

# **Country Office Evaluation: Rwanda**

## **Volume 1: Evaluation Report**

August 2018



**World Health  
Organization**

**WHO Evaluation Office**

## Acknowledgments

The evaluation team would like to thank the Head of the WHO Country Office in Rwanda and his team for their help in organizing the evaluation team visit in Rwanda and facilitating interviews with country partners. Their insights and perspectives on WHO's role and contributions in-country were invaluable.

We would also like to thank all the representatives from the Government of Rwanda, United Nations agencies, bilateral agencies and non-State actors who gave generously their time to inform this evaluation.

The purpose of publishing evaluation reports produced by the WHO Evaluation Office is to fulfil a corporate commitment to transparency through the publication of all completed evaluations. The reports are designed to stimulate a free exchange of ideas among those interested in the topic and to assure those supporting the work of WHO that it rigorously examines its strategies, results and overall effectiveness.

The analysis and recommendations of this report are those of the independent evaluation team and do not necessarily reflect the views of the World Health Organization. This is an independent publication by the WHO Evaluation Office. The text has not been edited to official publication standards and WHO accepts no responsibility for error. The designations in this publication do not imply any opinion on the legal status of any country or territory, or of its authorities, or the delimitation of frontiers.

Any enquiries about this evaluation should be addressed to:

Evaluation Office, World Health Organization

Email: [evaluation@who.int](mailto:evaluation@who.int)

## Table of contents

Executive summary .....	i
1. Introduction .....	1
1.1 Evaluation features .....	1
1.2 Methodology .....	2
1.3 Country context .....	4
1.4 WHO activities in Rwanda .....	6
2. Findings .....	9
2.1 Relevance of WHO's strategic choices .....	9
2.2 WHO's contribution and added value (effectiveness and progress towards sustainability) .....	13
2.3 How did WHO achieve the results? (Elements of efficiency) .....	21
3. Conclusions .....	29
4. Recommendations .....	33

The following annexes are available in Volume 2:

Annex 1: Terms of Reference

Annex 2: Evaluation methodology and evaluation matrix

Annex 3: WHO's main planning instruments and associated challenges

Annex 4: Evaluation observations per strategic priority of CCS 2014-2018

Annex 5: List of people interviewed

Annex 6: Bibliography

## Acronyms

AFRO	WHO Regional Office for Africa
CCM	Country Coordination Mechanisms (Global Fund)
CCS	Country Cooperation Strategy
COE	Country office evaluation
EDPRS 2	Republic of Rwanda Second Economic Development and Poverty Reduction Strategy (2013-2018)
EQ	Evaluation question
GDP	Gross Domestic Product
GNI	Gross National Income
GPW12	12 <sup>th</sup> General Programme of Work
HDI	Human Development Index
HQ	WHO headquarters
HSSP III	Third Rwandan Health Sector Strategic Plan (July 2012-June 2018)
IHR	International Health Regulations
IST	Intercountry Support Team
MDG	Millennium Development Goal
MMR	Maternal Mortality Ratio
MOH	Ministry of Health
NCD	Noncommunicable diseases
ODA	Official Development Assistance
PB	Programme budget
RBC	Rwanda Biomedical Centre
RSSB	Rwanda Social Security Board
SDG	Sustainable Development Goal
TOR	Terms of Reference
UHC	Universal Health Coverage
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNDAF	United Nations Development Assistance Framework
UNDAP	United Nations Development Assistance Plan

UNICEF	United Nations Children’s Fund
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WCO	WHO country office
WHO	World Health Organization

**Note: The reference to the Ministry of Health of Rwanda is understood to include its implementing agency, the Rwanda Biomedical Centre, unless otherwise stated.**

## Executive Summary

### Evaluation features

Country office evaluations are included in the WHO Organization-wide evaluation workplan for 2018-2019, approved by the Executive Board in January 2018. The workplan clarifies that country office evaluations *“will focus on the outcomes/results achieved by the country office, as well as contributions through global and regional inputs in the country. In addition these evaluations aim to analyse the effectiveness of WHO programmes and initiatives in the country and assess their strategic relevance within the national context”*. They encompass the entirety of WHO activities during a specific period. The country office evaluations aim to provide findings, recommendations and lessons that can be used in the design of new strategies and programmes in-country.

This country office evaluation was the second of this type undertaken by the WHO Evaluation Office and the first one to be conducted in the African Region. Its main purpose was to identify achievements, challenges and gaps and document best practices and innovations of WHO in Rwanda. These include not only results of the WHO country office (WCO) but also contributions at the regional and global levels to the country programme of work. As with all evaluations, this country office evaluation meets accountability and learning objectives and it will be publicly available and reported on through the annual Evaluation Report.

Its main objectives were to:

- a. Demonstrate achievements against the objectives formulated in the Country Cooperation strategy (CCS) and other relevant strategic instruments; and corresponding expected results developed in the WCO biennial workplans, while pointing out the challenges and opportunities for improvement.
- b. Support the WCO and partners when developing the next strategic instruments based on independent evidence of past successes, challenges and lessons learned.
- c. Provide the opportunity to learn from the evaluation results at all levels of WHO. These can then usefully inform the development of future country, regional and global support through a systematic approach to organizational learning.

The main expected use for this evaluation is to support the WCO, especially as it considers the upcoming CCS. Other main users of the evaluation are the WHO Regional Office for Africa and WHO Headquarters in order to enhance accountability and learning for future planning. The Government of Rwanda, as a beneficiary of WHO's actions, as well as the people of Rwanda, have an interest to be informed about WHO's achievements and be aware of best practices. This is also valid for other organizations, including development partners, national institutions and civil society.

Finally, over the medium-term, this evaluation will contribute to build a body of evidence around possible systemic issues to be addressed corporately, such as the development of models of WCO work/presence in middle- and low-income countries. Also, the Executive Board has direct interest in learning about the added value of WHO's contributions at country level.

Guided by the WHO evaluation practice handbook, the evaluation was based on a rigorous and transparent methodology to address the evaluation questions in a way that serves the dual objectives of accountability and learning. The methodology ensured impartiality and lack of bias by relying on a cross-section of information sources (from various stakeholder groups), including document review, and using mixed methods (e.g. quantitative and qualitative data) to ensure triangulation of information through a variety of means. The evaluation was conducted between April and July 2018 by a team from the WHO Evaluation Office.

## Relevance of the strategic choices

The priorities identified in the CCS 2014-2018 and updated in its 2016 revision were relevant to address Rwanda's major health needs and were coherent with government and partners' priorities, as expressed in the Third Rwandan Health Sector Strategic Plan (July 2012-June 2018) and the United Nations Development Assistance Plan (UNDAP). They were also coherent with 12<sup>th</sup> General Programme of Work in terms of health needs and alignment. To a large extent this is a reflection of good joint planning by key parties.

The systematic needs assessments and wide consultations that took place during the formulation of both versions of the CCS 2014-2018, and the ongoing engagement with the key national stakeholders, including the Ministry of Health and other relevant health sector institutions, UN agencies and other development partners, helped to facilitate the coherence and relevance of the strategic choices.

Furthermore, the evaluation has shown that the WCO is a relevant actor in the formulation of the national strategic plans of the Ministry of Health, both at the sector-wide level and specifically in relevant technical areas; as well as in the formulation of the newly developed UNDAP2, thus facilitating a high degree of alignment and coherence of the WCO with the national and development partners' strategies in Rwanda as they develop over time.

In recent years, Rwanda has shown dramatic progress in most observed health and development indicators. As part of the continuing commitment of the Government to achieve rapid socioeconomic development, the Ministry of Health drives the health agenda and places demands on the WCO for an innovative, fast, highly skilled and focused approach along Government priorities. In this context, any CCS needs to be a dynamic and evolving instrument. The revision of the CCS 2014-2018 in 2016, in response to the significant progress in achieving the Millennium Development Goals and the new Sustainable Development Goal agenda, is an example of WCO leadership and commitment to adapt the WHO CCS to the evolving situation and its intention to respond in the most effective manner to the needs of Rwandan people.

Consequently, the CCS includes an extensive number of focus areas without clear prioritization. Therefore, the CCS is responsive but provides limited guidance for strategic planning of WCO activities.

While there is no explicit reference to gender issues or gender-affirmative approaches in the CCS, most stakeholders consider gender equality to be part and parcel of WHO's work and approaches.

## WHO's contribution and main achievements

Both the Ministry of Health and Rwanda development partners recognized the significant role and contributions of WHO in health matters as well as the good and constructive collaborative relationships between WHO and the Ministry of Health and between WHO and the United Nations Country Team, other development partners and civil society.

WHO, through its WCO in Rwanda, is seen as a respected and technically expert voice in health matters and an essential contributor to advancing health achievements in Rwanda. The technical support of WHO seemed highly valued. The WCO's leadership and support for the health agenda were considered essential by the Ministry of Health and most development partners, including United Nations agencies.

The work of WHO was most notable in terms of convening partners; providing strategic and technical policy advice; provision and local adaptation of guidelines, norms and standards; and capacity building. In that context, it is apparent that the WCO has accomplished a great deal in many different areas and that staff and counterparts are justifiably proud of what has been achieved.

Specific achievements highlighted during the evaluation which are particularly significant are in the areas of support for development of health sector strategies and plans (i.e. the Third and Fourth Rwandan Health Sector Strategic Plans); technical assistance in the area of health financing; development of several disease-specific strategies and plans; normative and technical support in maternal and child care and family planning; introduction of new vaccines; and improvements in certification of causes of death. It is notable that many of these accomplishments came about as a result of highly effective collaboration with Ministry of Health and other partners, and also at the three levels of the Organization.

Noncommunicable diseases, particularly from a disease management point of view, and nutrition showed less progress and achievements, as did environmental health and social determinants of health. The fact that such programmes require strengthened cross-sectoral coordination and a multidisciplinary approach may pose additional strains on WHO's ways of working. Nevertheless, gaps in these areas flag the need to reconsider the role of WHO and its approach to these issues and multisectorality. In particular, given the importance of addressing noncommunicable diseases and chronic malnutrition in Rwanda, these areas become important priorities for WHO work in the near future. It is noted that mental health was not well featured in the WCO workplans.

Some stakeholders highlighted the need for strengthening the focus of some WHO activities, which call for reinforced results-based planning at the workplan level. Furthermore, stakeholders' expectations called for a renewed focus of WHO's work on new priority areas such as supporting district services planning and the quality of health services; strengthening data quality and health information systems; digital health; and, in particular, identifying mechanisms to ensure the financial sustainability of the health system and regulatory strengthening. There is also demand for broader WHO engagement in terms of supporting collaborative regional and subregional frameworks in order to enable the exchange and sharing of best practices with other peer countries as well as for facilitating the establishment of joint approaches to address common threats, such as communicable diseases (i.e. malaria).

Facing a growing demand for new and more technically sophisticated work, and considering the potential for misalignment of, or overriding, the CCS 2014-2018 strategic priorities with additional requests, the WCO needs to develop clear criteria for adapting its workplan and office capacity to the changing circumstances and requirements, while keeping in mind the new 13<sup>th</sup> General Programme of Work and the needs of the Rwandan people.

As has been the case until very recently for most programmatic planning in WHO, the WCO workplan followed the overall guidelines provided by the CCS 2014-2018, the 12<sup>th</sup> General Programme of Work and the respective programme budgets, but lacked a country-specific, measurable results framework and "theory of change" to guide the identification of the activities and projects that were most effective to achieve the WCO strategic priorities and expected outcomes. In the absence of such guiding framework, it is difficult for the evaluation to ascertain from the observed office deliverables the extent of achievement of the strategic priorities and expected outcomes assigned to the office. However, the evaluation found much anecdotal evidence of WHO's contribution to long-term changes in health status.

## Ways of working and programme management challenges

**Key contributions of core functions.** All core functions demonstrated their relevance for WHO's work in Rwanda. Notably, the evaluation showed evidence of effective WCO leadership and convening power, policy advice, provision of technical support, capacity building, and monitoring the health status and trends along the key strategic priority areas identified in the CCS 2014-2018. Nevertheless, several stakeholders identified opportunities for WHO to provide more direct support on strategy and policy issues at senior levels of the ministry, and furthermore to become a stronger advocate around unmet health priorities within and beyond the health sector through intersectoral

engagement (such as for noncommunicable diseases and social determinants of health). Stakeholders also expected WHO to be more proactive and solution oriented in terms of strengthening Rwandan institutions. They also requested WHO's support to strengthen regional cooperation and facilitate knowledge management, including sharing of best practices and exchange of experiences, at the regional and subregional levels.

**Partnerships.** In general, partner relationships appear to be good and supportive of effective joint working. The part played by inter-personal factors in building and maintaining such positive relationships was noted by several stakeholders.

At the Government level, the main partnership was established through the Ministry of Health. While this relationship was characterized as constructive and effective, a similar relationship at the district level was less clear. Likewise, relationships with other ministries and sectors were much less advanced leading to some concerns in terms of the intersectoral engagement that would be required to address the social determinants of health and the challenges of noncommunicable diseases in Rwanda.

The current development partnership structure in Rwanda, framed under a Government mandated division of labour, limits to some extent the opportunities for establishing other types of alliances outside the allocated partners. It may also complicate opportunities for resource mobilization at the national level. Feedback received from development partners showed a high degree of respect for, and positive collaboration with, WHO. Partnerships with nongovernmental organizations proved more limited and this is considered an area for further development.

The UN system in Rwanda has embraced the "Delivering as One" framework. UN agencies operate under a shared cooperation agreement, the United Nations Development Assistance Plan, which has recently been updated into a new UNDAF2, expected to provide a more flexible and strategic model of engagement and collaboration within the UN system. WHO leadership in the development of UNDAF2 was recognized.

The "Delivering as One" framework was characterized as showing some operational limitations given that it requires the commitment of agencies to move beyond their corporate interests. However, it provides WHO the opportunity to work intersectorally and engage in new partnerships. Nevertheless, it appeared that UNDAF had little practical impact on WCO's day-to-day activities and could not be shown to have contributed significantly to WCO outcomes.

However, UNDAF2 is expected to offer opportunities for closer alignment with the next CCS and to better reflect the WHO-Ministry of Health joint plan of work and WHO's comparative advantage.

