Enabel

Capacity Development Fund Health Sector Rwanda, Basket Fund: RWA 1208711

Internal End of Project reporting

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Table of contents

List of abbreviations

CDPF	Capacity Development Pooled Fund
CMHS	College of Medicine & Health Sciences
DfID	UK Department for International Development
DP	Development Partners
E&Y	Ernst & Young
GIZ	Gesellschaft für Internationale Zusammenarbeit
GoR	Government of Rwanda
FY	Financial Year
HRH	Human Resources for Health
HRIS	Human Resources Information System
HSSP	Health Sector Strategic Plan
HSWG	Health Sector Working Group
IPRC	Integrated Polytechnic Regional Centre
KfW	German Development Bank
MINEDUC, MoE	Ministry of Education
MoH	Ministry of Health
MTI	Medical Technology & Infrastructure division
PS	Permanent Secretary
RBC	Rwanda Biomedical Centre
SC	Steering Committee
SDC	Swiss Development Cooperation
SDG	Sustainable Development Goals
SNM	School(s) of Nursing and Midwifery
SPH	School of Public Health
SPIU	Single Project Implementation Unit
SWAp	Sector-Wide Approach
ToR	Terms of Reference
TWG	Technical Working Group
UR	University of Rwanda
USG	United States Government

Basic data of the Belgian contribution

Title of the programme	Capacity Development Pooled Fund		
Earmarking (sector/subsector/region)	Health – Human Resources for Health		
Country	Rwanda		
Period covered by SA; Period covered by CMO Amendments	12/06/2013 – 11/12/2016; 10/07/2013 –09/10/2015 SA and CMO extended until 31/12/2017 through an exchange of letters on 26/11/2015 and 14/03/2016.		
Financial data	**Total budget received by GoR**	**Belgian contribution**	**Other donors' contribution**
	RwF 5,735,257,634	€ 2.5 million[1]	€ 597,028 (GIZ & KfW) £ 2,038,156 (DFID) CHF 1,788,000 (SDC)
DAC – Code /Sector	12110 (Health)		
NI – Code	3013690		
NAV – Code	RWA 1208711		
Date of arrival of experts	**Public Health Expert** (financed on CDPF): • Dr Nicole Curti-Kanyoko: arrival in Kigali on 12th August 2012 - departure on 10th December 2014. • Replacement Dr Jan Borg: arrival in Kigali on 16th May 2015. **Public Financial Management Expert** (financed on JHSS): • Charlotte Taylor: arrival in Kigali on 2nd December 2013		

	FY 2013/14	**FY 2015/16**	**Total**
Instalments	€ 1 million	€ 1 million	€ 2 million
Committed (SA signed)	June 2013	June 2013	
Disbursed	October 2013	June 2016	

[1] € 0.5 million were transferred through Minisanté IV programme in January 2011 and € 1 million were transferred through CDPF basket fund support in October 2013.

1 Background Information and Rationale

1.1 Contributors to the CDPF

From the entry into force of the Specific Agreement (June 2013) until the end of 2017 (31st of December 2017 being the withdrawal date for the Belgian Cooperation from the basket fund), the Capacity Development Pooled Fund included two development partners namely: Belgian Development Cooperation and the Swiss Development Cooperation (SDC). The Fund formerly included UK Aid/DFID, German International Cooperation (GIZ) and German Financial Cooperation (KfW) who all phased out of the health sector in 2013 as a result of the division of labour initiated and implemented by the Government of Rwanda in 2010.

1.2 The period before 2012

Under the leadership of the MoH, Developing Partners (DP) convened in 2008 to put in place a Capacity Development Pooled Fund (CDPF) to support the capacity development in the health sector in the framework of the Sector Wide Approach.

For some donors, like Belgium, the Capacity Development Pooled Fund (CDPF) falls under the modality of basket funding, or earmarked budget support.
The CDPF was managed by the Ministry of Health (MoH), steered by a specific steering committee, and financed by various Development Partners (DPs): UK Aid (DFID), German Development Cooperation (GIZ and KfW) and the Swiss Development Cooperation (SDC). The Belgian Cooperation made an early contribution of €0.5 million to the CDPF in 2011 through the *Minisanté IV- Institutional support program* ahead of the formulation under the ICP 2011-2014 for the €2 million which is the project at hand in this report.

