Public Expenditure Performance in Rwanda: *Evidence from a Public Expenditure Tracking Study in the Health and Education Sectors*

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Abstract

This report is the result of a public expenditure tracking survey (PETS) of the flows of resources to and from the providers of public services in the health and education sectors (health and education administrators) in Rwanda. The PETS traced the flow of budgetary resources form the ministry of finance to primary health centers and a sample of primary schools by quarter for 1998 and 1999 and collected information on sources of income for the facilities, expenditures on basic services, and the practices of accountability at various levels. It also surveyed the administrators and facility heads on the problems on the problems they face, how these problems could be resolved, and the quality and impact of the delivery of public services. A parallel **Core Welfare Indicators Questionnaire (CWIQ) survey** collected information for the beneficiary assessment of public social and other services.

The study found substantial delays in the process of transfers of public resources from the central administration to primary beneficiaries, and possible leakages of funds at regional and district health and education offices. The discrepancy between the amounts transferred by the treasury through the banking system to regional health and education offices for local administration of facilities, and the corresponding amounts from the records of these offices tended to be significant and variable across regions. The study found rampant lack of accountability in these offices, with poor bookkeeping and lack of internal financial controls and auditing requirements. Thus, the discrepancies could be due to leakages in the system or the unreliable bookkeeping. In any case, the lack of accountability created an atmosphere for leakages and mismanagement of funds.

In both the primary education and health, the budgetary allocations of the central government only paid the salaries of teachers and health workers, hence the facilities relied on household contributions and fees, and sporadic contributions from donors and NGOs. In the context of widespread poverty, the contributions from households were inadequate to meet the minimum operational requirements of the primary education system. This lack of operational inputs compounded the challenges of a system with a relatively high pupil-to-teachers ratio (58) and even higher pupil-to-qualified teachers (larger than 100), with adverse implications on education outcomes. The CWIQ survey results found that the lack of textbooks was seen as a major constraint to improving the quality of education. The cost of health services to households was also a major deterrent to using them. The CWIQ survey also found that 95 percent of respondents who needed to see a health provider but did not do so cited the high costs, and among those that consulted a health provider, 80 percent were dissatisfied with the costs.

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Evidence from a Public Expenditure Tracking Study in the Health and Education Sectors

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Acknowledgements

This study is part of the series of analytical efforts to support the development of a sound public expenditure management system in Rwanda. Recent analytical work include two public expenditure reviews (PER) in 1995-96 and 1997-98, a social expenditure review in 1999, sector PERs in both the health and education sectors in 1998 and 2000, and a justice sector expenditure review in 2000. Ongoing efforts include a transport sector PER, a financial accountability review and action plan, an agricultural sector PER and a broad public expenditure management review of progress in the implementation of the MTEF. All the recent exercises focus on supporting the implementation of the MTEF.

This report is based on collaborative work by several people from the Government, World Bank, and DFID. The principal collaborators from the Government included Vincent Karega, head of the National Program for Poverty Reduction (PNRP), Mme Claudine Zaninka, head of the Poverty Observatoire, and the Directors of Planning in the ministries of education and health.

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The World Bank team comprised of Chukwuma Obidegwu (team leader), and included Hippolyte Fofack and Robert Ngong (consultant). Francois Kanimba, Menahem Prywes and Essimi Menye (consultant) contributed at various stages of the work. Essimi was primarily responsible for managing the parallel CWIQ survey.

The Steering Committee consisted of representatives of DFID, World Bank, MINEDUC, MINISANTE, MINECOFIN, and the Head of PNRP. The technical team consisted of Faustin Minani as Director of Tracking, Robert Ngong (consultant to the World Bank) as Technical Adviser, and the Directors of Plan in MINEDUC and MINISANTE. The research analysts/data collection group were Mme Solange Umulinga, Mme Sylvie Munyarugendo Ilibagiza, Alexis Gasore, Desire K Munyansanga, J. Baptists Mushumba, Uzziel Ndagijimana, Hormisdas Ndayishimiye, Yves Ntabana, Joseph Twagirimana and Fidele Uwizeye.

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I. INTRODUCTION

Over the past few years, especially since the 1994 genocide, the Government of Rwanda (GOR) has made improving social services delivery and outcome indicators one of its key policy objectives. This policy objective has been reflected in the steady increase in the budgetary allocation to the social sectors, particularly in education and health. The budget of education as a percentage of total government budget increased from 12.1 percent in 1996 to 30.2 percent in 2000. The increase in the share of the budget for health was modest, from 2.5 percent to 3.1 percent during the same period.[1] The number of primary schools increased by over 16 percent from 1845 to 2142 between 1995 and 2000; the number of secondary schools increased even more rapidly, by about 60 percent, from 111 to 177 during the same period. Budget support from the donors and multilateral agencies enabled the GoR to raise recurrent expenditures in the social sectors to improve service provision. Nevertheless, public spending on health and primary education, at the equivalent of US$1.2 per capita and US$17.3 per student respectively are very low by any standards (see Republic of Rwanda, 2001).