**Funding** remains critical for WHO's catalytic engagement in the country. The evaluation noted comments from several stakeholders concerning the limited resource base of the WCO in support of its workplan, considering that the current levels of financing were insufficient to enable WHO to fully achieve its objectives and maintain its leadership role. In addition, reliance on earmarked funding resulted in some disparities among resources allocated to individual programme areas. Timely receipt of funding was also identified as a challenge by a number of stakeholders. Misalignment between the financial cycles of WHO and the Government of Rwanda, as well as differences in their respective budgeting and planning processes, resulted in funding issues and implementation delays for some programmes.

**Staffing.** Staff of the WCO were recognised for their hard work and dedication, often across portfolios that were viewed as being demanding in terms of their breadth and diversity. At the same time, there were signals of evident gaps in staffing capacity for priority areas and for needed enabling functions, and several staff were responsible for very heavy portfolios, which could not be fully delivered.

Some stakeholders expressed concern about the adequacy of WHO staffing. The need to continuously upgrade the technical skills and expertise of WHO staff, particularly in view of the strong Government expectations to receive innovative solutions and highly-skilled support, was widely recognized throughout the evaluation. It was suggested that a WCO with more senior personnel with clearly targeted responsibilities might be better equipped to respond to the country's needs.

Most technical areas are staffed by National Professional Officers. Though most are technically competent, it may be challenging for them when having to present WHO positions in national fora where they may be more junior and less technically expert than their Government counterparts and there is also participation of international professional staff from other agencies/partners. Hence there is a need to consider the appropriate mix of international professionals and National Professional Officers that adequately responds to the emerging needs of the country.

The plan to engage senior United Nations Volunteers to work in technical roles within the WCO is a notable innovation to provide the necessary additional capacity for the office.

**Monitoring.** The difficulty in measuring results against planned targets and assessing WHO's contributions to the same are indications of a number of systemic challenges in planning and monitoring processes within WHO at both corporate and country levels. The lack of explicit outcome/impact targets in the CCS is not conducive to rigorous monitoring of achievements. This makes WHO's capacity to demonstrate results and contribution to health improvements at country level challenging.

The Biennial Reports for the periods 2014-2015 and 2016-2017 do not explicitly discuss progress towards stated objectives; nor does there appear to have been any formal mid-term, or other, review of progress. Therefore, it is difficult to judge the extent to which the more detailed aspects of the CCS have been addressed.

## Recommendations

1. The new Country Cooperation Strategy and the associated WHO country office programme of work should be developed to ensure a good strategic fit with the unmet needs of Rwanda, the directions set by its Government in the Fourth Rwandan Health Sector Strategic Plan, the 13<sup>th</sup> General Programme of Work and WHO's comparative advantage. It is recommended that the new Country Cooperation Strategy be more focused and that the WHO country office should continue to strengthen its role working at the strategic level.
  - i. Specifically, the WHO country office should provide leadership and policy advice support at the strategic level;
  - ii. Likewise the WHO country office should strengthen its advocacy and resource mobilization functions in view of the Sustainable Development Goal agenda, looking strategically beyond the health sector and, in particular, championing the complex, multifaceted and multisectoral noncommunicable disease agenda;
  - iii. The WHO country office needs to recognize the Government of Rwanda's ambitious development agenda and offer more innovative, flexible, proactive and technically sound responses;
  - iv. The WHO country office should be strategic, considering a more focused approach: do less, do it better, building on collaboration with other United Nations agencies as part of the Delivering as One approach, working at the upstream level, providing policy and technical/normative options and advice.

2. Recommended strategic priorities for inclusion in the new Country Cooperation Strategy are:
  - i. Support efforts to identify options to secure the financial sustainability of the Rwanda health system in support of Universal Health Coverage;
  - ii. Facilitate the institutional development of Rwanda's health system, including the strengthening of institutions such as the Food and Drug Regulatory Authority and the planning of health services at the district level;
  - iii. Further strengthen information systems, civil registration and vital statistics, the National Health Observatory and improve data quality in general, in consideration of Sustainable Development Goal monitoring requirements;
  - iv. Strengthen the quality of health service delivery, the fostering of evidence-based healthcare and consider the opportunity of adopting digital health approaches;
  - v. Strengthen work on noncommunicable diseases and nutrition;
  - vi. Consider assessing Rwanda's needs for mental health services;
  - vii. Emphasize the role of gender, human rights and equity as social determinants.
3. WHO's upcoming Country Cooperation Strategy needs to be articulated showing the causal path (theory of change) from all country-level activities and outputs to expected outcomes (in relation to achieving the WHO's triple billion goals) and finally to the expected impact on Rwanda's health. In particular,
  - i. The Country Cooperation Strategy results framework and biannual workplans need to clarify indicators and targets for each corporate output or outcome that are relevant for Rwanda;
  - ii. The WHO country Office's strategic priorities and workplans need to be properly and effectively communicated to Rwanda's stakeholders, clarifying WHO's role and functions within Rwanda's health landscape, as well as the WHO country office's goals and expected outcomes;
  - iii. The WHO country office should set up an internal monitoring framework to measure WHO's progress towards targets over the Country Cooperation Strategy implementation period and consider inclusion of indicators relating to gender and other social determinants of health.
4. Going forward, the WHO country office, in collaboration with the Regional Office for Africa, should review the office capacity and human resource and management plans in order to ensure that the new Country Cooperation Strategy priorities are adequately covered with the necessary financial and human resources:
  - i. The WHO country office staffing and skill-mix need then to be assessed in the light of the new Country Cooperation Strategy priorities, addressing gaps for relevant areas and providing capacity building opportunities to existing staff in order to be better prepared and respond more effectively to the needs of the country;
  - ii. The WHO country office should align and review the portfolio of its staff members with an aim to rationalize their burden of work and improve the coherence of their individual mandates, matching staff skills with their roles and responsibilities to the extent possible. Furthermore, polio transition efforts should also be taken into consideration.
  - iii. The WHO country office's capacity in terms of enabling functions, including procurement, project management and communications also needs to be assessed and strengthened where needed. Here, innovative solutions already being pursued, such as the use of United Nations Volunteers, could be a model for wider adoption.

In other instances, support from the intercountry support team, the Regional Office for Africa or headquarters could be resourced in a timely manner.

- iv. WHO should explore options to increase the funding base of the WHO country office in Rwanda.
5. WHO needs to strengthen mechanisms for coordinating and consolidating the provision of technical support from the three levels of the Organization, in order to increase its effectiveness and efficiency, and the organizational responsiveness to meet the needs and demands of Rwanda in accordance with the country cooperation strategy and the WHO-Ministry of Health agreed plans of work.
- i. WHO should promote regional initiatives aimed at facilitating country collaboration for shared health issues, including cross-border epidemics, common threats and emergencies, as well as the sharing and exchanging of best practices and joint learning at regional and subregional level.

# 1. Introduction

1. Country Office Evaluations (COE) are included in the WHO Organization-wide evaluation workplan for 2018-2019, approved by the Executive Board in January 2018. The workplan clarifies that COEs “*will focus on the outcomes/results achieved by the country office, as well as contributions through global and regional inputs in the country. In addition these evaluations aim to analyse the effectiveness of WHO programmes and initiatives in the country and assess their strategic relevance within the national context*”. They encompass the entirety of WHO activities during a specific period. The COEs aim to provide findings, recommendations and lessons that can be used in the design of new strategies and programmes in-country.

## 1.1 Evaluation features

2. **Context.** This COE was the second of this type undertaken by the WHO Evaluation Office and the first one to be conducted in the African Region. Its main purpose was to identify achievements, challenges and gaps and document best practices and innovations of WHO in Rwanda. These include not only results of the WHO country office (WCO) but also contributions at the regional and global levels to the country programme of work. As with all evaluations, this COE meets accountability and learning objectives and it will be publicly available and reported on through the annual Evaluation Report.

3. **Objectives.** This evaluation built on an analysis of relevant existing documents and data, complemented by the perspectives of key stakeholders, to:

- a. Demonstrate achievements against the objectives formulated in the Country Cooperation strategy (CCS) and other relevant strategic instruments; and corresponding expected results developed in the WCO biennial workplans, while pointing out the challenges and opportunities for improvement.
- b. Support the WCO and partners when developing the next strategic instruments based on independent evidence of past successes, challenges and lessons learned.
- c. Provide the opportunity to learn from the evaluation results at all levels of WHO. These can then usefully inform the development of future country, regional and global support through a systematic approach to organizational learning.

4. **Expected use.** The main expected use for this evaluation is to support the WCO, especially as it considers the upcoming CCS. Other main users of the evaluation are the WHO Regional Office for Africa (AFRO) and WHO Headquarters (HQ) in order to enhance accountability and learning for future planning. The Government of Rwanda, as a beneficiary of WHO’s actions, as well as the people of Rwanda, have an interest to be informed about WHO’s achievements and be aware of best practices. This is also valid for other organizations, including development partners, national institutions and civil society.

5. Finally, over the medium-term, this evaluation will contribute to build a body of evidence around possible systemic issues to be addressed corporately, such as the development of models of WCO work/presence in middle- and low-income countries. Also, the Executive Board has direct interest in learning about the added value of WHO’s contributions at country level.

6. **Scope.** The evaluation covered the period 2014-2017 and included all contributions from the WCO in Rwanda, AFRO and HQ over the same period.<sup>1</sup> It focused on WHO’s contribution to the

---

<sup>1</sup> Activities during the first quarter of 2018 were also considered.

objectives and the expected results defined in the CCS and the biennial country workplans as a whole rather than individual activities which have taken place during the period evaluated.

7. The CCS for the period 2014-2018 served as the reference to frame the evaluation scope. All other strategic contributions made by WHO were also considered.

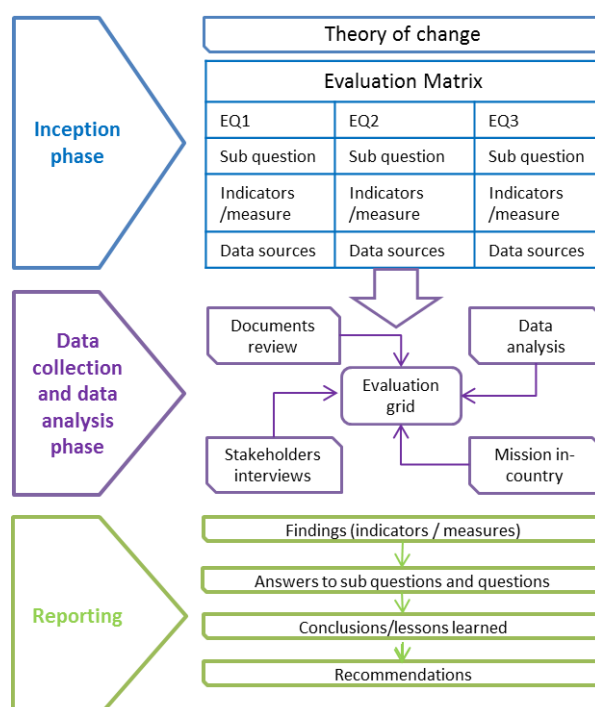
8. **Evaluation questions.** All COEs address the 3 main evaluation questions (EQ) identified below. The sub-questions are then tailored according to country specificities and detailed in an evaluation matrix (see Annex 2).

- **EQ1: Were the strategic choices made in the CCS** (and other relevant strategic instruments) **addressing Rwanda's health needs and coherent with government and partners' priorities?** (relevance). This question assesses the strategic choices made by WHO at the CCS design stage and in the formulation of the programme budget (PB) and its flexibility to adapt to changes in context.
- **EQ2: What is the contribution/added value of WHO towards addressing the country's health needs and priorities?** (Effectiveness/elements of impact/progress towards sustainability). To address this question, the evaluation assessed the WCO's activities and main results achieved.
- **EQ3: How did WHO achieve the results?** (efficiency) In this area the evaluation sub-questions cover the contribution of the core functions, the partnerships and allocation of resources (financial and staffing) to deliver the expected results.

## 1.2 Methodology

9. Guided by the WHO evaluation practice handbook, the evaluation was based on a rigorous and transparent methodology to address the evaluation questions in a way that serves the dual objectives of accountability and learning. The methodology (summarized in Figure 1 below and elaborated further in Annex 2) ensured impartiality and lack of bias by relying on a cross-section of information sources (from various stakeholder groups) and using mixed methods (e.g. quantitative and qualitative data) to ensure triangulation of information through a variety of means.

**Figure 1: Methodological approach**



10. The evaluation was conducted between April and July 2018 by a core team of five members. The WHO Evaluation Office formed a team led by Dr Elil Renganathan (Director-General's Representative for Evaluation and Organizational Learning) and supported by Itziar Larizgoitia (Senior Evaluation Officer), Simon Bettighofer (Evaluation Officer), and Dr Paul Janssen and Mr Philip Davies (consultants).

11. During the inception phase, the team reconstructed the evaluation theory of change<sup>2</sup> (see Figure 2) framing WHO's engagement in-country. The theory of change is aligned with the one validated by WHO in the context of the evaluation of WHO's presence in countries<sup>3</sup> and in the evaluation of the Thailand Country Office.<sup>4</sup> Using the theory of change, the team developed an evaluation matrix, unpacking for each evaluation question the specific indicators/measures for assessing each sub-question, as well as the data collection method and data sources used. The evaluation analysed the CCS in relation to other WHO planning documents as is further elaborated in Annex 3. It did so mainly using existing data collected by WHO and partners, complemented by direct feedback from Ministry officials, WHO staff and other development partners. After a comprehensive document review, the team conducted a 10-day mission in-country during which time it held a large number of interviews (list available in Annex 5). All the data were then analysed to produce the present report.

12. The theory of change clarifies WHO's contribution to the national health objectives and goals in terms of health outcomes and potentially the health impact of its collaborative programmes with the Government of Rwanda, as defined in the CCS 2014-2018 and the biennial workplans. It encompasses contributions from all levels of the Organization and all strategic contribution areas of WHO in-country.