The primary aim of the grant agreement of the CDPF '1', was to **ensure effective coordination and avoid parallelism and overlapping of activities for different donors and agencies** through:

- Creating a platform for debate and coordination of all initiatives on capacity building in the health sector (together with the HRH-TWG - Technical Working Group on Human Resources for Health and in communication with the other chairs of the TWG and their trainings activities)
- Developing the Human Resource Development Plan (HRDP) also called Annual Capacity Building Plan (ACBP) involving all contributing (pooled and non- pooled) development partners and implementing agencies.
- Managing all resources made available to the MoH for capacity building (including Capacity Development Pooled Fund (CDPF)/ Sector Budget Support (SBS) and other direct or indirect contributions (In order to have all contributions on plan and on budget even if handled through separate accounts).
- Conducting monitoring and evaluation of the progress and impact of capacity development activities at central and district level in cooperation with the CDPF secretariat and MoH' M&E team.

The first Grant Agreement was signed in October 2009 by the German Technical Cooperation (GTZ) (21st October 2009), the Swiss Agency for Development and Cooperation (SDC) (22nd October 2009), the Ministry of Health (MoH) (24th of October 2009), and later by the Belgium Development Cooperation (3rd August 2010). It established the donor commitments for the CDPF and set the objectives of the initial project as a joint initiative to support

technical assistance and capacity building in the health sector. The first grant agreement made the grant available for the period from October 2009 till December 2010.

A first amendment on the Grant Agreement was signed by the Ministry of Health (MoH), Belgium Development Cooperation, German Technical Cooperation (GTZ) and Swiss Agency for Development and Cooperation (SDC) in December 2010, extending the CDPF support with no additional cost until 31st December 2011.

1.3 The period from 2012 to 2017

The Capacity Development Pooled Fund (CDPF) is a co-financed pool by several development partners (DPs) and managed by the Single Project Implementation Unit of the Ministry of Health (SPIU/MoH).

The overall vision of the CDPF became to strengthen and develop capacities within the health sector, in line with the Health Sector Strategic Plan (HSSP) and the Human Resources for health (HRH) strategic plan, in order to contribute to enhanced quality outcomes in the delivery of health services.

The mission of the CDPF, which was established through grant agreements and memoranda of understanding in 2008, is to assure effective coordination and to avoid parallelism and overlapping of activities of various donors and agencies supporting capacity development initiatives in the Rwandan health sector. Major discussion and decisions are taken by the CDPF Steering Committee (SC), comprised of the Permanent Secretary of the MoH (as chair of the SC), relevant MoH units and desks (including the Directorate General of Planning, Health Financing and HIS and its SWAp Secretariat, and the Single Project Implementation Unit (SPIU) as the operational manager of the fund) complemented by representatives of DPs.

The CDPF evolved since the implementation of recommendations of the August 2011 audit which covered the period of 1 January 2008 to 31 December 2010. HRH capacity development was made a priority before identifying other capacity development components to be supported, since there was a perceived need to dramatically increase the number, quality, and skill-level of Rwandan clinicians and health sciences educators, including medical doctors (general practitioners, specialists, and subspecialists), nurses and midwives, allied professionals, hospital managers, etc.

After having put in place the needed management responses on the audit findings, a **second amendment** to the CDPF Grant Agreement was signed by Belgium Development Cooperation, German International Cooperation (GIZ), Swiss Agency for Development and Cooperation (SDC) and the Ministry of Health (MoH) in November 2012. The second amendment was elaborated in respect of the key decisions of the Steering Committee meeting held in December 2011.

Cornerstone of the new agreement was the validated a 3-year action plan to implement the HRH Strategic Plan (HRH SP) covering 2011–2016. The second amendment of the CDPF Grant Agreement was aligned to the work plan's initial duration of 3 years i.e. up to 30th June 2015.

The overall objective of the CDPF 2 was to strengthen and develop capacities within the health sector, in line with the HSSP and the HRH Strategic Plan, and to contribute to enhanced quality outcomes in the delivery of health services.

The strategic objectives of the CDPF derived from the HRH Strategic Plan are:

- To ensure a coordinated approach to HRH planning across the sector,
- To increase the quantity of HRH through increased numbers of trained and equitably distributed staff,
- To increase the quality of HRH, including improved productivity and performance of health workers,
- To increase capacity to plan, develop, regulate, and manage HRH.

