Analysis of the Integration of Health and Health Related SDGs in Rwanda

By

The Institute of Policy Analysis and Research (IPAR- Rwanda)

For

ACHEST

Contact Author: Alfred R. Bizoza, Research Director at IPAR-Rwanda

E-mail: a.bizoza@ipar-rwanda.org or alfredbiz23@gmail.com

September 2017

Table of Contents

1. Back ground 4
2. Study Objectives 5
3. National context 5
4. Methodology 8
5. Limitations of the Study 9
6. Findings 9
6.1. Institutional arrangement 9
6.2. Resource Mobilization 12
6.3. Integrating SDGS in the Sector Planning Process 13
6.4. Initial gap analysis of heath SDGs 15
6.5. Road map for the remaining phases of Health SDGs' integration 22
7. Discussion of major findings 23
8. Conclusions and Recommendations 25
Appendix 1: List of Major Documents Consulted 27
Appendix 2: List of Key Consultations 27

1. Back ground

[To be inserted by ACHEST]

2. Study Objectives

The overall objective of this case-study is to assess and document how Rwanda is prepared in the process of domesticating health SDGs. More specifically, the aim is to:

(1) Establish the extent have the health SDGs been introduced, adopted in national and health and health related sector plans?
(2) Determine to what extent have the interdisciplinary nature of SDGs been inclusive and cross cutting?
(3) Articulate to what extent are the common national and sectorial reporting frameworks been adopted?

3. National context

Rwanda is a landlocked country with a surface area of 26,338 km2. The temperature is generally good with an average temperature of 19.84□C; and the rainfall is estimated at 1,230.73 millimeters. In terms of macro-economic indicators, the following Table (1) provides a range of demographic and economic indicators. It is clear that Rwanda has performed well in some areas and others seem to reflect some of the challenges that the country may face in the future. For example, the population size is high and is increasing at a rate of 2.3% with a population density of 467 people per square kilometer. The Per Capita Gross Domestic is now estimated at US$ 720. The agriculture sector contributes 33% to the national GDP compared to 47% for the service sector and 14.4% for the industry sector.

Table 1: The Macro Economic Context at a Glance

Macro-economic indicator	2005	2010	2014/15
Population (million)	9.01	10.29	11.3
Population Growth Rate			
Life expectancy at birth (years)			64.5
Population Density (people/km2 in 2017			467
GDP (US$ million) Current	2,581	5,698	7,890
GDP (US$ million) Constant 2005	2,581	3,847	5,054
% GDP Growth Since Previous Year	6.9	7.3	7.0
GDP per capita (US$) Current	286.6	553.6	720
GDP per capita Growth (% annual)	4.9	4.5	4.8
Interest Rate	16.1	16.7	17.33
Export of Goods (% of GDP)	11.5	12.1	14.9
Import of Goods (% GDP)	25.2	28.0	30.5
% Population living below national poverty line	56.7	44.9	39.12
% Population living below the extreme poverty line	36	24	16

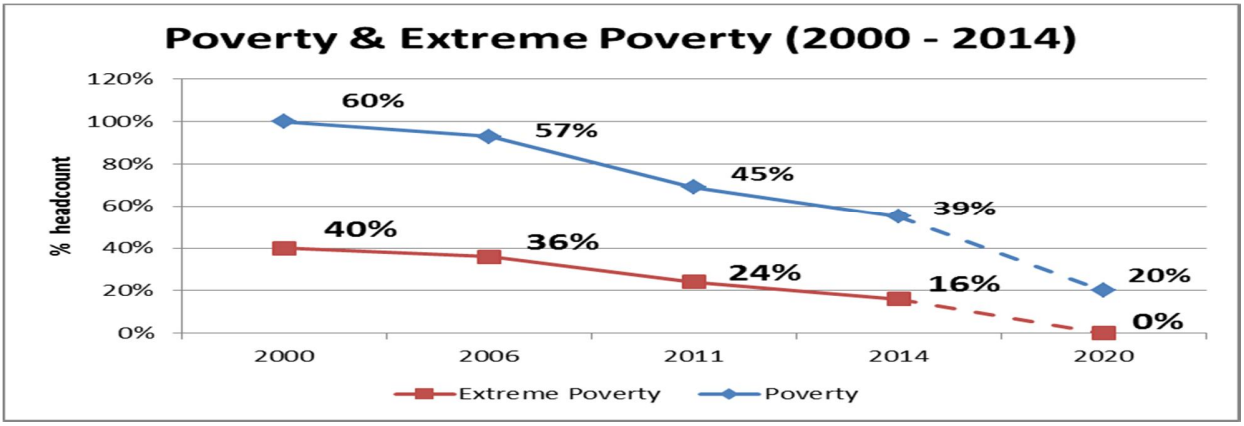
GDP by Type of Economic Activity (%)			
Agriculture	38.40	32.56	33.14
Industry	11.81	12.88	14.36
Services	42.64	48.27	47.06

Source: Adapted from Abbott and Mugisha (2016[1]) and NISR (2016).

National wise, Rwanda has embarked the process of integrating SDGs, a process that is on-going across many countries. This comes to complement and sustain some of the achievements made on the Millennium Development Goals (MDGs). From the evaluation report of MDGs; all MDGs targets have been met, except the ones on poverty, stunting and waged women employment. Extreme poverty and some health targets have been even exceeded. The areas of health related MDGs that Rwanda made very good progress include reduction of child mortality, improved maternal health, and combat of HIV/AIDS, malaria, and other diseases.

The country has embarked on the process of integrating SDGs and at the same time in the process of updating its main strategic development plans. Rwanda is now upgrading its vision 2020 to Vision 2050, the Economic Development and Poverty Reduction (EDPRS 2), and the Seven Years' Government Program, and subsequent sector and sub-sector strategic plans. Strategies implemented in the last five years and so; has enabled Rwanda's social and economic transformation. In the period 2011-2014, poverty and extreme poverty rates have reduced from 45% to 39% and 24% to 16%, respectively.