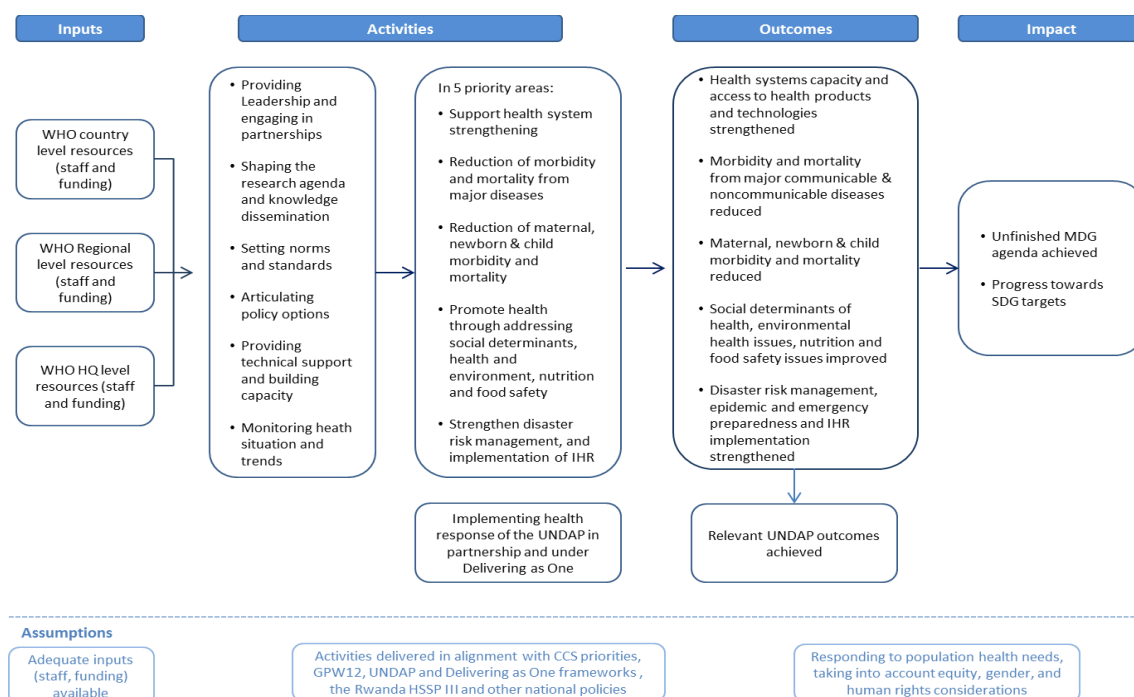
---

<sup>2</sup> Theory of Change is a description and illustration of how and why a desired change is expected to happen in a particular context. It is focused in particular on mapping out or "filling in" what has been described as the "missing middle" between what a program or change initiative does (its activities or interventions) and how these lead to desired goals being achieved (for further details see <http://www.theoryofchange.org/what-is-theory-of-change/>).

<sup>3</sup> WHO (2015). Evaluation of WHO's presence in countries. Geneva: WHO Evaluation Office (<http://www.who.int/about/evaluation/prepublication-country-presence-evaluation.pdf?ua=1>).

<sup>4</sup> WHO (2017). Country Office Evaluation – Thailand. Geneva: WHO Evaluation Office ([http://www.who.int/about/evaluation/thailand\\_country\\_office\\_evaluation\\_report.pdf?ua=1](http://www.who.int/about/evaluation/thailand_country_office_evaluation_report.pdf?ua=1)).

**Figure 2: Theory of Change – WHO contributions in Rwanda 2014-2017**



### 1.3 Country context

13. Rwanda is landlocked, hilly and fertile with a population of about 11.9 million people (2016) and a high population density.<sup>5</sup> The second Economic Development and Poverty Reduction Strategy 2013-2018 (EDPRS 2)<sup>6</sup> and Rwanda's long-term strategy Vision 2020<sup>7</sup> aim to transform the country from a low-income, agriculture-based economy to a knowledge-based, service-oriented economy with middle-income country status by 2020. Currently the Government of Rwanda has set the Vision 2050 as well as the first edition of the National Strategy for Transformation 2018-2024 which aims to make Rwanda a high-income country by 2050..

14. In 2015, Rwanda was classified by the UNDP in the low human development category with a Human Development Index (HDI) of 0.498, occupying the 159<sup>th</sup> position out of 188 countries and territories. Between 1990 and 2015, the HDI value more than doubled from 0.244 to 0.498, associated to increases in life expectancy at birth, mean years of schooling and expected years of schooling. Likewise, Rwanda's Gross National Income (GNI) per capita had increased by 91% between 1990 and 2015. Its HDI value is above the average of 0.497 for countries in the low human development group and below the average of 0.523 for countries in Sub-Saharan Africa. When the HDI is discounted for inequality, it falls to 0.339, representing a loss of 32% due to inequality. Other Sub-Saharan African countries of similar development category experience similar losses due to inequality. The overall female/male HDI ratio is 0.992, which is higher than the average for sub-Saharan Africa.<sup>8</sup>

<sup>5</sup> World Bank (2018). The World Bank in Rwanda (<http://www.worldbank.org/en/country/rwanda/overview>).

<sup>6</sup> Government of Rwanda (2013). Economic Development and Poverty Reduction Strategy II. 2013-2018. Kigali, Rwanda: Ministry of Finance and Economic Planning/Rwanda ([http://www.minecofin.gov.rw/fileadmin/templates/documents/NDPR/EDPRS\\_2.pdf](http://www.minecofin.gov.rw/fileadmin/templates/documents/NDPR/EDPRS_2.pdf)).

<sup>7</sup> Government of Rwanda (2012) Rwanda Vision 2020, revised 2012. Kigali, Rwanda, Ministry of Finance and Economic Planning/Rwanda: ([http://www.minecofin.gov.rw/fileadmin/templates/documents/NDPR/Vision\\_2020\\_.pdf](http://www.minecofin.gov.rw/fileadmin/templates/documents/NDPR/Vision_2020_.pdf))

<sup>8</sup> UNDP (2016). Briefing note for countries on the 2016 Human Development Report – Rwanda ([http://hdr.undp.org/sites/all/themes/hdr\\_theme/country-notes/RWA.pdf](http://hdr.undp.org/sites/all/themes/hdr_theme/country-notes/RWA.pdf)).

15. Rwanda has made outstanding socioeconomic progress in recent years with observed significant improvements in health and other key development indicators (Table 1). Poverty<sup>9</sup> declined from 57% in 2005 to 39% in 2013 with significant poverty reduction experienced particularly in rural areas.<sup>10</sup> The reduction in poverty was supported by a combination of factors including improved agricultural outcomes, increased number of agricultural businesses and increased farm wage employment. The country experienced solid economic growth over the last two decades: Between 2001 and 2015, real GDP growth averaged at about 8% per annum.<sup>11</sup>

16. According to the Global Health Observatory, the health expenditure per capita (in PPP) was Int\$ 143 in 2015, representing 7.9% of the GDP.<sup>12</sup> The country has attained the Abuja declaration of allocating 15% of the government budget allocated to health.<sup>13</sup> Official Development Assistance (ODA) for health to Rwanda had increased significantly during the last decade, although the aid dependency (ODA/GNI ratio) was reduced to 11% in 2015 versus 18.5% in 2000. The total disbursements of development partners in the fiscal year 2015/16 were US\$ 984.9 million which amounted to 66.6% of the total development finance. Health, Education and Social Protection together attracted as much as 44% of the total external funds in 2015-2016. The health sector appears to be the largest consumer of development finance with disbursements of US\$ 228.1 million.<sup>14</sup>

**Table 1: Selected population and health indicators**

Indicators	2000	2016
Total population (in million)	9.97	11.92
Population < 15 years (%)	44.3	40.5
Population 15-64 years (%)	52.5	56.6
Population > 64 years (%)	3.2	2.9
Population living in urban areas (%)	14.9	29.8
Life expectancy at birth, female (years)	49.2	69.2
Life expectancy at birth, male (years)	47.6	65.0
Fertility rate (births per woman)	5.6	4.2 (2014-15)
Family planning needs satisfied by modern methods (%)	11.4	66 (2014-15)
Infant mortality (per 1 000 live births)	115.6	32 (2014-15)
Maternal mortality (per 100 000 live births)	1 020	210 (2014-25)
Births attended by skilled health personnel (%)	31.3	91 (2014-15)
Current health expenditure (% of GDP)	4.6	7.9 (2015)
Current health expenditure per capita (PPP)	29.4	143.2 (2015)

Sources: WHO Global Health Observatory data repository, World Bank Open Data and Rwanda Demographic and Health Survey 2014-15.

<sup>9</sup> Poverty headcount ratio (at national poverty lines).

<sup>10</sup> World Bank (2018). World Bank Open Data (<http://databank.worldbank.org/data/source/poverty-and-equity>).

<sup>11</sup> World Bank (2018). The World Bank in Rwanda (<http://www.worldbank.org/en/country/rwanda/overview>).

<sup>12</sup> Global Health Observatory data repository (2018). Health financing. (<http://apps.who.int/gho/data/node.main.HEALTHFINANCING?lang=en>).

<sup>13</sup> Ministry of Health/Rwanda (2018). Fourth Health Sector Strategic Plan. July 2018-June 2024. Kigali, Rwanda: Ministry of Health/Rwanda.

<sup>14</sup> Government of Rwanda (2017). Rwanda Official Development Assistance Report - an extended review 2015/2016 Fiscal year. Kigali, Rwanda: Ministry of Finance and Economic Planning/Rwanda ([http://www.devpartners.gov.rw/fileadmin/user\\_upload/ODA\\_report\\_201516\\_2\\_.pdf](http://www.devpartners.gov.rw/fileadmin/user_upload/ODA_report_201516_2_.pdf)).

17. According to the Rwanda Demographic and Health Survey 2014-15,<sup>15</sup> more than 9 in 10 (93%) children aged 12-23 months received all basic vaccinations. The basic vaccination coverage increased from 75% in 2005 to 93% in 2014-2015. Children whose mothers have no education are the least likely to have received all basic vaccinations (86%), as are children living in the West province (90%) as opposed to those living in Kigali City (96%). Overall, 37% of children aged 6-59 months are anaemic (from 52% in 2005). Anaemia is most common in children living in the poorest households and with mothers lacking education. Nearly 38% of children under five are stunted, or too short for their age (indication of chronic undernutrition). Stunting is more common in West province (45%) as opposed to Kigali City (23%). In addition, 9% of children are underweight, or too thin for their age.

18. Seven percent of women are thin (BMI < 18.5). Comparatively, 21% of women are overweight or obese (BMI ≥ 25.0). Women in urban households are more than twice as likely to be overweight or obese compared to rural women (37% vs. 17%). Overweight and obesity increases with household wealth and education. Since 2005, overweight and obesity has increased from 12% to 21% in 2014-15.<sup>16</sup>

19. The HIV prevalence among people aged 15-49 years in Rwanda has remained stable over the last five years at 3%. Malaria as a major cause of childhood mortality has dropped significantly from the first position in 2005 to the fourth position in 2012.<sup>17</sup>

20. Estimates of the burden of disease in 2012 classified maternal, neonatal and nutritional conditions as the primary cause of disability-adjusted life years lost (DALYs), due to a combination of premature mortality and disability. Other infectious diseases were the second cause of DALYs, followed by HIV, TB and malaria.<sup>18</sup>

21. In 2011, the Rwandan Ministry of Health (MOH) developed the Third Health Sector Strategic Plan (HSSP III)<sup>19</sup> as a framework to provide strategic guidance to the health sector for six years, between July 2012 and June 2018. The HSSP III adopted the following priorities for implementation:

- Sustain the achievements in the fight for Maternal and Child Health and against infectious diseases – MDGs 1 (nutrition), 4 (child mortality), 5 (maternal health) and 6 (disease control) – and invest in prevention and control of noncommunicable diseases.
- Improve accessibility to health services (financial, geographical, community health)
- Improve quality of health provision (quality assurance, training, medical equipment, supervision)
- Reinforce institutional strengthening (especially toward district health services, district health units)
- Improve quantity and quality of human resources for health (planning, quantity, quality, management)

## 1.4 WHO activities in Rwanda

22. The WHO Rwanda CCS 2014-2018<sup>20</sup> outlines the medium-term framework for cooperation with the Government of Rwanda through five strategic priorities that guide the work of WHO in the country. These are:

---

<sup>15</sup> National Institute of Statistics of Rwanda, Ministry of Health/Rwanda, and ICF International (2016). Rwanda Demographic and Health Survey 2014-15. Kigali, Rwanda: National Institute of Statistics of Rwanda, Ministry of Health/Rwanda, and ICF International (<https://dhsprogram.com/publications/publication-fr316-dhs-final-reports.cfm>).

<sup>16</sup> Ibid.

<sup>17</sup> Ibid.

<sup>18</sup> WHO (2015): Rwanda: WHO statistical profile (<http://www.who.int/gho/countries/rwa.pdf?ua=1>).

<sup>19</sup> Ministry of Health/Rwanda (2012). Third Health Sector Strategic Plan (HSSP III, July 2012 - June 2018). Kigali, Rwanda: Ministry of Health/Rwanda ([http://www.moh.gov.rw/fileadmin/templates/Docs/HSSP\\_III\\_FINAL\\_VERSION.pdf](http://www.moh.gov.rw/fileadmin/templates/Docs/HSSP_III_FINAL_VERSION.pdf)).

- a. Support health system strengthening towards health service integration and universal health coverage;
- b. Contribute to the reduction of morbidity and mortality from major communicable and noncommunicable diseases and conditions towards consolidation of health-related MDG gains and achievements of post-2015 development goals;
- c. Contribute to the reduction of maternal, newborn and child morbidity and mortality;
- d. Promote health through addressing social determinants of health, health and environment, nutrition and food safety;
- e. Strengthen disaster risk management, epidemic and emergency preparedness and response; and implementation of the International Health Regulations.

23. The CCS priorities correspond to the priorities and programme areas defined in the WHO 12<sup>th</sup> General Programme of Work 2014-2019 (GPW12).<sup>21</sup> In addition, the country office has continued its work in the area of poliomyelitis eradication.

24. The WHO office in Rwanda delivers on its strategic priorities through its work across the WHO core functions. In this respect, the WCO supports the MOH and its implementation agency, the Rwanda Biomedical Centre (RBC),<sup>22</sup> in the development and implementation of evidence-based policies, strategies and guidelines; and contributes to strengthening institutional capacity for public health and to monitoring the health situation in the country. The WCO's work is conducted within the framework of WHO reforms and the WHO/AFRO Transformation Agenda which both aim to transform WHO in the African Region into a more responsive, fit-for-purpose and efficient leader in public health on the continent.<sup>23</sup>

25. The overall WCO expenditure (activities and staff costs) for the period 2014-2017 amounted to US\$ 12,5 million. The main source of funding over the period was flexible funding (64%). Other earmarked funding was provided by development partners, including the UK Department for International Development, the World Food Programme,<sup>24</sup> the UN Central Emergency Response Fund, the Canadian International Development Agency, the US Agency for International Development, GAVI, the Centers for Disease Control and Prevention and the Bill & Melinda Gates Foundation.

