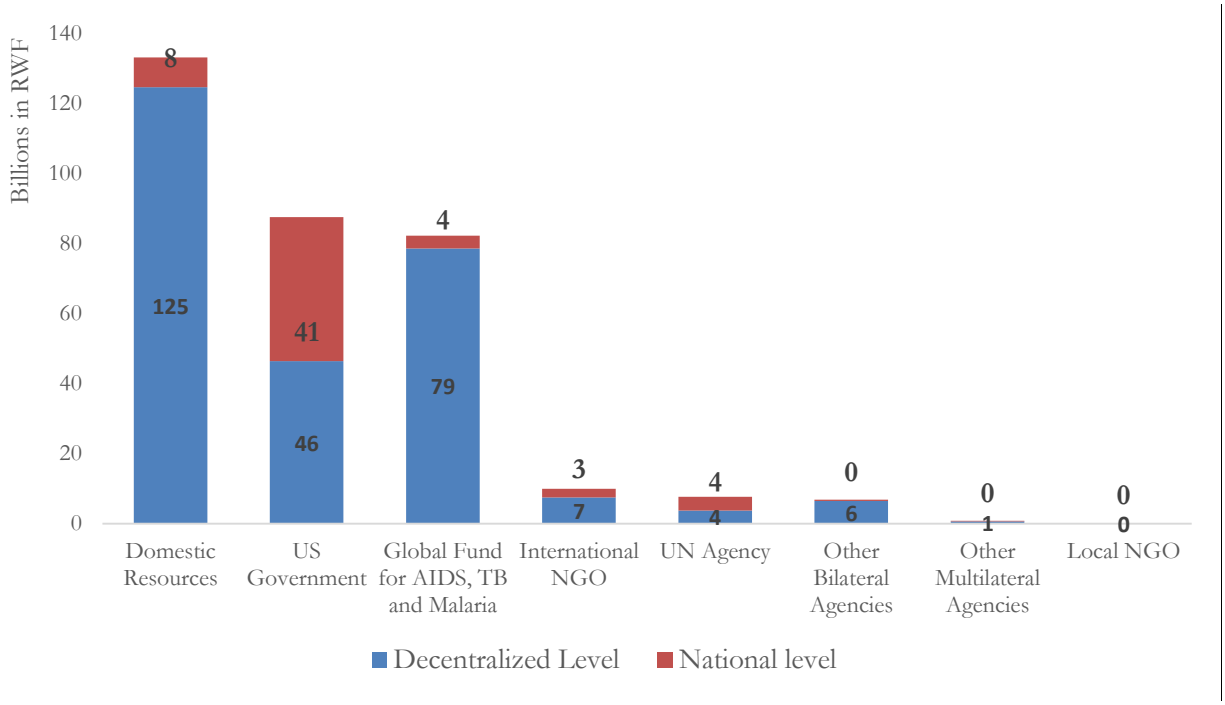


Figure 3.17 shows that the majority of funding from Domestic resources and Global Fund has been implemented at the district level. The majority of implementations at the national level have been funded by the US Government. However, these findings show levels of spending at decentralized levels but do not represent the level of disbursement (transfers) at the decentralized level.

In FY 2013/14, the majority (82%) of institutional health expenditure was implemented at the decentralized level, in line with the current decentralization policy.

Figure 3.18: Expenditure Trends by Location (National vs District Level)

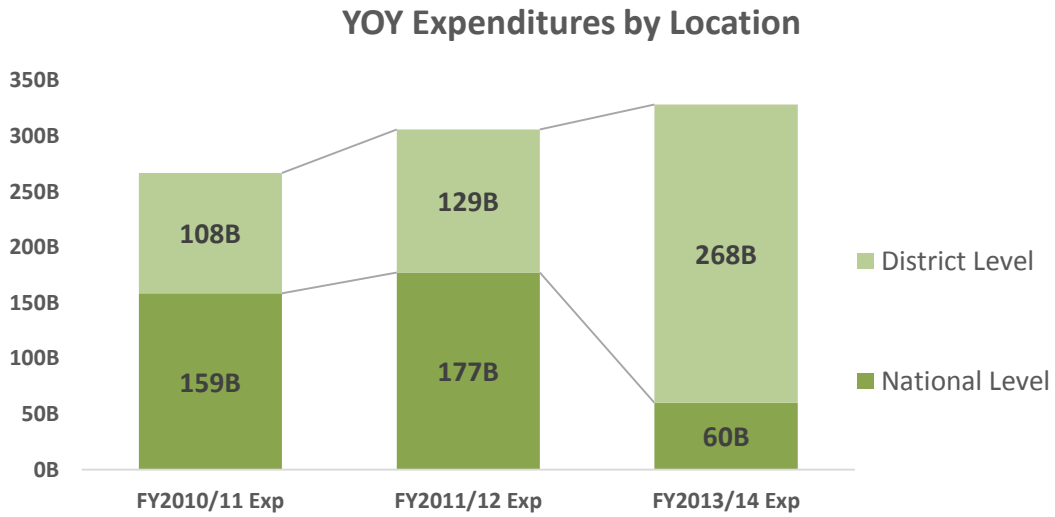


Figure 3.18 illustrates that more activities have been implemented at the district level in FY 2013/14 than FY 2010/11 and FY 2011/12.

Please note that previous HRTT data has resulted in misreporting of funding by location, as reporters selected national level rather than specifying the districts where implementation was assigned. With the development of SOPs and continued institutionalization of HRTT, misreporting of funding by location will be reduced.

3.7 Institutional Spending by Input (Cost Category)

Inputs are cost categories in which funds are spent in order to achieve health goals.

Figure 3.19: FY 2013/14 Expenditure by Input
Figure 3.20: FY 2014/15 Budgets by Input

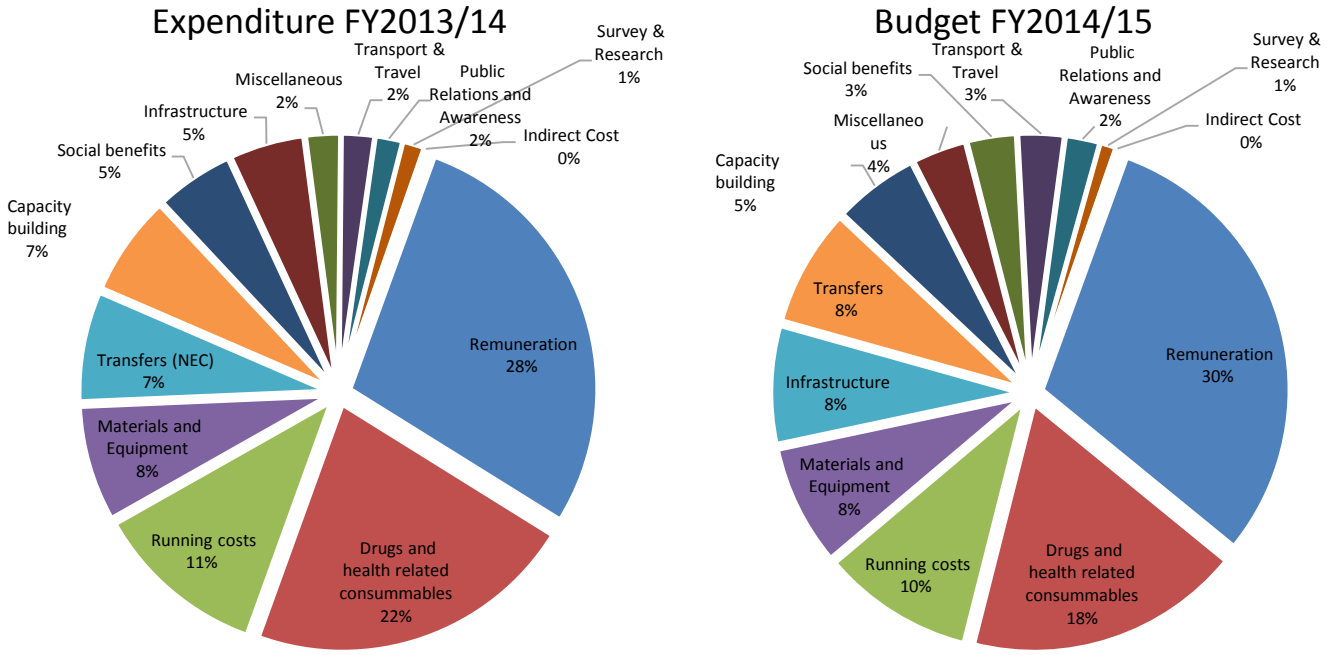


Figure 3.19 illustrates the allocation of spending and budgets across different input categories. The key cost drivers of budgets and expenditures are remunerations, accounting for 28% of the total FY 2013/14 expenditure, followed by drug and health related consumables accounting for 22%.