Figure 1: Poverty trends (2000-2014)



Source: Poverty Trends Profile, (NISR, 2015)

[1] Abbott P. and R. Mugisha (2016). *Mobilising and Managing External Development Assistance for Inclusive Growth: Rwanda Country Case Study*. Institute for Policy Analysis and Research –Rwanda, Kigali, Rwanda.

Rwanda has made progress on other areas of people's livelihoods such as in the education sector and social protection. Programmes under education and social protections such as Vision 2020 *Umurenge* Program, One cow per poor family program known as GIRINKA, inclusive education programme like 12 Years Basic Education, and Community Health Insurance (Mutuelle de Santé); all have contributed to poverty reduction and improved people's lives. For example, Community Health Insurance scheme has increased the rate of health insurance coverage which is now estimated at 81.3% (IPAR-2017).

The progress made on country's development is mainly explained by the visionary leadership and good governance, ownership of the development agenda through participation of a wide range of stakeholders in the planning and implementation of major development programmes, home-grown solutions, capacity development, and strong accountability mechanisms (Minecofin, 2016; IPAR-2017).

The SDG on health stipulates the need to "**Ensure healthy lives and promote well-being for all at all ages**". This goal entails nine targets related to :maternal mortality; end preventable deaths of newborn and children under 5 years of age; end the epidemics of AIDS, tuberculosis, malaria, and other water-borne diseases and other communicable diseases; reduce premature mortality from non-communicable diseases; strengthening the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol; reduce the number of deaths and injuries from road traffic accidents; ensure access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes; achieve health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all.

Reference to standard health indicators, the following Table (1) presents some trends as per current estimates by the National Institute of Statistics of Rwanda (NISR) in its various integrated household surveys (EICV 1, 2, 3, and 4), Demographic and Health Survey (DHS), and other thematic reports. It is clear from current estimates that there is important achievements that the country has made when compared to the period 2000/1 and 2014/2015. For example, infant mortality rate per 1000 live births has changed from 196/1000 to 50/1000. The SDG target on this particular indicator suggests a target of under-five mortality rate of 25/1000.

Apart from these standard health indicators, according to the Ministry of Health report, the number of health facilities increased from 1,161 in 2014 to 1,221 in 2015. In the same period, the number of medical doctors increased to 742 from 709 in 2014 and the number of population per one doctor also improved from 15,510 in 2014 to 15,479 in 2015. Furthermore, the 2014-2015 DHS shows the current fertility rate for women aged 15-49 is 4.2 to 6.1 in 20015. In addition, the vaccination

rate is estimated at 93% with 81% of the population possessing the mosquito net, 91% of deliveries are made at health facilities, and the stunting rate estimated at 38% (MoH, 2015)[2].

Table 2. Trends of health relevant indicators

Development Indicators	2000/1	2005/6	2010/11	2014/15
Access to Safe Drinking Water (%)	70,1	70,3	74,2	84,8
Access to Improved Sanitation (%)	50,4	58,5	74,5	83,4
Maternal Mortality Rate per 100,000 births	1071	750	476	210
Infant Mortality Rate per 1000 Live Births	107	86	50	32
Under-5-Years Mortality Rate per 1000 Live Births	196	152	76	50
Trend in Prevalence of Underweight Children (%)	24,5	18	11	9,3
Population Covered by Mutual Health Insurance (%)		38	68,8	76,3

Source: EICV1, 2, 3, and 4; National Institute of Statistics of Rwanda

4. Methodology

This section discusses briefly the methodology used to validate the objectives of this study. We started by a desk review to assess the existent to which health and health related SDGs are customized in the national planning and development frameworks. These include Rwanda's Vision 2020, the Economic Development and Poverty Reduction Strategy, and Health Sector and Sub-sector Strategic Plans. In the second stage, we conducted a cross-sector assessment to identify what health SDG indicators customized or already integrated in the monitoring and evaluation frameworks of major planning and development strategies. We used a matrix model to do the mapping of what SDG indicators that are fully, partially and not at all integrated. Reference was made also to the national Initial Gap Analysis Performed by UNDP and MINECOFIN in 2015. In the same report, the definition of the above three levels of integration are provided as follows:

(1) *Fully integrated SDG indicators* are indicators that are clearly formulated in the national development plans, implying the same meaning and measurement with the SDG indicator and not requiring further adaptation or adjustment for domestication purposes.

(2) *Partially integrated SDG indicators* are indicators that are partly captured in the national development plans in terms of formulation, disaggregation and measurement unit and content; calling for further adaptation and adjustment for full alignment with the SDG indicators.

2 MoH (2015). Demographic and Health Survey (DHS) 2014/15. Key findings. Ministry of Health, Kigali, Rwanda.

(3) *Not integrate SDG indicators* are indicators that are not at all reflected in any of the national development plans; hence calling their introduction in the respective sector strategic plans.

Furthermore, we performed some few but relevant consultations with selected key informants from the Ministry of Health, Ministry of Finance and Planning, RBS, and the school of health. These interviews provided information on possible challenges and opportunities for integrating SDGs in the planning process and to learn further how respective institutions in the health sector have started to integrate SDGs in their panning and institutional arrangement.

With respect to the analysis, the purpose is to respond to the question on "how are countries prepared to roll out and domesticate the health SDGs?" This involves the understanding of the on-going process of SDG domestication, how the planning process is ensuring consideration of health SDGs, what on-going policy and institutional reforms needed to support the domestication and implementation of health SDGs, how is the resource mobilization is taking into account the SDGs, and the extent to which the process of SDGs' integration is inclusive - participation and involvement of government entities, development partners, civil society organizations, the private sector, the academic and research institutions, think tanks, among others.

5. Limitations of the Study

Limited duration and budget allocated to this study constitute the major limitations of this study. Furthermore, since the integration process of SDGs is still on-going, it is not yet clear the extent to which the common and sectorial reporting frameworks have been adopted.

