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Building a healthy Rwanda

35 years of Rwandan-German Cooperation in health

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Acronyms and Abbreviations

AIDS	Acquired immunodeficiency syndrome
BMZ	Federal Ministry for Economic Cooperation and Development, Germany
CDPF	Capacity Development Pooled Fund
CBHI	Community-Based Health Insurance
CHUB	Centre Hospitalier-Universitaire de Butare (University Teaching Hospital of Butare)
CIM	Centre for International Migration and Development [1]
DED	Deutscher Entwicklungsdienst gGmbH (now GIZ)
EDPRS	Economic Development and Poverty Reduction Strategy
GBV	Gender-based violence
GDC	German Development Cooperation (comprising BMZ, GIZ and KfW)
GIZ	Deutsche Gesellschaft für Internationale Zusammenarbeit GmbH [2]
Global Fund	Global Fund to fight AIDS, Malaria and Tuberculosis
GTZ	Deutsche Gesellschaft für Technische Zusammenarbeit GmbH (now GIZ)
HCD	Human Capacity Development (formerly part of InWEnt, now GIZ)
HIV	Human immunodeficiency virus
HSSP	Health Sector Strategic Plan
InWEnt	Capacity Building International, Germany (now GIZ)
JADF	Joint Action Development Forum (at District level)
KfW	KfW Entwicklungsbank
MIGEPROF	Ministry of Gender and Family Promotion
MINALOC	Ministry of Local Administration, Community Development and Social Affairs
MINECOFIN	Ministry of Finance and Economic Planning
MINEDUC	Ministry of Education
MoH	Ministry of Health
M&E	Monitoring and Evaluation
NGO	Non-governmental organization
ONAPO	National Office of Population
PBF	Performance-Based Financing
PSI	Population Services International
SRH	Sexual and reproductive health
SWAp	Sector-Wide Approach
TB	Tuberculosis

[1] A joint operation of GIZ and the German Federal Employment Agency.

[2] The Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) GmbH was formed on 1 January 2011. It brings together the long-standing expertise of the Deutscher Entwicklungsdienst (DED) gGmbH (German development service), the Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ) GmbH (German technical cooperation) and InWEnt – Capacity Building International, Germany. For further information, go to www.giz.de.

Building a healthy Rwanda

35 years of Rwandan-German Cooperation in health

>> Dr. Agnes Binagwaho
Minister of Health – Rwanda

Foreword

In a relatively short time span, Rwanda has achieved progress in the health sector, with real impacts on the day-to-day lives of millions of Rwandans. The importance of strong ownership of the development agenda by the people of Rwanda, under the leadership of H.E the President of the Republic of Rwanda, H.E Paul Kagame cannot be overemphasized. It is His vision for Rwanda that no one gets left out of the development benefits that have shaped the health sector for the last 18 years. It is central to our success in implementing health reforms, providing universal health coverage, and sustaining efforts to reach the Millennium Development Goals.

The German Development Cooperation has played a valuable role in this achievement. From modest beginnings back in the 1960s, its support has grown and deepened over the decades. The range of health issues addressed in different projects and programmes has widened to cover almost all aspects of building a modern and effective health system.

This publication is a testament to our two nations' joint work in Rwanda's health sector over the years. Through its various technical and financial instruments, the German Development Cooperation has made a solid contribution to the health sector with its technical expertise, emphasis on needs-based instruments that are flexible and responsive, and consistent commitment to achieving results. The relationship has been a close one, valuable to both sides, and with a great deal of mutual learning over the years.

Looking ahead, Rwanda's path in reforming and improving the health system remains a challenge, however, one that we will follow with confidence and determination. Germany's long engagement in the sector has furnished important building blocks that have played a great role in building a healthy nation and improved quality of life for Rwandans. This publication is a fitting celebration of that engagement, and the people who made it a success.

Dr. Agnes Binagwaho
Minister of Health – Rwanda

>> Peter Fahrenholtz, Ambassador of the Federal Republic of Germany in Rwanda

Preface

For over three decades, Rwanda and Germany have been partners in Rwanda's health system.

Under the leadership of the Ministry of Health the Rwandan-German cooperation has contributed to the remarkable improvement of the health status of Rwandans, especially in recent years. Germany provided expertise and resources during difficult times and participated in the country's remarkable resurgence.

By mutual agreement, and in accordance with Rwanda's policy on division of labour in development cooperation, Germany's involvement in the health sector will be phasing out in April 2013 in order to focus on other sectors, namely Decentralisation and Good Governance, Employment Promotion and Technical and Vocational Education and Training.

To celebrate our shared history, we are pleased to offer this publication as a record of the partnership's challenges and achievements. Building a healthy Rwanda: 35 years of Rwandan-German cooperation in health describes the different areas of cooperation that have been supported since the early days, and highlights their achievements. The publication shows not only the geographic spread of activities, but the significant range of health and sector management issues addressed, particularly since the establishment of the Rwandan-German Health Programme in 2004.

The accomplishments of the partnership are ultimately due to the hard work of individuals from both countries who worked patiently together to solve problems and build a better health system for Rwanda's population. Although they are too numerous to mention individually in this foreword, we wish to take this opportunity to thank all who contributed to this cooperation for their efforts and dedication over the years. We hope that by quoting the remarks and publishing the photos of some of these individuals throughout the publication, the reader will get a sense of both the people and the strong ethos that made the partnership a success.

Peter Fahrenholtz
Ambassador of the Federal Republic of Germany

A brief history

As can be seen in the timeline provided in the centre of this publication, Rwandan-German cooperation in the health sector goes back many years, and has gone through many phases. This section describes that history in broad strokes, from the early 1960s to the current day. As summarised by Nils Warner, Head of Cooperation at the Germany Embassy in Kigali, 'This history shows how cooperation evolved gradually towards an integrated, multi-level and programme-based approach. Stand-alone projects turned into a comprehensive programme, different instruments of German technical and financial cooperation were increasingly combined, cooperation was extended from local to district and national level, and support became more and more aligned to national strategies.'

The early years

German support to Rwanda's health sector started immediately after independence, with the delivery of three ambulances in 1962. During the 1960s and most of the 1970s, assistance provided was limited to small-scale projects such as the short-term placement of a medical expert and the provision of x-ray equipment to Butare Hospital.

Continuous cooperation in the Rwandan health sector started in 1979 with the deployment of two German Development Workers by the former Deutscher Entwicklungs-dienst (DED, now GIZ). These were a social worker working in the Health Centre Ruheru, in Gikongoro Prefecture (today Southern Province), and a midwife in the maternity ward of Health Centre Janja, in Ruhengeri Prefecture (today Northern Province).

This support gradually expanded in terms of geographic coverage, fields of technical expertise, and numbers of personnel. Many of the Development Workers were physicians, including general practitioners and a variety of specialists such as paediatricians, surgeons or gynaecologists, who supported hospitals in medical education through formal courses, bed-side teaching (especially at the University Teaching Hospital of Butare and the Faculty of Medicine), on-the-job training and clinical services. Three other major types of support were provided: first, nursing training at the Nursing school of Byumba and other nursing schools before 1994 like Kilinda and Remera-Rukoma; second, midwifery service, training and support in a number of health centers; and third, training of lab-technicians in Gatagara school of lab-technicians and in several hospitals.

Consolidation in the 1980s

In 1982, DED set up a more comprehensive project supporting the hospitals of Bushenge, Kibuye and Kabaya and the respective regions with a focus on training and supervision, quality of care and drug supply. In 1986 cooperation was extended to Byumba hospital. The project also assisted in the development of infrastructure, and later in HIV prevention, family planning and reproductive health. Financing was channeled through the Deutsche Gesellschaft für technische Zusammenarbeit (GTZ, now GIZ) resulting in an early collaboration among German agencies in Rwanda.[3]

>> A community sensitization session on family planning in Gikongoro during the mid-1980s.

[3] Integrated Experts are employed directly by partner organisations and completely integrated into their structure in key positions. CIM helps partners to find those international specialists and tops up the local salary.

>> A long standing partner: students at the Nursing School in Byumba, which was built in 1995 with German support.

Conflict and genocide

When the civil war began in 1990, cooperation became increasingly difficult, and German support in the north (primarily Byumba Prefecture) came to a stop as the battle front drew closer. The genocide against the Tutsi between April and July 1994 forced complete interruption of regular programming for approximately one and a half years. However, emergency aid to the health sector in the form of supplies, equipment and vehicles was funded during this time by the German Federal Ministry for Economic Cooperation and Development (BMZ).

Scale-up of cooperation after 1994

After this dark period, projects gradually resumed, although these had to be substantially modified due to the dramatically changed situation. The project in Byumba initially helped to rehabilitate and build infrastructure devastated during the war and genocide. The family planning project was resumed and now included a HIV prevention component. In 1997, the approach of the German financial cooperation was redesigned and a programme was set up on national level focusing on family planning and HIV prevention through the social marketing of contraceptives, especially condoms. This was implemented by Population Services International (PSI), and continued successfully through several phases until 2012.

In 1995, a new GTZ project was established in Butare focusing on primary health care, HIV, other sexually transmitted diseases, and infrastructure. Starting in 2000, the former Capacity Building International (InWEnt, now GIZ) supported a number of measures for human capacity development such as trainings and curricula development. Employment of Integrated Experts resumed in 2003 via CIM.

Dr Pie Uwiragiye, Acting Director of Ruhengeri Hospital

'After the genocide, we did not have any experienced doctors. The experienced specialists sent by the German Cooperation, such as gynaecologists or paediatricians, helped by treating patients. But at the same time they also trained Rwandan doctors so that now we have doctors who can professionally manage cases in the main departments of the hospital.'

A comprehensive health programme: 2004–2012

In 2003, significant changes took place as health became one of Germany's three priority areas within its cooperation with Rwanda. The first steps towards a Sector-Wide Approach (SWAp) were taken to provide more coordinated support to the health sector under the leadership of the Ministry of Health and its first Health Sector Strategic Plan, which was adopted in 2005. The changes included: the gradual integration of all German implementing agencies under one programme (including joint objectives and indicators starting in 2007), a notable expansion in the technical areas supported by this programme, and more integrated multi-level support at both central and decentralised level. A more detailed discussion of the Rwandan-German Health Programme (henceforth referred to as 'the Health Programme') is provided in the following sections of this publication.

Phasing out

Following Rwanda's proposal on a new divison of labour among development partners in order to improve aid effectiveness, it was jointly decided in 2010 that the Programme would phase out by the end of 2012, and that German support would be concentrated to sectors other than health. The phasing out is accompanied by an independent evaluation of Rwandan-German cooperation in health, carried out by the German Institute for Development Evaluation.

During almost 35 successful years of continuous cooperation, the technical and financial support provided by Germany to the health sector has totalled approximately €61 million. In addition, 140 Development Workers provided support to the Rwandan health sector between 1979 and 2012.