Comparing FY 2013/14 expenditure and FY 2014/15 budget, allocation for remuneration is expected to increase from 28% of the 2013/14 expenditure to 30% of the FY 2014/15 budget. Allocation for infrastructure is also expected to increase to RWF 28 billion in FY 2014/15 budget from RWF 15 billion in FY 2013/14 expenditure.

Figure 3.21: Top 20 Inputs – FY 2013/14 Expenditure and Budget FY 2014/15

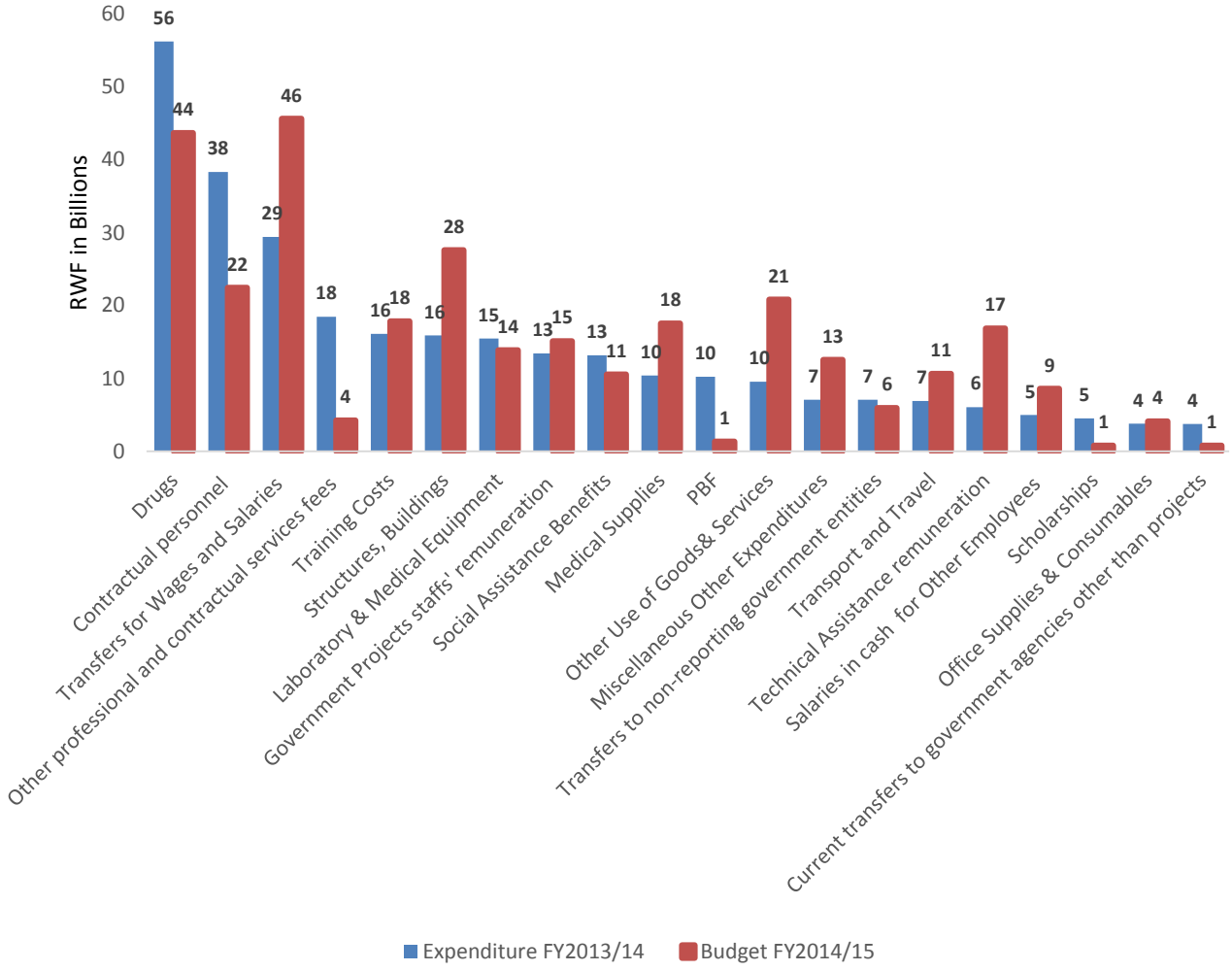


Figure 3.22: Expenditure Trends for Key Inputs

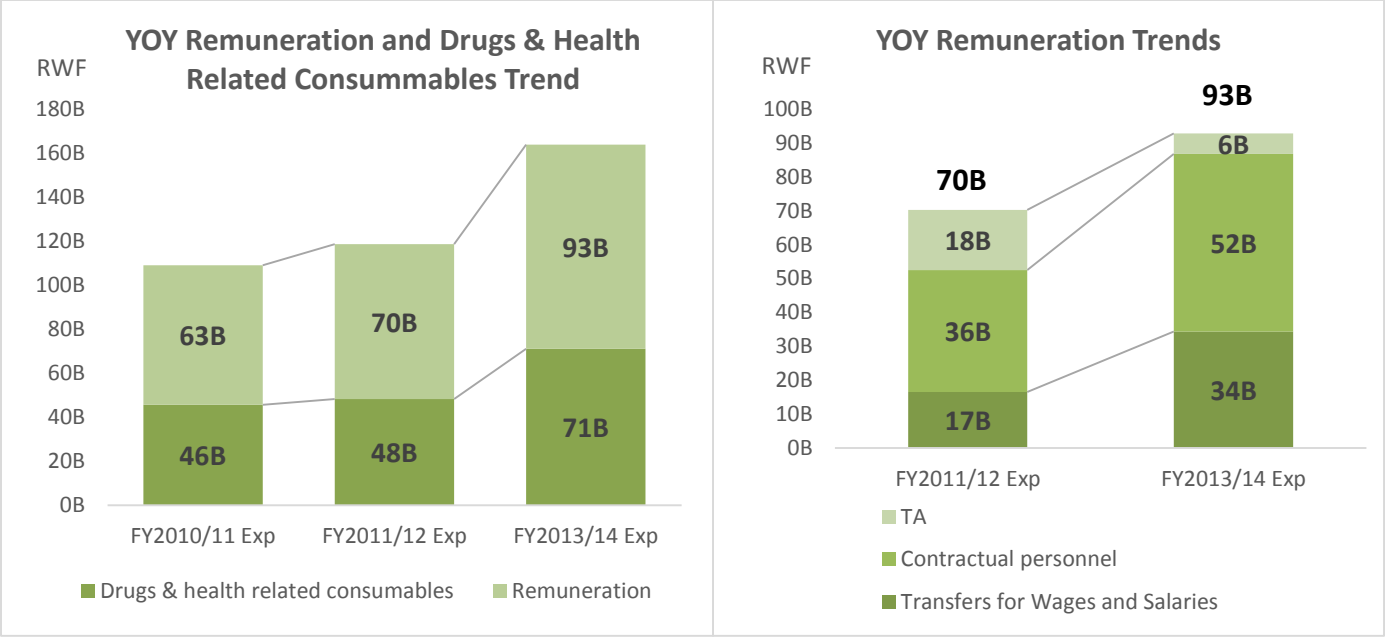


Figure 3.22 illustrates that remuneration and drugs and health related consumables have increased from 2010/11 to 2013/14. For remuneration, TA has decreased while contractual personnel and wages and salaries have increased.