6. Findings

This section presents main findings in terms of how Rwanda is prepared to domesticate and customize health and health related SDGs. We start by describing prevailing institutional arrangement and how this is inclusive of all stakeholders, resource allocation, and integration of health SDGs in the overall planning process and in the health sector in particular, the current roadmap for SDGs'integration. Information in this section was drawn mainly from the existing national development frameworks and Sector Strategic Plans. It is also informed by data obtained during the consultation with relevant Ministries and Organizations.

6.1. Institutional arrangement

Domestication of SDGs requires institutional arrangement to ensure that proper roles and responsibilities are clearly distributed among different institutions. In the post 2015 Agenda, Rwanda contributed to a number of regional frameworks such as the Common African Position on Post 2015 Agenda, Financing for Development (adopted in Addis Ababa July 2015 with the Addis

Ababa Action Agenda). The country selected to pilot SDGs on "Helping to Strengthen Capacities and Build Effective Institutions" to inform the formulation of the formulation of SDGs. The report was submitted to the UN after validation with relevant institutions. The report postulates that the role of human and institutional capacities and effective institutions and systems in delivering on MDGs and lessons for implementation of SDGs.

Some of the preparatory activities already implemented towards domestication of SDGs include the following (Minecofin, 2016): approval of a road map and coordination mechanism for domestication of SDGs in December 2015; translation of SDGs into Kinyarwanda as part of communication plan and the distribution of 2000 copies during the National Dialogue Meeting in December 2015; conducted various training and sensitization workshops/ campaigns at country level; planning gap analysis – to assess the extent to which existing national planning framework covers the SDGs, and guidelines for SDGs.

With respect to institutional arrangement, the proposed coordination mechanisms of SDGs provide roles, functions and organ responsible for implementing SDGs. Roles are clustered in terms of oversight and accountability, strategic orientation, strategic monitoring, technical advisory, national technical coordination, sector coordination, technical consultations, and Districts coordination (see Table 2).

Table (3) National Coordination Mechanisms for SDGs in Rwanda

Role	Organ	Functions
Oversight and Accountability	Senate and Parliament	Oversight of the progress, endorsing plans and budgets, demanding accountability
Strategic Orientation	Cabinet	Approval of financing and implementation plans, strategic guidance
Strategic Monitoring	Leadership Retreat Umushyikirano/National Dialogue	Annual Monitoring and Accountability
Technical Advisor	DPCG	Technical Advice and support to implementation
National Technical Coordination	MINECOFIN	Integrating SDGs in plans and budgets, Monitoring and evaluating progress,
Sector Coordination	Ministerial Clusters	Addressing Cross Sectoral issues
Technical Consultations	Sector Working Groups	Forum for engaging all stakeholders, monitoring sector level
Districts coordination	District Councils, Districts Joint Action Development Forums (JADFs)	Forum for engaging all stakeholders, monitoring District level
	Community Outreach through UMUGANDA and Districts administrative organs e. g. Sectors, Cells, Villages	Citizen Participation and engagement forums

Source: MINECOFIN, 2016

Particular to the health SDGs, these are coordinated within the organization and management of the health sector through a mechanism of stakeholders. These mechanisms are also recognized by the new draft of the National Reproductive, Maternal, Newborn, Child, and Adolescent Health Policy (2017-2030) yet to be approved by the cabinet.

Table (4). Institutional Arrangement at Sector Level

Level of Coordination	Entities/ Institutions concerned	Comment
Social Cluster Ministries	Ministry of Health (MoH), Ministry of Local Government (MINALOC), Ministry of Agriculture and Animal Resources (MINAGRI), Ministry of Gender and Family Promotion (MIGEPROF), Ministry of Education (MINEDUC), Ministry of Youth, Information and Technology (MYICT), MININFRA (Ministry of Infrastructure- Water and Sanitation) and the Ministry of Disaster Management and Refugee Affairs (MIDIMAR).	This cluster is led by the MOH
Health Sector Working Group (HSWG)	This is under the overall leadership of the Ministry of Finance and Planning, chaired by the Ministry of Health, with co-chair by the development partners in the health sector.	The co-chairmanship of the sector is done by a representative from development partners (both private and civil society organizations) on a rotation basis.
Joint Health Sector Review (JSR)	This coordination framework is made by the Ministry of Health, Rwanda Biomedical Centre (RBC) and Development Partners (DP), civil society organizations (CSOs) and the private sector.	This is chaired by the Ministry of Health and co-chaired by a representative from development partners.

6.2. Resource Mobilization

This sub-section describes resource mobilization both by the government and development partners. Despite the progress made in ensuring access to health services, health financing recurs as an issue that needs to be studied and modeled to ensure quality health care accessible (Musahara, 2017[3]). Currently, the sector is highly dependent on external funding although declining over time due to the global financing landscape of the sector. Reference made to the 2016/2017 budget, it is clear that the government is able to finance about 66% of its annual budget for this particular sector using domestically mobilized resources. If quality health is to be provided and since integrating SDGs require more efforts, alternative sources of funds need to be identified and mobilized.