The social indicators of Rwanda present a dismal picture. Table A.1 in the annex provides recent estimates of some Rwandan social indicators, along with estimates from neighboring countries and sub-Saharan countries as a whole for cross-country comparisons. Among the social indicators which are more sensitive to short-terms changes, the infant mortality rate and under-five mortality rates remain extremely high, at 131and 203 in 2000, respectively; maternal mortality rate is 810 in.2000.[2] Enrolment rates have been increasing at all levels of education but the quality of education is regarded to be very poor. Educational institutions lacked trained teachers, books and other educational materials. The health sector suffered also from the lack of qualified health professionals. The challenge of developing human resources, a key aspect of Rwanda's poverty reduction strategy, will require the commitment of more public resources to the education and health sectors but more importantly, progress will depend largely on the efficiency of use of these resources.

Government expenditure was 19.7 percent of GDP in 1999, comprising of 13.4 percent of recurrent spending and 6.3 percent in the largely donor funded development budget. Revenues amounted to 9.9 percent of GDP and thus external aid funded about half the budget. Due to concerns about security in the country and the Great Lakes region and Rwanda's involvement in the civil war in the neighboring Democratic Republic of the Congo (DRC), military expenditures were high, at about 4 percent of GDP. The burden of military expenditures and external debt service constrained expenditures in the social and economic sectors of the economy. Spending on the social sectors (education, health, gender, youth and reintegration) in 1999 was 4.3 percent of GDP compared to 4.2 percent for the

[1] The source of the data is the Ministry of Finance and Economic Planning MINECOFIN): **Rwanda Development Indicators (RDI)**, 2001.

[2] The **RDI** 2001 has the maternal mortality rate at 810 while the **African Development Indicators (ADI)** has 1300. The latter is used in Table 1since it is the source for other countries.

military. Nevertheless in the emergency and transition period following the genocide (1995-2000), relief organizations such as UNHCR and international NGOs funded the rehabilitation and operations of social infrastructure. These activities were not reflected in the budget. The presence of many international NGOs in the health sector relieved the pressure on the government to fund health sector rehabilitation and operations. Rwanda's total public expenditure per capita is now among the lowest in the region and declined from US$73 per capita in 1990 to US$40 in 2000, although the civil war and genocide increased the need for public expenditures. The effective use of the available resources is essential. In 1998, the Government introduced the prioritization of the budget, with the education and health sectors designated as priorities to receive increasing and protected budget allocations.

Since 1998, reviews of public expenditures in the social sector have provided the analytical basis for increasing budget allocations to social services. To supplement these largely "desk" exercises that relied largely on data from the Ministry of Finance and line ministries, it was decided to carry out a tracking survey of government expenditures on social services to determine the extent that funds reach the facilities that provide services to final consumers. The objective was to assess, through the flow of funds, whether there were delays and leakages of budget transfers, and hence, to gain insights into the links between inputs and outcomes and the utilization and accounting for those resources. The findings from the study were intended to inform the formulation of reforms to improve the effectiveness of budget spending and the impact on the intended beneficiaries.

Consequently, the Public Expenditure Tracking Study **(PETS)** was initiated in May 2000, to trace the flows and use of public expenditures from the Ministry of Finance and Economic Planning **(MINECOFIN)** to primary facilities and beneficiaries. PETS is not an audit of the public financial management system, rather it focuses on identifying areas of improvements in the efficiency of the administrative system. Hence, assessing whether the amount of funds appropriated actually reached intended beneficiaries was just as important as the objective of finding out whether the system in place consistently allowed for this amount to reach facilities in a predictable and timely manner, and was accounted for. In the past, similar studies were undertaken to assess the efficiency of public spending flows to the social sectors in a number of countries, including Ghana and Uganda (see Ablo and Reinikka (1998), Republic of Uganda (2000, 2001); Xiao and Canagarajah (2001)). The study by Ablo and Reinikka found that budgetary allocation can be misleading in predicting outcomes and impact, especially in the context of weak institutions where scope of leakages can be sizable.

This report is based on the data from a PETS survey of providers of public services in the health and education sectors (health and education administrators). The focus on the supply side is at variance with traditional beneficiary assessment that relies on information provided by users of public services (see van de Walle (1998), Demery (2000)). It draws on previous studies, but also extends beyond the flows of public spending aspects to assess the welfare effects of public service delivery, exploiting the combination of the PETS and CWIQ surveys.[3] This particular design was in response to the demands by Rwandan authorities who were also interested in assessing the nature and quality of the delivery of public services. Thus, in addition to the disbursement of funds at various administrative

[3] The Rwandan CWIQ draws on the prototype CWIQ and was adapted to include a household expenditure module to gain better insights on public spending allocation at the household level (see World Bank, 1999 for further details on the prototype CWIQ).

levels by quarter for 1998 and 1999, the enumerators collected information on sources of income for the facilities, expenditures on basic services, and the practices of accountability at various levels. Furthermore, the study surveyed the perceptions of the administrators and facility heads on the problems they face, how these problems could be resolved, and the quality and impact of the delivery of public services. A parallel **CWIQ** collected information for the beneficiary assessment of public social and other services.[4] The PETS covered two fiscal years, 1998 and 1999 and was limited to primary schools and health centers.

