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PERSPECTIVES ON IMPLEMENTING OBJECTIVE-ORIENTED HEALTH REFORMS



# Rwanda's Single Project Implementation Unit: An Effective Donor Coordination Platform in the Journey to Achieving Universal Health Coverage

Parfait Uwaliraye[a], Valencia Lyle[b], James Mwanza[b], Gilbert Biraro[c], Alexandra J. Earle[d], and Agnes Gatome-Munyua[e]

[a]Country Engagement, Financing Alliance for Health, Nairobi, Kenya; [b]Public Health Programs, Vital Strategies, New York, NY, USA; [c]Single Project Implementation Unit, Rwanda Biomedical Center, Kigali, Rwanda; [d]World Health Organisation, Geneva, Switzerland; [e]Results for Development, Nairobi, Kenya

**ABSTRACT**

Following the devastating 1994 Genocide, the Government of Rwanda and its citizens have worked relentlessly to rebuild the country and reassemble a strong health system. Immediately after the genocide, global development partners sought to swiftly provide aid and support to the country to address urgent health system needs. However, inadequate coordination of the influx of aid resulted in duplicated efforts and inefficient health sector management. In 1998, the Central Public Investments and External Finance Bureau undertook the monitoring and evaluation of donor-funded projects and management of the Public Investment Program. However, the Bureau had limited time, resources, and health system expertise, impeding its efforts to effectively coordinate development partners. To address these inefficiencies, the Rwandan government next adopted a Sector-Wide Approach to coordinate the support of development partners at the sector level. Again, this coordination approach did not adequately consider the health sector's needs. In 2011, the Single Project Implementation Unit (SPIU) structure was created to coordinate national- and district-level government sectoral initiatives, including ensuring that intended populations were included in planning and decision-making processes. In the health sector, this included a focus on the overall goal of achieving universal health coverage. The health sector SPIU has aided Rwanda in addressing systemic financing issues at all health system levels. Challenges remain; in particular, the SPIU has struggled to align some development partners with the Government's planning calendar to maximize efficiency. It also needs to optimize the use of technology in the health sector to ensure timely decision making.

**KEYWORDS**

donor coordination; health financing; efficiency; Rwanda; health system strengthening

## Introduction

In the aftermath of 1994 Genocide against the Tutsis, the Government of Rwanda and its citizens committed to rebuilding the country, including its economy, infrastructure, and social services.[1] While the government provided leadership in these efforts, there was an urgent need for donors and other "development partners" to provide financial support for Rwanda's transformative reconstruction.[2,3]

Rebuilding Rwanda's health system was a key part of the country's effort to "rise from the ashes." To reconstruct the nation's public health infrastructure so that it can respond to the many health needs of the population, the Ministry of Health (MOH) engaged with a range of development partners, including bilateral, multilateral, and non-governmental donors and organizations.[4] Over the years, many development partners have contributed to Rwanda's steady progress on building a stronger health system and ensuring critical health care services are accessible to all Rwandans.[3]

However, the urgency of the situation and inadequate coordination of the response led to inefficiencies and a lack of synergy among the various efforts.[4] For example, health sector development partners supporting disease prevention and treatment initiatives frequently ended up duplicating efforts.[5] Competition among development partners that all chose to work on a few selected determinants of health resulted in diverting critical time and resources away from other initiatives that could have propelled the nation's health system forward more effectively and efficiently. Setbacks in the years following 1994 demonstrated that good leadership and oversight from the MOH were needed to improve decision making and to maximize the impact of development partner support on health sector programming. Achieving the government's health sector reform objectives required coordination of support from an array of funders, partners, and citizens.

**CONTACT** Parfait Uwaliraye puwaliraye@financingalliance.org Country Engagement, Financing Alliance for Health, Landmark Plaza, 13th Floor, Argwings Kodhek Road, Nairobi, Kenya

This article has been corrected with minor changes. These changes do not impact the academic content of the article.