Since November 2011 to date, the CDPF has focused on providing financial support to HRH training programs, namely:

- General nursing upgrade programme (A2 to A1 upgrading)
- Midwifery pre-service training (A1 and A0),
- Training of biomedical technicians (A1),
- A clinical officers' program (A0),
- A hospital management Master's degree.
- Training in and under-graduate Medical laboratory technicians

These trainings were conducted at the 5 campuses or Schools of Nursing and Midwifery (Byumba, Nyagatare, Kabgayi, Kibungo, Rwamagana) under the University of Rwanda College of Medicine and Health Sciences (UR-CMHS); the Integrated Polytechnic Regional Centre of Kigali (IPRC-Kigali) and the School of Public Health (SPH).

A third amendment to the grant amendment was signed in September 2015 between the GoR and the remaining DPs to extend at no cost the CDPF operational (funded) period from October 2009 to the 31st December 2017. This extension foresaw important steps towards the closure of this phase of CDPF support also because there were no indications of future replenishments of the fund. The amendment (attached as annex) specifies the alteration of article 3.9 to "an external evaluation and final audit are planned to take place in September 2015 and September 2017 respectively and have been budgeted for in the CDPF budget." Furthermore article 6 section 6.4 was altered to: "The implementation of the project shall begin by June 2009 and will be completed latest by 31 December 2017. The recipient will write up a final report describing implementation and results of the project."

Although the 3rd amendment stipulated that the extension of the project should bear no extra cost, at the end of 2017 not enough funds were remaining to finance both the end evaluation and the final audit. An important reason for this shortage can be traced to the increment of annual school fees in 2017 imposed by the UR (see later). The end-evaluation was eventually financed in "régie" (with discretionary Enabel funds) and conducted by a national consultant in support of an EST-HQ (Enabel) expert. The final audit has not been conducted by the time of writing this report. The MoH is investigating how to mobilise (external to the CDPF) funds to finance what should be ideally an independent audit of the FY 2015/16 and FY 2016/17 till 31 December 2017.

2 The evolution of the CDPF in practice since 2012

This document has to be read in conjunction with the end evaluation report, the latest available audit report (financial and operational) of 2015-16, and the CDPF annual report 2017, attached as annexes. This report serves as a summary analysis of Enabel's engagement in the CDPF and touches upon lessons learned. Unfortunately at the writing of this end report an end audit covering the financial year 2016-17 and the first semester of 2017/18 was not available – although a requirement for appropriate management of the fund which the MoH committed to in the last grant extension agreement, financial means were lacking at the end

of 2017 for the conduct of such an exercise; the MoH is since looking for alternative ways to fulfil requirements – and some of the (final/evaluation) reports are suffering from incompleteness due to late or fragmented submission of reports by the SPIU MoH. This functional analysis leans therefore heavily on the end evaluation report and personal observations of the experts within Enabel.

2.1 The output

Since its inception in 2008, the CDPF evolved from general support to capacity development in de health sector towards predominantly contributing to the Ministry of Health (MoH) Human Resources for Health (HRH) strategic plan. The CDPF shaped itself increasingly towards a project format co-managed by the MoH and Development Partners (DPs).

The CDPF did make a significant contribution to perceived needs of the quantity of staff needs in the sector as identified in the HRH strategic plan (see Table 1), especially where it concerns midwifery and management skills, although the lack of coordination between the fund and the HRH TWG led to challenges of in training and post training placement. This was confirmed during supervision exercises that observed that despite these positive training results vis-à-vis the health system and health service delivery, some clear challenges remain with efficiently absorbing newly qualified staff (i.e. enabled to deploy newly acquired skills). In other words, while the CDPF sponsored courses are fully aligned with the government HRH strategies and plans (since 2012), little attention has been paid to the absorption of the new skills in the existing health system, the financial consequences and ensuing sustainability within the civil service employment framework.