26. Table 2 highlights the main areas of work undertaken by WCO Rwanda with the corresponding levels of investment over the two biennia.

**Table 2: WCO Rwanda expenditure in 2014-2015 and 2016-2017**

	2014-2015 (US\$)	2016-2017 (US\$)	Total (US\$)	Total (%)
<b>CCS priorities</b>				
1 Health system strengthening	518,604	662,299	1,180,903	9.4%
2 Communicable and noncommunicable diseases	1,970,181	925,674	2,895,855	23.1%

<sup>20</sup> WHO (2014). WHO Country Cooperation Strategy 2014-2018 Rwanda. WHO Regional Office for Africa ([http://apps.who.int/iris/bitstream/handle/10665/205893/CCS\\_Rwa\\_2014\\_18.pdf?sequence=1](http://apps.who.int/iris/bitstream/handle/10665/205893/CCS_Rwa_2014_18.pdf?sequence=1)).

<sup>21</sup> WHO (2014). Twelfth General Programme of Work 2014-2019. Geneva, World Health Organization ([http://apps.who.int/iris/bitstream/handle/10665/112792/GPW\\_2014-2019\\_eng.pdf?sequence=1](http://apps.who.int/iris/bitstream/handle/10665/112792/GPW_2014-2019_eng.pdf?sequence=1)).

<sup>22</sup> Hereafter, the reference to MOH is understood to include the RBC, unless otherwise stated.

<sup>23</sup> WHO/Rwanda. Making people healthier ([http://www.afro.who.int/sites/default/files/2017-12/WHO\\_17\\_Brochure\\_Website%20final%2011%2012.pdf](http://www.afro.who.int/sites/default/files/2017-12/WHO_17_Brochure_Website%20final%2011%2012.pdf)).

<sup>24</sup> Pass through funds from the Swiss Development Cooperation and the Government of the Netherlands.

3	Reduction of maternal, newborn and child morbidity and mortality	1,211,344	1,059,769	2,271,113	18.1%
4	Social determinants of health, health and environment, nutrition and food safety	298,515	371,472	669,987	5.3%
5	Disaster risk management, epidemic and emergency preparedness and response; International Health Regulations	339,998	455,969	795,967	6.4%
<b>Other activity areas</b>					
	Poliomyelitis eradication	1,151,158	475,991	1,627,150	13.0%
<b>Other expenses</b>					
	Corporate services / enabling functions <sup>25</sup>	1,116,548	1,971,147	3,087,695	24.6%
<b>Total</b>		<b>6,606,348</b>	<b>5,922,323</b>	<b>12,528,671</b>	<b>100.0%</b>

Source: WHO Global Management System data, expenditure mapping by evaluation team

27. The WCO also reported a number of efficiency and cost savings measures, including: rationalization of the office space, retirement of old and obsolete equipment; and better negotiation of service suppliers (internet, transportation) through the UN common services platform.

28. The WCO also contributes to implementing the health response of the UNDP in partnership with other UN agencies, and it coordinates health sector interventions within UNDP on behalf of other UN agencies involved in the sector. Within UNDP, the health sector priorities are reflected in the flagship programme document for 2013-2018 entitled “Strengthening health and population systems with improved governance, analysis and monitoring of results” and developed in partnership with the MOH. Most of the strategic priorities of the CCS are well aligned with UNDP priorities.

29. Health development activities in the country are coordinated by the Health Development Partners Group which is the highest-level coordination body in the country. Furthermore, the Health

**Box 1 – Country Coordination Mechanism (CCM)**

*As in many countries, the MOH and WHO jointly chair the CCM for the Global Fund to fight AIDS, Tuberculosis and Malaria.*

*In Rwanda, WHO alone chaired the important CCM sub-committee for selecting sub-recipients. The MOH, principal recipient of the grant, was confident to leave this responsibility to WHO.*

*This is an indication not only of the leadership role of the WCO, but also of its perceived objectivity and expertise.*

Sector Working Group is the key forum through which partners engage in policy dialogue for health-related matters and manage their relationship with the Government of Rwanda. WHO co-chairs the Country Coordinating Mechanism (CCM) for the Global Fund to fight AIDS, Tuberculosis and Malaria and is active in the various DPCG mechanisms in the sector.

<sup>25</sup> This includes: leadership and governance; transparency, accountability and risk management; strategic planning, resource coordination and reporting; management and administration; and strategic communications.

## 2. Findings

30. The findings of the evaluation are presented following the three main evaluation questions and sub-questions identified in the TOR (see Annex 1 for the full list). More detailed observations per CCS priority are available in Annex 4.

### 2.1 Relevance of WHO's strategic choices

#### Are the CCS and other relevant strategic documents based on a comprehensive health diagnostic of the entire population and on Rwanda's health needs?

31. The CCS 2014-2018 is well aligned with Rwanda's health needs, as presented in the HSSP III. The CCS (and HSSP III) is informed by the Rwanda Demographic and Health Survey 2010, routine Health Management Information Systems (HMIS) data, national surveys for immunization (2013), noncommunicable disease risk factors (STEPwise approach to surveillance (STEPS) survey of NCD risk factors, 2013), TB prevalence (2013), HIV prevalence and service delivery (TRACnet, 2014).

##### **Box 2 – Relevance of the CCS-2014-2018**

*Overall, the CCS 2014-2018 is relevant, in the sense that it articulates the health priorities of the country, based on health needs assessment, and aligns well with the MOH strategic directions (HSSP III), the UNDAF and GWP12.*

#### Are the CCS and other relevant strategic documents coherent with the Third Rwanda Health Sector Strategic Plan, other relevant national health strategies, and the SDGs targets relevant to Rwanda?

32. The Government of Rwanda has sought to establish ownership of the country's national development in keeping with the principles of the Busan Partnership for Effective Development Cooperation (2012). Consequently, the Government, and more specifically the MOH, plays a strong leadership role in the sector, including the establishment of a clear principle of 'division of labour' which specifies where and how development partners' respective contributions should be directed.

33. As a result, the CCS is coherent with the HSSP III, as it was developed jointly with the MOH. The WHO Representative is committed to align the next CCS to HSSP IV, which in turn has been developed with WHO technical assistance (following WHO support for the review of HSSP III).

34. To ensure continued relevance to the new global development agenda adopted in 2015, the CCS was revised in 2016 to reflect the move from MDGs to SDGs and the progress in meeting the MDGs, also shown by the findings of the Rwanda Demographic and Health Survey 2015 and the national immunization surveillance report 2015.

##### **Box 3 – Division of labour**

*The current development partnership structure in Rwanda is framed under a government mandated division of labour, which assigns responsibility for specific sectors to individual development partners. This principle may constrain the opportunities for establishing other types of alliances outside the partners assigned to work in the health sector.*

35. The CCS 2014-2018 supported the implementation of HSSP III which was aligned with the Rwanda Vision 2020, and the EDPRS 2. Rwanda recently developed a Vision 2050 and the National Transformation Strategy 2018-2024 to reach the vision. WHO is requested and committed to support the health component of the social transformation pillar, as part of UNDAF support for this strategy.

36. Most ministry officials see WHO as a trusted partner that can help advocate for national priorities with other development partners, based on its brand value and credibility. This happens in several policy platforms, where WHO has a major leadership role. As mentioned previously, WHO currently co-chairs the CCM and some key MOH technical working groups. The perception generally is that WHO is responsive to country and MOH needs, in particular in the areas of health systems strengthening; epidemic surveillance, and vaccination/EPI programming.

**Is the CCS coherent with the UNDAF? And are the key partners clear about WHO's role in Rwanda? Specificities of the partnership between WHO and the Government of Rwanda in the specific context of "delivering as one"?**

37. The CCS responds directly to UNDAF 2013-2018 Result Area 3: human development. It is specifically aligned with Outcome 3.1. "All Rwandan children, youth and families, especially the most vulnerable, access quality early childhood development, nutrition, education and protection"; Outcome 3.2. "All people in Rwanda have improved and equitable access to and utilize high quality promotional, preventive, curative and rehabilitative health services"; and Outcome 3.3. "Vulnerable groups have reduced exposure to livelihood risk, inequalities and extreme poverty". In addition, it also supports Outcome 1.3. "Rwanda has in place improved systems for: sustainable management of the environment, natural resources and renewable energy resources, energy access and security for environmental and climate change resilience in line with Rio+20 Recommendations for Sustainable Development".

38. The CCS document contains an overview of how each of the five strategic priorities and specific activities respond to multisectoral UNDAF outcomes and outputs, such as to early childhood development, nutrition, sustainable environment, risk exposure, disaster management and humanitarian security. The next CCS is likely to be aligned with the new UNDAF2, as WHO was heavily involved in developing this document and co-chaired the process. Some health-related priorities are already introduced in the UNDAF2, but need to be further developed in the next CCS.

39. In Rwanda, WHO uses the One UN effectively. On a programmatic level, it helps to engage with multiple stakeholders on cross-sectoral issues such as nutrition & food security and the humanitarian response in refugee camps. On a more practical level, WHO shares office space and facilities with UNICEF and UNAIDS, which strengthened the relationship.

40. Under the One UN, WHO is involved in a joint initiative on nutrition. In doing so, WHO has faced challenges, in part because coordination did not rest with the MOH, but was assigned to another ministry. In general, joint initiatives are considered to have been less efficient than originally hoped, as they remain amalgamations of individual agency interests. UNDAF2 will have no such joint initiatives, merely joint workplans around outcomes as and when there is a commitment.

41. The role and comparative advantage of WHO appears to be clear among key partners, i.e. UNICEF, UNAIDS and UNFPA. There is not much overlap between UN agencies working in health, possibly due to the leadership of the Government of Rwanda and the division of labour in place. WHO and UNFPA consider their joint work on developing guidance for practitioners on appropriate family planning interventions (Medical Eligibility Criteria Wheel) and tool as a good example of WHO doing upstream work (setting standards) and UNFPA doing downstream procurement and training.

**Box 4 – Delivering as One**

*The UN system in Rwanda has embraced the "Delivering as One" framework. UN agencies operate under a shared cooperation agreement (UNDAF) which has recently been updated into a new UNDAF 2, expected to provide a more flexible and strategic model of engagement and collaboration within the UN system. WHO leadership in the development of UNDAF 2 was recognized.*

## Is the CCSs coherent with the General Programme of Work and aligned with WHO's international commitments?

42. The CCS reflects the strategic priorities identified in GPW12, approved by the Sixty-sixth World Health Assembly in 2013. These priorities are: 1) communicable disease control; 2) NCD control; 3) health in the life course; 4) health systems; and 5) disaster preparedness and response. The GPW12 priorities are all well-covered under the CCS strategic priorities.

## Does the CCS support good governance, gender equality and the empowerment of women?

43. In terms of good governance, the CSS expresses support to strengthen capacity for health system governance and stewardship. WHO supported strategic planning, policy development, strategic information systems and the mid-term review of the HSSP III. An emerging issue in governance mentioned in the CCS is community participation in the management of health services.

44. The CCS recognizes the progress in gender equality promoted by the Government of Rwanda, and the supportive policy and legal framework for mainstreaming gender in socioeconomic sectors. While there is no explicit reference to gender issues or gender-affirmative approaches in the CCS, most stakeholders consider gender equality to be part and parcel of WHO's work and approaches.

## Has WHO learned from experience and changed its approach in view of evolving contexts during the course of the CCS 2014-2018?

45. The Government of Rwanda, provides dynamic leadership in the health sector. Priorities change regularly and progress is fast, therefore any CCS needs to be a dynamic and evolving instrument. For example, digital health is a current priority of the Government; however, it was not yet established as such in 2014 when the current CCS was agreed. Similarly, Rwanda became a 'flagship' for UHC with specific focus on: (a) improving service quality (recognizing that coverage is already good); and (b) health financing innovations. Because SDGs on maternal and child mortality were met in 2015, the focus shifted to address neonatal mortality and early childhood development.

### **Box 5 – Evolving health context**

*The WCO adapted to the evolving health context by revising the CCS in 2016 to remain relevant in the context of Rwanda achieving most of the MDGs and subsequently*

46. The WCO has been adaptable and pragmatic in this ever-developing context. As mentioned before, the CCS was reviewed and revised in 2016, the updated CCS policy objective explicitly mentioning support to achieve the SDGs. Health financing and early childhood development have become more prominent focus areas. On the other hand, WHO was pragmatic and chose not to engage in areas where it has no capacity or comparative advantage, for example directly supporting community health workers.

47. Challenges remain and will need to be addressed in the next CCS. For example, some MOH officials argue that the specific needs of Rwanda, as a rapidly developing country, will need to be better reflected in future WHO priorities. As a result, they suggested there was a need for WHO to offer more support in the scaling up of innovative solutions. In other areas, limited human or financial resources is a barrier to engage more effectively, for example in the area of NCDs and the epidemiological transition, including population ageing and mental health.

## Is the CCS strategic in identification of WHO's comparative advantage and clear strategy to maximise it and make a difference?

48. The CCS is clear about WHO's comparative advantage: provision of norms and standards, guidelines, policy development, research and evidence generation, technical support and capacity building. Implementation and financial support are clearly considered the mandate for others, and

most respondents agree. By and large, CCS strategies and WCO activities reflect these comparative advantages. That being said, the WCO support portfolio is very broad and ambitious and it is often difficult to balance available capacity with the expressed needs of the MOH.

49. WHO is strongly driven by a highly ambitious and dynamic national counterpart and work planning is also done within the context of guidance by the GPW and biennial programme budgets. The WCO therefore faces twin challenges: from the Government, which is dynamic and ambitious, to address rapidly evolving national priorities; and from WHO itself to meet wide-ranging global and regional targets. While those pressures, combined with finite financial resources, inevitably leave the WCO with little room to manoeuvre in terms of priorities, it is clear that the WCO has not been passive in terms of strategic choices.

### **Do the CCS and WCO position health priorities in the national agenda and in those of the national partners in the health sector?**

50. Whilst MOH officials expect WHO support for national priorities and strategies, they also expect WHO to provide technical guidance to the MOH in some areas as well. Planners are looking to WHO for innovative ideas to deliver on the country's ambitious goals, notably in respect of health-related SDGs.