The Rwandan-German Health Programme since 2004: an overview

The joint Health Programme, which started its operations in 2004, constituted a major change to Rwandan-German cooperation in the health sector. A major benefit, from the Rwandan point of view, was that of administrative efficiency. Instead of dealing with a range of independent projects run by multiple German implementing organisations, the Ministry of Health could now engage with one coherent programme covering the entire sector.

While the Rwandan Ministry of Health was already a key partner for German Development Cooperation (GDC), the relationship was further enhanced in 2003 when the GTZ project office moved from Butare to the capital, Kigali, and started providing direct technical support to the Ministry. At the same time, the longstanding cooperation of GTZ and DED with the prefectural governments of Byumba in the north and Butare and Gikongoro in the south was consolidated within the comprehensive programme.

Meanwhile, health became one of the three priority areas of German Development Cooperation in Rwanda. The former German implementing agencies – DED, GTZ (with CIM) and KfW – gradually integrated their activities and in 2007 agreed on common programme objectives and indicators. The 2007 programme proposal to BMZ, submitted on behalf of all German implementing agencies in the country, was the first proposal of its kind worldwide and marked a major milestone within German Development Cooperation. Thus, by the middle of the decade, the full range of instruments of German Development Cooperation (both technical and financial) was now being deployed in an integrated way.

A further milestone was achieved in January 2011 when all technical cooperation agencies (GTZ, DED and InWEnt) were integrated within GIZ.

Programme objectives and components

The overall objective of the Rwandan-German Health Programme was to improve the health status of the Rwandan population. As shown in Table 1, the three programme components focused on:

- health financing and system development
- sexual and reproductive health, including HIV and AIDS
- human resource development and health technology management.

The programme thus sought to support Rwanda's Economic Development and Poverty Reduction Strategy (EDPRS) and its successive Health Sector Strategic Plans (HSSPs), with which it was completely aligned. Elisabeth Girrbach, coordinator of the joint programme, explains: 'We selected these topics for the programme because they reflected best the priorities of the Ministry of Health and of German Cooperation in health.' While some new topics arose and others receded over the programme's two distinct phases (2004–2007 and 2008–2012), the overall focus of the components and their various activities remained the same. In addition to the programme components, the sector-wide approach, coordination and joint financing via sector budget support, and pooled funding were considered overarching topics relevant to all three components. As in other German projects in the country, mainstreaming was done with regard to HIV and AIDS, gender and gender-based violence, and sexual and reproductive health.

>> GDC health sector coordinator Elisabeth Girrbach and Rwanda's former Honourable Minister of Health Dr Richard Sezibera.

Table 1: Components of the Rwandan-German Health Programme

2004–2012

Overarching	
Sector-wide Approach and Joint Financing Mechanisms	
• Advise on Sector-Wide Approach • Development Partners Coordination	• Sector Budget Support • Capacity Development Pooled Fund

Component 1	Component 2	Component 3
Health Financing and System Development	Sexual and Reproductive Health and HIV and AIDS	Human Resource Development and Health Technology Management
• Community-Based Health Insurance • Health Financing Steering • Performance-based Financing • Public Financial Management • Decentralisation	• Family Planning • Mother-Child Health • Adolescent Sexual & Reproductive Health • Gender-Based Violence • Specific Diseases, notably HIV and AIDS	• Human Resources Development and Medical Education • Hospital Management • Medical Equipment and Maintenance • Support to Research

Source: GIZ Rwanda

Programme partners

The joint Health Programme demonstrated one of the key assets of German Development Cooperation: its multi-level approach. This comprises working simultaneously on central and decentralised levels, gathering practical knowledge of implementation on the ground, and feeding these first-hand experiences back into national policy dialogues.

At central level, the main partner of the programme was the Ministry of Health, along with affiliated institutions such as the Rwanda Biomedical Centre. The contractual frameworks of financial and technical cooperation were concluded with the Ministry of Finance and Economic Planning (MINECOFIN), which was also the recipient of Sector Budget Support to be channeled directly in to the Government's health sector budget. In some areas, collaboration extended to other ministries, such as the Ministry of Gender and Family Promotion (MIGEPROF) for gender-based violence and the Ministry of Local Administration (MINALOC) for health sector decentralisation. In the spirit of the sector-wide approach, close cooperation was also established with other development partners through various coordination forums. These forums included various the Sector Working Group, Technical Working Groups and the Development Partners Consultative Group, and German Development Cooperation also co-initiated specific joint financing mechanisms such as Sector Budget Support and the Capacity Development Pooled Fund. The implementation of the financial cooperation programme of social marketing of contraceptives was done by the NGO Population Services International (PSI) and the GIZ sub-component on health technology management was sub-contracted to the consulting firm SANIPLAN.

Within the Ministry of Health, decisions regarding the programme were taken in consultation with the Minister and the Permanent Secretary. The main counterparts on technical questions within the Ministry were the Director General of Clinical Services, the Partner Coordinator, the Directors of the Health Financing and Mother-Child Health Units, the Directors for Human Resources, Finance, Planning and Decentralisation, the Single Project Implementation Unit, the Maintenance Management Department of the Rwanda Biomedical Centre, and the Country Coordinating Mechanism of the Global Fund to fight AIDS, Malaria and Tuberculosis.

At decentralized levels, the programme was active in five districts and seven hospitals in Southern and Northern Provinces (see map in the section 'District and hospital support' below). The work in the districts of Gicumbi, Gisagara, Huye and Nyaruguru continued where DED and GTZ projects had already started,[4] whereas Musanze became a new partner district in 2007 on request of the Ministry of Health. In those districts, support was provided to District Hospitals in Byumba, Gakoma, Kabutare, Kibilizi, Munini and Ruhengeri, as well as to Health Centres within the catchment areas of the hospitals. The long-standing partnership with the University Teaching Hospital of Butare (CHUB), a national referral hospital located in Huye District, also continued. Important counterparts of the programme at district level included the District Mayors and Vice-Mayors of Social

[4] These districts were within the provinces of Butare, Byumba and Gikongoro respectively prior to the administrative reform of 2006 which reorganized the country into five provinces. These replaced the previous 12 provinces, which had in turn replaced the older system of prefectures.

>> Ruhengeri Hospital, one of the partners of the Health Programme at decentralized level.

Affairs, District Health Unit Directors, Directors of the *Mutuelle de santé* (described in greater detail below), and the hospital directors, administrators and technicians. The programme was also closely involved with Joint Action Development Forums (JADF), where coordination of development partners working at district level takes place.

Organisational structure and budget

While BMZ delegates based in the German embassy in Kigali function as the Head of all German Cooperation projects in Rwanda, technical leadership for the Health Programme was assumed by a priority area coordinator representing both GIZ and KfW. The first of these, Dr Andreas Kalk, was followed in 2008 by Elisabeth Girrbach; both were also the head of the GIZ health project.

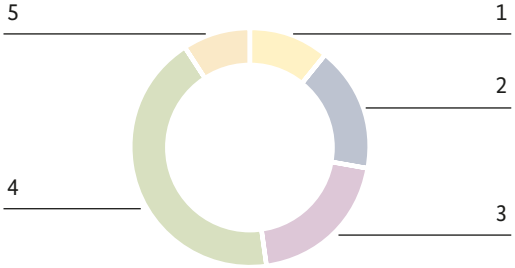
In 2012, the GIZ Programme had approximately 20 technical staff, including central-level advisors for all three programme components, district advisors and Development Workers, and a support team of ten. The GIZ country office provided administrative and accounting services, while programme design and implementation were done in close cooperation with the regional and sectoral departments at GIZ head office in Germany. KfW's activities were directed from head office in coordination with the KfW country office. Between 2004 and 2012, Germany's support to the Rwandan health sector totalled approximately €41 million, equally divided between technical and financial cooperation. Financial cooperation via KfW mainly included support for social marketing of contraceptives and related awareness campaigns, financing of health equipment for hospitals and health centres, and €13.1 million used to co-finance the health sector budget through health sector budget support, including a contribution of €100.000 to the Capacity Development Pooled Fund. Dr Daniela Beckmann, Director of KfW Office Kigali, explains this focus: 'I believe that the Sector Budget Support Health has provided value added to the traditional cooperation modalities by intensifying the coordination among the development partners as well as by refocusing the dialogue towards budget planning, execution and monitoring.'

For GIZ technical cooperation, Figure 1 shows the distribution per technical topic in the second phase of the Programme (2008–2012). About 47 % of this support went to districts and hospitals, while 53 % was provided at national level. In addition to GIZ technical advisors, a total of 34 Development Workers and seven integrated experts worked in Rwanda between 2004 and 2012 (see the timeline in the middle of this publication for additional budget details). Apart from numerous local trainings supported by GIZ, about 600 Rwandan health sector professionals participated in human capacity development measures at regional level.

Figure 1. Distribution of technical cooperation budget

2008–2012

1	SWAp & CDPF	11 %
2	Health financing	17 %
3	Sexual & reproductive health	20 %
4	Human resources development & health technology management	43 %
5	Health system & management strengthening	9 %



Source: GIZ Rwanda

Providing high-level coordination: SWAp, sector budget support and pooled funding

More than 80 development partners are currently involved in Rwanda's health sector, including public institutions as well as numerous private and civil society actors. With so many actors, it is difficult for their interests, priorities and procedures to be harmonised with each other and with the priorities of the national government.

Recognizing this challenge, the Ministry of Health takes a leadership role in coordinating stakeholders through a sector-wide approach (SWAp). With the vision of 'one plan, one budget, one report' (see Figure 1), Rwanda's health sector SWAp aims to align all important stakeholders with the priorities of the multi-year Health Sector Strategic Plan (HSSP). This includes coordinating activities and budgets, channelling more funds through the government budget, using national systems, and harmonizing reporting procedures.

Support to Rwanda's health SWAp

German Development Cooperation has supported strategic coordination efforts in the sector since 2003, contributing to all major milestones in the gradual development of the SWAp and its institutional structure through technical advice and financial support (see Figure 3 on page 13). For example, an integrated expert was placed in the Ministry of Health's SWAp secretariat in order to enhance the Ministry's capacity to steer the sector.

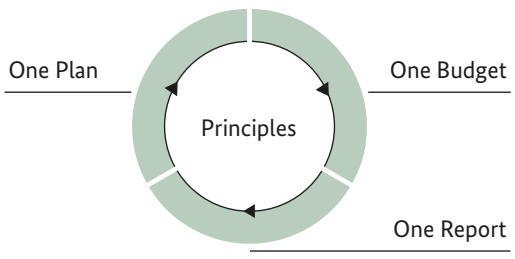
Beyond these specific contributions, German Development Cooperation has 'lived' its commitment to the SWAp in a number of ways. These include aligning programme objectives and indicators to Rwanda's priorities and strategies, and carrying out joint planning with the Ministry at central level and with districts and hospitals. German Development Cooperation was also closely involved in the development of successive Health Sector Strategic Plans and in the regular Joint Health Sector Reviews which started in 2006.