The study points to delays in transfers of public resources from the central administration to primary beneficiaries, and possible leakages between regional and district health offices. The discrepancy between the amount transferred by the Rwandan Central Bank (Banque Nationale du Rwanda) to regional health offices (RHO) for local administration of health services and the total amounts recorded to have been received by the RHOs tended to be significant and variable across regions. The study also found rampant lack of accountability, with poor bookkeeping and lack of internal financial controls and auditing requirements. Thus the discrepancies could be due to leakages in the system or the unreliable bookkeeping. In any case, the lack of accountability created situations for leakages and mismanagement. During the period 1998 and 1999, less than 22 percent of DHO carried out audits. For a given amount of resources allocated by the Central Bank, about 75 percent of it was recorded as received by RHO.

Similarly, the education sector faced a number of issues, mainly budgetary allocations were not commensurate with the needs and level of resources required for the sector. Most schools and education facilities, as a result, relied on household contribution and sporadic contributions from donors and NGOs. In the context of widespread poverty, the meager contributions from households were inadequate to meet the challenges of improving the poor education system. The relatively high pupil-to-teachers ratio (58) and even higher pupil-to-qualified teachers (larger than 100) reflects the significant resource deficit of the sector, and is an illustration of some of the challenges facing the education system with adverse implications for education outcomes.

This report is organized as follows. The next section provides a brief description of sampling methodology and fieldwork. Section III is on budget processes and flows of funds to the health and education sectors. Section IV traces the flow of funds in the health sector and section V traces the flows of funds and its use in the education sector. The last section of the report summarizes the findings and their implications for policy.

II. METHODOLOGY AND FIELDWORK

Sampling

The instrument for this assessment was a nation-wide survey of facilities and the relevant government offices and administrative services. In the health sector, the numbers of offices and health facilities were not very large; hence all the administrative and sub-

[4] The results from the CWIQ has been reported in Republic of Rwanda, ***Core Welfare Indicators Questionnaire (CWIQ) Survey 2001,*** National Poverty Reduction Program, Ministry of Finance and Economic planning, Rwanda.

administrative offices (11 Regional Health Offices **(RHOs)** and 40 District Health Offices **(DHOs)**) and all the 351 heads of health centers were surveyed.[5]

A different approach was used in the education sector. Specifically, a dual approach differentiating administrative units from education facilities was used during the sampling to achieve the objective of national coverage, in light of a relatively large number of education facilities. All administrative units, provincial and district levels offices were surveyed, but primary education facilities were sampled. Thus all the 12 Provincial Education Offices **(PEOs)**, and 154 District Education Offices **(DEOs)**, and a sample of 400 primary schools were surveyed out of the 2100 schools. The 400 schools were selected using a two-stage stratified random sampling method. Following a complete listing of schools in urban and rural areas, 43 and 357 schools were sampled in urban and rural areas, respectively, with probability proportional to the number of schools in the area. For the urban area, 9 of 43 schools sampled were from Kigali and all the remaining schools were sampled from "other urban" centers (essentially all provincial headquarters).

Table 1: Sampling Distribution of Health Facilities and Population Across Administrative Regions

					Health Centers responding fully	
Region	**Pop. as % of total**	**No of Health Districts**	**No of Health Centers**	**Avg. Pop. by Health Center**	**1998**	**1999**
Butare	9.76	4	37	20798	24	27
Byumba	8.93	2	25	28171	21	21
Cyangugu	7.53	3	23	25942	11	17
Gikongoro	5.58	2	22	20013	14	17
Gisenyi	10.32	3	25	32524	12	21
Gitarama	10.56	3	35	23782	23	25
Kibungo	9.20	4	32	22657	23	26
Kibuye	7.58	4	27	22142	23	24
Kigali	13.71	5	52	20779	22	31
Ruhengeri	12.86	4	33	30708	13	20
Umutara	3.88	3	24	12744	14	21
National	**100**	**37**	**335**	**23519**	**200**	**250**

Source: MINECOFIN, MINISANTE and PETS Survey.

Table 1 shows the distribution of the population, health districts and primary health facilities across administrative regions, indicating that health care facilities and population per health center were fairly evenly distributed across the country. While all primary health care facilities were surveyed some could not respond to the full range of items in the questionnaire. This was not due to any reluctance to share information but rather to the lack of information. The response rate (the number of facilities that were able to answer all the questions as percent of all facilities) varied across administrative regions and over time. For 1998, it ranged from 39 percent in Ruhengeri to 85 percent in Kibuye and for 1999, from 60 percent in Kigali to 89 percent in Kibuye. The response rate was consistently higher across

[5] Each region corresponds to a province except that Kigali Urban (PVK) and Kigali Rural (Kigali Ngali) are combined into one region (Kigali) in the health administrative system. In education, PVK and Kigali Ngali have separate provincial education offices. However, some facilities were inaccessible due to either security reasons or very poor roads from rains. The differences in the total number of schools and health centers in the selected sample versus the totals shown in individual tables are due to non-response in some facilities (because the head was absent or the information was not available or inaccessibility to certain zones.

all administrative regions in 1999, with the national average increasing from 60 percent in 1998 to 75 percent in 1999. Table 2 above provides the sampling distribution of educational facilities and district administrations across provinces.