**Table 1.** Timeline of the creation of donor coordination structures in Rwanda.

| Years | 1998-2004 | 2005-2010 | 2011-Present |
|---|---|---|---|
| **Coordination Structure** | **CEPEX** | **SWAp** | **SPIU** |
| Function(s) | Monitor donor funded projects in public investment program.<br>Not sector specific. | Donor coordination at sector level.<br>Integrate funding of government plans and one-sector strategy. | Focus on coordinating financing mechanisms from national to district levels.<br>Include beneficiaries in planning. |
| Context | Created four years after the 1994 Genocide when there was an influx of donors. | Developed after the Government of Rwanda signed the 2005 Paris Declaration and developed and implemented the 2006 Rwanda Aid Policy. | 2011 Rwanda Aid Policy Manual of Procedures was published the same year that SPIU was institutionalized.<br>Coordination had a clear objective of achieving universal health coverage. |
| Strengths | Served as step toward demonstrating national accountability and transparency. | Accorded government greater negotiating and management power. | Helped address systemic financing issues at all health system levels. |
| Weaknesses | Limited time, resources, health expertise, and heavy workload for staff.<br>Long project delays and inadequate sector program management. | Project delays caused by multiple management, budgeting and reporting processes.<br>Largely centralized with insufficient beneficiary participation. | Off-budget funding persists.<br>Challenges in getting some donors to align to planning cycle.<br>Insufficient digitization. |

As part of the special issue on "Objective-Oriented Health Systems Reform," this commentary explores the system-wide strategies and mechanisms that the Government of Rwanda has tested to strengthen donor coordination in the health sector, with a particular focus on progress toward the country's objective to achieve Universal Health Coverage (UHC). The government has made incremental progress, over time, with each new iteration of its efforts (see Table 1 for an overall timeline). Rwanda's current donor coordination system, a structure called the Single Project Implementation Unit (SPIU), has helped solidify the country's reputation for "effectively managing donors."[6] However, limited knowledge of the intricacies of this mechanism is publicly available. To address this knowledge gap, this commentary outlines the processes that were involved in developing the SPIU, discusses the platform's role in strengthening Rwanda's health system, and comments on opportunities to further improve the mechanism in support of national objectives.

## Initial Efforts to Address the Country's Need for Donor Coordination (1998–2005)

In 1998, a semi-autonomous governmental bureau called the Central Public Investments and External Finance Bureau (CEPEX) was charged with monitoring and evaluating donor-funded projects across all ministries and managing the Public Investment Program.[5,7] CEPEX was established under the Ministry of Finance and Economic Planning (MINECOFIN), which represented a step toward demonstrating national accountability and transparency in funding for development programs. However, several challenges quickly emerged. CEPEX was charged with overseeing the monitoring and evaluation of donor-funded programs across all public sectors, but its employees had limited subject-matter expertise in various sectors, including health.[8] As the sole monitoring and evaluation entity, CEPEX employees were burdened with heavy workloads, causing long delays and turnaround times. This led to major bottlenecks and inadequate sector-level program management.[5,9,10] Furthermore, CEPEX precluded efficient donor coordination by requiring excessive appraisal and evaluation procedures for every developmental project, even when a single development partner was implementing multiple projects.

## Transitioning to a Sector-Wide Approach (2005–2010)

In 2005, the Government of Rwanda signed the Paris Declaration on Aid Effectiveness, as did its development partners.[11] To achieve the goals of the Paris Declaration, the Government of Rwanda then developed and implemented the 2006 Rwanda Aid Policy, which provided pragmatic and Rwanda-specific guidance to global donors and aid recipients on improving aid effectiveness.[12]

In early 2006, the Government of Rwanda also introduced the Sector-Wide Approach (SWAp) as a solution to CEPEX's shortcomings in donor coordination.[13,14] MINECOFIN continued as the lead institution, supporting other ministries to implement their sector-specific SWAps.[15] As CEPEX was phased out, former CEPEX employees were moved to the External Finance Unit of MINECOFIN, which was created in 2005. New employees were hired to establish MOH's SWAp desks, which were located in the Health Financing Unit. This new donor coordination mechanism aimed to push and assist donors to integrate their separate funding efforts into national-level government plans so that they were all contributing to a single sectoral strategy.[13,14,16] The sectoral strategy was outlined in the Rwanda Aid Policy[12] and the Donor

Division of Labour in Rwanda Policy.[17] These documents encouraged both proper consultation with the Rwandan population and adequate distribution of development partners across the country to avoid duplication of efforts. These coordination activities were to be conducted while processing individual memorandums of understanding with MOH. The SWAp, along with these policy documents, endowed the government with greater negotiating and management power when dealing with development partners.[18]

During this period, the government also pooled some external funding with domestic funding.[14] External funding accounted for 68% of total health expenditures in 2010—this proportion decreased over time, reaching 42% in 2020.[19,20] Most donors (especially the bilateral and multilateral donors) adopted either a sector budget support model or a project support model.[13] These models are designed to ensure that external resources are reflected in the government's budget and, by channeling donor funds through national systems to support a specific program, align with sectoral strategic plans.