From 2009 to 2010, German Development Cooperation acted as 'shadow co-chair' of the Health Sector Working Group. It also took on co-chair functions in the Technical Working Groups on family planning (2000–2005), health financing (2005–2012), health technology management (2009–2012) and adolescent sexual and reproductive health (2010–2012). Within the Development Partners Group, German Development Cooperation sought to strengthen donor coordination in order to create synergies and to avoid gaps and overlaps.

At district level, the Programme's technical advisors facilitated coordination between District Health Units and District Hospitals and provided support to the Joint Action Development Forum. The Forum is the main coordination organ of the SWAp at this level, and involves all relevant local authorities and partners. In 2004, the Programme created a coordination and information-sharing mechanism called the German Country Team Health, which brought together the BMZ-funded agencies and projects funded by German NGOs as well as the Partnership between Rwanda and Rhineland-Palatinate.

Figure 2. SWAp principles and vision

Principles
Ownership
Alignment
Harmonisation
Managing for Results
Mutual Accountability



Source: GIZ Rwanda

Figure 3. SWAp Milestones

2003	Sectoral cluster
2004	Conceptualisaton of the SWAp
2005	**Health Sector Strategic Plan – HSSP I**
2006	First **Joint Health Sector Review**
2007	**SWAp Memorandum of Understanding** First Health Sector Coordination Group Design of Sector Budget Support and Pooled Fund **Joint Annual Work Plan** (later **Health Resource Tracker**)
2008	**Capacity Development Pooled Fund – CDPF** SWAp Coordinator MoH First Development Partners Group
2009	**HSSP II** Restructuring of Sector in Health Sector Working Group and Technical Working Groups First tranche of German **Sector Budget Support** Health
2010	**SWAp Manual and Roadmap** Division of Labour Policy
2011	Joint mid-term review of HSSP II CDPF and SWAp technical advisor (CIM) SWAp workshops
2012	**HSSP III** Development of **District SWAp Guidelines**

Source: GIZ Rwanda

Sector budget support and pooled funding

Since 2003, German Development Cooperation has used joint financing mechanisms which reflect the spirit of the SWAp. For example, Germany was among the three bilateral donors supporting the Ministry of Health directly through sector budget support, together with Belgium and the United Kingdom.

Between 2008 and 2012, a total of €13 million in sector budget support was provided by KfW as part of Germany's financial assistance to the country. This arrangement, which demonstrated a considerable degree of trust in the national systems and their ability to perform, helped reduce transaction costs, strengthened local capacities through the use of national systems and supported the Government in implementing its ambitious health sector programmes. Accountability for the utilisation of funds was provided through joint performance reviews based on indicators drawn from Rwanda's Economic Development and Poverty Reduction Strategy (EDPRS).

Closely related to the development of the SWAp and its 'one budget' principle is the sector budget support package developed in 2007, together with the Capacity Development Pooled Fund (CDPF). The latter received contributions from GIZ and KfW as well the Belgian, British and Swiss Cooperation. Although included in the overall Government budget, these funds were earmarked for capacity development and jointly managed by the CDPF donors and the Ministry of Health. Among other activities, the CDPF was used to assist the development of the Health Sector Strategic Plan, the SWAp secretariat, and the training and education of health personnel such as nurses and midwives.

Michel Gatete, MoH Partner Coordinator & Nina Siegert, Integrated expert at MoH SWAp Secretariat

>> Michel Gatete at the district health SWAp workshop in October 2012.

>> Nina Siegert listens while Regis Hitimana, who is in charge of planning and M&E in the Ministry of Health, explains the SWAp principles to district stakeholders.

Michel comments, 'In 2011, after two years of search, we finally found a highly qualified advisor via CIM to support us in decentralizing the SWAp and improving coordination among CDPF stakeholders. With Nina Siegert's excellent support, we have improved our processes a lot.' For her part, Nina says, 'Working within the SWAp Secretariat has given me the opportunity to understand the complexity of partner coordination within a SWAp environment, as well as a unique insight to the sector through the lenses of very different partners and stakeholders.'

>> CBHI members present their insurance cards in Gisagara District.

Health financing: improving financial protection and access to health care

In just over 18 years since the conflict ended, Rwanda has succeeded in rebuilding its health system and significantly improved the health status of its population. Considered a 'best practice country,' it is internationally recognized for its pioneering efforts in providing health insurance coverage through Community-Based Health Insurance (CBHI) and for improving the quality of health service delivery through Performance-Based Financing (PBF). Moreover, Rwanda is one of the few African countries on track to attain its Millennium Development Goal targets in 2015. A global research project conducted by Overseas Development Institute in September 2011 recognized that Rwanda has delivered unexpected progress in health, and asserted that effective partnership between donors and the government, coupled with a community health insurance system covering the whole population, has been instrumental in this success.[5]

German Development Cooperation has contributed to this challenging but fulfilling process in many ways over recent years. For example, it has been the co-chair of the Health Financing Working Group, which serves as a venue to discuss health financing issues, translate objectives into coherent joint action plans, and coordinate support of various partners. It has also assisted the Ministry of Health in policy, capacity and institutional development in order to meet the implementation challenges of CBHI, PBF and health financing in general.

CBHI – commonly known as the *Mutuelle de santé* – is the cornerstone of access to health care for about 9 million Rwandans. Members can avail themselves of a comprehensive benefit package from health centres, district hospitals and specialized hospitals following an established referral mechanism. On the health care provider side, the government has initiated PBF to provide incentives for good performance in service delivery both in quantity and quality, thus increasing utilization of health services and value for CBHI members.

The German Government has accompanied this process via its implementing agency GIZ, which was also involved in other activities such as poverty identification, premium subsidy for the poorest, policy development, and coordination of development partners. At the district level, GIZ supported and trained local partners to implement CBHI, to strengthen community participation, and to reach *Imihigo* targets for insurance coverage (*Imihigo* is an innovative Rwandan governance tool involving performance contracts between the President and district mayors, which includes insurance coverage as an indicator). GIZ has also supported the implementation of PBF since 2007.

With the high CBHI coverage, a functioning PBF approach, strong community networks, strong government leadership, and partnership with stakeholders, the Rwandan health sector has achieved remarkable progress. While Rwanda takes pride in its achievements, it is also mindful of the challenges of implementation. These include ensuring the financial and institutional sustainability of the insurance scheme, increasing the capacity of districts to perform their role in a decentralized context, and maintaining health care quality.

[5] Overseas Development Institute (2011). Mapping progress: evidence for a new development outlook, London. Available at: http://www.developmentprogress.org/sites/developmentprogress.org/files/dps_synth_report_-_digital.pdf

Maternal and child health and family planning

Rwanda's progress in improving maternal and child health (MCH) in the past ten years has been remarkable, with the country on track to meet the Millennium Development Goals on key indicators by 2015: As shown in Table 2, infant mortality, under-five mortality, and maternal mortality rates all declined steeply between 2005 and 2010.

For Dr Anicet Nzabonimpa, MCH/FP/HIV Integration Coordinator in the Ministry of Health, the success of the national Maternal and Child Health Programme is due to its having been adopted as a national priority. Placing it in the context of the Imihigo performance-based contracts and indicators, he explains, 'For maternal health, to take one example, the number of deliveries done in a health centre is evaluated.' Another successful strategy has been to work at different levels simultaneously: 'Services are available at the community level via Community Health Workers,' he says, 'and at health facility level via trained health personnel. So we focus on both, demand and supply side. Additionally we have a strong steering structure, the Technical Working Group on Maternal and Child Health, which ensures the on-going quality control of policies, guidelines and manuals.'

Table 2. Maternal and child health targets and achievements

2005–2015

Indicators	Baseline 2005	Mid-term Review June 2008	Mid-term Review Aug 2011	Target 2012	Target 2015
Infant Mortality Rate (per 1,000)	86	62	50	37	28
Under Five Mortality Rate (per 1,000)	152	103	76	66	47
Maternal Mortality Rate (per 100,000)	750	NA	487	455	268

Sources: Demographic and Health Surveys (DHS) 2005, 2007/08 (interim), 2010;[6]
Economic Development and Poverty Reduction Strategy.[7]

[6] National Institute of Statistics of Rwanda, Ministry of Health, Orc Macro (2005). Rwanda Demographic and Health Survey 2005, Kigali and Calverton MD.
National Institute of Statistics of Rwanda, Ministry of Health, ICF Macro (2009). Rwanda Interim Demographic and Health Survey 2007–2008, Kigali and Calverton MD.
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[7] Republic of Rwanda (2007). Economic Development & Poverty Reduction Strategy, 2008–2012, Kigali. Available at: http://siteresources.worldbank.org/INTRWANDA/Resources/EDPRS-English.pdf

>> Dr Peter Weis, a public health physician serving as GTZ resident family planning advisor, stands in front of ONAPO's office in Gikongoro, 1987

A holistic approach to family planning

Rwanda is one of the most densely populated countries in Sub-Saharan Africa. This makes population growth a serious challenge to the population's health as well as to the country's economic growth and development. To increase uptake of contraception and reduce fertility rates, family planning was officially introduced as a national priority by the Rwandan Government in 1962. However, systematic programming did not begin until the 1970s due to opposition from the Catholic Church.

Dr Peter Weis, who today is the head of the GIZ German BACKUP Initiative, was technical advisor on family planning to the National Office of Population (ONAPO) from 1985 to 1990: 'When I began in 1985,' he remembers, 'it was obvious that there was a big unmet need for family planning. There were too many pregnancies and too many that were badly attended, which resulted in high maternal and high infant mortality rates and poor maternal and child health. At that time, Rwanda's total fertility rate – the average number of children that a woman would give birth to over her lifetime – was around 8.5. In addition, we found a complex situation of both low demand for contraceptives and poor supply.'

Using focus-group methods, Weis and his colleagues from German Development Cooperation listened to the population's feelings about their situation. 'Women faced a dilemma,' he says. 'Societal, religious and family expectations on women were high; giving birth was seen as their duty. It was especially men who argued that many children are needed to care for them in their later years, and to support the work on the small farms. Consequently, women did not know how to limit the pregnancies without putting domestic peace with their husbands at risk.'

HIV and AIDS were increasingly recognized as a public health problem in those years, with the first cases in Rwanda having been identified in 1983. 'However, a holistic concept on sexual and reproductive health was still missing,' he recalls. 'AIDS was seen as a male problem, while maternal and child health – including family planning – was seen as a female issue.' It became obvious that both men and women had to be involved in family planning activities. The efforts made at that time met with a small degree of success, with contraceptive use increasing from 1% in 1985 to 6% in 1989 in Butare and Gikongoro, the two southern prefectures supported by German Development Cooperation.

The conflict and genocide disrupted family planning programmes and services, and significantly weakened the Rwandan health sector. A substantial drop in contraception uptake was noted during and following the genocide.