51. WHO has influenced the national dialogue on priority setting for health through pivotal technical support for the review and revision of the HSSP and is broadly seen as useful and effective in supporting and influencing health priorities and narratives in Rwanda, like its role in the several MOH technical working groups.

52. WHO provides long-term technical assistance in key health policy areas, such as the long-term health economist at the Rwanda Social Security Board supporting health financing strategies in support of progress towards Universal Health Coverage (UHC). Short-term technical assistance in the same area supported development of the health insurance policy and Community-Based Health Insurance (CBHI) scheme.<sup>26</sup>

#### **Box 6 – Implementing CBHI to improve access to health services**

##### **Challenge:**

*how to address financial barriers to ensure better population access to health care services*

##### **How was it addressed?**

- *Supporting the development of national health financing policy and CBHI*
- *Resource mobilization through the UNDAF mechanism*
- *Institutional capacity building in CBHI management and health financing for UHC*
- *Advocacy for the mainstreaming of the UHC principles in health sector policies*

##### **Outcome**

- *Increase of CBHI coverage from 76.3% in 2014 to 82.9% in 2016/2017*
- *Increase in health care service utilization from 0.9 visits in 2009 to 1.72 visits per inhabitant in 2016*
- *Introduction of 6 new vaccines into routine immunization system*
- *Reduction in under-five mortality from 196 in 2000 to 50 per 1,000 live births in 2015*

<sup>26</sup> WHO (2017). Celebrating the work of WHO country teams: a collection of country office experiences (2017). Geneva, World Health Organization (CCU/17.10) and Rwanda Ministry of Health data

53. A good example of WHO influencing health priorities outside the MOH was the SDG policy brief, developed to step up efforts in the transition from MDGs to the more ambitious and equity focused SDGs. Similarly, WHO helped draft relevant chapters of the UNDAF2, after supporting the health sector policy gap analysis (a UNDP tool) as part of the Common Country Assessment. Despite these successes, it remains a challenge to influence agendas and policies in non-health ministries, to address other determinants of health.

### **Summary of key findings**

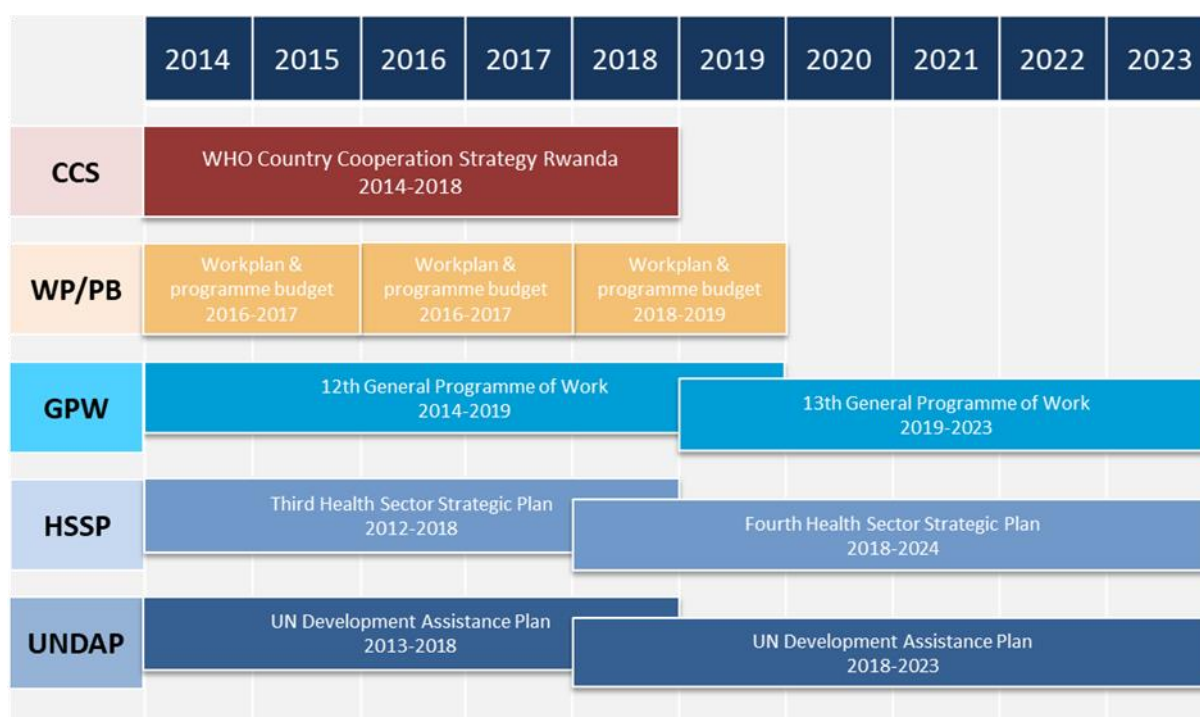
- Overall, the CCS 2014-2018 is relevant, in the sense that it articulates the health priorities of the country, based on health needs assessment, and aligns well with the MOH strategic directions (HSSP III), the UNDAF and GWP12.
- The CCS recognizes progress of the Government of Rwanda in advancing governance, gender equality and the empowerment of women, but these principles are not explicitly translated into priority focus areas or areas for activities.
- The CCS articulates the comparative advantage of WHO along the WHO core functions as defined in GPW12 which continue to guide the WCO strategies and activities.
- WCO has been effective in ensuring the MOH has access to policies needed to achieve its ambitious goals in the area of policy development, and articulating health priorities.
- Ministry leaders expect WHO to provide objectivity and policy alternatives in a multi-stakeholder environment where innovation is rapid.
- The WCO adapted to the evolving health context by revising the CCS in 2016 to remain relevant in the context of Rwanda achieving most of the MDGs and subsequently adopting the SDGs.
- However, there are unmet health priorities and demands. A challenge for the WCO is to remain responsive to the demands of a very pro-active and assertive national counterpart, in a context of rapid innovations in health care programming and service delivery and an ambitious SDG agenda, with the increasing need for intersectoral engagement.
- As a result of many demands and high expectations of the Government of Rwanda, the CCS includes an extensive number of focus areas, without clear prioritization. Therefore, the CCS is responsive but not as strategic as it could be.
- One UN and Delivering as One has advantages, such as efficiencies in office facilities and joint planning. On the other hand, Joint UN programs and projects do not seem to necessarily be more relevant or effective than coordination when and where appropriate, as was the case in the past.

## **2.2 WHO's contribution and added value (effectiveness and progress towards sustainability)**

### **To what extent were the country biennial work plans based on the focus areas as defined in the CCS and other relevant strategic instruments?**

54. As shown in Figure 3, the timeline of the CCS Rwanda (2014-2018) is reasonably aligned with GPW12 (2014-2019). While the timeframe of a CCS usually covers four to six years, workplans are organized per biennium. For the WCO Rwanda, the workplan 2014-2015 coincided with the launch of the CCS while the next CCS (2019-2024) will begin halfway through the biennial workplan 2018-2019. Furthermore, the CCS timeframe is well aligned with those of the HSSP and UNDAF.

**Figure 3: Alignment of CCS with other planning documents**



Source: Own illustration

55. As determined by WHO's Global Management System, workplans are structured per programme area and related outcomes and outputs as defined in GPW12 and the biennial corporate programme budgets. Accordingly, the WCO Rwanda workplans are also structured by GPW programme area and thus do not clearly indicate which activities were carried out per CCS strategic priority. Due to this systemic problem, there is no clear link between workplans drafted at country level and the strategic priorities established in the CCS. Further details on WHO's main planning instruments and associated challenges can be found in Annex 3.

56. The CCS document provides a validation of the CCS strategic agenda against GPW categories, which is however incomplete.<sup>27</sup> The WCO has not explicitly translated the PB corporate outcome and output targets as measurable outcomes and outputs at country level nor has it developed its own results framework (or logical framework or impact pathway or theory of change) specifying its expected contribution to each priority for the CCS period with corresponding baselines and targets. As there was therefore no documented traceability of how each individual activity in the workplans at country level supported CCS priorities, the evaluation team had to do a mapping of the programme areas included in the workplans against the CCS priorities.

### What were the main results achieved?

57. The following sections present the WCO's achievements for each of the CCS priority areas, most of which are formulated as support activities. Some activities resulted in clear outputs (e.g. number people trained), for others qualitative evidence is found of progress towards the implicit objectives (e.g. capacity increase, adoption of normative guidance). The data however does not allow an attribution of national outcomes (e.g. increased service coverage) or impacts (e.g. improved health) to WHO activities. This is again more of a systemic issue rather than a country-specific shortcoming.

<sup>27</sup> WHO Regional Office for Africa (2014). WHO Country Cooperation Strategy 2014-2018 Rwanda, p. 49 ([http://apps.who.int/iris/bitstream/handle/10665/205893/CCS\\_Rwa\\_2014\\_18.pdf?sequence=1](http://apps.who.int/iris/bitstream/handle/10665/205893/CCS_Rwa_2014_18.pdf?sequence=1)).

***Priority 1: Support health system strengthening towards health service integration and universal health coverage***

58. Most respondents consider WHO's contribution to health systems strengthening in Rwanda significant. Key achievements in this area include the following:

- Support for national health policies, strategies and plans, including technical assistance for the mid-term review of HSSP III and development of the HSSP IV, and also:
  - health financing systems and CBHI management systems;
  - the Health Financing Strategic Plan and health insurance; and
  - the first Africa Health Forum focusing on UHC in 2017.
- Support for health systems, information and evidence, including:
  - guidance to integrate health indicators in the EDPRS 2 monitoring system in line with UHC principles;
  - domestication of health SDGs and their indicators;
  - Support for a National Health Account tool to track health financing, including financial sustainability for funds from, for example, GAVI/Global Fund;
  - introduction of medical certification of causes of deaths to strengthen the civil registration and vital statistics system; and
  - support for a real-time strategic information system such as the National Health Observatory.
- Specific research activities, supported across several priority areas, including:
  - a study on the impact of peer support on HIV treatment adherence, resulting in revised national guidelines for HIV care;
  - Prepex operational research on non-surgical circumcision;
  - documentation of a mobile health camp strategy of a referral hospital, Kigali; and
  - development of a research and development strategy and plan of the military and referral hospital, Kigali.
- Support for access to medicines and health technologies and strengthening regulatory capacity including:
  - Support for development of a policy which integrates patient safety components such as quality assurance standards and health services accreditation;
  - technical expertise for the establishment of a Food and Drug Regulatory Authority; and
  - technical expertise for ISO accreditation for the National Reference Laboratory, so that certain tests can be introduced.
- Support for increasing the quality and quantity of human resources for health was included in the CCS 2014-2018, but de-prioritized in the 2016 revision.

***Priority 2: Contribute to the reduction of morbidity and mortality from major communicable and noncommunicable disease***

59. Most of WHO's support was dedicated to communicable disease policy and strategy development. Key achievements are:

- support for the review and revision of national strategies for HIV, viral hepatitis, TB and malaria, including an M&E plan for HIV;
- HIV strategies for a treat-all, HIV self-testing policy and elimination of mother-to-child HIV transmission;
- 'End TB' strategy and targets; and
- costing of the national malaria strategy.

Additional high-level achievements are:

- support for analysing malaria resurgence data and policy;
- technical support for the development of TB, malaria and HIV proposals; and
- co-chairing the CCM (including overseeing the selection of sub-recipients).

60. In terms of normative guidance for disease management protocols, WHO supported:
- Adoption and use by the MOH of Gene Xpert machines to diagnose multi-drug resistant tuberculosis;
  - revision of HIV and hepatitis management guidelines;
  - revision of malaria case management guidelines, including quality control/quality assurance guidelines; and
  - training pharmacists and nutritionists on management of HIV and TB patients.
61. For neglected tropical disease programming, WHO supported:
- risk assessments for yellow fever, trypanosomiasis and meningitis;
  - mass drug administration activities against soil-transmitted diseases and schistosomiasis; and
  - training on human African trypanosomiasis surveillance for National Reference Laboratory and health facility staff.
62. NCD policy and program development is considered by both WHO and others as an area where gaps remain to be addressed, since the development of the NCD strategy in 2012. Support consisted of:
- a (repeat) STEPS survey to determine the prevalence and risk factors of some NCDs;
  - support for tobacco control legislation and information, education and communication materials for smoke-free environments;
  - coordination of monthly Kigali car-free days and free NCD check-ups;
  - an epilepsy survey, resulting in an NGO project on epilepsy/mental health; and
  - review of malnutrition management protocols, information, education and communication materials on nutrition for students, and training on field level operational research on nutrition.

### ***Priority 3: Contribute to the reduction of maternal & newborn and child morbidity and mortality***

63. In the area of maternal and newborn and child health, WHO supported:
- development of the Maternal, Newborn and Child Health Strategic Plan 2018-2024;
  - review and revision of guidelines for post-partum haemorrhage and Integrated Management of Childhood Illness (IMCI);
  - adaptation of the medical eligibility criteria wheel for family planning;
  - capacity building, focusing on emergency obstetric care, essential newborn care, family planning, IMCI, the family planning methods wheel and maternal death surveillance and response; and
  - the biannual national 'MCH awareness week'.
64. In the area of vaccine preventable diseases, WHO supported:
- introduction of new vaccines, e.g. rubella and measles combined vaccine
  - measles elimination through the introduction of the measles elimination module of surveillance and capacity building for district EPI supervisors and EPI committees
  - the shift from trivalent to bivalent oral polio vaccines in April 2016; and

- monitoring of the national immunization program through development of the One Health plan, a national immunization coverage survey and a study on rotavirus vaccine effectiveness.

65. In the area of nutrition, WHO supported the multi-sectoral Early Childhood Development action plan and its implementation, plus a nutrition status assessment to assess causes of stunting. As part of the joint UN initiative for (mal)nutrition & food security, WHO supported:

- development of information, education and communication material;
- training of community health workers;
- development of a national protocol on nutritional care and a guideline on “Formulated complementary foods”;
- training on nutrition surveillance and response, food security and eye care; and
- recruitment of a national research officer for operational research on malnutrition interventions.