Despite the aforementioned improvements, challenges remained.[21] SWAp's operationalization was centralized at the national level at various ministries. Yet these ministries had limited involvement with program implementers and the Rwandan population, especially in decentralized sectors.[21] As with CEPEX, the SWAp also contributed to delays in the initiation of many approved projects, which then necessitated project extension requests.[21] The delays primarily occurred while trying to reconcile donors' vertical interventions at the sector level. The government lacked a sufficiently strong and institutionalized coordination entity to reinforce program alignment and integration for optimal use of existing resources.

Further, the involvement of multiple project management units created project management difficulties. Many development partners maintained their own project management units, forcing projects to deal with multiple management systems, budgeting and reporting processes, monitoring and evaluation procedures, and employee remuneration practices.[22] These issues were compounded by high employee turnover, undermining project continuity. Additionally, there were significant coordination challenges when sub-recipients of vertical funding were required to submit multiple reports to different project management units.[23] Lastly, the SWAp continued to fall short in sufficiently including the Rwandan population in decision-making and planning at the district level. The centralized nature of the SWAp and its focus on high-level priorities continued to prevent the health sector from achieving its stated goals.

## Adoption of the Single Project Implementation Unit (SPIU) (2010–2011)

Recognizing that project implementation occurs at the district level, in 2008 and 2009, MINECOFIN conducted consultative meetings with district-level administrations to elicit their suggestions on the program planning and design process.[23] Subsequent consultations were conducted with the high-budget ministries to get their buy-in on proposed reforms.[17] With input and support from both central and decentralized government entities, a more decentralized model of the SPIU was identified as the ideal structure for donor coordination at the sector level. The SPIU was redesigned to address the various challenges experienced with CEPEX and SWAp institutionalization.[14] In 2010, MINECOFIN and the Ministry of Public Service and Labour jointly submitted the updated SPIU implementation modality to the Cabinet for approval. Once approved, an SPIU was established at each Ministry to serve as an integrated and coordinated project management mechanism.[14]

The MOH's SPIU was established in February 2011.[24] The SPIU was designed to ensure that health program funding allocation would be implemented and monitored at the district level in a timely manner. The SPIU was later embedded within the Rwanda Biomedical Center (RBC), which was established in 2011 as the implementation arm of the MOH. The MOH then focused its efforts on resource mobilization and negotiation with donors.[25]

Using the SPIU framework, the MOH negotiated with donors and allocated funding to the priorities detailed in the 2009 Health Sector Strategic Plan (HSSP).[26,27] The MOH would first negotiate and subsequently conduct orientation meetings to communicate programmatic activities and other relevant information to the population.[23,27] For example, to increase community engagement in programs, the SPIU supported community training in monitoring and evaluating program requirements.[26] The MOH would prepare memorandums of understanding between the SPIU and district-level administration. With each district as a budget entity, the SPIU signed one memorandum of understanding that included all the related programs supported by on-budget external funding, as agreed in the negotiation and planning processes.

When the SPIU was established, key development partners (the World Bank, GAVI, and the Global Fund) embraced the reform and used it to channel their funding through national systems.[27] The number of participating donors doubled the following year, with PEPFAR, UN agencies, Belgian Technical Cooperation, and the European Union joining the platform. Over time, the SPIU has contributed to shifting the focus of

funding to allow it to address human resources for health, information systems, supply chain systems, health financing initiatives such as performance-based financing, and other initiatives that contribute to achieving UHC.[28] The SPIU has aided in aligning donors under one plan, with one budgeting and coordinating mechanism, and has implemented this approach from the national level down to the individual level.[1,27,29]

The design and implementation of the SPIU as a donor coordination platform in health and other sectors was made possible by consistent political commitment from the country's top leadership.[30,31] The government's emphasis on multisectoral collaboration, integrated planning and budgeting, and openness to continuous reforms to strengthen public institutions helped facilitate the adoption of the SPIU mechanism.

## How the SPIU Strengthens Rwanda's Health System

The SPIU has enabled the Rwandan health sector to overcome several of the challenges associated with previous donor coordination mechanisms.[23] First, the SPIU has reduced health sector transaction costs by sharing project management mechanisms, harmonizing unit costs, and standardizing employee remuneration across all health projects. For example, projects may share one accountant, consolidating all budgets and reports, and one legal advisor who works on all project-related legal matters. Previously, each project had its own accountant and legal advisors.