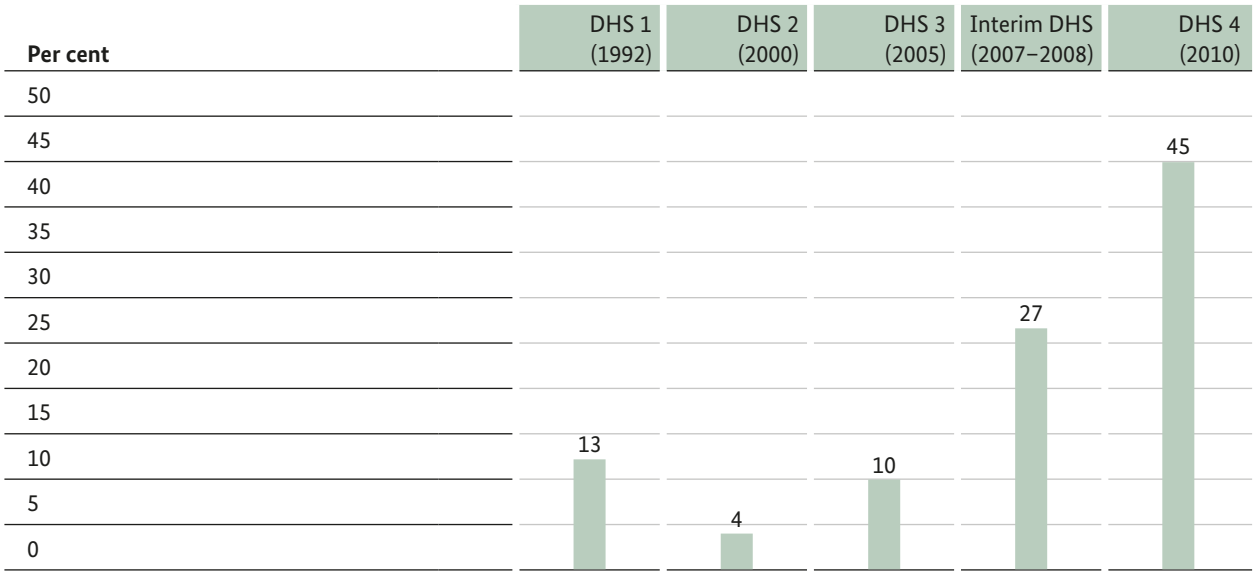
In 2003, a new approach was launched in the form of Rwanda's First National Reproductive Health Policy. Under the policy, three priorities – family planning, the prevention and treatment of sexually transmitted infections and HIV and AIDS, and safe motherhood and child health – were adopted for sexual and reproductive health programming. Using a mix of strategies, Rwanda placed family planning within a broader concept of sexual and reproductive health that included gender-related approaches. One innovation was the introduction of so-called Secondary Health Posts. In contrast to Catholic health centres which only offer counselling on the traditional birth control methods, the Secondary Health Posts offer free contraceptives and family planning counselling free of charge.

As shown in Figure 4, the use of modern contraceptives rose from 4 % of women of reproductive age (15–49 years) in 2000 to 45 % in 2010. Moreover, the total fertility rate has fallen to 4.6 children per woman, almost half of what it was in 1985.

German support to these efforts was provided in a variety of ways. At central level, German Development Cooperation has supported the Technical Working Group in the Ministry of Health in such activities as revising the Family Planning National Policy and Strategy and developing training manuals for health professionals. At district level, German support was widened to five partner districts, and included health care provider trainings on family planning, with an emphasis on long term contraceptive methods such as intra-uterine devices and implants. Family planning sensitization activities at community level are a major activity, with a special focus on adolescent sexual and reproductive health.

Figure 4. Use of modern contraceptive methods by women in a union aged 15–49

1992–2012



Source: DHS for the years given, including an interim DHS in 2007–2008.

>> Participants in a PSI campaign to promote contraceptives, 2005.

Social marketing

Social marketing uses commercial marketing techniques to promote public goods like health and healthy behaviour. Subsidized products are sold via commercial channels and promoted via brand communication, and a range of activities and campaigns are used to influence consumer knowledge, attitudes and behaviours.

The Rwandan Social Marketing Programme is implemented by the international NGO Population Services International (PSI) and its Rwandan affiliate Society for Family Health. KfW has supported the programme since 1996 and to date has invested €14.4 million in it. Between 1996 and 2005, the focus was on the social marketing of condoms in order to sustainably reduce the transmission of HIV. The Prudence Plus brand of condoms was made available at affordable prices to a general public. As well as opening up 'sales points' willing to sell condoms – a hard enough task given the highly stigmatized product – the programme initially worked to reach the general public and especially high-risk groups in more urban settings. Later on, it concentrated more on rural areas and youth. Activities included the production of TV and radio commercials and a soap opera called Solange, all of which aimed to make it easier for Rwandans to talk about HIV and condoms and actually dare to ask for them in shops and pharmacies.

Menya Ukuri (Know the Truth) and Umugabo Nyawe (The Real Man)

In 2003, when the Rwandan government re-designated family planning as a key economic, security and health priority, KfW shifted its focus from HIV to family health. A new social marketing programme was designed to increase the availability of affordable hormonal contraceptives and condoms and to promote their utilization. The programme started out with oral contraceptive pills and three-monthly injections under the brand name of Confiance and launched a hormonal implant in 2011 in close cooperation with the Ministry of Health.

Since injections and implants must be dispensed by formal medical services, the programme supported the training of health service providers such as private nurses and doctors in family planning clinics (these were complementary to the training provided to public sector health providers). Communication activities were devised to target complex personal and social issues including fear of side effects, myths and misconceptions about hormonal contraceptives, and social norms that pressure women and men to have children before they are ready. A national multi-media campaign called Menya Ukuri (Know the Truth) addressed the myths preventing women from using modern contraceptive methods. The campaign used a 'cinemobile' to take a video on family planning into rural areas. The video addressed key barriers to family planning, and showed Confiance clearly as a new product on the market. It generated great interest and debate in target communities.

In 2012 a mass media campaign called *Umugabo Nyawe* (The Real Man) encouraged men to support their partners in the use of modern contractive methods. Activities included a theatrical drama about family planning methods, which shows the role that men should play in their family to support their spouses. The campaign also included a football match aimed at attracting the attention of men, the main target group for the campaign. Thirty journalists from different media channels attended the event and information about the event and campaign was disseminated through TV, radio and newspapers.

Coverage of all women and men, adolescents and vulnerable groups with family planning is far from being achieved, but Rwanda has made good progress towards this goal.

Menya Ukuri: Know the Truth.

'When you stop using hormonal contraception, you can still give birth to healthy children. See your health provider for more information.'

Box 1. Obstetric fistula: preventable and treatable

Obstetric fistula is a severe medical condition in which a hole develops after obstructed labour between either the rectum and vagina or between the bladder and vagina. It poses a special risk for women living in remote areas far from health facilities and for very young mothers. As well as constant incontinence, women with obstetric fistula face great stigma and are often isolated or rejected by their families and the greater community. Fortunately, uncomplicated fistula cases can be treated with a success rate of over 90 % with reconstructive surgery, and even operations for complicated fistulae have a success rate of around 60 %.

The Rwandan-German Health Programme has contributed to introducing routine obstetrical fistula repair at the Academic Teaching Hospital in Ruhengeri since 2005. Each year a training workshop is held at the hospital, and radio announcements are made offering women the possibility of treatment. While to date the operation has been performed by a foreign expert, the workshop provides an opportunity for Rwandan doctors to learn how to perform the surgery.

Besides general support for maternal and child health in district hospitals and the treatment of fistula cases in workshops, German Development Cooperation also supported the training of local health staff by the two staff gynaecologists at the University Training Hospital in Butare and in Ruhengeri.

The Health Programme has also provided technical support for a Working Group on Obstetric Fistula led by the Ministry of Health. The Working Group aims to create a sustainable programme of obstetric fistula prevention and treatment by putting in place a reference centre for obstetric fistula repair and integrating knowledge into existing structures and in medical education. Dr Yacouba Zanré, a gynaecologist-obstetrician who has been working as development worker in Ruhengeri Hospital and operated many fistula cases, lauds this approach: ‘A very positive development at national level has been the recognition that all partners need to work within a national framework to effectively fight against obstetric fistula.’

>> Dr Yacouba Zanré, Development Worker with Ruhengeri Hospital.

Historical Overview of Rwandan-German Cooperation in Health

1962–1978	1979	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994

Projects (title, implementing agency, funds, partners)

- 3 ambulances — €21k (1962)
- Integrated Expert — CIM — Shyira Hospital (1990–1994)
- Med. Expert — €6k (1965)
- 106 Technical assistants — DED — Different locations (1979–1994)
- Improvement of rural health services in Byumba prefecture — DED, financed via GTZ — €6.6m — Hospital Byumba, Nursing school Byumba (1982–1994)
- X-ray Butare — €79k (1968)
- Promotion of family planning — GTZ, cooperation with KfW — €4.3m — ONAPO, Prefectures Gikongoro, Butare, Cyangugu (until 1993) (1986–1994)
- Sector programme family planning (1991–1994)
- Emergency aid — mostly KfW — €1.1m(late 1994 & 1995) — Regular projects interrupted for 1,5 years (1994)