Figure 3.23: Expenditure Trends by Remuneration (National Level vs Decentralized Level)

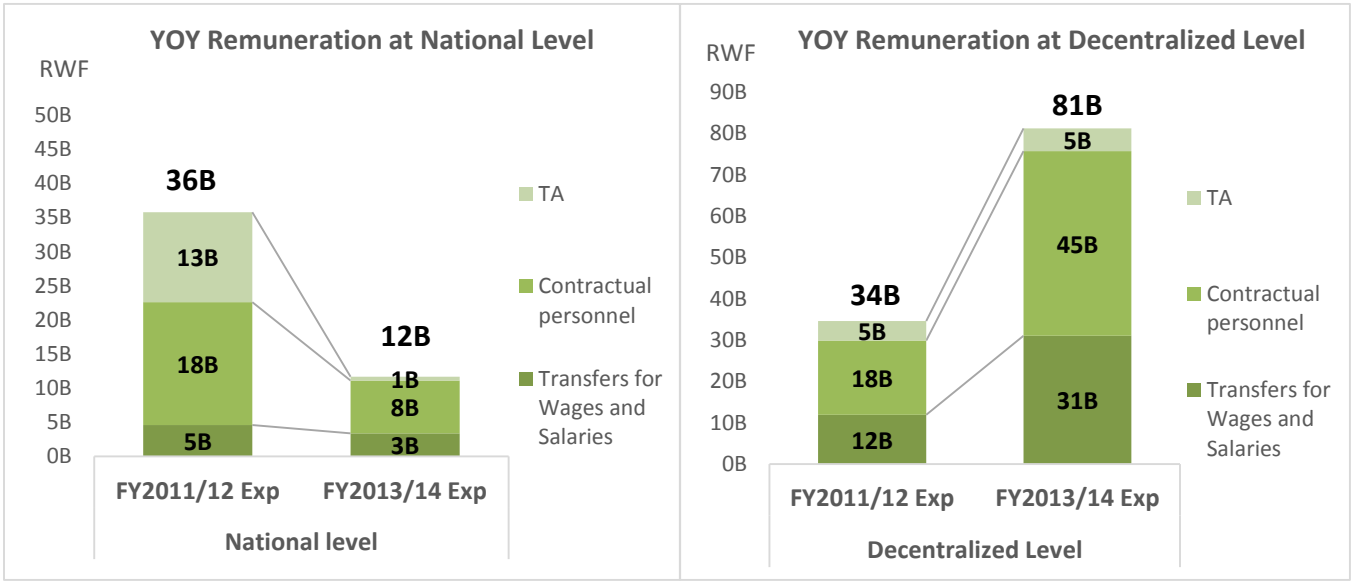


Figure 3.23 illustrate the trends for remunetation brokendown by categories at national level vs decentralized level. It shows the increase on the total amount spent on remuneration in health sector and the shifting of amount spent on each category of remuneration at national level decreased while the amount spent at decentralized level increased from FY2011/12 to FY2014/15.

4. Key Findings, Challenges and Recommendations

4.1 Key Findings

Total spending in health is increasing

Health spending has progressively increased from RWF 267 billion in 2010/11 to RWF 328 billion 2013/14. Budgets have also increased over time from RWF 321 in 2010/11 to RWF 360 billion in 2014/15. However, as mentioned earlier, the data from the HRTT does not represent total health spending, as the data from health centers, private companies and clinics, and some civil society organizations and faith-based organizations have not been collected in this exercise.

Proportion of domestic funding sources is increasing

Domestic expenditures have increased from RWF 85 billion (32% of total institutional expenditures) in 2010/11 to RWF 133 billion (41% of total institutional expenditures) in 2013/14. Domestic expenditures include both GoR central budget, earmarked district transfers and internally generated revenue.

Proportion of external funding sources is decreasing

External expenditures have increased from RWF 181 billion in 2010/11 to RWF 195 billion in 2013/14. While the overall funding from external sources is increasing, the proportion is declining from 68% in 2010/11 to 59% in 2013/14.

When comparing 2011/12 expenditure to 2013/14 expenditure, external funding is decreasing from RWF 223 billion in 2011/12 (73% of total institutional expenditures) to RWF 195 billion (59% of total institutional expenditures) in 2013/14. These findings are consistent with the declining share of activities implemented by international NGOs and the exit of some Development Partners from the health sector.

Strong shift in health spending to support decentralized levels

For 2013/14 expenditures, the largest proportion of health spending has been at the decentralized level of health service delivery. The current shift in health spending at the decentralized levels supports the current GOR decentralization strategy.

HIV/AIDS, STIs, and other blood borne diseases spending continue to be highest relative to other diseases

The disease prevention and control program is the largest spending area. Its sub-program of HIV/AIDS, STI, and blood borne diseases continues to be the largest source of spending, relative to other disease areas. Majority of the funding for disease prevention and control program is provided by external sources, comprising multilateral and bilateral agencies – The Global Fund to Fight AIDS, Tuberculosis and Malaria - SSF-HIV and the US government - PEPFAR.

In FY 2013/14, the combination of actual spending to care for, treat, control and prevent HIV/AIDS amounted to RWF 76 billion. The budget for FY 2014/15 is approximately RWF 33 billion higher than the previous fiscal year's expenditure, highlighting an increase in planned investments in HIV HIV/AIDS, STI and other blood borne diseases. As mentioned earlier, we are not able to compare the 2013/14 expenditures with previous years as the MTEF programs and subprograms were changed.

Remuneration, drugs and consumables account for approximately 50% of the health sector spending.

Remunerations are the largest funding input category in the health sector. Its overall share, when combined with drugs and other consumables, is relatively high – about 50% of the total health spending. Nearly half of the funds for remuneration go to contractual personnel.

4.2 Key Challenges and Recommendations

1. There is need to develop SOPs and operating manuals for clearly harmonizing the interpretation of the classification tree and the data collected. Doing so, will help to better link the activity purpose and beneficiaries to other frameworks, including the MTEF, NHA, and other health sector strategic plans.

2. Due to the high turnover of the personnel in reporting institutions, there is a need of a continuous training and capacity building before next round of data collection.

3. More commitment is required by all the stakeholders to ensure quick and effective data collection. Some institutions do not accurately report into the HRTT leading to incompleteness in data. They must also work toward ensuring that the data provided is of high quality and the exercise is conducted in a timely manner. All institutions should collaborate more closely and be more responsive to the requests of the HRTT team.

Annex 1: Institutions Reported in Round 4 Data Collection

Organization type	# of Institutions Expected to Report	# of Institutions Reported	# of Institutions Not Reported
Bilateral agencies	3	3	0
Administrative District	30	29	1
District hospitals	42	35	7
GoR institutions	2	2	0
International NGOs	43	40	3
Local companies	1	1	0
Local NGOs	8	7	1
Ministries	1	1	0
Referral hospitals	6	6	0
UN agencies	4	4	0
Grand Total	**140**	**128**	**12**

Institution Type	Institution Name	Institution Unit
Bilateral agencies	Belgian Government	Belgian Technical Cooperation (BTC/CTB)
	Swiss Development Cooperation	Programme Sante Grand Lac (PSGL)
	US Government	USAID
District governments	Bugesera District	Bugesera District
	Burera District	Burera District
	Gakenke District	Gakenke District
	Gasabo District	Gasabo District
	Gatsibo District	Gatsibo District
	Gicumbi District	Gicumbi District
	Gisagara District	Gisagara District
	Huye District	Huye District
	Kamonyi District	Kamonyi District
	Karongi District	Karongi District
	Kayonza District	Kayonza District
	Kicukiro District	Kicukiro District
	Kirehe District	Kirehe District
	Muhanga District	Muhanga District
	Musanze District	Musanze District
	Ngoma District	Ngoma District
	Ngororero District	Ngororero District
	Nyabihu District	Nyabihu District
	Nyagatare District	Nyagatare District
	Nyamagabe District	Nyamagabe District
	Nyamasheke District	Nyamasheke District
	Nyanza District	Nyanza District
	Nyarugenge District	Nyarugenge District