Table 1: Training achievements CDPF since 2012 (taken from the end evaluation)

Program	**Activities**	**HRH plan target**	**Total of students enrolled**	**CDPF share (vs. HRH targets)**
Nursing Program (e-learning)	Upgrading A2 to A1	5287	**791**	**15%**
Midwifery Program	Train A1 Midwives	600	**298**	**49.7 %**
	Train A0 Midwifery Teachers	125	**134**	**107.2 %**
Clinical Officers Program	Train A0 Clinical Officers	500	**112**	**22.4 %**
Hospital Management Program	Train Hospital Managers (Master's degree)	50	**63**	**126%**
Biomedical Engineering Technology Program	Train A1 Biomedical Technicians (advanced diploma)	180	**157**	**87%**
Medical Laboratory Technicians, A1 Program	Train A1 Medical Laboratory Technicians	2511	**243**	**9.6%**
Masters in Biomedical Engineering	Training abroad (France)		**1**	
Total		**9,253**	**1,799**	**19.4 %**

The CDPF has been contributing to the review of training curricula, especially in the area of the use of modern technology for distance learning (e-learning) in combination with face to face training and in addressing challenges of absence from the place of work and family for classroom training requirements at remote training institutions. This will have a lasting

impact on the quality of training for health staff. However, there were some challenges along the road. There was a long delay in starting the training for an advanced degree for biomedical technicians. The design initially uncovered important difficulties of combining training with a full time job. To accommodate for the difficulties profound changes needed to be made to the duration and timing of the course. The CDPF has not addressed task shifting, an important omission in a resources scarce environment. This might have been an outcome of the insufficient coordination of capacity building initiatives in the sector where the dominant vision in the sector was to push sophistication (in terms of staff qualification) down the health delivery system. Capacity building for community health programmes therefore disappeared partially from the radar.

2.2 The management

The Steering Committee (SC) has been meeting infrequently and with varying engagement and involvement of contributing and implementing partners. The waning interest in the fund by both partners and MoH because replenishment became increasingly doubtful, possibly played a role. Strategic issues regarding the sustainability of the CDPF HRH development and the role of the fund in other areas of capacity development were insufficiently discussed during the SCs. Meetings tended to be predominantly pulled in the direction of operational SPIU issues, also because of its composition that included funders, intermediate management and beneficiary institutions as equal members. The CDPF might therefore have missed opportunities to contribute to the ongoing health sector reforms.

Financial reporting towards the SC weakened over the course of the intervention for reasons that will be explained later in this report. The SPIU MoH shared documents often at short notice hampering sufficient analysis by SC members. Variances between budgets and actual expenditures remained insufficiently explained. This importantly hampered making strategic decisions for the use of dwindling balances towards the end of 2017 that led to still unresolved issues on the closure of the current training efforts of the fund.

An important lesson learned from the CDPF is that the MoH and the Ministry of Education (MINEDUC) need to discuss ways forward on the support for running (in service) HRH training activities to ensure sustainability of training capacity and curricula. This is important regardless of the continuation of the CDPF entity and should be a central issue in ongoing discussions on labour market analysis and projections.

2.3 Supervision and quality control

No regular supervisions by the SPIU to ensure the quality of training was conducted on a routine basis. Joint supervision visits were organized by MOH and DPs to oversee the work of the sub-recipients in terms of management and progress of the CDPF implementation at their level. Focus group discussions were sometimes organized with the beneficiaries of the training. In total three supervisions were conducted: one in October 2013, another one in April 2015 and the last one was conducted in October 2016. Findings from these visits were systematically shared with the SC but little follow-up of recommendations was ensured. Institutionalised relationships of the CDPF (SC) with important operational strategy platforms (i.e. the Technical Working Groups, specifically the HRH TWG) were virtually absent.

Some cross cutting challenges for the CDPF supported institutions and students were repeatedly observed during these joint supervision exercises:

- While faculty was perceived as sufficient, especially in the area of supportive facilities (library, ICT, skills laboratories) needs to expand were identified.