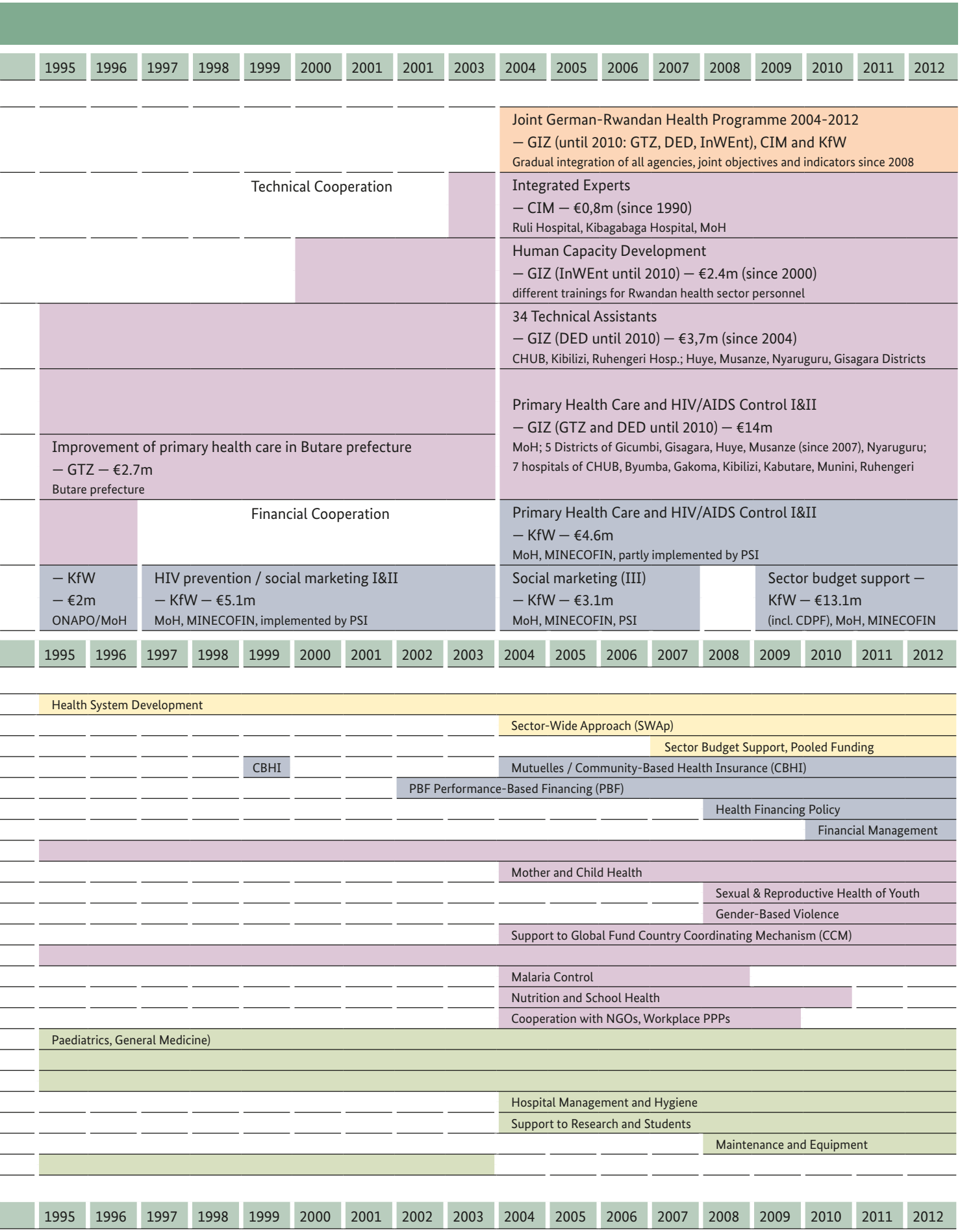
1962–1978 | 1979 | 1980 | 1981 | 1982 | 1983 | 1984 | 1985 | 1986 | 1987 | 1988 | 1989 | 1990 | 1991 | 1992 | 1993 | 1994

Topics (per programme component)

- **Overarching**
  - SWAp & Joint Financing
- **Component 1**
  - Health Financing
- **Component 2**
  - Sexual & Reproductive Health (1986–1994)
  - Specific Diseases
- **Component 3**
  - Human Resource Development, Health Technology Management
  - HIV&AIDS Control (1991–1994)

- Clinical
  - Human Resource Development: Nursing, Midwifery, Medical Doctors in Different Specialities (Internal, Gyn/Obs, Neurology, Surgery, Radiology, Clinical Services, Laboratory Work, Nurses, Pharmacists (by Development Workers) (1979–1994)
  - Medical Education (1982–1994)
- Equipment
  - Infrastructure (1982–1994)

1962–1978 | 1979 | 1980 | 1981 | 1982 | 1983 | 1984 | 1985 | 1986 | 1987 | 1988 | 1989 | 1990 | 1991 | 1992 | 1993 | 1994


1995 1996 1997 1998 1999 2000 2001 2001 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012
Joint German-Rwandan Health Programme 2004-2012
— GIZ (until 2010: GTZ, DED, InWEnt), CIM and KfW
Gradual integration of all agencies, joint objectives and indicators since 2008
Technical Cooperation
Integrated Experts
— CIM — €0,8m (since 1990)
Ruli Hospital, Kibagabaga Hospital, MoH
Human Capacity Development
— GIZ (InWEnt until 2010) — €2.4m (since 2000)
different trainings for Rwandan health sector personnel
34 Technical Assistants
— GIZ (DED until 2010) — €3,7m (since 2004)
CHUB, Kibilizi, Ruhengeri Hosp.; Huye, Musanze, Nyaruguru, Gisagara Districts
Primary Health Care and HIV/AIDS Control I&II
— GIZ (GTZ and DED until 2010) — €14m
MoH; 5 Districts of Gicumbi, Gisagara, Huye, Musanze (since 2007), Nyaruguru;
7 hospitals of CHUB, Byumba, Gakoma, Kibilizi, Kabutare, Munini, Ruhengeri
Improvement of primary health care in Butare prefecture
— GTZ — €2.7m
Butare prefecture
Financial Cooperation
Primary Health Care and HIV/AIDS Control I&II
— KfW — €4.6m
MoH, MINECOFIN, partly implemented by PSI
— KfW
— €2m
ONAPO/MoH
HIV prevention / social marketing I&II
— KfW — €5.1m
MoH, MINECOFIN, implemented by PSI
Social marketing (III)
— KfW — €3.1m
MoH, MINECOFIN, PSI
Sector budget support —
KfW — €13.1m
(incl. CDPF), MoH, MINECOFIN
1995 1996 1997 1998 1999 2000 2001 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012
Health System Development
Sector-Wide Approach (SWAp)
Sector Budget Support, Pooled Funding
CBHI
Mutuelles / Community-Based Health Insurance (CBHI)
PBF Performance-Based Financing (PBF)
Health Financing Policy
Financial Management
Mother and Child Health
Sexual & Reproductive Health of Youth
Gender-Based Violence
Support to Global Fund Country Coordinating Mechanism (CCM)
Malaria Control
Nutrition and School Health
Cooperation with NGOs, Workplace PPPs
Paediatrics, General Medicine)
Hospital Management and Hygiene
Support to Research and Students
Maintenance and Equipment
1995 1996 1997 1998 1999 2000 2001 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012

>> A National Police officer practices taking a DNA sample during a multi-sectoral training on gender-based violence prevention and response.

A multi-sector response to gender-based violence

Niko zubakwa, ntuzahave cyangwa ngo umene ibanga ry'urugo (Bear it: that is what keeps households together, stay with your husband and keep the secret of the family.)

This old Rwandan proverb expresses a cultural stance that makes it difficult for victims of domestic violence to speak out and seek help.[8] Out of fear and shame, they often decide to 'keep the secret' and the crimes remain 'invisible.' Although reliable data are difficult to collect, the 2010 Demographic Health Survey recently showed that domestic violence is very common in Rwanda: two in five women reported that they had experienced physical violence at least once since the age of 15. One in five women had experienced sexual violence sometime in the past. Most often, the perpetrator is the husband or intimate partner.

Although women and girls are disproportionately affected, gender-based violence can affect both men and women. 'Expectations on both men and women are high in our society, there is another proverb saying that a real man does not cry openly or express his emotions in public,' explains Caroline Mukasine, responsible for gender and the prevention of gender-based violence in the Ministry of Health. 'So, like the women, men also remain silent and this creates frustration. We need to break that culture of silence. It is not about denying our culture, but to overcome its negative aspects.'

Gender-based violence (GBV) in Rwanda existed before the war but became an integral part of the conflicts and was used as a weapon during the genocide. While 75 to 80 % of the victims of war and genocide were male, it is estimated that between 250,000 and 500,000 women became victims of rape and other gender-based violence in this period.

Although the country is peaceful today, domestic violence is often a problem in post-conflict societies, and recent research shows that Rwanda is no exception.[9]

Nonetheless, the Government of Rwanda has made steady progress in reducing inequalities between men and women. 'The political and legal framework in Rwanda is well elaborated,' Caroline Mukasine explains. 'We have a national policy against gender-based violence, a law on child protection, an important law on matrimonial relationships which recognizes equal property rights for spouses, and most importantly the law against gender-based violence which also defines the forms of gender-based violence. At the community level, there are local GBV committees formed by community representatives. They play an important role with regards to prevention as well as reporting.'

However, there is still a need to combine the different response systems to create a functional and effective multi-sectoral response to gender-based violence. Victims need a variety of services from different service providers such as health facilities, the police, the legal sector and civil society.

Until 2012, the German Development Cooperation and UNICEF co-chaired a national multi-sectoral working group under the Ministry of Gender and Family Promotion (MIGEPROF). The group brought together line ministries such as the Ministry of Health and the Ministry of Justice, and key institutions such as the National Public Prosecution Authority and the National Police. It provided technical support for Rwanda's first Policy and Strategic Plan against Gender-based Violence, and helped draft practical guidelines for referral and integrated services for victims at district level.

[8] The Rwandan policy against gender-based violence uses the term 'victim' rather than 'survivor.' Although the latter term has been adopted internationally to highlight the strength, resilience and capacity of people who have been subjected to gender-based violence, in Rwanda 'survivor' is used solely to refer to survivors of the genocide.

[9] RWAMREC, MenEngage, ICRW, UNDP (2010). Masculinity and Gender-based violence in Rwanda. Experiences and perceptions of men and women.

>> GIZ trained peer educators in ‚theatre for development' addressing health, gender and gender-based violence.

With Health Programme assistance, capacity-building activities were undertaken at all levels, including training of trainers, training of health service providers, appointment of focal persons at health facilities, training of Community Health Workers, the police, local leaders, and the wider community. In addition, GIZ National Technical Advisors based in four districts supported the creation of multi-sectoral working groups on gender-based violence. These groups meet monthly, and include local authorities such as police officers, prosecutors, hospital directors, health centre focal persons, and civil society representatives.

Caroline Mukasine underlines the value of German Development Cooperation's multi-sectoral approach: 'The working groups give service providers the important possibility of identifying needs such as better medical and social care and support, and conservation of evidence for prosecution, including DNA. Additionally it allows service providers to discuss gender, violence and conflicts among themselves and within their community. Remember, it is not always easy to overcome the culture of silence, for themselves as well as in discussion with others.'

>> Kigali, March 2011: Young people discuss their ideas during a consultative stakeholder workshop to prepare the national policy on Adolescent Sexual and Reproductive Health.

Adolescent sexual and reproductive health

Rwanda is very young: 67 % of the total population is under 25 years old. Adolescents are vulnerable to a variety of sexual and reproductive health risks including sexually transmitted infections, HIV and AIDS, early or unwanted pregnancy, unsafe abortion, and gender-related violence. Evidence shows that withholding information and services from adolescents only increases a risky and unprotected sexual initiation.

Giving them a voice: involving young people in sexual and reproductive health policy

When a small group of representatives from different ministries, institutions and development partners first met in May 2010 at the Ministry of Health, the Working Group on Adolescent Sexual and Reproductive Health was born. Dr Diane Mutamba, responsible for Adolescent Sexual and Reproductive Health and Rights in the Ministry of Health explains: 'We were lacking a common definition of what youth friendly services mean for Rwanda's young people and how these services should be offered in the health facilities. Therefore the establishment of a national working group focusing on adolescent issues was very important to harmonize approaches and put new strategies on the way forward.'