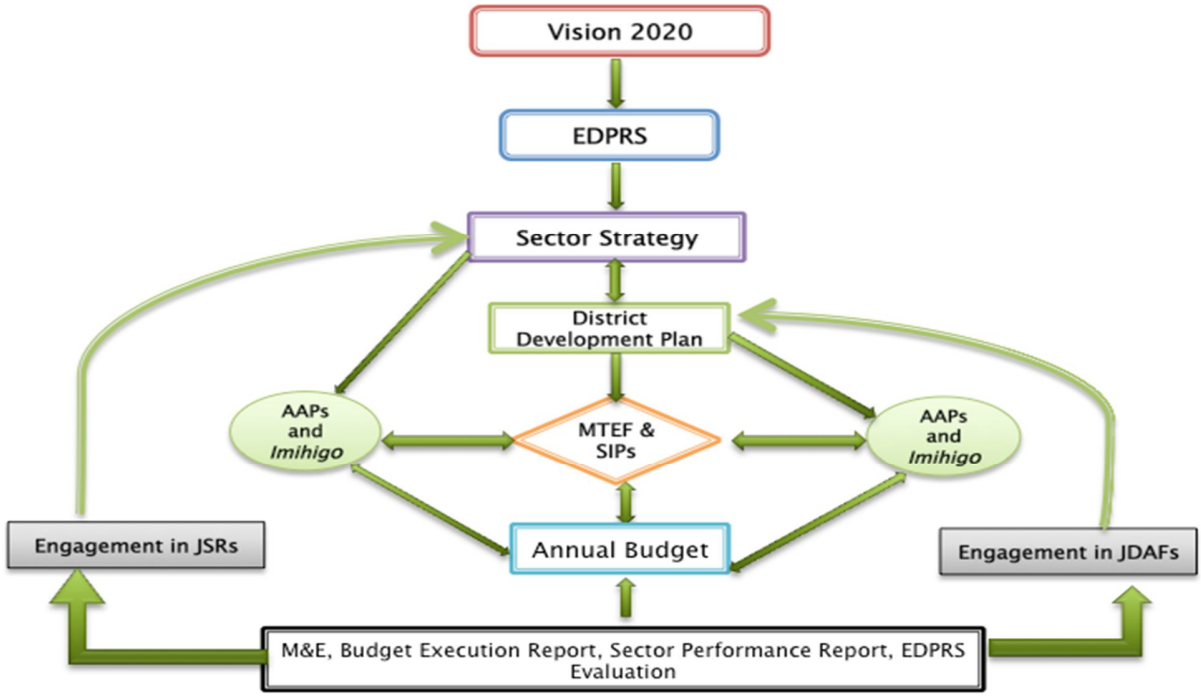
[3] Musahara (2017). *Unpublished*. Selected Sector analysis in the context of SDG GAP Analysis, Kigali, Rwanda.

6.3. Integrating SDGS in the Sector Planning Process

Considering the national coordination mechanisms, technical consultations are done at the level of the sector where two important forums play important role in the planning. These include the Sector Working Group and the Joint Sector Review which involves also the Forward Looking Joint Sector Review. In its meeting of 30th June 2016, it is clear that on the agenda was a presentation on how to integrate SDGs in the health Sector. During the same presentation, it was highlighted health related SDG indicators that are fully reflected in the Rwanda' Health System, those that are partially reflected and those that are not reflected at all. It was highlighted in the same meeting the need to go beyond indicators' coverage but also reflect on the expected impact from those indicators. In addition part of the discussion was the need to enforce the integration of SDGs in the Health Sector M&E and on the potential cost of surveys needed to measure some of these additional indicators.

The planning process of the health sector follows the overall planning mechanisms led by the Ministry of Finance and Economic planning. Reference is made to the national development frameworks namely the vision 2020, the EDPRS, the Sector Strategic Plans (SSPs), and the District Development Plans (DDPs). **Figure 1** depicts how the vision is translated into the Mid-Term Plan (EDPRS), SSPs, and decentralized systems of implementation and accountability.

Figure (2) National Planning Framework



Source: MINAGRI (2017). Presentation at the Workshop on "Citizen's Participation in the Planning Process in Agriculture, Kigali, Rwanda.

The planning process involves all stakeholders at different levels. At this level, other ministries and development partners are also invited and they contribute to the policy planning and are also concerned with the integration of SDGs in the sector planning. Apart from the Ministry of Health, the following Table depict other Ministries and development partners members of the JSR.

Table (5). Institutions and organizations participating to the JSR for the health Sector

Government Institutions	**Non-Government Organizations**
Ministry of Health(MOH)	Partners in Health
Ministry of finance and Economic Planning (MINECOFIN)	CDC Global Health
Rwanda Biomedical Center	JHPIEGO Rwanda
The Prime minister's office (PRIMATURE)	RNGO's Forum
National institute of statistics Rwanda	Clinton health Access initiative (CHAI)
Rwanda biomedical Center	Access to Health
Rwanda Military Hospital	Catholic Relief Services (CSR)
Ndera Hospital	One Family Health
National Paralympics Committee Rwanda(NPC)	
Development Partners	**Local NGOs and Private Sector**
World Health Organization (WHO)	RRP+(Rwanda network of people living with HIV/AIDS
UNICEF	ABASIRWA
WFPA	PwC Rwanda(Price water house coopers Rwanda
Belgian development Agency(BTC)	MSH(Management Science of Health)
Swiss Agency for development and cooperation(SDC)	Kigali Hope Association
USAID	
Belgium Embassy	

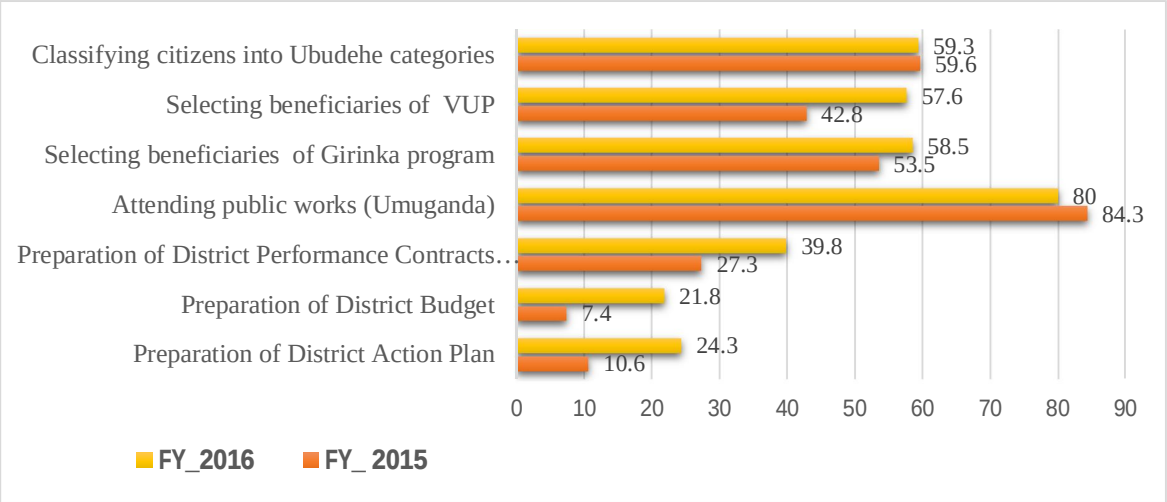
Source: Drawn from the JSR meeting held on 30th June, 2016