- Supervision and guidance during clinical placement (at the work place) were erratic and insufficiently mitigated through IT technology (internet connectivity at the place of work was often absent).
- Private institutions (faith based SNMs) in particular observed preventable student drop-out rates among e-learning students due to lack of support.
- Students observed that the annual fees are prohibitive for private enrolment threatening the sustainability of the CDPF supported programs; this has become even more of an issue now that fees have raised further in 2017-18.
    - In 2012 fees went down from 1,250,000 RwF to 600,000 RwF, the budget of CDPF was committed accordingly. However, this reduction negatively impacted the capacity of the schools to solving some problems related to quality improvement of the end results.
    - In 2016 fees were raised to 900,000 RwF per annum and in 2017 again to 1,500,000 RwF. This first led to a CDPF deficit even for students who had already started training.
    - Currently there is clearly a drop in enrolment at almost every level because of the very high tuition fees, leading to cancelations of certain training modules at the UR.
- The market for newly acquired management skills (with specific reference to the Master's degree in Hospital Management and Administration as taught by the School of Public Health (SPH)) appears to be smaller than foreseen. Graduates often return to subordinate positions not able to practice their new expertise.
    - Conditions were not in place for clinical officers to be deployed in the Rwandan Health System. The presence in the organic framework of MoH prior to the decision to train the clinical officers would have allowed an easy placement into the public and private institutions and then facilitate their quick recruitment. However, it seems training did not lead to any placement as expected at the Health Centre level.

2.4 Finances

With all DP's funding commitments fulfilled and the last of the committed transfers effectuated, interest from the MoH and DPs to properly monitor the implementation and achievement of the stated goals decreased. The fact that in the last years the remaining balance in the fund was solely furnished by the Belgium Cooperation meant that in effect Enabel was the only partner with interest in following up the quality of the intervention with the Single Project Implementation Unit (SPIU). However, the CDPF is seen as a relatively small project by the MoH that does not always have a high place among its top priorities. Following up on Steering Committees, targets set and the quality of reporting were increasingly difficult.

Although external audits were scheduled to be conducted once every Financial Year and means to finance these audits reserved in the CDPF, the decreasing interest was illustrated by the last operational and financial audit that out of necessity had to cover two financial years (2014/15 and 2015/16). Even at the time of writing this document, the operational report has not been submitted to partners and has therefore hampered the proper evaluation of management procedures and practices.

3 Enabel's engagement and interaction with the CDPF

3.1 Anchorage

The performance of the CDPF was impacted on by some unexpected environmental factors and changing contexts. Although largely unforeseen, this has in turn affected the relevance of the CDPF multi Development Partner's basket as an anchorage and entry point for Belgium support to capacity building within the MoH and for service delivery. Important changes of direction that had severe implications for the objectives and its implementation of the fund were:

- The decision of division of labor led by the GoR in 2010 impacted the CDPF by reducing the potential DPs donating into the fund.
- The separation of the policy and strategy function of the MoH from implementation (RBC) has had some side effects for the management of 'external' projects. The establishment of a separate SPIU for the two entities has led to further fragmentation and in general weaker management of projects.
- The change of the management location for the CDPF: It was managed by the MoH until 2012. Following to the recommendation of 2011 audit report it shifted from the MoH to the SPIU of the MoH. In 2014/15, the single SPIU hosted at MoH was split into two entities, one remaining at MoH and the other moving to RBC together with big donor funded programmes (GF, GAVI). Budgets moved along with the SPIU(s) resulting in increased resource allocation for RBC (as implementing agency) compared to MoH. Given its thematic focus, CDPF remained under SPIU/MoH, while most of the staff of the former SPIU went to RBC/SPIU. This led to a loss of continuity and institutional memory. These changes have impacted significantly the implementation of the CDPF.
- The multiple reforms at the schools level also raised the issue of technical ownership and management at level of the sub-beneficiaries. Three public SNM, the SPH and KHI merged into the CMHS, centralizing the financial flows but adding an additional level of transaction between CDPF and campuses.
- The Government of Rwanda's (GoR) institutional changes that shifted the responsibility for training programmes and its quality control to the Ministry of Education (MINEDUC) and the concurrent centralization of training funds had profound effects on operationalizing the CDPF. Close engagement with UR to start driving the implementation process of capacity development in the health sector is necessary in the future. Articulation of the HRH TWG of the MoH and the MINEDUC/UR, the platform where this engagement should occur, needs to be strong and strategic.
- Ongoing decentralisation of budget and management authority for service delivery towards the districts (District Health Management Team, District Health Unit) has changed the specific demands on the different levels of the health service delivery system. While the CDPF focused on technical health service delivery skills it did not have the flexibility to respond to new capacity demands in terms of management skills at the decentralised level. All available funds were fully committed to support already enrolled cohorts.
- Coordination of HRH takes place on different platforms including the HRH TWG in the MoH and the CDPF. Moreover, numerous individual projects include elements of capacity developments. There is an urgent need to empower the Capacity and Employment Services Board (CESB, previously the NCBS) to lift the level of

coordination of capacity development initiatives above the level of line ministries. Enabel did embark on a separate intervention outside the health sector, the …. to strengthen the coordination capacity within the CESB/NCBS. However, the CESB has continue to struggle with severe credibility issues among the line ministries, the capacity building of which it is supposed to coordinate and was therefore never really implicated in the CDPF.