Second, the SPIU addressed the causes of high employee turnover. Between 2017 to 2020, human resources for health expenditure increased by 18.19% from 108.41 million USD in 2017 to 128.13 million USD in 2020.[20] The additional funding supported employee rationalization, with a sharing services approach, and salary harmonization across donor-supported projects. This increased employee retention and led to reduced time spent on recruiting new employees. This, in turn, resulted in fewer requests for project extensions related to delays in project registration processing.[32]

Third, the SPIU's project tracking systems have simplified project coordination and reporting. The SPIU systems enable the government to include all donor-financed projects in the National Budget, which facilitates streamlined execution and accounting.[12] The system also allows the government to monitor activities, prevent duplication of activities, and harmonize performance targets.[12] Additionally, the SPIU monitoring systems enable the synchronization of unit costs across all projects. That is, the government can compare interventions across projects to ensure that appropriate amounts of funding are allocated to various system inputs, including medical equipment, infrastructure, human resources development, and distribution of medications.[23]

Lastly, certain SPIU grants have specifically supported the development and maintenance of data systems to promote evidence-based policy- and decision-making to address the health needs of the population.[33] For instance, if data from the Health Management Information Systems show that pregnant women are not attending the recommended number of antenatal care visits, MOH can negotiate with donors to allocate more funding toward infrastructure and health promotion activities to encourage greater antenatal care uptake.

## The SPIU's Remaining Challenges

The SPIU has been more successful than previous attempts to coordinate the implementation of health

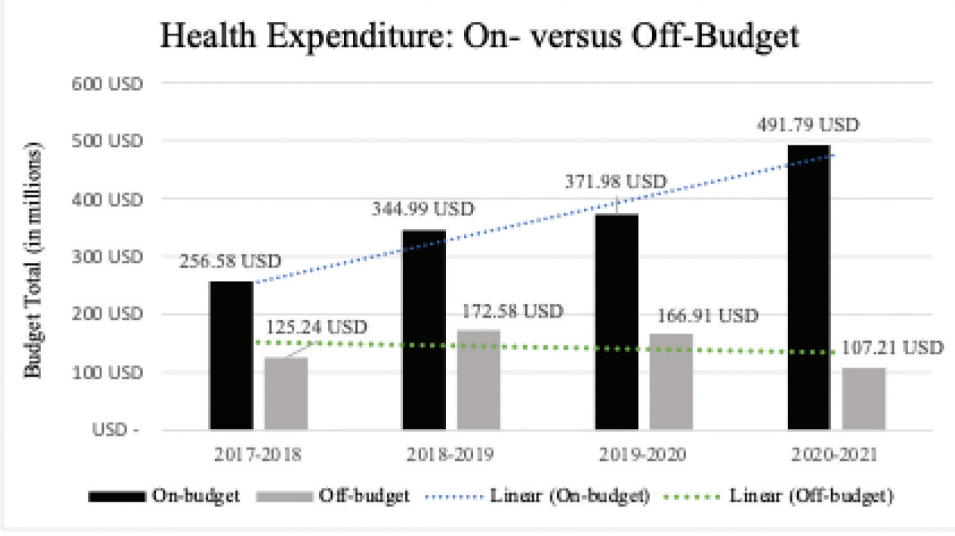


Figure 1. On- and off-budget health expenditure (2017 – 2021).

sector projects, but several challenges remain. One of the leading challenges is some development partners continued preference for off-budget funding (see Figure 1 for an overview of on- and off-budget health expenditures from 2017 to 2021).[20,34]

The lack of timely and accurate information on all external funding flowing to the health sector continues to hamper the government's prioritization and resource allocation processes. Additionally, there is significant room to enhance the use of technology to make the health sector more efficient and accountable. While some processes in the health sector have been digitized, other systems remain paper-based. A more comprehensive and interoperable digitized system could further improve current SPIU planning, budgeting, and decision-making processes by providing more real-time data and reducing the time and effort spent on data triangulation and analysis. Future research should explore how the SPIU influences development aid effectiveness in Rwanda.

## Conclusion

The SPIU has played a pivotal role in improving the coordination of financial assistance provided to Rwanda by encouraging efficient resource allocation to health sector priorities. The SPIU enables the Government of Rwanda to align available domestic and external resources with its HSSP; thus, all funding is coordinated to efficiently and effectively address national priorities, including by contributing to UHC objectives.[35,36]

The success of the SPIU illustrates the importance of country-led donor coordination mechanisms to safeguard gains made in disease control and improving health system performance. To sustainably maintain these gains, the health sector requires strong leadership, effective policy dialogs, continuous capacity building, and the willingness of all stakeholders to constantly reassess their strategies to continue improving. The SPIU has provided a firm foundation for Rwanda's ongoing efforts to build on progress and address persistent challenges. In particular, the SPIU is an important mechanism contributing to the nation's progress toward its goal of achieving UHC by 2030.

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## ORCID

Valencia Lyle http://orcid.org/0000-0003-2073-4143

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