#### *Priority 4: Promote health by addressing social determinants of health, health and the environment, and food safety*

66. WHO provided significant support to several ministries to address social determinants of health, including support for:

- development of national strategies, operational plans and adaption of guidelines (on nutrition, food safety, health care waste management, water and sanitation and school health);
- development of a multi-sectoral road safety strategy and annual road safety campaigns by the Ministry of Infrastructure and National Police;
- development of a school health programme by the Ministry of Education;
- tobacco control law enforcement by several public, private and civil society organizations; and
- research on social determinants of health.

67. WHO supported the development of the National Health Promotion Policy & Strategic Plan and subsequent capacity building for district level health promotion staff and community health workers on social mobilization and demand creation. WHO also supported national health promotion campaigns, for example:

- National Maternal and Child Health week;
- World AIDS Day 2017;
- World Hepatitis Day 2017; and
- campaign for provision of hepatitis B vaccine among adults in two districts.

68. In the area of water and food safety, WHO supported:

- development of the Water, Sanitation and Hygiene (WASH) national strategy;
- development of the food safety law and implementation plan;
- development of the environmental health policy and strategic plan;
- development of the healthcare waste management strategy;<sup>28</sup>
- development of the national Codex Alimentarius;
- the 2017 Global Analysis and Assessment of Sanitation and Drinking-Water (GLAAS 2017) Report for Rwanda, which was completed and published by WHO - GLAAS is now being used by Rwanda as a tool for monitoring both inputs (such as human resources and finance) and the enabling environment (including laws, policies and monitoring);

---

<sup>28</sup> (Dir Environmental Health MOH)

- capacity building on WASH for community health workers in refugee camps;
- capacity building for district hospital environmental health officers on water testing and food safety testing kits (WHO also provided the kits); and
- a workshop on the Libreville Declaration on Health and Environment 2018, including a situation analysis.

***Priority 5: Strengthen disaster risk management and epidemic emergency preparedness and response; and implementation of the International Health Regulations***

69. In the area of outbreak control, WHO supported:
- development and implementation of a roadmap to address the International Health Regulations (IHR 2005), after a joint external evaluation;
  - elaboration of the national plan for outbreak response and disease preparedness;
  - training and expertise for Avian Influenza surveillance, case detection and laboratory confirmation;
  - a risk assessment study for yellow fever and meningitis; and
  - Ebola preparedness and response planning and sensitization;
  - investigation of two measles outbreaks, resulting in supplementary immunization for children; and
  - investigation of malaria and typhoid outbreaks in the refugee camps.
70. WHO supported the Ministry of Disaster Management to undertake a rapid disaster risk assessment through flooding with guidelines, protocols and capacity building. As part of a joint UN program, WHO supported procurement of laboratory equipment for flood-prone districts.
71. In terms of support for surveillance systems, WHO provided support for the development of national strategies, adaptation of guidelines and training to move from paper-based to electronic Integrated Disease Surveillance & Response (IDSR).
72. WHO supported health care in the refugee camps, including:
- recruitment of a public health officer for prevention and control of epidemics;
  - alignment of surveillance and HIV/TB services in the refugee camps with national systems;
  - Purchase of kits for malaria/cholera outbreak control and training for community health volunteers;
  - quality assurance of health services; and
  - training for health workers on IDSR, IMCI and EPI.

***In brief***

73. WCO has made progress on all priority areas of the CCS 2014-2018. Stakeholders agree that the support to the MOH in national policy and strategy development and governance has been especially strong, and that WHO expertise has been instrumental in the review and revision of several communicable disease programs. Capacity building in family planning and immunization programming has contributed to achievement of MDGs in all these areas.

***Box 7 – WHO support for health agenda in Rwanda***

*WHO, through its WCO in Rwanda, is seen as a respected and technically expert voice in health matters and an essential contributor to advancing health achievements in Rwanda. The technical support of WHO was highly valued. The WCO's leadership and support for the health agenda were considered essential by the MOH and most development partners,*

### **What has been the added value of regional and headquarters contributions to the achievement of results in country?**

74. Inputs were received from the Intercountry Support Team (IST), AFRO and HQ in the development of the CCS 2014-2018 and its revised version.

75. The WCO team recognize the usefulness of IST, AFRO and HQ support, and their overall alignment with CCS priorities. Expertise from, or contracted through, the IST, AFRO and HQ has contributed significantly to the achievements in Rwanda. Government development partners in general do not differentiate the source of WHO support, thus underlining WHO working as one across the three levels of the Organization.

76. Examples of key AFRO/IST contributions include:

- mid-term review of the HSSP III;
- establishment of the national health observatory;
- yellow fever and meningitis risk assessments;
- yellow fever surveillance system;
- development and wide distribution of the family planning methods wheel; and
- IMCI survey.

77. Examples of joint HQ/AFRO contributions are:

- mid-term reviews of national HIV, TB and malaria national strategic plans;
- introduction of measles/rubella, rotavirus, human papilloma and inactivated polio vaccines into the routine immunization system; and
- Support for elaboration of national maternal and child mortality estimates.

78. Several MOH counterparts participated in the first AFRO Health Forum (in Rwanda) with a focus on UHC, and appreciated a platform to share and learn about this national priority. Government counterparts recognize the added value of regional collaboration (and regional WHO support) in the area of cross border challenges, including malaria resurgence, lessons learned from other countries, and technical expertise to complement country office expertise.

### **What has been the contribution of WHO results to long-term changes in health status in Rwanda?**

79. WCO considers the main WHO contribution to Rwanda as improved health governance, increased health coverage and improved health status. Evidence of improved health governance is the effective coordination of the health sector and availability of reliable health information for planning. Increased health coverage is evident through reformed health financing systems, improved equity in financial risk protection and routine immunization coverage of 93%. Finally, examples of improved health outcomes to which WHO has contributed are reduction in HIV and TB prevalence rates; attainment of all health-related MDGs; and reduction in maternal and child mortality. Stakeholders concur with this self-assessment and specifically mention WHO's contribution to health system strengthening, epidemic preparedness & surveillance and support for UHC.

80. In terms of WHO-specific contributions or added value, the evaluation found frequent mention of WHO as a neutral broker to objectively provide policy alternatives vis-à-vis other development partners, effectively done through the WHO Representative co-chairing important platforms, and WHO regional and global normative guidance and expertise on crucial issues, contributing to national policies, strategies and plans.

81. However, in the absence of a theory of change for the WCO or a monitoring system that allows assessment of outcome and impact level results, it is difficult to conclusively attribute any of the impressive health improvements in Rwanda to WHO. An additional challenge is that other development partners support the Government to achieve UHC, most often in close collaboration,

specifically within the One UN. Despite the absence of clear evidence of attribution, the evaluation found much anecdotal evidence of WHO's contribution to long-term changes in health status.

### Is there national ownership of the results and capacities developed?

82. The evaluation found ample evidence of national ownership of the results of WHO support. A major reason for national ownership is that all WCO activities are planned jointly with the MOH and consolidated in joint action plans. This reflects both the Government's requirement that WHO (and other development partners) respond to national needs and priorities, as well as WCO's responsiveness to and understanding of national priorities.

83. A strong indicator that WHO support results in national ownership is the national health sector strategy, given the important WHO contribution to its review and revision. The same applies to the many technical and disease specific policies and strategies developed with WHO technical expertise. In most cases, the MOH takes the lead and ownership is therefore to be expected. An example of national adoption of innovation initiated by WHO is PLHIV peer support for HIV treatment adherence, where WHO supported community-led research and facilitated dissemination of the resulting evidence.

#### **Box 8 – Community-led health research**

*The WCO provided financial and technical support for RRP+, the national network of PLHIV, with operational research on peer support to increase adherence to HIV treatment. The WCO also contributed to dissemination of the findings through a joint workshop with RRP+ for development partners and the MOH. As a result, the PLHIV peer support model is included in the national HIV management protocol, and the MOH currently provides training and support for its implementation. Innovations and lessons learned from this case study are:*

- *Support for community based organisations is within the mandate of WHO and the scope of the CCS, and can result in improved national health outcomes*
- *Evidence generated locally helps improve advocacy*
- *Support for dissemination of research findings to policy makers and programme planners adds to effectiveness of operational research support*
- *Community involvement in design and implementation of research adds to its relevance.*

84. Although national ownership will support sustainability of WHO's efforts in Rwanda, financial sustainability remains a challenge. More than half the costs of programmes like health insurance, HIV treatment and new vaccines depend on external contributions, despite Rwanda's aims to become donor-independent by 2030.

#### **Summary of key findings**

- *The CCS 2014-2018 priorities are reflected in the several biennial workplans and budgets during this period.*
- *The CCS 2014-2018 does not contain a theory of change that can explain the attribution of WHO support to UHC or improved health outcomes in Rwanda. It is therefore challenging to assess impact of WHO in Rwanda*
- *The CCS 2014-2018 does not contain a results framework including indicators for success, targets and baselines, hence quantifying progress is only possible at input (resources) and output (activities) level. Assessing outcomes relies on qualitative methods.*
- *WHO, working in partnership with the MOH, has made significant contributions to the improved health outcomes in Rwanda. The main achievements are in the area of health systems strengthening and communicable diseases. Important contributions have been in support of policy and strategy development for health financing, health sector governance,*

and normative guidance for general and disease specific strategies and protocols.

- WHO has contributed to policies, programs and service delivery in maternal and neonatal health, immunization and refugee settings, including health promotion and intersectoral work on social determinants.
- Long-term contribution to Rwanda's health system and health outcomes is likely because WHO support is responsive to MOH priorities and technical assistance is jointly developed and planned.
- WHO provided expertise for key policies and strategies (including review and revision of the HSSP) that are likely to benefit Rwanda beyond the duration of the CCS
- The contributions of the IST, AFRO and HQ complement the expertise available in the WCO and are appreciated by both WCO and counterparts.
- MOH recognizes the added value of regional support, especially on cross border issues such as epidemics and knowledge management.

## 2.3 How did WHO achieve the results? (Elements of efficiency)

### Contribution of the core functions

85. The six core functions<sup>29</sup> of WHO are:

- providing leadership on matters critical to health and engaging in partnerships where joint action is needed;
- shaping the research agenda and stimulating the generation, translation and dissemination of valuable knowledge;
- setting norms and standards and promoting and monitoring their implementation;
- articulating ethical and evidence-based policy options;
- providing technical support, catalysing change, and building sustainable institutional capacity; and
- monitoring the health situation and assessing health trends.

86. The contributions of each core function towards progressing the WHO Rwanda CCS 2014 - 2018 are briefly summarised below.

87. **Leadership.** In keeping with the principles of the Busan Partnership for Effective Development Cooperation (2012), the Government of Rwanda has sought to establish ownership of the country's national development. Consequently, the Government, and more specifically the MOH, plays a strong leadership role in the sector, including the establishment of a clear principle of 'division of labour' which specifies where and how development partners' respective contributions should be directed. As a result, there is less need or opportunity for WHO to play the same leadership role as might be required in other countries. Nevertheless, the WCO has played a significant role in supporting the

#### **Box 9 – Development priorities**

*Reflecting its commitment to the principles set out in the Busan Partnership for Effective Development Cooperation (2012), the Government of Rwanda plays a strong role in establishing development priorities. In driving the health agenda, the Government and the MOH place demands on the WCO for innovative, fast, highly skilled and focused approaches along government priorities, given Rwanda's achievements and pace towards development. The Government's Health Sector Strategic Plan defines clear goals and expectations which have shaped WHO's*

<sup>29</sup> WHO (2014). Twelfth General Programme of Work 2014-2019, page 20. Geneva, World Health Organization ([http://apps.who.int/iris/bitstream/handle/10665/112792/GPW\\_2014-2019\\_eng.pdf?sequence=1](http://apps.who.int/iris/bitstream/handle/10665/112792/GPW_2014-2019_eng.pdf?sequence=1)).

development of health sector strategies and plans, including as a neutral broker and convenor in the sector, and also plays a lead role in several technical working groups. It has proved adept at developing effective partnerships with other agencies when required. The WHO Representative serves as Vice-Chair of the Global Fund CCM but the fact that WHO does not currently (co-) chair the overarching Health Sector Working Group was seen by some stakeholders as unusual.

88. **Research.** WHO's support for a number of surveys in Rwanda, including the STEPS survey and other disease-specific surveys, was viewed very positively. WHO has also contributed to the development of information resources to support research and, in some cases, supported operational research. WHO's role in research is complemented by a strong network of internationally-linked research institutions in Rwanda. Stakeholders appreciated WHO's ability to provide Rwanda with access to knowledge from other countries but a number saw opportunities for greater knowledge sharing, including the potential to 'export' key learnings from Rwanda for the benefit of other health systems.

89. **Norms and standards** were noted as areas where WHO has provided significant support to Rwanda's health sector and were viewed as a key component of strategic-level input. Maternal and child health, family planning, communicable disease (notably HIV and malaria) and NCDs were highlighted as areas where WHO's input, often via mobilisation of international technical experts, was particularly valued.

90. Articulating **Policy options** constituted one of the strongest functions undertaken by WCO. Staff were extensively engaged in the formulation of HSSP III and, more recently, HSSP IV which are key policy instruments for the sector. WHO has also provided extensive support for policy development in areas such as health financing, health promotion and environmental health. The fact that WHO is seen as offering objective policy advice in an environment where some partners seek to advocate strongly for their particular point of view was noted positively.

91. **Technical support** has been provided across all strategic priority areas by staff from all levels of WHO (country, regional and headquarters) as well as WHO-funded consultants. It was suggested by some stakeholders that levels of technical expertise available within WCO were variable and, in some cases, requests for technical support could not be met. The tendency for WCO to default to training and capacity building as the modalities for technical support was also noted. It was also suggested that there could be opportunities for WHO to provide increased support for activities at district level although the modalities by which these could be achieved were not immediately apparent.

92. **Monitoring the health situation** has largely been accomplished by means of support for surveys and the establishment of the national health observatory. The WCO has also been effective in mobilising support (typically from the IST or AFRO) in response to disease outbreaks. The rapid pace of development in Rwanda over recent years has been reflected in changes in the health situation and, consequently, in support needs. Close monitoring of health trends is thus vital if responses are to keep pace with the country's needs.

## Contribution of strategic partnerships to the results achieved

93. Over the period of the CCS 2014-2018, WCO has worked in partnership with government institutions, UN agencies and other development partners in order to achieve results. Feedback from those parties generally showed a high degree of integration and positive collaboration with WHO. Partners recognized WHO's status as a respected and independent voice in the health sector, commended its technical expertise and respected its contributions to leadership but, at the same time, they identified opportunities for WHO's support to be more focused and timely.