Due to the longstanding experience in strengthening sexual and reproductive health services for young people, German Development Cooperation was selected to co-chair the Working Group with UNICEF. To create demand and acceptance of sexual and reproductive health services among young people in Rwanda, the Working Group involved them in all stages of elaborating the policy, including a series of consultative workshops. As a result, Rwanda`s policy not only builds on international definitions of youth friendly sexual and reproductive health services but – perhaps most important – reflects the recommendations of the Rwandan adolescents.

With support of the Health Programme, the Ministry of Health and the Rwanda Biomedical Center developed a range of information, education and communication materials. This includes a booklet called *Teta est-elle têtue?* ('Is Teta stubborn?') which was designed for children and adolescents, but especially young girls. It focuses on strengthening women and young girl's ability to say no to unprotected sexual intercourse, cross-generational sex, and gender-based power imbalances. The booklet has been distributed to schools and youth centres, and will be used as part of a minimum adolescent sexual and reproductive health 'package' at health facilities and the community level.

>> The booklet Teta est-elle têtue? helps girls to say 'Oya!' (No!).

>> In a rural market in Huye District, peer educators perform a theatre play on sexual and reproductive health of youth.

Peer education

Peer education has been a special focus of the Health Programme. In four target districts, young volunteers selected by local health centres have been trained in sexual and reproductive health and rights using participative methods such as theater performances or sport competitions. They easily reached their peers, but also the wider community including parents, teachers, local opinion and religious leaders. Some especially creative groups of young people even set up cooperative income-generating activities around the health centres such as small-scale farming. According to Samuel Uwizeyimana, National Technical Assistant from German Development Cooperation based in Huye District, 'Such activities help them to start a healthy sexual and reproductive life at the same time as they become productive members of society. They learn about sexual and reproductive health, but also about farming and activities like book keeping.' Over the years, a total of 1610 peer educators in the four districts have been trained.

From 2013 onwards, all health centres in the 30 districts that have been supported by the Health Programme will include a team of two community peer educators, one male and one female. They will be selected and supervised by the health centre focal point for adolescent sexual and reproductive health and rights.

'Peer education is important because it involves adolescents and they are less afraid to ask for services,' Dr Diane Mutamba explains. 'Past experience had shown us that youth involvement is key to the success of youth programmes. At the same time we will strengthen the supply side, because we train health care providers who then offer improved services.'

>> Nurse in Byumba Hospital – a competent work force is essential for the future of Rwanda's health system.

Human resources development and medical education

An effective health system depends on a skilled workforce that is sufficient in number, evenly distributed, and motivated to provide good service. Under the general term Human Resources for Health (HRH), the training and management of health personnel is a priority for health policy and strategies in Rwanda.

Since 1979, German Development Cooperation has supported capacity development for medical doctors, midwives, nurses, interns, and health personnel in general under the coordination of the DED, through the secondment of medical experts to teaching institutions and hospitals. Germany continued and intensified its support in this area after the war and genocide, when health workers and doctors had been killed or fled the country.

Since 2004, when the Health Programme was established, support to the Ministry of Health has aimed to ensure a coordinated approach to developing and managing health system staff. This included efforts at the policy making level at the Ministry of Health, but also at the service delivery level in the teaching hospitals. A number of specialists, mainly German doctors, have helped to improve teaching methods and medical curricula in collaboration with the Faculty of Medicine. While doing on-the-job training with young Rwandan doctors, they have enhanced the quality of the clinical care provided as well as supporting them in their research and publications.

Human Capacity Development

The two main components of health system strengthening in Rwanda are decentralisation of health service management and sustainable health financing mechanisms. Both require increased numbers of skilled health professionals in the districts including doctors, pharmacists, nurses, administrators of health services and district hospitals, teaching staff, and professionals of other health related areas.

German support to strengthening human resources in the health sector through training was primarily provided by the former agency InWEnt (now GIZ) the heading of Human Capacity Development (HCD). All training activities were integrated in regional programmes, partnering with Cameroon, Kenya, Malawi, and Tanzania. The main focuses were on health system strengthening, HIV and AIDS, and orthopaedic technology.

Around 600 Rwandans have directly participated in HCD activities under the Health Programme, and the majority have continued to invest in their education and share their knowledge after returning home. Most of the courses focused on the three areas of health system strengthening, HIV and AIDS, and orthopaedic technology.

From 2003 to 2005, HCD/InWEnt carried out professional training for district doctors in collaboration with the Rwandan School of Public Health. In following years, the range of courses and events expanded dramatically. Training events after 2005 were increasingly designed as 'blended learning' courses, combining classroom teaching with computer-mediated modules.

A highlight was the 'International Leadership Training in Hospital Management' course, for which a total of 20 participants from the five partner countries were selected every year. After a 6-month preparation in their home countries the participants joined a 12-month course at the University of Neu-Ulm in Germany, which included a four month German language course, five-months of hospital management theory, and three-month vocational work experience at German hospitals). After returning to their countries they elaborated their own projects for improving management processes in their hospitals. Since 2005, 20 participants from Rwanda have completed the course.

>> Rwandan participants in the International Leadership Training in Hospital Management, 2006–2007: Donatien Bajyanama, Béatrice Uwayezu, Edward Kamuhangire and Innocent Karengera (left to right).

With the aim of combating HIV, HCD/InWEnt adopted a multi sector approach including prevention, reduction of the social and economic consequences, treatment and care. To enable professionals to carry out HIV prevention activities themselves, HCD/InWEnt carried out trainings for both medical and non-medical personnel on a variety of topics. The activity began in 2004 when, in collaboration with the Kigali Health Institute, HCD/InWEnt trained teaching staff of national nursing schools. These in turn have since trained 245 students and members of anti-Aids-clubs about the medical and social aspects of HIV and AIDS. This was followed by a number of other courses aimed at different groups. In 2009, for example, 55 health professionals in 12 health centres in Huye district were trained on HIV and reproductive health of young people. For a different audience, the blended learning course 'HIV and Gender: From knowledge to practice' taught non-medical personnel from diverse sectors (education, health, economy) and institutional levels (government, NGOs, private sector) to develop gender-oriented HIV prevention activities. Nine participants from Rwanda attended this course.

Since 2003, HCD/InWEnt has supported the Tanzania Training Centre for Orthopaedic Technology (TATCOT). In 2006 and 2007, three Rwandan orthopaedic technologists completed their diploma for orthopaedic technology and contributed to greater access to orthopaedic technology in Rwanda. In 2008, a nine-month e-learning course on spinal orthotics took place, which was particularly designed for alumni of the diploma course. Two out of 20 participants came from Rwanda.

Box 2. Neurology in a Rwandan University Teaching Hospital

By Dr Celestin Kaputu

Since April 2011, I have been working as a neurologist in the University Teaching Hospital of Butare (CHUB). My work can be summarized in three areas: patient care, medical education, and research.

First of all, I am involved in the management of common neurological pathologies. For example, one of the major challenges in the south of Rwanda is neurocysticercosis, which is a tapeworm infection of brain tissues caused mainly by eating infected pork meat. The most important complications of this condition are convulsions (seizures) that are often difficult to control with the available antiepileptic drugs.

Secondly, I support the medical school's efforts in improving health care delivery through my contribution to the ongoing training of medical students and doctors. This will enable them to effectively treat common neurological conditions, which they are likely to encounter in their daily work as general practitioners.

Finally, I participate in research through medical students and postgraduate final dissertations. This applies to the medical students at the end of their internship and doctors at the end of their training (specialist candidates).

During regular ward rounds, we teach while treating. Through the bed-side teaching, medical students doing their internship and post graduate students have the opportunity to learn how to conduct neurological examination and to manage common neurological ailments. They also become familiar with electroencephalography and electromyography machines as well as the interpretation of examination results.

I give a course in neurology with a research component at the Faculty of Medicine of the National University of Rwanda, where I supervise final year dissertations of medical students in numerous subjects. An example of the research carried out is a study on the clinical and epidemiological profile of epilepsy in CHUB, which is going on with the collaboration of the outpatient department. The aim at the end of this study is to control the preventable causes of convulsions in the southern province, such as unfavourable birth conditions or problematic food habits due to lack of education.

In conclusion, the three areas of my work give me the opportunity to be in the teams that make the job exciting. It also makes me forget the heavy workload I have!

>> Training while treating: Dr Kaputu with a patient and some of his students.

Health technology management

Under Component 3 of the Health Programme, hospitals received a range of support in the area of Health Technology Management (HTM) and Maintenance. A wide variety of equipment and technologies are found within health facilities such as medical equipment, energy equipment, workshops, and tools for workshops. HTM therefore deals with the management of all those technologies and all the human resources development required for their proper utilization. While the term is often thought to apply only to maintenance and repairs, many other skills are required in order to manage properly the maintenance department of a hospital.

While designing the new phase of the Health Programme in 2007, KfW and the Ministry of Health decided to finance additional equipment for hospitals. As most of the equipment provided in the previous phase had become run-down, the Rwandan authorities, GTZ and KfW hired an international expert to analyze the situation and propose a sustainable maintenance approach for hospitals. The study highlighted a variety of challenges, from the lack of systems needed to identify all of the Ministry of Health assets at national level and hospital level to the limited know-how available in maintenance and HTM in general. However, the study also found strong points such as the availability of technicians and engineers trained in subjects such as electronic, electrical and electromechanical engineering who could be turned into biomedical engineers and technicians.

In the years since the analysis was produced, much has been achieved. At central level, the Health Programme initiated the establishment of a Working Group on Geographical Access and Healthcare Technology Management in 2009 and acted as its co-chair. Support of GDC at central level also included technical assistance in the elaboration of the new national policy on engineering and maintenance, standards for health facilities infrastructure and equipment, and a medical equipment maintenance database.

At health facilities level, German Development Cooperation provided medical equipment, rain water collection tanks, and tools for maintenance and repairs. The equipment was accompanied by theoretical and on-the-job training on medical equipment maintenance, repair and management. Updates of inventories have been going on since 2008 in each of the partner district hospitals, and Germany was the first development partner to support hospital maintenance departments with tools. As Marcel Ntuyekunkiko, head of maintenance in CHUB, says, 'It is really highly thoughtful of the German Cooperation to support us in this area, as no other development partner gave it any importance.'

In spite of the remarkable progress, much remains to be done. Health Technology Management is a new topic in Rwanda, and a great deal of health technology has been neglected for decades. Due to the advocacy done during the last years, there is now more awareness of its importance at central and health facilities level. Yet more organisational and quality assurance is still needed, and there are serious funding gaps for preventive maintenance, repairs, and spare parts purchase that need to be addressed urgently. An inventory system at national and decentralized levels has still to be set up and the number of biomedical engineers in the country still needs to be increased. On a positive note, however, the first batch of biomedical technicians has just graduated in Rwanda and they will work on improving HTM in the country.

>> Anesthesia machine in Byumba Hospital provided by the German Cooperation in 2010.