Institution Type	Institution Name	Institution Unit
	Nyaruguru District	Nyaruguru District
	Rubavu District	Rubavu District
	Ruhango District	Ruhango District
	Rulindo District	Rulindo District
	Rusizi District	Rusizi District
	Rwamagana District	Rwamagana District
District hospitals	Bushenge DH	Bushenge DH
	Butaro DH	Butaro DH
	Byumba DH	Byumba DH
	Gahini DH	Gahini DH
	Gakoma DH	Gakoma DH
	Gihundwe DH	Gihundwe DH
	Gisenyi DH	Gisenyi DH
	Gitwe DH	Gitwe DH
	Kabaya DH (not completed)	Kabaya DH (not completed)
	Kabgayi DH	Kabgayi DH
	Kabutare DH (not completed)	Kabutare DH (not completed)
	Kaduha DH (not completed)	Kaduha DH (not completed)
	Kibagabaga DH	Kibagabaga DH
	Kibirizi DH	Kibirizi DH
	Kibogora DH	Kibogora DH
	Kibungo DH	Kibungo DH
	Kigeme DH	Kigeme DH
	Kinihira DH	Kinihira DH
	Kirehe DH	Kirehe DH
	Kirinda DH	Kirinda DH
	Kiziguro DH	Kiziguro DH
	Masaka DH	Masaka DH
	Mibirizi DH	Mibirizi DH
	Mugonero DH	Mugonero DH
	Muhima DH	Muhima DH
	Muhororo DH	Muhororo DH
	Munini DH	Munini DH
	Murunda DH	Murunda DH
	Nemba DH	Nemba DH
	Ngarama DH	Ngarama DH
	Nyagatare DH (not completed)	Nyagatare DH (not completed)
	Nyamata DH	Nyamata DH
	Nyanza DH	Nyanza DH
	Remera-Rukoma DH	Remera-Rukoma DH
	Ruhango DH (not completed)	Ruhango DH (not completed)
	Ruhengeri DH	Ruhengeri DH

Institution Type	Institution Name	Institution Unit
	Ruli DH	Ruli DH
	Rutongo DH (not completed)	Rutongo DH (not completed)
	Rwamagana DH	Rwamagana DH
	Rwinkwavu DH	Rwinkwavu DH
	Shyira DH	Shyira DH
GoR institutions	RBC	CS Division
		ESR Division
		HIV/AIDS Division
		MCCH Division
		MH Division
		MOPD Division
		MPPD Division
		MRC Division
		MTI Division
		NCBT Division
		NCD Division
		NRL Division
		PMEBS
		RHCC Division
		SPIU
		TB Division
		VP
	UR/College of Medicine and Health Sciences	College of Medicine and Health Sciences / UR
International NGOs	Abt Associates	Abt Associates
	Access Project	ACCESS PROJECT
	AHA	AHA
	AIDS Healthcare Foundation	AIDS Healthcare Foundation
	AVSI	AVSI
	Better World Rwanda	Better World Rwanda
	Breast Cancer Initiative East Africa (BCIEA) Inc.	Breast Cancer Initiative East Africa (BCIEA) Inc.
	CARE International	CARE International
	Catholic Relief Service	Catholic Relief Service
	CBM	CBM
	CDI (CHAI)	CDI (CHAI)
	CHEMONICS/Rwanda Family Health Project	CHEMONICS/Rwanda Family Health Project
	CHF-Global Communities	Global Communities
	Compassion International	Compassion International
	Concern Worldwide	Concern Worldwide
	Cure International	Cure International
	Drew Cares International	Drew Cares International
	EGPAF	EGPAF

Institution Type	Institution Name	Institution Unit
	fADA	fADA
	FHI 360	FHI 360
	Gardens for Health International	Gardens for Health International
	Handicap International	Handicap International
	Health Development Performance	HDP
	Health Poverty Action	Health Poverty Action
	IHANGANE Project	IHANGANE Project
	Institute for Reproductive Health	Institute for Reproductive Health
	International Rescue Committee	International Rescue Committee
	JHPIEGO	JHPIEGO
	JSI	JSI
	Management Sciences for Health (MSH)	Management Sciences for Health (MSH)
	Maryland Global Initiatives Corporation	Maryland Global Initiatives Corporation
	Medicus Mundi	Medicus Mundi
	MSPH Rwanda LLC	MSPH Rwanda LLC
	SAN FRANCISCO	SAN FRANCISCO
	Save the Children International Rwanda	SCI Rwanda
	Society for Family Health	Society for Family Health
	The Fred Hollows Foundation	The Fred Hollows Foundation
	Vision for a Nation Foundation	Vision for a Nation Foundation
	World Relief	World Relief
	World Vision	World Vision
Local companies	One Family Health - CFW	One Family Health
Local NGOs	African Evangelistic Enterprise	AEE Rwanda
	CARITAS RWANDA	CARITAS RWANDA
	FXB RWANDA	Turengere Abana
	Imbuto Foundation	Imbuto Foundation
	Red Cross Rwanda	Red Cross Rwanda
	RINDA UBUZIMA	RINDA UBUZIMA
	UPHLS	UPHLS
Ministries	MoH	Accreditation
		Administration & Human Resource
		CBHI
		Decentralization & Integration
		E-Health
		Environmental Health
		Finance
		HMIS
		HRH
		PBF
		Pharmacy

Institution Type	Institution Name	Institution Unit
		Public and Private Health
		SAMU
		SWAP
Referral hospitals	CHUB	CHUB
	CHUK	CHUK
	KACYIRU POLICE Hospital - KPH	KACYIRU POLICE Hospital - KPH
	King Faisal Hospital - KFH	King Faisal Hospital - KFH
	NEURO PSYCHIATRIC HOSPITAL OF NDERA (HNN)	NEURO PSYCHIATRIC HOSPITAL OF NDERA (HNN)
	Rwanda Military Hospital - RMH	Rwanda Military Hospital - RMH
UN Agencies	UNAIDS	UNAIDS
	UNFPA	UNFPA
	UNICEF	UNICEF
	WHO	WHO

Annex 2: HRTT Data Structure

At the highest level, data within the HRTT is organized according to individual data reporting entities. In each round of data collection, reporting institutions enter detailed information about their projects and activities for two periods – the past fiscal year and the current fiscal year. For the purposes of the HRTT, activities are specific interventions that aim to improve health outcomes in Rwanda, whereas projects incorporate several activities that are aligned with each other under a common vision. Work done by an institution is reported to the HRTT using a common framework of activities grouped within projects, regardless of how it may be structured in their individual work plans.
Table A2.1 summarizes the information collected by the HRTT and A2.2 provides a summary of Financial Flows.

The data collected by the HRTT is best thought of in terms of three levels: reporting institutions, projects, and activities. At the institutional level, the HRTT requires each reporter to specify their fiscal year and the currency in which their budget and expenditure data is denominated.

At the project level, the HRTT collects each project's name, description, and start and end date. The HRTT collects information on the funds received during the past fiscal year as well as funding expected in the current fiscal year from each funding source (all the activities within a project are assumed to have the same funding sources). At the activity level, the HRTT collects each activity's name and description. The HRTT then collects information on spending by each implementer of that activity during the past and current fiscal years. The implementer can either be the reporting institution or a sub-recipient who receives funds from the reporting institution to carry out a given health activity. Finally, reporters can list administrative and management costs, either by project or for their organization as a whole.