At decentralized level, the planning process is inclusive and participatory as it allows partners and citizen to participate in the preparation of the District Development Plans, the District Budgets, and District performance contracts. At District level, the proposed SDG coordination mechanism namely JADFs enages all stakeholders at District level and is expected to perform as well the role of SDG monitoring. For citizen, Rwanda considers citizen's participation high priority in the ovearral planning process and programme implementation. Subsequently, every year there is an assessment to measure wether the planning process is inclsive of citizens in the district planning, budget design and district performance contracts. These are the main planning tools and frameworks at District level. Thefollowing Figure depicts a sample of the levels of citizen's participation as measured by the Citizen Report Card produced by Rwanda Governance Board (2016).

The same Figure (2) presents levels of citizen's participation in the implmentation of Home Grown Solutions or programmes of which majority are trelated to social protection (VUP, Ubudehe, and

GIRINKA- One cow per poor family programme) and health is part of priority areas of interventions. For example, Ubudehe categorization is mainly done by citizens who will classfy people into four levels of wealth categories; those in category 1 and 2 are directly supported to have access to community health insurance.

Figure (3). Levels of Citizen's Participation in the planning process at District level



6.4. Initial gap analysis of heath SDGs

There is an initial gap analysis done at national level in December 2015, which the Government completed with the support from the One UN helped to assess its readiness to implement the SDGs and to establish the degree of alignment –at the indicators 'level- between the current national development framework and the SDGs (Bizoza, 2015). This initial assessment helped the government of Rwanda and development partners to identify which SDG indicators already fully or partially covered by the national and sector planning frameworks and possible adjustments, and opportunities for a successful domestication of SDGs in Rwanda.

Therefore, this section focuses on gaps identified on health related SDGs to assess the extent to which these are integrated in the sector planning documents. The SDG-3 "*Ensure healthy lives and promote well-being for all at all ages***"** encompasses the main targets related to health. It has 12 targets and 25 indicators as depicted in the matrix bellow. Out of 25 indicators, five were categorized as fully reflected in the national planning, five were found to be partially reflected, and fifteen were found not reflected at all as depicted in table 5 bellow (Bizoza, 2015). Beyond these directly related health SDGs, there are other SDGs that contribute to the quality of health and the well-being for people at all ages and these include:

1: SDG-2: End hunger, achieve food security and improved nutrition and promote sustainable agriculture; **2: SDG- 5:** Achieve gender equality and empower all women and girls; **3: SDG- 16**: Promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable and inclusive institutions at all levels

Table (6). **Health SDGs' integration gap analysis**

Reference #-	The SDG Target	SDG Indicator	Level of Coverage		
			FR	PR	NR
3.1.	By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births	Maternal mortality ratio	x	0	0
		Proportion of births attended by skilled health personnel	x		
3.2.	By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births	Under-five mortality rate	x		
		Neonatal mortality rate Report of the Inter-Agency and Expert Group on Sustainable Development Goal Indicators (E/CN.3/2016/2/Rev.1) 5/25 Goals and targets (from the 2030 Agenda) Indicators	x		
3.3.	By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases	Number of new HIV infections per 1,000 uninfected population, by sex, age and key populations		x	
		Tuberculosis incidence per 1,000 population			x
		Malaria incidence per 1,000 population		x	
		Hepatitis B incidence per 100,000 population			x
		Number of people requiring interventions against neglected tropical diseases			x
3.4.	By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being	Mortality rate attributed to cardiovascular disease, cancer, diabetes or chronic respiratory disease			x
		Suicide mortality rate			x
3.5.	Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol	Coverage of treatment interventions (pharmacological, psychosocial and rehabilitation and aftercare services) for substance use disorders			x
		Harmful use of alcohol, defined according to the national context as alcohol per capita consumption (aged 15 years and older) within a calendar year in litres of pure alcohol			x

Reference #-	The SDG Target	SDG Indicator	Level of Coverage		
			FR	PR	NR
3.7	By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes	Proportion of women of reproductive age (aged 15-49 years) who have their need for family planning satisfied with modern methods	x		
		Adolescent birth rate (aged 10-14 years; aged 15-19 years) per 1,000 women in that age group		x	
3.8	Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all	Coverage of essential health services (defined as the average coverage of essential services based on tracer interventions that include reproductive, maternal, newborn and child health, infectious diseases, non-communicable diseases and service capacity and access, among the general and the most disadvantaged population)			x
		Number of people covered by health insurance or a public health system per 1,000 population		x	
3.9	By 2030, substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination	Mortality rate attributed to household and ambient air pollution			x
		Mortality rate attributed to unsafe water, unsafe sanitation and lack of hygiene (exposure to unsafe Water, Sanitation and Hygiene for All (WASH) services) Report of the Inter-Agency and Expert Group on Sustainable Development Goal Indicators (E/CN.3/2016/2/Rev.1) 6/25 Goals and targets (from the 2030 Agenda) Indicators			x
		Mortality rate attributed to unintentional poisoning			x
3.a.	Strengthen the implementation of the World Health Organization Framework Convention on Tobacco Control in all countries, as appropriate	Age-standardized prevalence of current tobacco use among persons aged 15 years and older		x	
3.b.	Support the research and development of vaccines and medicines for the communicable and non-communicable	Proportion of the population with access to affordable medicines and vaccines on a sustainable basis			x