### **Box 10 – Strategic partnerships**

*The evaluation showed a high degree of alignment and coherence of strategic priorities and directions between the WCO and the MOH, and between the WCO and development partners, including UN agencies and bilateral organizations. To a large extent, that is a reflection of good joint planning by key parties.*

### **Government institutions**

94. Rwanda places government at the heart of development. The country's EDPRS 2 states that the Ministry of Finance and Economic Planning is responsible for implementation and monitoring of the Strategy while also noting the role played by the Health Development Partners Group and highlighting the importance of mutual accountability between the Government of Rwanda and its development partners.

95. The Health Sector Working Group is the key forum through which partners engage in policy dialogue with the health sector of the Government of Rwanda. The role of Health Sector Working Group Co-Chair, which might be seen as one which would naturally be undertaken by WHO, has been assigned to USAID for some time.

96. The main Government of Rwanda development partners with whom WHO collaborates are the MOH and its implementing agency, the RBC. Within the Rwandan context, the role of MOH focuses principally on development and enforcement of policy and regulations. RBC's main role, in contrast, is design and delivery of national disease prevention and control programmes.

97. WCO has therefore had to manage partnerships with both MOH and RBC in order to pursue the goals of the CCS. The evaluation gathered consistent evidence of good and supportive relationships between the WCO and both MOH and RBC which were clearly conducive to effective joint working. The part played by inter-personal factors in building and maintaining such positive relationships was noted by several stakeholders.

98. Responsibility for service delivery at local levels in Rwanda rests with provincial and/or district administrations and it appears that WHO may have had less opportunity to develop effective partnerships with those tiers of government. A number of stakeholders identified opportunities for WHO to be more actively engaged at the district level. Clearly, improving service quality, developing village-level health services and strengthening the roles of community health workers could be achieved either through enhanced policy support at central level or by direct local-level partnerships.

99. Staff from WCO have also recently been supporting the Rwanda Social Security Board (RSSB) in connection with the country's CBHI scheme. WHO has assisted with strategic planning, development of measures to increase the scheme's financial sustainability and a review of provider payment arrangements. Partnership with RSSB has clearly been effective as an approach adopted by WHO to pursue its goal of supporting Rwanda's progress towards UHC.

100. There has been some collaboration between WHO and the Ministry of Infrastructure in respect of policies and M&E for water and sanitation but WCO involvement with other Government of Rwanda bodies outside the health sector is reportedly limited. As already mentioned, the Government of Rwanda's division of labour approach assigns responsibilities for specific sectors to

individual development partners. As a result, WCO's primary relationship is with Government agencies in the health sector. Nevertheless, it is apparent that WCO has also collaborated with a number of other ministries. Such collaboration will be essential if WHO seeks in future to engage more broadly on the social determinants of health in order to address the challenges of emerging infectious diseases and NCDs in Rwanda.

### *UN agencies*

101. The Government's division of labour approach means that support to Rwanda's health sector, while substantial, is delivered by relatively few agencies outside the Government itself. As a result, WCO's partnership relations with other UN agencies and development partners are relatively uncomplicated.

102. The Rwanda UNDAF for the period 2013-2018 focused on three areas: Economic Transformation; Accountable Governance; and Human Development. WHO was identified, alongside a number of other UN agencies, as a contributing agency in the Human Development area.

103. WHO co-chaired the development of UNDAF2 which again identifies three 'Strategic Priority Areas and Results': Economic Transformation; Social Transformation; and Transformational Governance. The new UNDAF proposes that WHO should be a contributing agency in both Social Transformation and Transformational Governance.

104. WHO's principal partners within the UN system in Rwanda are UNICEF, UNAIDS and UNFPA all of which indicated that they enjoyed positive relationships with the WCO. In keeping with the Government of Rwanda principle of division of labour, agencies' roles were clearly defined and understood with little or no duplication of effort. Partner UN agencies were all of the view that WCO had, on occasions, been handicapped by lack of suitably skilled staff.

105. Stakeholders' views varied significantly on the relevance and impact of the UNDAF and the supporting strategy of 'Delivering as One'. Those within the UN system (including WCO staff) suggested that it had been effective as a means to improve communication among agencies, to reduce potential duplication of effort and to achieve savings through shared support services while noting that there was still scope to strengthen joint planning. Views from within Government of Rwanda and other development partners were less positive, however. Their comments included suggestions that 'Delivering as One' had been 'invisible' or 'insufficient' and had not achieved enough in terms of reducing competition among UN agencies. The new UNDAF2 seeks to address these concerns.

### *Other development partners*

106. There are currently three main bilateral development partners in Rwanda's health sector: the US Government (CDC and USAID), Belgium (Enabel) and Switzerland (Swiss Agency for Development and Cooperation). Partnerships for specific programmes are also in place with international organizations such as GAVI and the Global Fund.

107. WCO's principal means of engagement with bilateral partners is through their collective membership of the Health Development Partners Group, the Health Sector Working Group and various technical working groups. As a result, there appears to be good coordination in respect of planning. More generally, however, few examples were cited of WHO working directly alongside bilateral partners to deliver programmes.

108. There has been limited collaboration with nongovernmental organizations. This reflects the fact that WCO has opted not to use direct financial contributions due to previous concerns regarding reporting and accountability.

## How did the funding levels and their timeliness affect the results achieved?

109. The Rwanda CCS 2014-2018 does not include any detail of anticipated financial requirements or how they will be met (e.g. assessed versus voluntary contributions).

110. Budget data for the two biennia, 2014-2015 and 2016-2017, which are summarised in Table 3, indicate an overall underspend of 9% against planned budget across the four-year period. However, when expenditure and implementation rates are considered in relation to funding available during this period, the implementation rates are higher (95%).

**Table 3: Planned cost, available funds and expenditure by strategic priority (2014-2017)**

	Planned cost (US\$)	Funds available (US\$)	Expenditure (US\$)	Expenditure as % of planned cost	Expenditure as % of funds available	Expenditure as % of total expenditure
<b>CCS priorities</b>						
1 Health system strengthening	1,345,793	1,203,639	1,180,903	87.7%	98.1%	9.4%
2 Communicable and noncommunicable diseases	4,013,185	3,413,248	2,895,855	72.2%	84.8%	23.1%
3 Reduction of maternal, newborn and child morbidity and mortality	1,840,099	2,492,525	2,271,113	123.4%	91.1%	18.1%
4 Social determinants of health, [...] nutrition and food safety	742,058	706,239	669,987	90.3%	94.9%	5.3%
5 Disaster risk management, [...] International Health Regulations	898,479	820,395	795,967	88.6%	97.0%	6.4%
<b>Other activity areas</b>						
Poliomyelitis eradication	1,556,480	1,697,327	1,627,150	104.5%	95.9%	13.0%
<b>Other expenses</b>						
Corporate services / enabling functions	3,394,538	2,876,912	3,087,695	91.0%	107.3%	24.6%
<b>Total</b>	<b>13,790,632</b>	<b>13,210,285</b>	<b>12,528,670</b>	<b>90.8%</b>	<b>94.8%</b>	<b>100.0%</b>

Source: WHO Global Management System data, expenditure mapping by evaluation team

111. These expenditure and implementation patterns are consistent with a country office dependent not only on predictable funds such as the assessed contributions but also to some extent on other earmarked donor funds, whose predictability and timeliness of receipt is not always assured.

112. Timeliness of funding was also identified as posing challenges by a number of stakeholders. Misalignment between WHO and the Government of Rwanda financial years as well as differences in their respective budgeting and planning processes has resulted in difficulties for some programmes. It was suggested that this problem could be alleviated if WHO was willing and able to transfer funds directly to MOH or channel them through third parties (such as GAVI) and allow them to be held for future expenditure against agreed budgets.

113. Several stakeholders as well as WCO staff themselves expressed a view that current levels of financing were insufficient to enable WHO to fully achieve its objectives. Shortages and timeliness of funding were among the most frequently identified challenges for the WCO.

114. While shortage of funds is likely to be an almost universal concern among country offices, the consistent record of high utilisation of allocated funds achieved by the Rwanda WCO, and the emerging opportunities for the WCO to contribute further towards the health sector goals of Rwanda, clearly show that the Rwanda WCO should be in a good position to manage and implement against higher and increased country office budgets in the future.

#### **Was the staffing adequate in view of the objectives to be achieved?**

115. As at December 2017, WCO staffing comprised two international staff, 21 national staff, nine staff employed under special service agreements and two (one international and one national) interns.

116. The evaluation recognized the limited resource base of the WCO in support of its workplan. There were gaps in HR capacity for priority areas and for needed enabling functions.

117. Most staff are responsible for a broad and varied portfolio. In addition, they sometimes have to take on tasks when other staff leave, putting pressure on their performance and organizational credibility.

118. While several WCO staff members were identified as making significant contributions, stakeholders' views on the adequacy of WCO staffing were mixed. It was suggested that WCO effectiveness could be enhanced by rebalancing the workforce to encompass more skilled and experienced staff working across a more sharply focused range of activities. Senior MOH officials, in particular, identified an opportunity to work more closely with WCO staff whose levels of seniority and experience were closer to their own.

119. Most technical areas are staffed by National Professional Officers. Though most are technically competent, it may be challenging for them when having to present WHO positions in national fora where they may be more junior and less technically expert than their Government counterparts and there is also participation of international professional staff from other agencies/partners. Hence there is a need to consider the appropriate mix of international professionals and National Professional Officers that adequately responds to the emerging needs of the country.

120. An innovative approach to building staff capacity that will be trialled during 2018 is the use of senior United Nations Volunteers to work in technical roles within the WCO. It is anticipated that the first such appointment will provide support in the areas of resource mobilisation and external communication.

121. It should be noted that the Rwanda WCO participated in a formal functional review in June 2018 which is expected to provide further recommendations on the adequacy of current staffing arrangements and identify opportunities for improvement.

#### **What were the monitoring mechanisms to inform CCS implementation and progress towards targets?**

122. The CCS 2014-2018 indicates that a mid-term review would be conducted in 2016-2017. That does not appear to have taken place although a revised version of the CCS was published in May 2017.

123. Monitoring has thus been based on feedback from a staff retreat coupled with the two Biennial country office reports for the periods 2014-2015 and 2016-2017 and the Programme Budget Performance Assessments for the two biennia. While those reports mirror the CCS by referencing the same strategic priority areas, they do not discuss progress and achievements at the lower level of disaggregation adopted in the CCS itself. In some cases, therefore, it can be difficult to judge the extent to which the more detailed aspects of the CCS have been addressed.

124. It is notable that the CCS 2014-2018 does not define any specific quantitative (or qualitative) performance measures or targets to assess what has been achieved by, or with the support of, the WCO. In the absence of such metrics, monitoring of achievements is clearly a challenge – both as a means not only to identify the need for adjustments to goals or activities during the period of the CCS but also to evaluate its overall impact at the end of its life. A number of stakeholders suggested that the WCO could usefully seek to adopt results-based approaches to planning and performance assessment.

125. The lack of performance measures in the CCS, and the resultant inability to rigorously assess progress, is particularly unfortunate in the Rwandan context since the country's health system benefits from generally good information systems, many of which have been developed with WHO support. It is disappointing, therefore, to see that the WCO is not itself using data from those systems to measure its own achievements in support of Rwanda's health agenda. This is an area for improvement.

### To what extent has the CCS been used to inform WHO country workplans, budget allocations and staffing?

126. As noted above, the WCO's biennial reports are structured in line with the strategic priorities identified in the CCS 2014-2018. However, that is not the case when it comes to the underlying biennial workplans which are built around the PB framework and hence do not consistently map directly onto the strategic priorities set out in the CCS.

#### Summary of key findings

- All six core functions contributed to the achievements of the Rwanda WCO over the period 2014-2018. The greatest impact appears to have stemmed from support in the development and articulation of **policy options**, while provision of **technical support** and engagement in respect of **norms and standards** also made significant contributions. Provision of **leadership** in the context of a strong Government-led development agenda was provided through senior-level engagement in numerous cross-agency working groups. Efforts in respect of **research** and **monitoring the health situation** were worthwhile but less substantial and focused mainly on support for surveys and building IT capacity.
- Partnerships between WHO and the Government, which operate under the guidance of the Government's principle of division of labour, are generally strong and effective. The architecture of Rwanda's health sector requires the WCO to engage extensively with both the MOH and the RBC – and those relationships are good. There has also been successful collaboration between WHO and the RSSB in efforts to strengthen health financing through improvements to the CBHI Scheme. There is scope for WCO to further develop its ties to other national Ministries in order to address social determinants and to build better partnerships with sub-national levels of Government where much responsibility for health care delivery lies.
- Collaboration among UN agencies in Rwanda takes place in the context of the UNDAF. From the WHO perspective, key partners are UNICEF, UNFPA and UNAIDS – all of whom consider their relationship to be good. On a broader front, there was no clear consensus on the significance and impact in operational terms of UNDAF and 'Delivering as one' with the views of UN staff generally being more positive than those of Government or other development partners.
- The Government's division of labour approach limits the range of other development partners with which WHO can engage other than through various sectoral technical and other working groups. Nevertheless, where such collaboration takes place, it appears to be supportive of CCS objectives.
- The Rwanda WCO has a good track record in respect of resource utilization with an overall

*implementation rate for the last two biennia of 95%. It was suggested that the WCO needed to be better funded and the fact that financial management appears to be sound suggests any such increase in budget would be well utilized in support of agreed objectives.*

- Staff of the WCO were recognized for their hard work and dedication, often across portfolios that were viewed as being demanding in terms of their breadth and diversity. At the same time, stakeholders' views on the adequacy of WCO staffing were mixed. It was suggested that a WCO with more senior personnel with clearly targeted responsibilities might be better equipped to respond to the country's needs.*
- The lack of explicit outcome/impact targets in the CCS is not conducive to rigorous monitoring of achievements and there do not appear to have been any formal mid-term, or other, reviews of progress.*
- There are also no clear links between the strategic priorities established in the CCS and the workplans drafted at country level. Clearly, those are issues which should be addressed in preparing the next CCS.*

### 3. Conclusions

127. Based on the findings presented in the previous section, the following conclusions are articulated around the three main EQs all of which inform the recommendations presented in Section 4.