Table A2.1: Summary of Information Collected by HRTT

Reporting Organization	Project	Activity
• Organization Name • Contact Person • Fiscal Year • Default Currency	• Name of project • Description of project • Funding sources for the project • Disbursements received in past FY by funding source • Expected disbursements in current FY by funding source • Project-specific administrative costs	• Name of activity • Description • Expenditures in past FY by implementer • Budget in current FY by implementer • Disaggregation of spending by location (districts or national level) • Disaggregation of spending by purposes • Disaggregation of spending by purposes • Beneficiaries

The HRTT focuses on four key financial variables: disbursements received in the past fiscal year; disbursements expected in the current fiscal year; expenditure in the past fiscal year; and the budget for the current fiscal year.

Table A2.2: Summary of Financial Flows Captured by the HRTT

	Past Fiscal Year	Current Fiscal Year
Funds Received	Disbursements received from each funding source for a given project	Disbursements expected from each funding source for a given project
Funds Spent	Expenditures by each implementer of an activity	Budget for each implementer of an activity

Disbursements are funds received from a funding source, and they occur at the project level. While expenditures are funds spent by implementers and were collected at the activity level. Additionally, budgets are planned expenditure for the upcoming year and were also collected at the activity level. Disbursements received in the past year could be higher or lower than the total expenditure in that year. This is because institutions may not have spent 100% of the funds they received (which would cause expenditure to be less than the funds received) or may have carried forward unspent funds from the previous year (which would cause expenditure to exceed the funds received). Similarly, their budget for the current year may be higher than the disbursements expected if they are using any surplus funding from the past year to finance future activities.

At the activity-level, the HRTT collects a range of information about how the funds are being spent. Reporters disaggregate their activity spending by purpose, input categories, and location using standardized classification structure provided by the HRTT. Each of these dimensions is described in brief below.

Activity Purpose
The activity purpose captures the purpose of spending within an activity (e.g., Improving Mental Health care services, Behavior Change Communication (BCC), Income Support for PLHIV, etc.). The purpose classification structure is a combination of different sources, such as the Medium Term Expenditure Framework (MTEF), National Strategic Plans, NHA and NASA.

Inputs
The HRTT requires reporters to break down budgets and expenditures for each activity by inputs or cost categories. The input categories include drugs commodities and consumables, communication and advertising, food supplies, infrastructure, maintenance, medical equipment, transport and travel, remuneration, capacity building, PBF, and other miscellaneous spending. For each activity, reporters specify the amount spent on each of the relevant cost categories.

Location
The ongoing decentralization in the health sector has led to stakeholders being interested in knowing where the spending is taking place. Data reporters to the HRTT specify the percentage of spending that occurs at the national level versus the decentralized level (in each of Rwanda's 30 districts). The criterion for selecting the location is the geographical location of the intended beneficiaries, rather than either the location of the reporting organization or where the financial transaction may take place.

Annex 3: Exchange Rates

Fiscal Year	Exchange Rate 1 USD = RWF
FY 2010/11	580
FY 2011/12	595
FY 2012/13	630
FY 2013/14	680
FY 2014/15	688.8

Source: MINECOFIN

Annex 4: Financing Sources and Implementers

Financing Sources	RWF	RWF	RWF	RWF
Health System Actor	**FY 2010-11 Expenditure**	**FY 2011-12 Expenditures**	**FY 2013-14 Expenditures**	**FY 2014-15 Budget**
Bilateral Agencies	82,392,294,400	103,334,235,480	94,415,039,788	119,249,602,676
Multilateral Agencies	79,675,718,820	99,943,666,060	90,706,214,131	98,430,457,456
Central Government Revenue	64,610,939,760	66,121,539,610	84,236,970,791	84,027,784,585
NGO	19,089,169,380	19,334,972,440	10,037,281,028	11,516,887,744
Internally Generated Revenue	20,859,651,280	17,104,279,955	48,861,454,992	46,859,808,754
Total	**266,627,773,640**	**305,838,693,545**	**328,256,960,729**	**360,084,541,216**

Implementers	RWF	RWF	RWF	RWF
International NGOs	58,898,117,820	73,875,391,590	71,917,327,411	63,270,507,970
MOH Institutions	61,854,770,480	55,767,601,295	57,187,750,492	66,295,239,823
District Governments	22,157,825,840	45,264,034,165	7,369,354,730	4,873,103,699
RBC Institutions	53,499,613,540	44,529,197,265	60,912,900,167	112,399,376,000
Referral Hospitals	23,779,748,860	24,442,790,995	43,524,517,998	40,736,390,346
Local NGOs	7,915,007,120	18,144,607,110	9,073,829,853	10,721,851,656
Bilateral Agencies	14,034,776,780	13,869,544,605	8,989,085,920	9,215,780,973
Other Ministries	7,860,912,840	11,430,537,265	1,181,459,887	1,427,898,242
Health Centers	8,876,021,880	8,867,145,770	13,263,339,777	14,719,882,087
District Hospitals	6,335,752,380	7,760,320,225	48,951,255,956	32,323,187,261
CBOs	0	1,069,966,485		
UN Agencies	1,415,226,100	817,556,775	11,665,346	91,308,706
Unclassified	0	0		
Other GoR institutions	0	0	5,866,688,193	3,959,695,452
Council	0	0	7,785,000	50,319,000
Total	**266,627,773,640**	**305,838,693,545**	**328,256,960,729**	**360,084,541,216**

Annex 5: Details of all Funding Sources

Funding Source	Funder type	FY2013/14 Expenditure	FY2014/15 Budget
US Government	Bilateral Agency	87,533,686,358	98,096,325,937
Rwanda Government	Central Government Revenue	84,236,970,791	84,027,784,585
Global Fund	Multilateral Agency	82,202,690,957	93,352,559,082
King Faisal Hospital - KFH	Internal Generated Revenues	15,577,125,081	8,632,826,517
Rwanda Military Hospital - RMH	Internal Generated Revenues	9,321,358,480	9,067,798,216
RBC	Internal Generated Revenues	5,237,455,293	9,789,971,449
UNICEF	Multilateral Agency	3,729,173,420	7,007,573,180
Belgian Government	Bilateral Agency	3,123,708,383	2,941,589,682
CHUK	Internal Generated Revenues	2,118,544,531	4,139,238,181
CHUB	Internal Generated Revenues	1,868,825,146	2,066,002,239
Compassion International	NGO	1,449,635,000	927,126,600
UNFPA	Multilateral Agency	1,360,211,299	390,529,306