District and hospital support

The Health Programme has provided a range of support to the District Health Units of five partner districts – Gicumbi, Gisagara, Huye, Musanze and Nyaruguru – as well as their respective District Hospitals and the University Teaching Hospital Butare (CHUB). A key principle was to provide feedback on experiences at central and district level, and to improve cooperation between the two levels. In line with the sector priorities defined by the Ministry of Health and in District Development Plans, support was given in all three programme components (health financing and system development; sexual and reproductive health; human resource development and health technology management) as well as to cross-cutting issues such as gender. The Programme's District Technical Advisors provided most of the capacity development for district-level institutions and personnel.

Planning and coordination

Among other activities, GIZ supported evaluations of *Imihigo* performance contracts and the preparation of district action plans. It also participated in activities related to district health system management, assessment, monitoring and evaluation, including formulation of recommendations. Finally, GIZ provided support to the districts' Joint Action Development Forums (JADF) and their health sub-commissions.

Health financing

As discussed earlier, Performance-Based Financing (PBF) is aims to improve quality of health service delivery by giving financial incentives to well performing staff. Rigorous evaluation has demonstrated that PBF has improved maternal and child health outcomes in Rwanda by delivery in health facilities and increasing prenatal care quality.[10] German Development Cooperation therefore supported PBF in Ruhengeri Hospital which led to improvements in management and clinical services. It also assisted focal points of PBF steering committees of districts in database management. According to Tito Turatsinze, GIZ District Technical Advisor for Gicumbi and Musanze, 'This has helped to improve the quality of services given to people because providers have become more motivated.'

Between 2004 and 2012, membership in the Community Based Health Insurance (CBHI) across the country as whole increased from 44 % to 91 % in 2012 of the population. At district level, German Development Cooperation supported the orienting of new managers, and collaborated with the district directors in supervision of individual sections (i.e. offices) in order to improve management. Supervision visits focused on reviewing the managers' performance, monitoring newly trained managers, verifying billing processes and bank statements, and verifying the efficient use of existing financial and administrative tools. Materials and equipment were provided to CBHI sections with demonstrated needs.

In 2005, a German-supported social fund was established in seven hospitals to support uncovered costs of the poorest of the poor. In addition, the social funds help cover the costs of CBHI members who cannot afford co-payments, are temporarily unable to pay premiums, or need support in associated costs like transport and food, etc. The social funds are thus a social safety net for emergencies.

>> Byumba Hospital has received German Development Cooperation support, including the supply of ambulances.

[10] Basinga et al. (2011). Effect on maternal and child health services in Rwanda of payment to primary health-care providers for performance: an impact evaluation. Lancet, 377: 1421–28.

>> Jean-Marie Sinari, GIZ district technical advisor (left), and Athanase Karemera, district health officer of Nyaruguru (right), collect feedback during the joint planning of GIZ and district partners in January 2012.

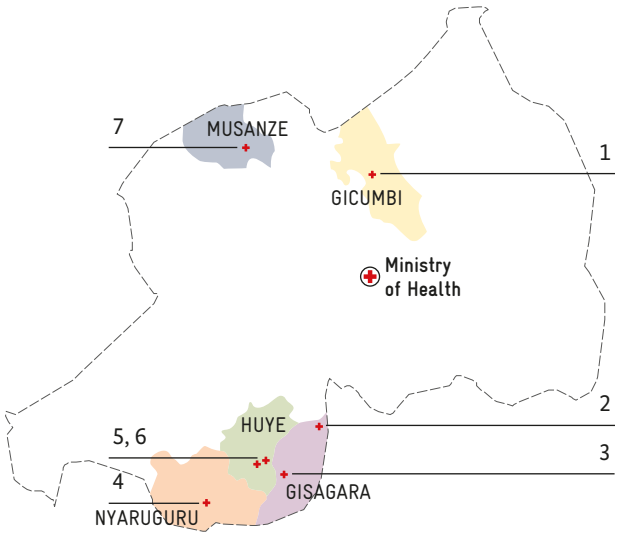
Reproductive health

The Health Programme supported family planning, mother and child health, adolescent sexual and reproductive health, and gender-based violence in the five target districts. The key instrument in the area of reproductive health was technical assistance provided by Technical Advisors and Development Workers based in the districts. Activities included trainings on family planning with an emphasis on long-term contraceptives, the provision of contraceptives via a social marketing approach (financed by KfW), sensitization activities at the level of the community, and the provision of family planning equipment for Secondary Health Posts. In the field of mother and child health, German Development Cooperation assisted in trainings on emergency obstetrical and neonatal care, and on the integrated management of childhood illnesses. Doctors recruited as Development Workers helped implement delivery of routine obstetrical fistula repair at Ruhengeri Hospital and carried out yearly training workshops on dealing with fistula.

Many challenges remain at district and hospital level, including inadequate coordination between district authorities and hospitals, high staff turnover, and the need to improve management capacity. Moreover, improving equipment and staffing of health centres will be crucial to achieving the health-related Millennium Development Goals. Nevertheless Jean-Marie Sinari, GIZ District Technical Advisor for Huye and Nyaruguru, is convinced that a corner has been turned: 'The joint planning of activities and joint evaluations has helped establish a culture of participatory planning, continual monitoring of activities and performance orientation in our partner districts.' Adds Dr Silvestre Ndagimana, Director of Kibilizi Hospital in Gisagara District, 'The activities we have done together with GIZ have been based on the principle of equity and aimed at strengthening the capacities of staff. Those activities have been really important for the management of the hospital and for better care of patients.'

Map 1. Partner Districts and hospitals in the north and south of Rwanda.

1	Byumba District Hospital
2	Gakoma District Hospital
3	Kibilizi District Hospital
4	Munini District Hospital
5	University Teaching Hospital of Butare
6	Kabutare District Hospital
7	Ruhengeri District Hospital



Box 3. Reducing neonatal mortality through Kangaroo Mother Care in Munini District Hospital

>> In the year after the implementation of Kangaroo Mother Care at Munini District Hospital, the infant mortality rate dropped by 69 %.

In much of Sub-Saharan Africa, the highest risk period in an infant's life is the first 48 hours after delivery. Deaths most commonly occur due to sepsis and pneumonia. With this in mind, Rwanda has adapted the use of the Kangaroo Mother Care (KMC) method to improve neonatal care. KMC comprises the early, prolonged, and continuous skin-to-skin contact between the mother (or substitute) and her baby, both in hospital and after early discharge. It also includes support for positioning, feeding (ideally exclusive breastfeeding), and prevention and management of infections and breathing difficulties.

In recent years, German Development Cooperation has supported Munini District Hospital in building capacity for mother-child health, with a focus on KMC that was implemented by the neonatology department (support in this area was also given to the University Teaching Hospital Butare). All paediatric and maternity staff were trained on KMC and child health audit, and a KMC room was set up. The hospital has also provided venues for staff debates and feedback to reinforce use of KMC. In addition, all doctors were trained in the use and interpretation of echography.

In one year following implementation in 2010, Munini District Hospital reduced its neonatal death rate from 77 per 1000 live births to 25, a reduction of 69 %. This is an outstanding achievement. Not only was Munini the most successful district hospital in reducing neonatal deaths, but it was also the most successful in reducing maternal death rates.

Supporting Rwanda's applications to the Global Fund

Malaria, tuberculosis (TB) and AIDS claim millions of lives every year in the developing world. In 2002, the Global Fund to Fight AIDS, Malaria and Tuberculosis was set up to specifically target resources to fight these diseases in middle and low income countries. To date, programmes supported by the Global Fund have provided AIDS treatment for 3.6 million people, anti-tuberculosis treatment for 9.3 million people and 270 million insecticide-treated nets for the prevention of malaria. A total of US$ 22.9 billion has been provided for more than 1,000 programmes in 151 countries.

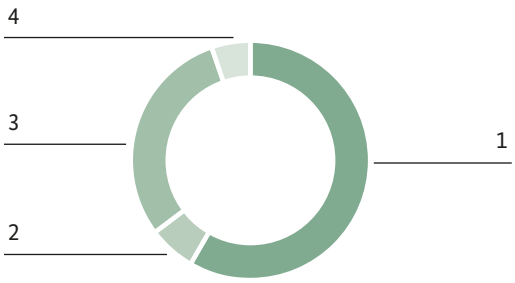
Rwanda is a beneficiary of the Global Fund and has so far been approved grants worth US$ 912 million. HIV and AIDS have received the greatest proportion of funds (see Figure 5). A total of five grants for HIV and AIDS, four grants each for TB and malaria, and one grant for health systems strengthening have been approved for Rwanda over the past decade.

For the application process to be successful, the applicant country has to submit viable project proposals; once approved, it must be able to effectively employ these funds. This requires specialised expertise. The German BACKPUP Initiative was set up specifically to provide countries and civil society organisations with the necessary support to successfully apply for grants and implement various approved programmes.

Working with the Health Programme, BACKUP has supported 20 activities that have supported Rwanda in its dealings with the Global Fund. These activities have included conducting situation analyses for particular topic areas, developing grant proposals, and implementing approved projects. For example, support was provided for a successful National Strategy Application for a Global Fund grant for HIV and TB. The National Strategic Plan was developed with the broad participation of all stakeholders involved in addressing HIV, AIDS and TB such as communities, civil society organizations, ministries and development partners.

Figure 5. Global Fund grants to Rwanda as of 2012

1	HIV and AIDS	$532.591.980
2	Tuberculosis	$58.344.072
3	Malaria	$273.246.193
4	Other	$48.535.127



Source: Global Fund, Rwanda Portfolio, October 2012.[11]

[11] Global Fund (2012). Rwanda Portfolio. Available at http://portfolio.theglobalfund.org/en/Grant/Index/RWN-M-MoH.

Another example was support for the proposal on health system strengthening that was approved in 2005. This grant was revolutionary because it was the first time worldwide that a Global Fund grant could be used not only for disease-specific measures but also for broader health system strengthening. At the time, large parts of the Rwandan population were unable to pay for health services and were often faced with poor quality services that were delivered at a high cost. Apart from training health personnel, the grant has been primarily used to subsidize health insurance membership for indigents and vulnerable groups. As of 2010, the programme had already enabled insurance coverage for 1,557,709 very poor people, as well as 82,892 orphans and 146,130 people living with HIV. The grant was thus instrumental in Rwanda's move towards universal coverage, which saw membership in community-based health insurance rise from 44 % in 2005 to 91 % in 2012.

As shown in Table 3, the country has made strong progress on all three Global Fund diseases over the past decade.

Table 3. HIV and AIDS, malaria and tuberculosis indicators for Rwanda

2002 and 2010

Diseases	Indicators	2002	2010
HIV and AIDS	Prevalence of HIV (age 15–49)	3.9 %	3.0 %
Malaria	Reported malaria deaths	3167	670
Tuberculosis	Incidence of tuberculosis (per 100,000 population)	225	106

Sources: WHO Global Health Observatory, Rwanda Demographic and Health Survey 2000 & 2010, UNAIDS 2008 Report on the global AIDS epidemic, WHO World Malaria Report 2011

Mainstreaming HIV, sexual and reproductive health, and gender-based violence responses

Could HIV impact on the attainment of programme or project goals? Does the programme or project inadvertently contribute to spreading HIV? Can the programme or project – within its given mandate – contribute to the given sector's HIV response?