Table 2: Sampling Distribution of Educational Facilities and School Age Population Across Provinces

Province	School age population as % total	N° of districts	N° of Primary schools	N° of schools sampled	Avg. N° of students per school
Butare	7.5	20	189	33	586
Byumba	8.6	15	170	31	748
Cyangugu	7.3	12	171	34	628
Gikongoro	6.5	13	161	31	593
Gisenyi	12.8	12	228	44	828
Gitarama	10.9	17	279	46	578
Kibungo	8.0	11	156	27	754
Kibuye	6.7	9	192	39	515
Kigali Rural	11.2	16	205	40	807
Kigali	3.7	3	54	8	998
Ruhengeri	12.6	16	229	45	810
Umutara	4.3	7	108	12	589
All	**100.0**	**151**	**2142**	**390**	**689**

Source: MINEDUC.

Administrative Arrangements

Staffs from the Ministry of Finance and Economic Planning (MINECOFIN), the Ministry of Education (MINEDUC) and the Ministry of Health (MINISANTE) were involved in the process right from the start, to ensure ownership and technical soundness of the findings. As Rwanda was still in the early stage of post-conflict institutional restoration, a good and shared understanding of the institutional dynamics was important for the credibility of the exercise. Before the design of the questionnaire, a review of the institutional framework for the flow of resources was undertaken. Prior to the fieldwork, a core group of staff from the MINECOFIN, MINEDUC and MINISANTE met regularly and discussed the institutional framework, the design of the questionnaire, the arrangements for the collection and analysis of data. The Steering Committee of the PETS discussed the recommendations of the core group and advised the survey team on technical issues related to sample design and selection procedures, content of the questionnaire and scope of the expenditure tracking study.[6] It was through this process that it was decided not to conduct a beneficiary survey as part of the PETS, but rather to modify the planned CWIQ survey to obtain information on of beneficiary perceptions about social services.

On the recommendations of the Steering Committee, six different questionnaires were designed to collect information on the flows of funds, the use of funds and the impact as perceived by service providers, at the provincial, district and facility levels in both the health and education sectors. At the facility levels, the school headmasters and heads of the health centers provided the information. The questionnaires were designed to collect statistics on each of the facilities surveyed. For the education sector, this included data for

[6] Members of the Steering Committee include senior level staff from the Ministries of Finance, Education, and Health, and Representatives from DFID and the World Bank.

calculating dropout and progression rates, number of qualified staff, number of classrooms and children per classroom, and some measures of the quality of facilities. For the health sector, the data included: number of qualified staff, number of households serviced by health center, numbers of various standard equipment for medical and logistical purposes, and numbers of fee exemptions. The survey also asked questions on compliance by administrative offices and facilities with any guidelines and procedures governing the use of funds, and good governance practices such as book keeping, financial management accounts, and record keeping. In addition, the survey sought the assessment of the challenges in the sectors by the local administrators and facility heads.

Trained survey enumerators conducted the surveys. The survey data were complemented with statistics on education and health inputs and outcomes from the relevant ministries. Senior officials from MINECOFIN, MINEDUC, MINISANTE and the central bank - Banque Nationale du Rwanda (BNR) were interviewed to obtain information on the flow of funds through their institutions. The flows were traced through all the nodes of the flow of funds except the commercial banks that naturally were unwilling to divulge to the public any available information on their clients' accounts.

III. BUDGET PROCESSES: FLOWS OF FUND IN THE HEALTH AND EDUCATION SECTORS

Budget Elaboration and Funds Release Processes:

This section provides a brief summary of the process of elaboration of the education and health budgets and a review of the different channels through which the funds allocated for health and education flow to the ultimate user/facility. During the period covered by the study, 1998-1999, the elaboration of budget in the health and education sectors started with discussions at the sectoral level (central and peripheral services and administrations) followed by discussions between sectoral ministries and the MINECOFIN. The regional and districts officers, including heads of public facilities did not contribute to the elaboration of the budget either in the health or education sector. A relatively large share of the aggregate education budget (more than 90 percent) covered wages and administrative expenses.

The non-wage budget allocations in **education** to the provincial and district levels, which covered operational expenses including the purchase of basic equipment and materials and transport of education officers was not based on any assessments of the needs in different regions/districts. In the 1998 and 1999 budgets, a lump-sum of RWF5 million was allocated to each provincial office, regardless of the number of schools, pupils and district offices within the jurisdiction or the requests for additional resources by facilities as a result of increasing enrollments in the provinces. All heads of PEOs and DEOs interviewed indicated that they did not prepare a budget and that the equal lump sum allocation to each province was a disincentive to the formulation of a budget at the provincial/district level. In the **health sector**, the budget preparation process recognized regional differences in needs and endowments; the total amount allocated to RHOs varied from about 10 million RWF in Cyangugu to over 20 million in Gisenyi and Ruhengeri (See Table 3).