Funding Source	Funder type	FY2013/14 Expenditure	FY2014/15 Budget
World Vision	NGO	1,309,046,636	1,452,730,860
NEURO PSYCHIATRIC HOSPITAL OF NDERA (HNN)	Internal Generated Revenues	1,226,772,671	1,399,048,734
UNHCR	Multilateral Agency	1,193,689,873	857,379,388
Muhima DH	Internal Generated Revenues	1,057,667,920	1,090,458,551
United Kingdom (UK)	Bilateral Agency	1,021,348,802	3,849,133,366
WHO	Multilateral Agency	979,378,740	1,224,591,480
Ruhengeri DH	Internal Generated Revenues	785,810,465	-
Kinihira DH	Internal Generated Revenues	781,127,148	621,725,888
EGPAF	NGO	777,152,960	614,432,360
Partners in Health (PIH)	NGO	741,725,218	672,530,381
Germany Government	Bilateral Agency	702,655,375	42,760,016
Swiss Development Cooperation	Bilateral Agency	696,782,546	1,446,604,902
Netherlands Government	Bilateral Agency	640,047,002	2,600,264,365
Kibogora DH	Internal Generated Revenues	561,148,870	-
Byumba DH	Internal Generated Revenues	555,019,704	920,102,119
Kirehe DH	Internal Generated Revenues	541,959,182	541,959,182
Hewlett Packard	NGO	539,772,440	312,324,630
One Family Health - CFW	Internal Generated Revenues	524,464,442	910,453,589
Kibungo DH	Internal Generated Revenues	520,905,941	516,665,725
Gisenyi DH	Internal Generated Revenues	480,433,238	-
Nemba DH	Internal Generated Revenues	474,068,921	439,212,467
Mibirizi DH	Internal Generated Revenues	468,612,491	17,579,205
Kigeme DH	Internal Generated Revenues	457,745,954	725,916,450
Kiziguro DH	Internal Generated Revenues	457,588,028	623,113,633
ELMA	NGO	436,722,520	450,972,844
Kibagabaga DH	Internal Generated Revenues	428,513,613	299,486,169
Kabgayi DH	Internal Generated Revenues	419,587,337	-
CBM	NGO	415,314,080	445,362,926
Emory University	NGO	412,361,520	362,447,344
Gihundwe DH	Internal Generated Revenues	402,563,818	454,550,149
Nyamata DH	Internal Generated Revenues	400,435,045	598,091,553
Gahini DH	Internal Generated Revenues	392,490,545	508,871,709
AVSI	NGO	391,810,017	528,303,777
AIDS healthcare foundation	NGO	378,814,967	737,019,256
Brothers of charity	NGO	372,755,115	569,431,441
European Union	Multilateral Agency	366,598,121	226,551,416
Nyanza DH	Internal Generated Revenues	352,677,474	365,245,718
Saudi Fund	Bilateral Agency	349,903,977	-
Remera-Rukoma DH	Internal Generated Revenues	341,939,796	617,437,657
Masaka DH	Internal Generated Revenues	323,395,606	-
Muhororo DH	Internal Generated Revenues	300,456,778	617,500,000
Columbia University/ICAP	NGO	299,644,580	310,962,640
Access Project	NGO	299,339,089	471,702,820
Gitwe DH	Internal Generated Revenues	294,885,630	-

Funding Source	Funder type	FY2013/14 Expenditure	FY2014/15 Budget
Ngarama DH	Internal Generated Revenues	275,869,760	-
Rwinkwavu DH	Internal Generated Revenues	263,384,410	499,777,412
World Bank	Multilateral Agency	244,984,952	3,133,809,381
Irland Government	Bilateral Agency	224,659,550	233,469,334
One UN	Multilateral Agency	220,225,242	289,714,037
Shyira DH	Internal Generated Revenues	209,978,032	-
Vision for a Nation Foundation	NGO	203,412,332	630,529,860
UNAIDS	Multilateral Agency	202,727,720	101,431,429
Gardens for Health International	NGO	201,107,962	322,906,527
KACYIRU POLICE Hospital - KPH	Internal Generated Revenues	200,805,636	-
Bushenge DH	Internal Generated Revenues	197,033,273	330,381,783
European Developing Countries Trial Partnership	Multilateral Agency	192,018,400	81,071,592
Kibirizi DH	Internal Generated Revenues	191,939,258	-
Butaro DH	Internal Generated Revenues	187,793,046	449,263,211
Gakoma DH	Internal Generated Revenues	185,708,376	268,561,882
Catholic Relief Service	NGO	171,360,163	27,540,290
Mugonero DH	Internal Generated Revenues	170,850,139	152,346,060
Stanford University	NGO	168,138,338	272,522,500
The Fred Hollows Foundation	NGO	129,266,347	583,637,899
Institute for Reproductive Health	NGO	128,564,200	339,457,400
Medicus Mundi	NGO	124,467,046	55,454,599
Murunda DH	Internal Generated Revenues	117,029,022	-
Kirinda DH	Internal Generated Revenues	116,038,633	-
IHANGANE Project	NGO	112,165,320	57,893,640
Better world Rwanda	NGO	101,824,000	99,760,000
PACKARD Foundation	NGO	99,977,755	146,590,920
World Relief	NGO	98,068,132	101,569,867
Swidish International Development AAgency	Bilateral Agency	89,760,116	78,350,897
Better Together	NGO	86,616,492	-
Damian Foundation	NGO	81,570,797	89,548,059
fADA	NGO	75,430,944	77,537,600
CDI (CHAI)	NGO	73,031,272	-
American Red Cross	NGO	69,694,143	30,745,316
Rockefeller Foundation	NGO	62,611,680	217,906,013
Handicap International	NGO	50,084,000	-
Cure International	NGO	45,644,775	79,187,787
WASH Project	NGO	45,502,398	-
Munini DH	Internal Generated Revenues	44,543,126	-
Mairie Bilbao	Bilateral Agency	32,487,680	-
Red Cross Rwanda	NGO	27,966,113	-
ENGALYNX	NGO	21,033,975	-
Rwamagana District	Internal Generated Revenues	19,068,933	-
WFP	Multilateral Agency	14,515,408	33,673,396

Funding Source	Funder type	FY2013/14 Expenditure	FY2014/15 Budget
Breast Cancer Initiative East Africa (BCIEA) Inc.	NGO	12,962,840	27,414,240
WaterAid	NGO	8,289,035	33,469,000
VSI	NGO	6,044,000	-
MSV	NGO	4,303,070	-
Kirehe District	Internal Generated Revenues	4,000,000	-
Rwamagana DH	Internal Generated Revenues	3,834,200	-
FK	NGO	3,714,756	-
Duke University	NGO	335,000	4,189,764
GAVI ALLIANCE	Multilateral Agency	-	1,675,573,666
Ruli DH	Internal Generated Revenues	-	196,223,306
OneDollarGlasses	NGO	-	113,760,000
SUN (Scale Up Nutrition Mouvment)	NGO	-	109,677,590
International Development Research Center (CANADA)	NGO	-	88,232,500
University of Liverpool	NGO	-	82,280,408
Segal Family Foundation	NGO	-	29,672,500
MOPACUR	NGO	-	16,846,770
International Federation of Red Cross and Red Croissant	NGO	-	13,180,789
JP Morgan	NGO	-	10,028,027
Mairie Leioa	Bilateral Agency	-	9,142,236
Mairie Zuia	Bilateral Agency	-	7,962,046
Grand Total		**328,256,960,729**	**360,084,541,216**

Annex 6: Classification Tree - Activity Purposes Structure

Domain of Intervention	Sub domains of Intervention	Activity Purposes
Administration and support Services		
	Business strategy	
		Identification and fonctionality of business opportunities
	Corporate services	
		Capacity Development and technical assistance
		Distribution of human resources for health in all health facilities
		functionning support services
		Management Support
		Procurement and Logistical support
		Public Financial Management
		Staff remuneration and incentive
		Support all councils, professionals bodies and other institutions
	Planning and M&E	
		Development of new policies and strategies
		Development, dessemination and implementation of planning documents

Domain of Intervention	Sub domains of Intervention	Activity Purposes
		Monitoring and evaluation of programmes
Clinical Services		
	Accreditation	
		Assessment of meeting standards for accreditation
		Develop policy and procedures for accreditation
		Monthly accreditation facilitation
		The use of updated data for evidance based
		Training of surveyors and facilitators on different aspect of accreditation(Quality, IPC...)
		Update of accreditation standards
	Environment Health	
		Increased sensitization of the community on hygiene and sanitation for behaviounal change through mass media
		Reinforce community based environmental Health program
		Reinforce legal framwork, planning and M&E of environmental health program
		Reinforce water quality, food safety, infection sefety health care waste management
	Nursing	
		Improving the quality of nursing and midwifery education and training
		Strengthening Nursing and Midwifery Services
	Pharmacy	
		Ensure pharmaceutical products
		Inspection and supportive supervision of pharmaceutical establishment both public and private
		Pharmaceutical regulation and quality control
		Policy, law and guide lines development and reviews
		Regional harmonization and cooperation
		Regulation and institutionalization of traditional medicine
	Private Health Facilities	
		Authorization to open a private health facilities and to start activities
		Coordination of private health facilities
		Formulation of norms and standards regarding private health facilities
		Regulation of private health facilities
		Supervision and Inspection of private health facilities
	Public Health Facilities	
		Guides and protocols that govern public health facilities
		Health policy that governs public health facilities
		Monitoring of the implementation guides, protocols and health policy
		Support the health management team at Districts
	Specialized Health Services	
		Clinical and operational research
		Mentorship and supervision of District hospitals