Reference #-	The SDG Target	SDG Indicator	Level of Coverage		
			FR	PR	NR
	diseases that primarily affect developing countries, provide access to affordable essential medicines and vaccines, in accordance with the Doha Declaration on the TRIPS Agreement and Public Health, which affirms the right of developing countries to use to the full the provisions in the Agreement on Trade-Related Aspects of Intellectual Property Rights regarding flexibilities to protect public health, and, in particular, provide access to medicines for all	Total net official development assistance to medical research and basic health sectors			x
3.c.	Substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries, especially in least developed countries and small island developing States	Health worker density and distribution			x
3.d	Strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks	Percentage of attributes of 13 core capacities that have been attained at a specific point in time.			X

Notes: FR- Fully reflected, PR- Partially reflected, NR- Not Reflected

After the initial stage of gap analysis, the Ministry of Health and partners further made a proposal of a set of SDG indicators to be considered or domesticated in the health sector and strategic planning. The main leading criteria in this selection process was the national context and the health information system of Rwanda. The process involved not only the selection but also the adaption in terms of formulation and measurement of selected indicators. Those not selected were also proposed to be re-allocated to other sectors taking into account the mandate and expertise area of the institution. For example the target indicator 3.4.2 on Suicide mortality rate falls under the Ministry of Justice having Police related roles in its mandate.

The Ministry of Health like other ministries received some technical support in this process from the Ministry of Finance and Planning and the National Institute of Statistics. The role of specific technical working groups and committee was as well crucial at this stage of selecting the SDG indicators to be maintained for the health sector. Main consultative discussions at sector level were done through the Sector Working Groups, Joint Sector Review, and various meeting and workshops with the District representatives held last year towards end November 2016. The following Table highlights the selected indicators proposed by the Ministry of Health to the Ministry of Finance and Economic Planning.

Looking at this Table (6) bellow and Table (5), it is clear that some SDG indicators were not maintained by the Ministry of Health in their proposal to the Ministry of Finance and Economic Planning. These include SDG indicators: [3.3.4, 3.4.1., 3.4.2]; [3.5.1, 3.5.2]; [3.8.1]; [3.9.1, 3.9.2, 3.9.3]; [3.a &3.d] (see Table 5 above). The indicators proposed by the MOH to be considered in the sector planning are estimated 20 indicators: 2 for SDG-2; 3 for SDG-5; 2 for SDG-16; and 13 for SDG-3 (see Table 6).

Table (7). List of Proposed Indicators by the Health Sector to be approved by relevant entities by November 2017

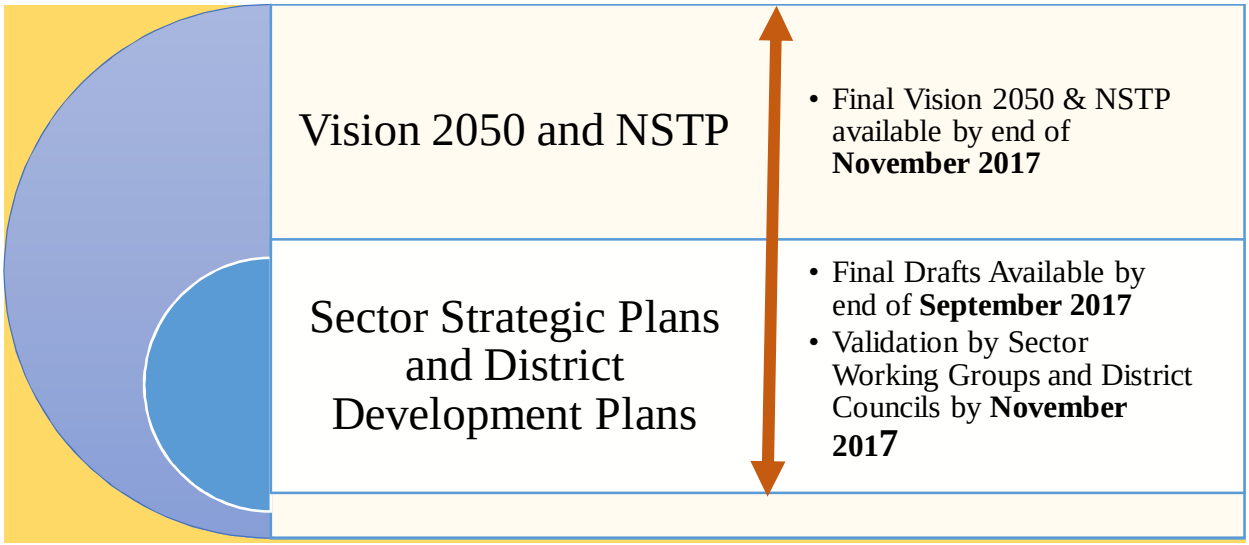
Serial #	SDG target	Selected SDG Indicator by MOH	Baseline	Target
Goal #2: End hunger, achieve food security and improved nutrition and promote sustainable agriculture				
2.2.1	Prevalence of stunting (height for age <-2 standard deviation from the median of the World Health Organization (WHO) Child Growth Standards) among children under 5 years of age	Prevalence of Stunting (Ht/Age) among children 6–59 months	38 % (DHS 2015)	12
2.2.2	Prevalence of malnutrition (weight for height >+2 or <-2 standard deviation from the median of the WHO Child Growth Standards) among children under 5 years of age, by type (wasting and overweight)	% of children under age 5 who are underweight	9% (DHS 2015)	<5%
Goal #3: Ensure healthy lives and promote well-being for all at all ages				
3.1.1	Maternal mortality ratio	Maternal mortality ratio/100,000 Live Births	210	<70
3.1.2	Proportion of births attended by skilled health personnel	% of births attended in HFs	91 % (DHS 2010)	>90%
3.2.1	Under-five mortality rate	Under-five mortality rate per 1,000 live births	50	<25
3.2.2	Neonatal mortality rate	Neonatal mortality per 1,000 live births	20	<12
3.3.1	Number of new HIV infections per 1,000 uninfected population, by sex, age and key populations	HIV incidence rate per 100 adults person years	0.027 (Source RAIHIS 2015)	0.027
3.3.2	Tuberculosis incidence per 1,000 population	Tuberculosis incidence rate/ 1,000 population	63 (WHO report 2015)	13
3.3.3	Malaria incidence per 1,000 population	Malaria prevalence among children 6-59 months	2 % (DHS 2015)	2%
3.7.1	Proportion of women of reproductive age (aged 15-49 years) who have their need for family planning satisfied with modern methods	Contraceptive utilization rate for modern methods women 15-49 years	44 % (DHS 2015)	60
3.7.2	Adolescent birth rate (aged 10-14 years; aged 15-19 years) per 1,000 women in that age group	% of teenage pragnancies (<15-19 yrs)	5.5% (DHS 2015)	2.7%