Table 3: Distribution of Education and Health Facilities and Resources Across Regions						
	Education Sector			Health Sector		
Regions	No of Primary Schools	School age population	Amount received (RWF)	No of health centers (HC)	Pop. by HCs	Amount received (RWF)
Butare	189	110,680	5	37	192,379	17.42
Byumba	170	127,213	5	25	352,134	16.40
Cyangugu	171	107,467	5	23	198,891	10.02
Gikongoro	161	95,423	5	22	220,141	14.6
Gisenyi	228	188,753	5	25	271,034	20.42
Gitarama	279	161,239	5	35	277,461	16.72
Kibungo	156	117,568	5	32	181,255	15.76
Kibuye	192	98,843	5	27	149,460	16.73
Kigali	259*	219,273*	10*	52	216,104	17.72
Ruhengeri	229	185,528	5	33	253,343	20.18
Umutara	108	63,585	5	24	101,954	13.91
All	**2142**	**1,475,572**	**60**	**335**	**212,942**	**179.9**

Source: MINEDUC and MINECOFIN
** Kigali and Kigali Rural are combined*

The approach to budgeting at the level of sector ministries reflected a host of factors connected to the challenges of post-conflict recovery. In 1998 and 1999, Rwanda was in the early process of rebuilding its public institutions following the devastation of the genocide. This large turnover of staff following this tragedy led to the loss of institutional memory. Many of the key staff were not only new to government but also new to Rwanda. Government revenues were low and the donors financed a large part of public services that did not pass through the Government's budget that in any case was work in progress. Sector ministries did not have the capacity for budgeting and planning and lacked a rigorous institutional framework for intra-sectoral budget preparation.

The Government initiated budget reforms began in 1998 and, in this context, PETS was a useful intervention as it helped to understand the budget practices that had evolved and thus provide a better grasp of the challenges to the reform efforts. [7] Since 2000, the Government has adopted and is implementing an MTEF approach to budgeting that would require a rigorous and program based budgeting process in line ministries. In the 2001 budget, the central government introduced systematic transfers to local authorities for education and health services. These transfers attempted to reflect the differences in needs and endowments across regions. Rwanda is also implementing a political decentralization program that has started to shift budgetary and legislative power and responsibility to district councils.

Flows of Fund Processes

Operational Budget: Once the National Assembly approved the budget in the Annual Finance Law, the flow of funds process would start with a request by the sectoral ministry to MINECOFIN for the release of funds from specific budget lines. A summary of this process of release of funds to RHOs/DHOs and PEOs/DEOs was as follows:

[7] The 1998 budget was the first after the genocide that was in line with the legal and institutional requirements for national budgets.

- ***Sector ministry*** The budget accounting officer in the ministry submitted a formal request to MINECOFIN for the release of funds, with clear indication of the amount to be paid to the commercial bank account of the provincial/regional office.
- ***MINECOFIN:*** The Department of Budget in MINECOFIN would review the request and verify that it was consistent with the budget appropriations. Once cleared, the request was transmitted to the Office of the Treasurer (OT) for verification of the availability of funds. Any delays at this level would not be the result of cumbersome administrative procedures but often due to non-availability of funds at the time of the request.
- ***National Bank of Rwanda (BNR)*** Once the request went through the internal clearance process within MINECOFIN and approved, the OT authorized the BNR to credit the account of the provincial office at a commercial bank. BNR transferred the funds to the Kigali headquarters of the commercial bank with the account of the provincial office.
- ***Commercial Banks:*** The headquarters office of commercial bank remitted the funds to the relevant branch for the benefit of the provincial office. No delays occurred at this level of the channel since the transaction was purely internal to the Bank.
- ***Provincial Education Offices and Regional Health Offices:*** These administrative units remitted funds to the district level offices.
- ***District Education Offices and District Health Offices:*** This was the end of the flow chain, as no funds were remitted to schools or health centers.

Wages and Salaries: The Government paid the salaries and wages of staff in ministries, provincial and district offices directly to the bank accounts of individual staff. The Ministry of Public Service and Labor managed the central payroll system for all the non-teaching civil servants while MINEDUC managed that for teachers. Teachers and health staff regularly received their salaries through the banking system but there was a problem about establishing the actual number of teachers and non-teaching staff. In 1999, a census of civil servants including teachers led to the removal of over 6,000 presumably ghost teachers from the payroll. However, some of these ghosts were non-teaching staff or temporary/substitute teachers. Government policy was to pay only teachers.

Donor Funded Projects: Capital expenditures in education and health were largely financed by donors and the donor funds were channeled directly to the projects. However, donor supported projects also financed the activities of education and health facilities through in-kind contributions such as textbooks and medical equipment and supplies. Foreign NGOs also provided direct assistance to local facilities. However, donor and NGO assistance was often sporadic and difficult to systematically trace and quantify. Even with the external funding included in the budget, facility managers would often not know in advance whether they would benefit and the amount and timing of delivery of assistance.

Contribution from Households: This was a major source of financing for education and health facilities and included payments of school fees directly to education facilities, payments of health care services and the purchase of drugs as part of the cost-recovery mechanism that was standard practice in the health sector. In education, households also contributed directly to the schools through Parent Teachers Associations (PTAs).

IV. TRACKING OF THE FLOWS OF FUNDS IN THE HEALTH SECTOR

Overview

MINISANTE was responsible for defining and co-coordinating national health policy, providing pharmaceuticals and designing and implementing special programs targeted at specific diseases (malaria, HIV/AIDS) or preventive measures (vaccinations, maternal health care). At the provincial level, the eleven Regional Health Offices (RHOs) provide administrative, supervisory and planning capacity at the regional level and supervised health activities of districts. DHOs (each covering on average 1 district hospital and about 10 health centers) provided similar services at the district level. Below this level were the health centers that provided first care to the local population.