Domain of Intervention	Sub domains of Intervention	Activity Purposes
		Specialised health services delivery
		Teaching and Training
Disease Prevention and Control (Other)		
	Epidemic Surveillance and Response (ESR)	
		Appropriate management of diseases outbreaks and others events of public health importance
		Appropriate manegement of Emerging, outbreaks Diseases and other events of public health importance
		capacity building for conducting opearational research for EID staff
		Emerging and re-emerging Disease outbreaks and other events of public health importance
		Integrating all public and private health facilities and the community into IDSR
		Promoting Human capacity for EID operation research
		Public is aware of the mode of transmission and prevention of epidemic prone diseasess
		Staff remuneration and functionning support services6
		Strengthening the capacity of the center for treatment and research on other epidemic
		Strengthening vaccination interventions.
		Sustaining Influenza Surveillance Networks and Response to seasonal and Pandemic
	Mental Health	
		Improving Mental Health care services
		Improving Mental health care services in referral and decentralised level
		Increasing Awareness on drug use prevention and control
		Increasing Awareness on mental health to reduce the stigma towards mental disorders
		Staff remuneration and functionning support services5
		Strengthening fighting against drug abuse
	Rwanda Health Communication Center (RHCC)	
		General population is reached by mass media on diseases prevention and control
		Health sector communication materials edited, produced and disseminated
		Staff remuneration and functionning support services are provided
District Operations		
	Disease control	
		CHW cooperatives
		Clinical Operations
		Support CBHI
	Health Infrastructure, equipment and goods	
		Management support.
		Support CBHI.

Domain of Intervention	Sub domains of Intervention	Activity Purposes
	Health staff management	
		Staff remuneration and incentive.
Geographic Accessibility		
	Geographic Accessibility	
		Health Equipment
		Health Infrastructure.
Health Financing		
	Community Based Health Insurance (CBHI)	
		Financing of pooling risk
		Human Resources
		Management of technical support CBHI staff
		Management system of CBHI at district and national level
		Monotoring and evaluation of CBHI
		Payment of annual subscription to CBHI for Indigents
		Planning and Administration
		Produce and disseminate IEC materials
		Research and publication activities
		Sensitization of CBHI & media campaign
	PBF	
		Coordination Meeting and Workshop
		Human Resource
		Living Support to Clients/Target Populations
		Maintenance and overheads
		Monitoring & Evaluation PBF activities
		Reseach
Health Service Delivery		
	Medical Research Center (MRC)	
		Ensure research in Rwanda is following rules and regulations
		General population can access health information on web
		Improve Clinical research practice and regulatory framework in Rwanda
		Improve evidence based decision making in prevention, diagnostic, care and treatment of diseases
		Increase Capacity of MRC and other RBC divisions in grant and proposal writing and management
		Staff remuneration and functionning support services3
	National Center for Blood Transfusion (NCBT)	
		Effective management of blood and transfusion activities
		Increase availability of quantity and quality of blood products
		Increase blood donations
		Increase blood donors

Domain of Intervention	Sub domains of Intervention	Activity Purposes
		Increase new blood donors
		Increase regular blood donors
		Reduce blood transmitted infections markers
		Staff remuneration and functionning support services2
		Strengthening of blood transfusion services
	National Reference Laboratory (NRL)	
		Ensure Laboratory infrastructure meets required National Norms and standards
		Quality of laboratory services is delivered and stock out avoided
		Skilled laboratory technologist to provide lab services (human resources)
		Staff remuneration and functionning support services are provided.
		Strengthening Supply chain management system of reagents and equipement
		Testing of all outbreak and referred specimens
	SAMU	
		Assure rapid transportation of all casualties and patients with any kind of emergency problem towards an appropriate health institution providing ongoing care
		Immunisation of samu staff from communicable diseases, use of PPEs
		Improve reception and regulation of calls, actions, and follow up of ambulances all over the country
		Pre-hospital care protocols and disasters contigency plans used by pre-hospital care providers
		Staff management and administration
		Train regularly PH, HC and DHs emergency personnel for an adequate care of emergencies
Health Support Systems		
	Decentralization	
		Regulatory Framework, and Decentralization
	Human Resource for Health (HRH)	
		Build the capacity of SOM, SON and SPH faculty
		Continuing Professional Development (CPD) Programme is implemented and monitored
		Facilitate recruitment of US Institution faculty to strengthen the management and administration of CMHS schools and sites
		Medical doctors admitted for specialization are remunerated every month
		Medical internship policy development and government administration
		Midwives admitted for A1 level are remunerated every month
		Provide equipments and supplies to CMHS schools and sites
		Recruit US Institution faculty to work in Rwanda's health professional education institutions and sites
		Strengthen HR in management of HIV, MCH and other infections in infants and children
		Strengthen HR in management of MCH, HIV and other diseases in pregnant women for nursing and midwifery services

Domain of Intervention	Sub domains of Intervention	Activity Purposes
		Strengthen HR in management of MCH, HIV and other infectious US and Rwandan diseases in adults care
		Strengthen HRH in management of MCH transmission of HIV and other infectious disease in pregnant woman
		Strengthen HRH in management of MCH, HIV and other surgical conditions
		Strengthen HRH in management of MCH, HIV provision of surgical care
		Strengthen the management of hospitals for better integration of HIV services within the health system
		Support the development and implementation of academic programs (SOM,SON ,…)
		Support US Institution faculty before and after arrival in-country
		Utilize monitoring and evaluation data
	Medical Technology and Infrastructure (MTI)	
		Control the local health technologies market
		Ensure Preventive and curative maintenance of medical infrastructures and equipments
		Improve medical maintenance financing
		Improve the regulatory and institutional framework of medical maintenance field
		Staff remuneration and functionning support services
		Upgrading and Streingthening Medical mentainance center staff capicities
Leprosy		
	Care and Treatment	
		Develop the referral system
		Reduce the new cases with grade 2 disability by leprosy
	M&E	
		Improve the quality of leprosy services
	Prevention	
		Increase sensitisation, information and communication in order to reduce stigma against people affected by leprosy
	social support for leprosy Patients	
		Strengthen leprosy activities in endemic sites
Non communicable Diseases		
	Community sensitization for behavioral change and early detection	
		Community awareness
		Health facilities awareness
		Screening and Outreach program
	Prevention and control of NCDs risk factors	
		Develop partnership for research
		Improve national response for prevention and control of NCD

Domain of Intervention	Sub domains of Intervention	Activity Purposes
		Multisectoral coordination and fund mobilization
		Strengthening the Monitoring and Evaluation system for NCDs
	Primary and specialized health care and treatment	
		Decentralization of NCD service to DHs, HCs, Community
		Ensure quality of NCD services
		Ensure readiness of NCD services
Planning & Information		
	Information & Technology	
		Better data recording, collection and archiving.
		E-health planning and administration
		Ensure E-Health Systems are Utilized in Health Facilities
		Health Information Management
		HIS (Health Information System) planning and administration
		Human Resources.
		ICT Infrastructure available and functional at Central level and Health Facilities
	Planning and M&E	
		Capacity strengthening
		Decentralized guidelines for operational plan developed
		M & E of Programs
		Planning document developed , disseminated and implemented
		Planning/budgeting
	SWAP	
		Intersectoral activities
		Mobilizing funds and M&E for HRH increased capacity
		Sector coordination and partnership
Resource Mobilisation		
	Pooled Financing	
		Financial Support.
	Sector Budget Support	
		Financial support
Maternal Child and Community Health		
	Adolescent Sexual Reproductive Health and Rights	
		Coordination, evidence based planning M&E, resource mobilization, and ownership strengthened
		Expand access and utilization of quality adolescent and young adult friendly sexual and RH services and products
		Improve RH knowledge, skills and attitudes
		Supportive legal and socio-cultural environment for ASRH & R enhanced
	Child Health	
		Coordination and implementation of the strategy