3.2 Gender as a transversal issue

Although the CDPF had the opportunity to include clauses on gender equality (recruitment, training, allocation of human resources), this has not been a consideration in the implementation of the fund. However as the main thrust of the programme has been the training of nurses and midwives, a category of professionals dominated by women, a limited role in women's empowerment could be claimed.

4 Lessons learned for Enabel and contribution to basket funds

The CDPF project has/will run out of with the completion of the currently enrolled cohorts for the different disciplines and will probably not be able to continue in the same way. However, the challenge of human resources for health development remains key for Rwanda, especially with the new HSSP 4 and its required skills mix of health service providers. The following elements will be critical for sound HRH development (from the 'end evaluation' CDPF 2018; conducted by Enabel in "régie" under the consultancy budget):

- Planning and management of health professionals in a manner which allows the rural remote areas to benefit from well qualified staff.
- Development of incentives promoting equal distribution.
- Replacement strategies for those leaving the sector by new qualified staff in the context of efficiency and efficacy.
- Motivation of the health professionals to retain them in the health sector.
- Strengthen comprehensive offer of e-learning and upgrades: the e-learning program allows large numbers of people to acquire knowledge at a low cost and in a harmonized way. It is also a way of sustaining capacity development into the health sector by using this training model for continuous education.
- Avail an affordable e-learning for A2 nurses who remain in the health system and are still young will allow them to be upgraded by their own means and avoid them the temptation of leaving their profession. The MoH can play an important role to have this under the MoE responsibility.
- Continuous professional development to be accredited at adequate levels (different professional bodies, independent commissions).
- Organize mobility and promotion policies and strategies.
- Workout of individual career development, including motivation modalities that can encourage younger professionals to improve their skills (knowledge, practices, attitudes).
- It is the mandate of the Ministry of Education to produce professionals for the next generations. However, the Ministry of Health, as principal client, must be involved in the clinical training of health professionals to monitor quality.
- The field of capacity development (mentorship and supervision) requires enough financial resources and will put pressure on the financing of the health sector in Rwanda in general.

The evaluation of the CDPF concluded that:

- CDPF was highly relevant in the changing economic, epidemiology and strategic context of Rwanda
- CDPF was highly effective in the production of HRH with 1,799 individuals upgraded, but the effectiveness on other objectives (see 3.2 and 3.3) was low
- Efficiency:
  - Considering the median cost for training abroad for A0 midwives or nurses (cost in 2006 for A0 nurse and A0 MHMA: 50 000 USD/pp), CDPF was efficient
  - But the efficiency was clearly negatively impacted by the weak follow-up by the CDPF management and steering on dropouts, retention and reimbursement
- Coordination was present but it is insufficiently clear if this was attributable to the CDPF
- Sustainability: the developments on HRH training have high potential and shaped the new educational landscape of Rwanda. The SWAp era seems to be coming to an end, new partnerships, new modalities are to be integrated in future approaches.

4.1.1 Management, governance and design lessons learned

An important turning point for the CDPF was the year 2012 when the SC decisions were implemented to align the purpose of the fund fully with the Human Resources for Health (development) strategy. It committed all funds contained at that time towards specific training to fulfil capacity needs in the health care delivery system. However, in doing so the other objectives of the CDPF were demoted to the second rank. What was a flexible source for innovation and coordination of capacity building initiatives in the sector became *de facto* an output funded project.

Capacity building is different from a project type of intervention because goalposts for capacity building are continuously moving concurrently with the reform/development agenda of the sector. Because formal training as an instrument for capacity building, after first projection on needs, requires a long-term commitment with specific output targets, it lends itself better for a time-bound project approach. In effect the transformation of CDPF in a project type of intervention led to a reduced strategic role of the fund in providing a flexible resource for capacity building. It can be argued that finally this led to less interest of other DPs in replenishing the fund.