A District Health Management Team (DHMT), headed by a medical doctor in the DHO, managed the district health delivery systems. The team organized planning, delivery, supervision, training and accountability of health centers and the district hospital. A health committee that included representatives of the community managed each health center. The committee, accountable to the DHMT, managed health center funds and provided the link between the community and the technical practitioners and policy makers. No public funds were allocated to these health committees even for salaries, as a seat on these was on an unpaid, voluntary basis. The committee relied on donations for any occasional expenditure incurred.

The public funding for each health region and DHMT was determined in the internal budget process of MINISANTE, taking into accounts the needs of the region as well as the resources available from the projects of donors and NGOs. Salaries of the regional health officials in RHO, the DHMT, and the qualified staff at health centers were approved by MINISANTE and paid centrally. The operational spending of the RHO, DHO and DHMT was included in the budget of MINISANTE and paid directly by MINECOFIN to the regional offices at the request of MINISANTE. From 1999, the RHOs became involved in the budget process of MINISANTE.

Flow of funds

The flow of funds were initiated by MINISANTE, with the process depending on nature of the expenditure. Wage payments, the bulk of the expenditure in the health sector by the central government, involved two operations. MINISANTE supplied its payroll to MINECOFIN and monthly payments from central bank to commercial banks' accounts of staff became regular until requested otherwise by MINISANTE. This transaction involved the central bank and commercial banks and suffered no observable systematic delays or leakages.

Non-wage transfers to RHOs were to be disbursed quarterly. MINISANTE would authorize the release of funds through a simple request letter-format to the MINECOFIN, indicating the amount and specifying the beneficiary office. Once approved by MINECOFIN, the funds would flow from the BNR to the commercial bank account of the RHOs. For calendar year 1999, about RWF 135 million was transferred to the 11 RHOs by BNR. There was no significant gap between the aggregate amount transferred by the end of the year and the amount allocated. However, the cumulative amount of flows up to the end

of the third quarter showed substantial delays in the release of funds across regions. Table 4 shows that, on average, only about 20 percent of the budgeted funds were released in the first three quarters while 80 percent were released at the end of the year. These delays were largely attributed to the pattern of inflows of resources to the Treasury and the application of the cash budgeting system in MINECOFIN. [8]

Table 4: Funds Transferred to RHOs (RWF) in 1999

RHO	Total Amount Transferred to RHO.	Portion Transferred in Dec. (end of year)	
	Total Amount	Total	As % of total transfers to RHO
Butare	14.581.152	12.081.152	83%
Byumba	12.623.836	9.448.836	75%
Cyangugu	9.303.074	6.803.074	73%
Gikongoro	10.817.656	8.317.656	75%
Gisenyi	16.640.052	10.667.252	64%
Gitarama	12.076.564	11.361.464	94%
Kibungo	12.925.822	10.425.822	81%
Kibuye	14.354.800	11.174.800	78%
Kigali	13.516.740	11.016.740	82%
Ruhengeri	15.071.156	8.317.656	55%
Umutara	12.246.228	9.746.228	80%
Total	**135.787.080**	**109.360.680**	**80%**

Source: NBR
Gisenyi and Rhuhengeri were exceptions because of the need to address the damage caused by violent insurgency by the militia operating from the neighbouring country.

The processing time within each institution (except for MINECOFIN) averaged 2 working days between receipt of request and execution. At MINECOFIN, the processing time was much longer and not predictable. If the funds were readily available, it took about five working days to process a request and approve the release of the funds. The BNR, which generally transferred funds to commercial banks head offices upon receipt of an approved request, was the most efficient link in the channel. The amounts credited were identical to amounts advised by MINECOFIN, indicating complete compliance. Commercial Bank managers indicated that it took on average less than three to five working days to credit the accounts at provincial branches, once advised by the BNR. The whole process took a total of 15 days on the average to close the loop.

While the funds for the RHOs, once approved by MINECOFIN, were released and credited to their bank accounts reasonably promptly, transfers from the RHOs to the DHOs were erratic. The study found not only delays in transfers but also possible leakages in the transactions between the RHOs and DHOs. District offices received funds only at the discretion of the regional offices. With no agreed budgets for the RHO and DHO or even formal prior understandings on the amounts and timing of transfers to the DHO, and the poor bookkeeping at both the RHOs and DHOs, a proper assessment of delays and leakages (diversion to illegitimate uses) at this node was not possible.

[8] Funds were generally available in the third quarter when the bulk of taxes were paid in and towards the end of the fiscal year when donor budget support became available. The system should improve with the introduction of withholding taxes in 2000 and improvements in the programming of donor budget support. Nevertheless, MINECOFIN staff disputed the findings of the survey, insisting that the delays could not be so stark.