Serial #	SDG target	Selected SDG Indicator by MOH	Baseline	Target
3.8.2	Number of people covered by health insurance or a public health system per 1,000 population	% of population covered by CBHI	91 % (MTR report 2015)	
3.b.1.	Proportion of the population with access to affordable medicines and vaccines on a sustainable basis	% of Health Facilities with no stock out of tracer drugs	98%	100%
3. B.2.	Total net official development assistance to medical research and basic health sectors	% MOH allocated to research	1% (MTR report 2015)	
3.c.1	Health worker density and distribution	Doctor /100,000 population Nurse /1,000 population Midwife//1,000 population Lab technician/1,000 population	1 Doctor /11,993 (MTR report 2015)	
Goal #5: Achieve gender equality and empower all women and girls				
5.2.1	Proportion of ever-partnered women and girls aged 15 years and older subjected to physical, sexual or psychological violence by a current or former intimate partner in the previous 12 months, by form of violence and by age	% of never married women who experienced physical violence since age of 15 yrs	25% (DHS 2015)	
5.2.2	Proportion of women and girls aged 15 years and older subjected to sexual violence by persons other than an intimate partner in the previous 12 months, by age and place of occurrence.	% of women aged 15-49 yrs. Experienced sexual violence	22% (DHS 2015)	
5.6.1	Proportion of women aged 15-49 years who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care	% of women who know any 21ontraceptive method	99.5%	100%
Goal #16: Promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable and inclusive institutions at all levels				
16.1.3	Proportion of population subjected to physical, psychological or sexual violence in the previous 12 months	% of women aged 15-49 yrs who have ever experienced physical or sexual violence	44% (DHS 2015)	
16.2.3	Proportion of young women and men aged 18-29 years who experienced sexual violence by age 18	% of women aged 25-29 who have ever experienced Physical or sexual violence	47% (DHS 2015)	

6.5. Road map for the remaining phases of Health SDGs' integration

One of the question to answer in this background paper is whether there is a specific road-map of implementing SDGs. For the case of Rwanda, as already indicated, the process started immediately September 2015 after the release of the Agenda 2030. The integration of SDGs has been coupled with the overall strategic Planning process. From the 13th National *Umushyikirano* held in December 2015; His Excellency President Paul Kagame announced the need to develop the new long term Vision 2050 for Rwanda (Minecofin, 2017). The current Vision 2020 remains with less than 4 years to be completed while a new Seven Years Government Programme is required for the new government mandate of 7 years (2017-2024). Furthermore, the existing Economic and Poverty Reduction Strategy (EDPRS-2) remains with less than a year and most of subsequent Sector –Strategic Plans are expected to end June 2018.

Cognizant of the need to integrate important regional and global commitments (SDGs, EAC Vision 2050, and Africa Agenda 2063) in long and medium plans, the on-going elaboration of various strategic documents is taking into account the above rationale. Proposals of SDG indicators to be considered for each sector have been made so far and the final list of selected SDG indicators for each sector are expected to be ready by November 2017. This implies that the integration of SDGS is being made by each specific sector using the existing planning process and coordination mechanism as above demonstrated. The following chart gives some of key timelines of the proposed road map for the development of new Sector Strategic Plans and District Development plans, and Vision 2050 and the National Strategy for Transformation and Prosperity (NSTP1-former EDPR-2). This intuitively reflect the duration of full integration of SDGs in all sectors and the health Sector in particular.



7. Discussion of major findings

This paper looked at the readiness of Rwanda in integrating health SDGs as part of the regional initiative by ACHEST to assess the extent to which concerned countries are prepared to domesticate health and health related SDGs in Rwanda, Uganda, Tanzania, Ethiopia, Kenya, Zimbabwe, and Zambia. The analysis looked at various thematic areas including the institutional arrangements, integration of the SDGs in the national planning process and with focus to the health Sector, resource mobilization and funding of SDGs, the monitoring and evaluation framework, the current roadmap, and the role of Health related Think Tank. From the findings the following are key observations.

On *institutional arrangement*, Rwanda has already in place the overall institutional and national coordination mechanism for SDGs. It is done in a way each expected role is assigned to the existing body or council at all levels of governance. These roles comprise the oversight and accountability, strategic orientation, strategic monitoring, technical advisory, technical and sector coordination, technical consultations and District coordination. The organs implementing these roles and related functions include those with the oversight roles (such as Senate and Parliament), the cabinet expected to provide the overall strategic orientation, and the Sector working groups for the technical consultations. It is clear that the institutional arrangement in place takes into account participation of all stakeholders including citizen's participation though their pacification and engagement forums such as *Umuganda*[4].

However, while the process is inclusive, the role of the research and Think Tank institutions is not clearly stated so as to appreciate from the early stage of SDG's implementation the expected role of the think tank; including research and policy analysis, programme and policy evaluation, and advocacy among others. Particular to the health sector, apart from the School of health of the University of Rwanda and the research by IPAR-Rwanda in some areas of health related research; there is no a specific think tank on health. Greater coordination and engagement of the existing ones is capital to ensure that research and policy analysis is integral part of the national development and implementation of the SDGs. Similarly, the role of the private sector must be given a special attention since the country is aiming to have a private-led economy. The expected role must be well defined to ensure that private sector's involvement is well capitalized into the planning and implementation of programmes to achieve SDGs.