Domain of Intervention	Sub domains of Intervention	Activity Purposes
		Creation of institutional and economic environment favourable to the transition to the scale of intervention package
		Extension of the coverage of integrated interventions quality package for the health of the mother, the newborn baby and the child.
		Increase services demand and use
	Community Health	
		Community full participate in all community health programs
		Improve knowledge and skills for CHWs to deliver quality integrated community health package
		Strengthen CHWs cooperatives motivation through community PBF
		Strengthen quarterly integrated meeting (mainly on evidence based planning, resource mobilization and M&E) with patners
	Family Planning	
		Condom Family Planning Programmes
		Family Planning & RH not disaggregated
		FP programs that could not be disaggregated
		Identify and apply innovations to support effective practices in FP
		Implant-related Family Planning programmes
		Increase the correct knowledge, acceptability and use of the full range of FP methods and services in the community (Demand)
		Injectable-related Family Planning programs
		IUD Family Planning programmes
		Promote the use of natural method of FP
		Strengthen and sustain a supportive environment for comprehensive FP programs
		Support sustainable FP service delivery systems in both the public and private sectors (Supply)
	Gender Based Violence (GBV)	
		Provide comprehensive services to victims of GBV
	Maternal and Neonatal Health	
		Ensure availability of sustainable MNH programming and funding mechanism at all levels
		Increase access to high quality MNH services along the continuum of care
		Increase community mobilization for, participation in, and use of MNH services
		Lesson learned and generated and used for national or international MNH programming, evaluated, disseminated, and scaled up
	Nutrition	
		Behaviour Change Communications
		Coordination of Nutrition Partners
		Elimination of micronutrient deficiencies
		M & E for Nutrition activities at all levels
		Multi-sectoral District Plans to Eliminate Malnutrition (DPEMs)
		Prevent and manage malnutrition in children under the age of 5 years (focus on those aged less than two years, and in pregnant and lactating mothers.

Domain of Intervention	Sub domains of Intervention	Activity Purposes
		Prevention and management of nutritional deficiency and excess-related diseases
		Strengthen identification and management of under nutrition
	Vaccination Program	
		Ensure Management of vaccines supply chain
		Improve NTD prevention
		Reinforce Immunization system
		Staff remuneration and functionning support services1
		strengthening Vaccination interventions
		Support HCs & DHs
		Vaccine preventable deseases division will be moved from KACYIRU to Juakali
Malaria and Other Parasitic Diseases		
	Care and Treatment	
		Malaria Drug Supply and Pharmaceutical Management
		Malaria in Pregnancy
		Malaria treatment in the community
	Coordination	
		Staffing and Administration
	IEC	
		Behavior Change Communication (BCC)
	M&E	
		Epidemic preparedness and response
		Malaria reactive detection in 6 districts
		Monitoring and Evaluation for Malaria Programs
		Research conducted
		Supervisison of health facilities and the community
	Neglected Tropical Disease (NTD)	
		NTD prevention and cases management
	Prevention	
		Indoor Residual Spraying-IRS
		Insecticide-treated Nets- LLINs (ITN)
		Integrated Vector Management (IVM)
	System strengthening	
		Capacity Building
		Health Systems Strengthening
		Transition
Tuberculosis and Other Respiratory Diseases		
	Care and Treatment	
		High risk groups
		Implement collaborative TB/HIV activities
		Improving diagnosis
		MDR-TB: preventing and controlling MDR-TB
		Patient support

Domain of Intervention	Sub domains of Intervention	Activity Purposes
		Procurement and supply management
		TB Co-infection
		TB management
	Coordination	
		Staffing and Administration.
	IEC	
		Advocacy, communication and patients' charter
		Community DOTS and social mobilization
	M&E	
		Logistics, programme management, and supervision
		Monitoring and evaluation, Etb
	Prevention	
		Childhood TB control interventions
		Infection control
	System strengthening	
		Cross-cutting HSS relevant beyond TB control: Performance Based Financing (PBF)
		HRD (Human resource development)
		Programme-based operational research
		Sharing innovations that strengthen systems, including the Practical Approach to Lung Health (PAL)
		TB Engage private sector
HIV/AIDS and STIs Diseases		
	Care and Treatment	
		Adherence follow up
		Adult antiretroviral treatment
		ARV not desaggregated
		Community-Based Medical Care
		Enrollment and bio-chemical follow up
		Enrollment of people tested HIV positive
		HIV Clinical Laboratories
		Infection control
		Management OI
		Management STI
		Mental health support
		Nutritional service for household at risk
		Nutritional service for moderatly malnurished
		Nutritional service management
		Nutritional service to severly malnurished
		Paediatric antiretroviral treatment
		Pre-ART care and palliative care
		Prophilaxis for adults
		Prophilaxis for children
		Provider-initiated testing and counselling (PITC)
		Psychosocial counseling
		TB screening and diagnostics for PLHIV

Domain of Intervention	Sub domains of Intervention	Activity Purposes
		TB treatment for PLHIV
	Coordination	
		AIDS-specific institutional development / Community mobilization
		CSO
		Other ministry
		Planning
		RBC
	Health System Cost	
		Health infrastructure
		Human resource for health
		Laboratory Strengthening
		Procurement and logistics
		Supervision & mentoring
		Synergies with health sector
	Impact Mitigation	
		Awareness campaign on rights of PLHIV and gender equity
		Child participatory approach
		Cooperatives are established, operational and functional
		Education Support
		Empowerment of PLHIV on their rights
		Gender programmes
		Health Services for OVC
		HIV Policy Advocacy
		Income Support for PLHIV
		Innovative and inclusive approaches to access to finance and resources
		Law reform and enforcement
		Management and coordination OVC program
		Nutrition Support for OVC
		Orphans and Vulnerable Children Support
		Promote good nutritional practices
		Psychosocial Support for OVC
		Shelter support
		Social economic Support for PLHIV
		Social protection
		Social Protection for OVC
		Socio Economic Support for OVC
		Special social economical empowerement to young people living with HIV
		Start up Kit
		Stigma reduction
		Workplace
	M&E	
		Advocacy, communication and culture for HIV M&E
		Data disseminination and use
		HIV Evaluation and Research Agenda

Domain of Intervention	Sub domains of Intervention	Activity Purposes
		Human Capacity for HIV M&E
		National and sub-national HIV databases
		National, Multi-sectoral HIV M&E Plan
		Organizational Structures for HIV M&E Systems
		Partnerships to plan, coordinate, and manage the HIV M&E system
		Routine HIV programme monitoring
		Strategic Information for HIV
		Supportive supervision and data auditing
		Surveys and Surveillance
	Prevention	
		Blood safety
		Community mobilization
		Condom Distribution
		Condom procurement
		EMTCT surveillance
		Family planning integrated HIV services
		GBV
		HIV counseling and testing
		IEC for HIV
		Male Circumcision
		Management of STI general population
		Non ARVs related component of PMTCT
		PMTCT services
		Post Expose Prophilaxis
		Pre-exposure prophylaxis for serodiscordant couples
		Prevention services for other key populations
		Programmes for children and adolescents
		Programmes for men who have sex with men
		Programmes for sex workers and their clients
		Universal precautions
		Vaccination
Medical Procurement and Production		
	Medical Procurement	
		Adequate storage and efficient inventory management
		Ensure availability of Pharmaceutical products
		Ensure Continuity of supply chain services
		Ensure good management
		Implement Health care technology management programs
		Improve Stakeholders Relationship and information share
		Staff remuneration and functionning support services4
	Medical Production	
		Conduct Research on Haemodialysis solution in MPD
		Equipment readiness to produce according to GMP
		GLP training of staff
		Produce Infusions

Domain of Intervention	Sub domains of Intervention	Activity Purposes
		Quality control of production and validation of selected MPDD imports
		Reduced blood transmitted infections markers