Table 5: Transfers of operational expenses to the DHO in 1999						
Province	**Amount Transferred to RHOs by BNR (FRW).**	**Amount recorded as received by RHOs**		**Amount transferred to DHO**		
		Total Amount (FRW)	As % of Amount Transferred	Total Amount (FRW)	As % of total amount transferred to RHO	As % of amount received by RHO
Butare	14.581.152	11.006.750	75.5	3.800.750	26.1	34.5
Byumba	12.623.836	5.500.000	43.5	1.800.000	14.3	32.7
Cyangugu	9.303.074	3.000.000	32.2	4.250.000	45.7	141.7
Giknongoro	10.817.656	13.317.656	123.1	-	-	-
Gisenyi	16.640.052	6.000.000	36.1	3.087.500	18.5	51.5
Gitarama	12.076.564	11.785.716	97.6	-	-	-
Kibungo	12.925.822	7.500.000	58.1	-	-	-
Kibuye	14.354.800	13.674.800	95.3	4.275.772	29.8	31.3
Kigali	13.516.740	17.692.172	130.9	-	-	
Ruhengeri	15.071.156	7.500.000	49.8	300.000	1.9	4.0
Umutara	12.246.228	6.000.000	48.9	-	-	-
Total	135.787.080	102.977.094	75.8	17.514.022		17
Source: data collected from BNR, RHOs and DHOs						

Table 5 below provides the transfers of funds from the information received from the BNR, the RHOs and the DHOs in 1999. It shows a large gap between the amount transferred as per the BNR, and the amount the DHOs acknowledged to have received. There are also discrepancies between the amounts presumably transferred to the DHOs by the RHOs and the corresponding amounts received by the DHOs. As a percentage of total amount transferred to RHO, the amount received by DHO varied between 1.9 percent in Ruhengiri to 45.7 percent in Cyangugu. Similarly, as a percentage of amount recorded as received by the RHO, the amount transferred to DHO varies between 4 percent in the province of Ruhengeri to 51 percent in Gisenyi. These discrepancies could be due to leakages in the system or poor bookkeeping or to both, indicating a failure of accountability. Regarding transfers to DHOs, the data was incomplete and many regions: Gikongoro, Gitarama, Kibungo, Umutara, and Kigali had no data. Regional health officials cited the absence of budgets for their activities and the lack of guidelines for the use of funds as the sources of major inefficiencies and causes of delays and potential leakages. A summary of problems encountered in the flow of funds from RHO to DHO includes:

- The release of the bulk of the funds at the end of the year carried a higher risk of leakages.
- There were no guidelines on the utilization of funds by RHOs. The central authorities did not always monitor utilization and use of funds.
- When MINECOFIN authorizes the releases of funds, it did not formally notify the beneficiary parties. Thus, the details or breakdowns of the releases were not always available. On the other hand, commercial bank managers generally informed provincial officials promptly, by telephone, on receipt of releases, followed by a bank advice.
- RHOs did not formally notify DHOs of receipt and availability of funds. DHOs had to keep checking at the RHOs and with the banks' office.

- In all cases, the levels of funding provided were, in the view of administrative and facility heads, grossly inadequate for RHOs and DHOs to carry out their responsibilities.

Financing of Health Centers

No financial transfers were made from the central government budget to the health centers except the salaries of qualified health staff working at the centers. The centers operated along the guidelines proposed by BAMAKO Initiative that stipulated among other things that the beneficiary population should meet the cost of primary health care services. Thus, user fees and sales of medicines were the principal sources of funding for operations and maintenance of health centers. Consultation fees were on average 200 RWF per individual but free for children less than 5 years. Table 6 shows estimates of receipts at health centers. Healthcare centers received sporadic material assistance from the Government, donors and NGOs in the form of medicines and medical supplies and equipment, and for the rehabilitation of facilities.

Table 6: Income (FRW) Generated by District Health Centers Over 1998 and 1999 period

Health Region	# DHO	# Health Center	Calendar Year 1998			Calendar Year 1999		
			# Health Center responding	Availability accounting records	Fees collected (RWF)	# Health Center responding	Availability accounting records	Fees collected (RWF)
Butare	4	37	24	23	70695499	27	26	93033856
Byumba	2	25	21	21	69296012	21	21	64785926
Cyangugu	3	23	11	11	84424944	17	17	103264689
Gikongoro	2	22	14	14	29270135	17	17	39499420
Gisenyi	3	25	12	9	29253080	21	20	47938288
Gitarama	3	35	23	23	84424944	25	25	103264692
Kibungo	4	31	23	23	61155837	26	26	62682547
Kibuye	4	27	23	22	72708659	24	23	79369317
Kigali	5	54	22	22	137544998	31	31	1734838 97
Ruhengeri	4	32	13	13	39789191	20	20	65877184
Umutara	3	24	14	14	28124529	21	20	46210881
Total	**37**	**335**	**200**	**195**	**706.687.828**	**250**	**246**	**705.926.800**

Source: data collected at the level of Primary Health Centers

With poverty incidence of over 60 percent, a large number of patients could hardly mobilize the required fees and could not afford the treatment. Over 81 percent of administrators of health centers stated that inability to pay for medical services was the main obstacle to the use of health centers. This was supported by results from the CWIQ survey. Among people who were sick, needed to consult a health practitioner and did not do so, the vast majority did not do so due to the high cost. Furthermore, 50 percent of those who consulted with the health system were dissatisfied with the cost of services. As Rwanda has system of exemption from fees for the vulnerable groups as well as the very poor, the health centers were obliged to offer services to a large number of customers free of charge, further increasing their financial burdens. Since the health centers bore the cost of implementing the policy of exemptions, the practice/implementation differed among regions/districts.