These are the three HIV mainstreaming questions that every programme or project in Sub-Saharan Africa mandated by BMZ has to take into account. In the Rwandan-German cooperation, mainstreaming started in 2005 and is even more complex, addressing not only sexual and reproductive health (SRH) but also gender-based violence (GBV) and other gender related issues. But does a health programme, dealing precisely with these topics also have to mainstream them? 'Yes!' asserts Dr André H. Mbayiha, former advisor for maternal and child health and currently HIV focal person of the Health Programme. 'We have to ask ourselves the three mainstreaming questions like every other programme. And even more because HIV control is part of our mandate, so we have to make sure to mitigate possible negative impacts between the programme goals and HIV, SRH and GBV.'

Consequently, until mid-2012, the focal point in charge of HIV, SRH and GBV Mainstreaming for the German cooperation in Rwanda was provided by the GIZ health programme. This not only allowed programme staff to provide technical support, but also to gain valuable knowledge and information from their contacts in national institutions, involvement on the policy level, and participation in different national working groups. On policy level, Rwanda set a very ambitious mainstreaming framework by integrating HIV, with linkages to gender and sexual and reproductive health in its Economic Development and Poverty Reduction Strategy (EDPRS) for all sectors by 2008. Today, the Rwandan Government and national institutions support HIV mainstreaming, and organisations and companies in the public and private sectors are expected to take it into account.

Internally, a comprehensive workplace programme dealing with the wellbeing of GDC staff was set up. Using the medical and health expertise of Health Programme colleagues, peer educators were trained in every programme and organisation. Emmanuel Ntoranyi, driver and peer educator in the Health Programme, comments, 'I am proud to be a peer educator because this has allowed me to change and to acquire new knowledge. After the trainings I shared this knowledge with my colleagues and I think internal mainstreaming had a positive impact as I could observe a change in their comprehension and behaviour. For the future, I would like to always be a peer educator in my family, my village, Rwandan society and everywhere where I will be.'

However, the strong involvement of the Health Programme also presented a challenge. As mainstreaming topics are related to health, it was sometimes difficult to communicate the fact that mainstreaming does not only concern the health programme. Colleagues from other programmes would make comments like, 'You already take HIV, SRH and GBV into consideration in the Health Programme, so we don't have to do it in our work'. Today, however, mainstreaming topics are integrated in all GDC activities, and the 'One Mainstreaming' team will assure that mainstreaming will remain successful after the departure of the Health Programme.

>> Emmanuel Ntoranyi, driver and peer educator in the GIZ health programme

Box 4. A day for the whole family

>> Activities at the German Development Cooperation Staff and Family Day, 2010.

The first GDC Staff and Family Day, held in 2010, was the result of staff recommendations to have an event that included partners and children. Held with the participation of GTZ, DED and KfW staff, the day was a highly successful event, attracting approximately 300 people to share fun and awareness on theme of 'Health and Rights.' In addition helping plan the day's activities, almost all members of the Health Programme volunteered to conduct awareness raising sessions on different topics for all age groups, working together with peer educators. Innocent Kamali, national advisor for HIV, SRH and GBV mainstreaming, commented that, 'This event gives participants the opportunity to discuss topics with their families that are usually taboo.' Sandy Kubaj, advisor for HIV, SRH and GBV mainstreaming and GDC focal point, agreed, and added, 'For me, this event was not merely a part of the mainstreaming work or a means to raise awareness. It created a sense of belonging to GDC and a space for personal exchange amongcolleagues.'

>> Innocent Kamali and Sandy Kubaj at the German Development Cooperation Staff and Family Day, 2010.

>> Rwanda's healthy future: children at the German Development Cooperation Staff and Family Day, 2010.

An orderly phasing-out

In 2010, Rwanda embarked on a policy to rationalize the division of labour among development partners, proposing that each development partner should be active in no more than three sectors. In line with the 2005 Paris Declaration on Aid Effectiveness, the policy targeted objectives such as reducing the transaction costs that result from having to deal with multiple donors, ensuring an adequate distribution of partners across sectors according to Rwanda's development priorities, and making best use of each partner's comparative advantages.[12]

Following a proposal from the Government of Rwanda, the BMZ agreed to move out of health and to concentrate German Development Cooperation activities within the sectors of decentralisation and good governance, employment promotion and technical and vocational education and training. It was further agreed that German support to the Rwandan health sector would end in December 2012, although some technical assistance will continue until April 2013 to finish on-going projects.

In the transition period from 2010 to 2012, German support was gradually reduced in some areas and the programme was further focused according to health sector priorities. The discussion of options for handover of responsibilities and the actual replacement of German support, where needed, took place in 2012. This process was carried out jointly with the Ministry of Health as well as district and hospital partners, and in close consultation with other development stakeholders. As part of the phasing-out process, the two governments also decided to commission an independent evaluation of 35 years of cooperation (with a focus on the period 2004–2012), which is to be carried out by the newly founded independent German Institute for Development Evaluation.

During 35 years of continuous cooperation between 1979 and 2012, Germany provided technical and financial support valued at over €60 million to the Rwandan health sector. A total of 140 Development Workers participated in a wide range of activities. Systems have been created, policies devised, a great deal of training provided, and programmes funded and set in motion.

But most important of all, there is abundant evidence that these activities and the people who implemented them have helped to build a healthier Rwanda.

[12] See: OECD-DAC (2011). Rwanda: An Example of Country Leadership in Division of Labour. WP-EFF Task Team Division of Labour and Complementarity.
MINECOFIN (2010). Donor Division of Labour in Rwanda, September 2010.

Health Programme Staff, 2004–2012

GDC Health Sector Coordinators and Heads of GIZ Health Programme (GTZ until 2010)	
Elisabeth Girrbach	2008–2012
Dr Andreas Kalk	2004–2007

KfW Health Programme Staff	
Dr Kai Gesing	2003–2013
Hubert Eisele	2006–2011
Dr Wolfgang Weth	2011–2013

GIZ Technical Staff (GTZ until 2010)	
Ronald Bauer (SANIPLAN)	2008–2012
Anja Fischer	2006–2010
Alex Hakuzimana	2006
Peter Jäger (SANIPLAN)	2010–2011
Simon Kanyaruhago	2009–2011
Celestin Karamira	2007–2010
Evangeline Kayitesi Gakuba	2005–2007
Valentine Kilibazayire	2007
Dr Christoph Larsen	2008–2010
Dr André Havugimana Mbayiha	2010–2012
Bernard Zahinda Masheka	2008–2009
André Mboulé (SANIPLAN)	2008–2009
Didier Mukama (SANIPLAN)	2008–2012
Georgette Mutabazi	2006
Dr Olivia Nieveras	2011–2013
Marie Florence Prümm	2009–2012
Laurette Rudasingwa	2007
Viktor Siebert	2012
Jean–Marie Sinari	2011–2012
Tito Turatsinze	2011–2012
Théoneste Twahirwa	2009–2012
Claudine Uwase	2006–2007
Reinelde Uwukunda	2008–2010, 2012

GIZ Development Workers (DED until 2010)	
Claudia Fuchs	2005–2011
Friederike Amani Paul	2006–2007
Dr Thomas König	2006–2008
Dr Andreas Kiefer	2009–2012
Dr Irmgard Bruckmaier	2009–2010
Dr Hans–Jochen Diesfeld	2008
Dr Ruth Rottbeck	2007–2010
Dr Andrew Bourne	2007–2009
Dr Bettina Schulz	2007–2009
Kirsten Pörtner	2007–2008
Rose Feiler	1999–2006
Antje Strenger	2002–2006
Telse Badil	2001–2005
Dr Evert Jan Schouten	2003–2006
Dr Walter Krezdorn	2003–2007
Dr Olaf Müller	2003–2007
Juri Bergmann	2005–2007
Dr Bettina Utz	2005–2009
Sandy Kubaj	2008–2012
Innocent Kamali	2008–2012
Nina Hansing	2012
Wadislaus Rzepka	2007–2008
Süster Strubelt	2010–2011
Alessia Radice	2008–2010
Stefanie Dschida	2010–2011
Dr Carla Boehme	2009–2010
Dr Eva Grabosch	2005–2009
Dr Uwe Maas	2010–2011
Jeanne Kampire	2011–2012
Samuel Uwiyeyimana	2011–2012
Therèse Mujawamariya	2011–2012
Viktoria Stöger–Eising	2011–2012
Dr Yacouba Zanré	2010–2013
Dr Célestin Kaputu	2011–2013
Dr Roswitha Mersmann	2009–2012
Rose–Marie Heijens	2009–2011

>> GDC Health Programme Rwanda Staff, 2012, in front of the programme office in Kigali.

GIZ–CIM Integrated Experts	
Dr Lizet Boerstra	2010–2013
Oliver Briet	2008–2010
Dr Alfred Jahn	2003–2011
Gabriele Kampen	2007–2008
Dr Michael Kramer	2008–2009
Dr Odette Mukabayire	2007–2012
Nina Siegert	2011–2013

GIZ Support Staff (GTZ until 2010)	
Mohamed Dusabimana	2011–2012
Nathalie Kayiramirwa	2005–2006
Angelique Kwitonda	2011–2012
Jean–Pierre Mahoro	2007–2012
Monique Muhongerwa	2004–2006
Francois Munyampirwa	2003–2007
Deo Munyanshoza	2006–2012
Marthe Nirere	2003–2012
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Jonas Nizeyimana	2007–2012
Samuel Nizeyimana	2007
Emmanuel Ntoranyi	2006–2012
Ina Kalisa Rukundo	2006
Rosette Ugiraneza	2005–2012
Agnes Uwiduhaye	2006
Daniel Zabahimana	2000–2007

>> GIZ Team, 2007.

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Elisabeth Girrbach
Health Coordinator of the German Development Cooperation in Rwanda

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Registered offices
Bonn and Eschborn, Germany

Friedrich-Ebert-Allee 40
53113 Bonn, Germany
T +49 228 44 60-0
F +49 228 44 60-17 66

Dag-Hammarskjöld-Weg 1–5
65726 Eschborn, Germany
T +49 6196 79 - 0
F +49 6196 79 - 1115

info@giz.de
www.giz.de

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Viktor Siebert
Andrew Wilson
Elisabeth Girrbach

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On behalf of
Federal Ministry for Economic Cooperation and Development (BMZ)

Addresses of the BMZ offices
BMZ Bonn
Dahlmannstraße 4
53113 Bonn, Germany
T +49 228 99 535 - 0
F +49 228 99 535 - 3500

BMZ Berlin | im Europahaus
Stresemannstraße 94
10963 Berlin, Germany
T +49 30 18 535 - 0
F +49 30 18 535 - 2501

poststelle@bmz.bund.de
www.bmz.de