#### Relevance of the strategic choices

128. The priorities identified in the CCS 2014-2018 and updated in its 2016 revision were relevant to address Rwanda's major health needs and were coherent with government and partners' priorities, as expressed in the HSSP III and UNDAF. They were also coherent with GPW12 in terms of health needs and alignment. To a large extent this is a reflection of good joint planning by key parties.

129. The systematic needs assessments and wide consultations that took place during the formulation of both versions of the CCS 2014-2018, and the ongoing engagement with the key national stakeholders, including the MOH and other relevant health sector institutions, UN agencies and other development partners, helped to facilitate the coherence and relevance of the strategic choices.

130. Furthermore, the evaluation has shown that the WCO is a relevant actor in the formulation of the national strategic plans of the MOH, both at the sector-wide level and specifically in relevant technical areas; as well as in the formulation of the newly developed UNDAF2, thus facilitating a high degree of alignment and coherence of the WCO with the national and development partners' strategies in Rwanda as they develop over time.

131. In recent years, Rwanda has shown dramatic progress in most observed health and development indicators. As part of the continuing commitment of the Government to achieve rapid socioeconomic development, the MOH drives the health agenda and places demands on the WCO for an innovative, fast, highly skilled and focused approach along Government priorities. In this context, any CCS needs to be a dynamic and evolving instrument. The revision of the CCS 2014-2018 in 2016, in response to the significant progress in achieving the MDGs and the new SDG agenda, is an example of WCO leadership and commitment to adapt the WHO CCS to the evolving situation and its intention to respond in the most effective manner to the needs of Rwandan people.

132. Consequently, the CCS includes an extensive number of focus areas without clear prioritization. Therefore, the CCS is responsive but provides limited guidance for strategic planning of WCO activities.

133. While there is no explicit reference to gender issues or gender-affirmative approaches in the CCS, most stakeholders consider gender equality to be part and parcel of WHO's work and approaches.

#### WHO's contribution and main achievements

134. Both the MOH and Rwanda development partners recognized the significant role and contributions of WHO in health matters as well as the good and constructive collaborative relationships between WHO and the MOH and between WHO and the UN Country Team, other development partners and civil society.

135. WHO, through its WCO in Rwanda, is seen as a respected and technically expert voice in health matters and an essential contributor to advancing health achievements in Rwanda. The technical support of WHO seemed highly valued. The WCO's leadership and support for the health agenda were considered essential by the MOH and most development partners, including UN agencies.

136. The work of WHO was most notable in terms of convening partners; providing strategic and technical policy advice; provision and local adaptation of guidelines, norms and standards; and capacity building. In that context, it is apparent that the WCO has accomplished a great deal in many different areas and that staff and counterparts are justifiably proud of what has been achieved. Specific achievements highlighted during the evaluation which are particularly significant are in the areas of support for development of health sector strategies and plans (i.e. HSSP III and HSSP IV); technical assistance in the area of health financing; development of several disease-specific strategies and plans; normative and technical support in maternal and child care and family planning; introduction of new vaccines; and improvements in certification of causes of death. It is notable that many of these accomplishments came about as a result of highly effective collaboration with MOH and other partners, and also at the three levels of the Organization.

137. NCDs, particularly from a disease management point of view, and nutrition showed less progress and achievements, as did environmental health and social determinants of health. The fact that such programmes require strengthened cross-sectoral coordination and a multidisciplinary approach may pose additional strains on WHO's ways of working. Nevertheless, gaps in these areas flag the need to reconsider the role of WHO and its approach to these issues and multisectorality. In particular, given the importance of addressing noncommunicable diseases and chronic malnutrition in Rwanda, these areas become important priorities for WHO work in the near future. It is noted that mental health was not well featured in the WCO workplans.

138. Some stakeholders highlighted the need for strengthening the focus of some WHO activities, which call for reinforced results-based planning at the workplan level. Furthermore, stakeholders' expectations called for a renewed focus of WHO's work on new priority areas such as supporting district services planning and the quality of health services; strengthening data quality and health information systems; digital health; and, in particular, identifying mechanisms to ensure the financial sustainability of the health system and regulatory strengthening. There is also demand for broader WHO engagement in terms of supporting collaborative regional and subregional frameworks in order to enable the exchange and sharing of best practices with other peer countries as well as for facilitating the establishment of joint approaches to address common threats, such as communicable diseases (i.e. malaria).

139. Facing a growing demand for new and more technically sophisticated work, and considering the potential for misalignment of, or overriding, the CCS 2014-2018 strategic priorities with additional requests, the WCO needs to develop clear criteria for adapting its workplan and office capacity to the changing circumstances and requirements, while keeping in mind the new GPW13 and the needs of the Rwandan people.

140. As has been the case until very recently for most programmatic planning in WHO, the WCO workplan followed the overall guidelines provided by the CCS 2014-2018, GPW12 and the respective PBs, but lacked a country-specific, measurable results framework and "theory of change" to guide the identification of the activities and projects that were most effective to achieve the WCO strategic priorities and expected outcomes. In the absence of such guiding framework, it is difficult for the evaluation to ascertain from the observed office deliverables the extent of achievement of the strategic priorities and expected outcomes assigned to the office. However, the evaluation found much anecdotal evidence of WHO's contribution to long-term changes in health status.

### Ways of working and programme management challenges

141. **Key contributions of core functions.** All core functions demonstrated their relevance for WHO's work in Rwanda. Notably, the evaluation showed evidence of effective WCO leadership and convening power, policy advice, provision of technical support, capacity building, and monitoring the health status and trends along the key strategic priority areas identified in the CCS 2014-2018. Nevertheless, several stakeholders identified opportunities for WHO to provide more direct support

on strategy and policy issues at senior levels of the ministry, and furthermore to become a stronger advocate around unmet health priorities within and beyond the health sector through intersectoral engagement (such as for NCDs and social determinants of health). Stakeholders also expected WHO to be more proactive and solution oriented in terms of strengthening Rwandan institutions. They also requested WHO's support to strengthen regional cooperation and facilitate knowledge management, including sharing of best practices and exchange of experiences, at the regional and subregional levels.

142. **Partnerships.** In general, partner relationships appear to be good and supportive of effective joint working. The part played by inter-personal factors in building and maintaining such positive relationships was noted by several stakeholders.

143. At the Government level, the main partnership was established through the MOH. While this relationship was characterized as constructive and effective, a similar relationship at the district level was less clear. Likewise, relationships with other ministries and sectors were much less advanced leading to some concerns in terms of the intersectoral engagement that would be required to address the social determinants of health and the challenges of NCDs in Rwanda.

144. The current development partnership structure in Rwanda, framed under a Government mandated division of labour, limits to some extent the opportunities for establishing other types of alliances outside the allocated partners. It may also complicate opportunities for resource mobilization at the national level. Feedback received from development partners showed a high degree of respect for, and positive collaboration with, WHO. Partnerships with nongovernmental organizations proved more limited and this is considered an area for further development.

145. The UN system in Rwanda has embraced the "Delivering as One" framework. UN agencies operate under a shared cooperation agreement, the UNDAF, which has recently been updated into a new UNDAF2, expected to provide a more flexible and strategic model of engagement and collaboration within the UN system. WHO leadership in the development of UNDAF2 was recognized.

146. The "Delivering as One" framework was characterized as showing some operational limitations given that it requires the commitment of agencies to move beyond their corporate interests. However, it provides WHO the opportunity to work intersectorally and engage in new partnerships. Nevertheless, it appeared that UNDAF had little practical impact on WCO's day-to-day activities and could not be shown to have contributed significantly to WCO outcomes.

147. However, UNDAF2 is expected to offer opportunities for closer alignment with the next CCS and to better reflect the WHO-MOH joint plan of work and WHO's comparative advantage.

148. **Funding** remains critical for WHO's catalytic engagement in the country. The evaluation noted comments from several stakeholders concerning the limited resource base of the WCO in support of its workplan, considering that the current levels of financing were insufficient to enable WHO to fully achieve its objectives and maintain its leadership role. In addition, reliance on earmarked funding resulted in some disparities among resources allocated to individual programme areas. Timely receipt of funding was also identified as a challenge by a number of stakeholders. Misalignment between the financial cycles of WHO and the Government of Rwanda, as well as differences in their respective budgeting and planning processes, resulted in funding issues and implementation delays for some programmes.

149. **Staffing.** Staff of the WCO were recognised for their hard work and dedication, often across portfolios that were viewed as being demanding in terms of their breadth and diversity. At the same time, there were signals of evident gaps in staffing capacity for priority areas and for needed enabling functions, and several staff were responsible for very heavy portfolios, which could not be fully delivered.

150. Some stakeholders expressed concern about the adequacy of WHO staffing. The need to continuously upgrade the technical skills and expertise of WHO staff, particularly in view of the strong Government expectations to receive innovative solutions and highly-skilled support, was widely recognized throughout the evaluation. It was suggested that a WCO with more senior personnel with clearly targeted responsibilities might be better equipped to respond to the country's needs.

151. Most technical areas are staffed by National Professional Officers. Though most are technically competent, it may be challenging for them when having to present WHO positions in national fora where they may be more junior and less technically expert than their Government counterparts and there is also participation of international professional staff from other agencies/partners. Hence there is a need to consider the appropriate mix of international professionals and National Professional Officers that adequately responds to the emerging needs of the country.

152. The plan to engage senior United Nations Volunteers to work in technical roles within the WCO is a notable innovation to provide the necessary additional capacity for the office.

153. **Monitoring.** The difficulty in measuring results against planned targets and assessing WHO's contributions to the same are indications of a number of systemic challenges in planning and monitoring processes within WHO at both corporate and country levels. The lack of explicit outcome/impact targets in the CCS is not conducive to rigorous monitoring of achievements. This makes WHO's capacity to demonstrate results and contribution to health improvements at country level challenging.

154. The Biennial Reports for the periods 2014-2015 and 2016-2017 do not explicitly discuss progress towards stated objectives; nor does there appear to have been any formal mid-term, or other, review of progress. Therefore, it is difficult to judge the extent to which the more detailed aspects of the CCS have been addressed.

## 4. Recommendations

1. The new Country Cooperation Strategy and the associated WHO country office programme of work should be developed to ensure a good strategic fit with the unmet needs of Rwanda, the directions set by its Government in the Fourth Rwandan Health Sector Strategic Plan, the 13<sup>th</sup> General Programme of Work and WHO's comparative advantage. It is recommended that the new Country Cooperation Strategy be more focused and that the WHO country office should continue to strengthen its role working at the strategic level.
  - i. Specifically, the WHO country office should provide leadership and policy advice support at the strategic level;
  - ii. Likewise the WHO country office should strengthen its advocacy and resource mobilization functions in view of the Sustainable Development Goal agenda, looking strategically beyond the health sector and, in particular, championing the complex, multifaceted and multisectoral noncommunicable disease agenda;
  - iii. The WHO country office needs to recognize the Government of Rwanda's ambitious development agenda and offer more innovative, flexible, proactive and technically sound responses;
  - iv. The WHO country office should be strategic, considering a more focused approach: do less, do it better, building on collaboration with other United Nations agencies as part of the Delivering as One approach, working at the upstream level, providing policy and technical/normative options and advice.
2. Recommended strategic priorities for inclusion in the new Country Cooperation Strategy are:
  - i. Support efforts to identify options to secure the financial sustainability of the Rwanda health system in support of Universal Health Coverage;
  - ii. Facilitate the institutional development of Rwanda's health system, including the strengthening of institutions such as the Food and Drug Regulatory Authority and the planning of health services at the district level;
  - iii. Further strengthen information systems, civil registration and vital statistics, the National Health Observatory and improve data quality in general, in consideration of Sustainable Development Goal monitoring requirements;
  - iv. Strengthen the quality of health service delivery, the fostering of evidence-based healthcare and consider the opportunity of adopting digital health approaches;
  - v. Strengthen work on noncommunicable diseases and nutrition;
  - vi. Consider assessing Rwanda's needs for mental health services;
  - vii. Emphasize the role of gender, human rights and equity as social determinants.
3. WHO's upcoming Country Cooperation Strategy needs to be articulated showing the causal path (theory of change) from all country-level activities and outputs to expected outcomes (in relation to achieving the WHO's triple billion goals) and finally to the expected impact on Rwanda's health. In particular,
  - i. The Country Cooperation Strategy results framework and biannual workplans need to clarify indicators and targets for each corporate output or outcome that are relevant for Rwanda;
  - ii. The WHO country Office's strategic priorities and workplans need to be properly and effectively communicated to Rwanda's stakeholders, clarifying WHO's role and functions within Rwanda's health landscape, as well as the WHO country office's goals and expected outcomes;

- iii. The WHO country office should set up an internal monitoring framework to measure WHO's progress towards targets over the Country Cooperation Strategy implementation period and consider inclusion of indicators relating to gender and other social determinants of health.
- 4. Going forward, the WHO country office, in collaboration with the Regional Office for Africa, should review the office capacity and human resource and management plans in order to ensure that the new Country Cooperation Strategy priorities are adequately covered with the necessary financial and human resources:
  - i. The WHO country office staffing and skill-mix need then to be assessed in the light of the new Country Cooperation Strategy priorities, addressing gaps for relevant areas and providing capacity building opportunities to existing staff in order to be better prepared and respond more effectively to the needs of the country;
  - ii. The WHO country office should align and review the portfolio of its staff members with an aim to rationalize their burden of work and improve the coherence of their individual mandates, matching staff skills with their roles and responsibilities to the extent possible. Furthermore, polio transition efforts should also be taken into consideration.
  - iii. The WHO country office's capacity in terms of enabling functions, including procurement, project management and communications also needs to be assessed and strengthened where needed. Here, innovative solutions already being pursued, such as the use of United Nations Volunteers, could be a model for wider adoption. In other instances, support from the intercountry support team, the Regional Office for Africa or headquarters could be resourced in a timely manner.
  - iv. WHO should explore options to increase the funding base of the WHO country office in Rwanda.
- 5. WHO needs to strengthen mechanisms for coordinating and consolidating the provision of technical support from the three levels of the Organization, in order to increase its effectiveness and efficiency, and the organizational responsiveness to meet the needs and demands of Rwanda in accordance with the country cooperation strategy and the WHO-Ministry of Health agreed plans of work.
  - i. WHO should promote regional initiatives aimed at facilitating country collaboration for shared health issues, including cross-border epidemics, common threats and emergencies, as well as the sharing and exchanging of best practices and joint learning at regional and subregional level.