With regard to *integration process of the health and health related SDGs*, Rwanda has made tremendous progress as far as SDG's domestication is concerned. Currently, apart from the initial

[4] *Note:* The term *Umuganda* derives from Kinyarwanda and expresses the idea of building a house collectively. Nowadays it refers to the rallying of communal labour for the reconstruction and repair of basic public development infrastructure under the supervision of village heads. *Umuganda* requires everyone to contribute free labour, even the president of the state and other political leaders (Bizoza,2011).

gap analysis done December 2015 at indicator level, the policy gap analysis has also be conducted now being at its final stage. Other progress made include the proposal of SDG indicators by each sector and their integration in the on-going Sector Strategic Plans and national development frameworks such as Vision 2050, Seven Years Government Programe and the new National Strategy for Transformation and Prosperity – equivalent to EDPRS. Since not all sector SDG indicators are integrated by responsible; it is important to ensure that all SDG targets are within their respective sectors that they ought to belong based on the sector mandate.

On the Resource Mobilization, it was found that there is no specific budget planning for SDGs' implementation. But integrating SDGs might require additional activities calling for more budget than the usual. Alternative sources of funds by the government and the development partners will be needed to ensure that all activities planned to achieve SDG targets are effectively implemented. Particular to the heath sector, the current level of financial dependence of the health sector which is around 35% will need to be reduced through other innovative options by partners in the sector.

With respect to *Monitoring and Evaluation Frameworks*, the SDGs will not be implemented in isolation but will require and requires consideration of all sector strategic plans. For the health sector, the information needed to monitor the performance on the indicators will be generated from the existing data systems such as the Demographic and Population Health Survey (DHS), the Health Information Management System (HMIS), Civil Registration and Vital Statistics (CRVS) Systems (related to legal and analysis and vital events in the population), National statistics by the National Institute of Statistics of Rwanda (NISR), and other administrative data generated by Rwanda Biomedical Center (RBC) and the Ministry of Health.

8. Conclusions and Recommendations

This study assessed and document the current status on the integration of health related SDGs in the overall planning process and in the health sector and strategic plans. Findings stipulate that since the adoption of the Agenda 230, Rwanda has initiated the process of domesticating all SDGs and those of the health sector in particular. The leadership and political will constitute a strong comparative advantage and an enabling condition for successful integration and achievements of the SDGs. With the current roadmap, Rwanda will have fully integrated SDGs in the national planning process and individual sector plans by end of November 2017. The process has been so impressive and inclusive despite some little representation from the academia, research and think tank institutions. The country is recently going through various upgrading of the national and strategic plans which in turn constitute a very good opportunity to integrate SDGs indicators seemingly new compared to the existing standard indicators.

In view of the above, the following Recommendations have been formulated:

(1) The government and partners should seek how to continue engaging all stakeholders in the remaining phases of SDGs and with a particular consideration of the private sector, civil society, and research institutions, think tanks, and the academia;

(2) Since it has been observed that there is no specific health think tank that would independently monitor the progress made against the SDG targets; there is need to establish the links between existing Think Tank namely IPAR-Rwanda and the School of Health to ensure that there is an independent entity that is involved in research and evaluation of health related programmes towards SDG targets;

(3) Despite some of the communication materials available from the website of MINECOFIN and other portals; it would be good to ensure easy communication of the SDGs by the community so that they are aware of these targets and how they relate to the socio-economic development process in Rwanda. More awareness and training programmes on SDGs are strongly recommended for increased awareness by the population;

(4) Particular to this project, ACHEST will need to establish strong linkages with partner institutions in the respective countries to maintain the momentum of health policy research to inform the policy and the planning processes in the health sector. These include the School of Public Health of the University of Rwanda, Rwanda Biomedical Center of the Ministry of Health; and the Institute of Policy Analysis and Research (IPAR-Rwanda);

(5) Results of this study are based on a scoping study; a deepen analysis will be need to understand whether the current programming is robust enough to ensure achievement of Health SDGs in particular.

Appendix 1: List of Major Documents Consulted

#	Title of the Document	Period / Year
1	The Third Health Sector Strategic Plan (HSSP-3)	2013-2018
2	Rwanda's Vision 2020	2000-2020
3	Rwanda's Economic Development and Poverty Reduction Strategy (EDPRS-2)	2013-2018
4	The 2030 Agenda for Sustainable Development (SDGs)	2015-2030
5	Security Sector Strategic Plan (SSSP)	2013-2018
6	Initial Gap Analysis of SDGs in Support of Joint Efforts by Rwanda and the One UN Country Team to domesticate the Sustainable Development Goals (SDGs), by A. Bizoza (2015), Commissioned by MINECOFIN in Collaboration with UNDP.	2015-2016
7	Rwanda's Approach to Implementing the SDGs, by MINECOFIN	2016
8	Rwanda Citizen Report Card (CRC), by Rwanda Governance Board (RGB)	2016
9	Evaluation of the Seven Years' Government Programme (7YGP), Draft Report, Commissioned to IPAR-Rwanda by the Office of the Prime Minister, Rwanda.	2017

Appendix 2: List of Key Consultations

#	Name of the Institution	Person Consulted	E-mail address
1	Ministry of Health (MOH)	Director General in Charge of Planning	parfait.uwaliraye@moh.gov.rw
2	Ministry of Finance and Economic Planning	Director General in Charge of Planning and Research	godfrey.kabera@minecofin.gov.rw
3	UNICEF	Nutritionist	jeannette.kayirangwa@wfp.org

4	Rwanda Biomedical Center , Ministry of Health	Deputy Director General	jameskamanzir@gmail.com
5	School of Public Health , University of Rwanda	Academic staff and Researcher	aline.umubyeyim@gmail.com
6	College of Economics and Business	Academic Staff and Researcher	ruharamch@yahoo.fr