The management situation of the training components under the purview of the SPIU in the MoH, has during the CDPF period virtually changed into a 'contract culture' between MoH and the University of Rwanda (Ministry of Education), with the operational and technical branches of the health ministry one step further removed. This has consequences for the implementation of long term HRH strategies and responsiveness to the rapidly changing (including financing) context of the health sector and the medium and long term sustainability strategies that have to go hand in glove with human resource recruitment, and, specifically, quality control of health care delivery. This is the responsibility of the routine service delivery departments of the MoH. Capacity (development) is necessary in the fine-tuning between the two ministries (MoE and MoH) and coordination of HRH needs. Although the organisational changes between the MoH and the MoE were driven by externalities, there were opportunities missed by the CDPF partners to influence this process.

Although the CDPF's objectives include space for internal sector coordination for capacity building, the 'end evaluation' points at insufficient evidence for this distinct function. The overall task of HRH coordination within the sector and with DPs resorts under the HRH

Technical Working Group. With hindsight and to emphasise the innovative and policy dialogue aspects, the anchorage of the CDPF here would have been more natural - in analogy with the later development of the District Challenge Fund (a fund for small operational research at the district level initiated by service providers) under the Knowledge Management and Research Technical Working Group. For day to day management going through the SPIU would still have been a GoR requirement, however, insufficient links to the DG Planning (as the 'umbrella' for the TWGs) did hamper effectiveness. It is the considered opinion of the author that the sustainability of (basket) funds that flexibly resources sector development and innovation adapted to ever changing needs, should not be trusted to the intermediate of a (government) project management unit and should go directly to strengthening concerned departments/institutions.

The formulation by the GoR of a vision 2050 and a National Strategy for Transformation for the (economic) development of the nation requires multi sector coordination. The current HSSP 4 is developed in line with these strategies and offers opportunities for new initiatives that embark on consistent contextual capacity building that can build on the experiences of the CDPF.

4.1.2 Possible new roles of 'a CDPF' for health sector capacity building

4.1.2.1 Private sector

All scenarios for the future health sector and health service delivery in Rwanda include an enhanced role for the private sector in service provision and support roles. Private investment in the sector is expected to buffer possible gaps in public budgets and expenditures. A viable service industry that caters beyond borders with high quality specialist care (medical tourism) could possibly address long term sustainable development of and investment in the sector and attract private sector engagement. However, it is important that impact on the routine primary health care services for the Rwanda population is not put in jeopardy in the short term. This requires careful phasing inter alia of the mix of service providers and capacity. The capacity requirements for the private and public sector need to be included in development plans. Private investors (in the health sector) could be a new source of funding for capacity development. The scope to include the private sector in the resource mobilization as well as the output of 'a CDPF' – call for 'proposals', selection and coordination – should be explored.

4.1.2.2 Decentralisation and health sector management/planning capacity

The HRH focus of the CDPF in line with the HRH strategy and sustainability plan has foremost aimed at technical competencies, admittedly with some high level administration training for hospital administrators. With a shift of planning for the delivery of health services to the district level and increasing autonomy of cost centres at that level (although currently only internally generated funds can be used by facilities to autonomously hire (extra) staff), combined with the aim of Universal Health Coverage and diversification in payment for services (CBHI, co-payment) there will be an increased demand for an appropriate and pragmatic management skill mix at the peripheral levels. Several (DP funded) programmes are currently addressing district level capacity (MSH, UNICEF, Enabel). A new 'CDPF' could (financially, if need arises) support these initiatives technically and in terms of coordination/aligning under the umbrella of the HRH Technical Working Group and after submission of proposals. The fund could strive to institutionalize the training capacity (i.e. to instil planning competencies and toolkits at peripheral levels) that will be spearheaded by the named projects.

4.1.2.3 How could such a 'new CDPF' work?

Radical thinking: The current Steering Committee could be transformed into an executive board committee constituted by the government and funding partners (and other share/stakeholders) managing the 'new CDPF' as a trust fund. It would sit e.g. quarterly to entertain the defence of proposals that are originating from health service delivery entities (private and public) in Rwanda and make decisions on priority, relevance, effectiveness of implementation arrangements and budgets and eventually decide whether or not to fund. This will return maximum flexibility to the use of the pooled fund with which it could react fast on changing situations and immediate needs. Issues of the constitution of the executive board in practical terms and possible conflicting mandates of members need to be resolved.