Apart from to poverty, the poor quality of health services was an important deterrent to the use of these services. More than three-quarters (78 percent) of primary health care administrators indicated that more people would use the health centers if the overall quality of services were improved and the centers were better staffed with qualified health personnel. Significant disparities in fee incomes existed between urban and rural areas, with the capacity to pay much lower in the rural areas than the urban centers. Besides, the overall quality of staffing and services in urban health centers was much better in urban areas. The lower fee collections in rural areas compromised the quality of services offered in these poor regions. The survey requested health center administrators to rank the priorities of the health system. The top priorities, which reflect the costs and quality concerns, were as follows (by order of importance):

- reinforcing mutual healthcare insurance schemes,
- taking steps to improve the quality of healthcare,
- reinforcing preventive hygiene campaign, and
- continuing government assistance to vulnerable groups.

Financial Management

The study found that financial management in RHOs and DHOs was poor. The officials surveyed were not aware of any written instructions on how funds should be managed and of any formal requirement for accounting for the funds provided and for the preparation of audits and financial reports. While over 80 percent of DHOs produced financial and administrative reports in 1998 and 1999, but without clear instructions for these reports, it is difficult to assess their quality and relevance. Furthermore, the RHOs and DHOs received no feedback from higher-level authorities. Internal controls and auditing were weak; less than 22 percent of DHOs carried out an audit during 1998 and 1999.

Unlike RHOs and DHOs, administrators at health centers generally kept financial accounts and produced financial management information over time. Over 97.5 percent and 98.4 percent of health centers respondents indicated that they kept accounting records in 1998 and 1999 respectively, and that they updated these accounts regularly. Health centers that reported to local management committees, and adhered to the basic rules of financial management did better than RHOs and DHOs that reported to Kigali. The management committees in these health centers functioned relatively well and the health centers managed the funds collected with a greater sense of accountability.

V. TRACKING THE FLOW OF FUNDS AND ITS IMPACT IN THE EDUCATION SECTOR.

Overview and Key Players

The role of MINEDUC was to supervise, co-ordinate and plan education policy and activities. Administrators at the provincial and district levels assisted central authorities in implementing educational policies. The provincial education officer was responsible for implementing the policies of the MINEDUC in the province, organizing exams, assessing teachers' qualifications and monitoring teachers' performance. The provincial education

officer was assisted by an education specialist, a planning specialist and a finance specialist. The district education officer reporting to the provincial education officer, was responsible for supervising and assisting individual school management in service delivery, including responding to individual school staffing requests, for quality control and the distribution of textbooks. Parent Teacher Associations **(PTAs)** were the other key players at the school level. They were involved in supervising individual school affairs. PTAs also managed individual school funds, and played a lead role in identifying families and individuals needing assistance for school expenses. These individuals and families were often exempted from payment of school fees.

Financing of Primary Schools

The central education budget paid for operational costs of provincial and district administration, teachers' salaries and benefits, including housing allowances and health subsidies, and provided a small contribution for teachers' textbooks. The schools received no other funds from the central government's recurrent budget. Public schools occasionally received assistance from donor-funded projects in the form of textbooks, building of classrooms, desks and chairs. (Private schools represent about 5 percent of schools and do not receive any public funds.) The amount RWF 5 million was allocated by the central budget to each province to cover provincial administrative costs (purchase of materials, per diems, fuel, and light repairs) regardless of the number of schools or number of pupils under the jurisdiction. This amount was for the use of PEOs and to a lesser extent DEOs.

School fees and other contributions from parents were the primary source of funding of operational expenses for primary schools. The direct cost to parents of primary education was estimated to be RWF555 per pupil per year.9 This included the centrally stipulated school fees of RWF 300 per year, charges of RWF100 per pupil per annum for 5th year exam papers, RWF 7 per pupil per trimester for provincial exams and RWF 3 per pupil per trimester for fuel costs of the DEO. Some schools accepted payments in kind. The amount collected in all districts, excluding the City of Kigali (PVK), in 1998/99 was FRW13.3 million, doubling to FRW27.1 millions in 1999/2000.10 These funds were retained by schools at their local bank accounts and primarily used for the purchase of scholastic materials, construction and rehabilitation of school buildings, sports and leisure, and transfers to district offices to cover the transportation costs of DEOs for their occasional visits to the schools. The amount of these transfers to DEOs varied between regions and increased significantly between 1998/99 and 1999/2000. Nationally, the overall amount transferred from schools to the district education offices increased from FRW0.66 million to FRW1.5 million, in the latter case representing about 5.5 percent of the total amounts collected as school fees (Table 7).

Parents and the communities made ad-hoc contributions to schools through specific fundraising activities co-coordinated by the PTA. These included financial and in-kind contributions in the form of manual labor for rehabilitation and construction work at the school. Many schools raised funds from the sale of the harvest from school gardens and from raising livestock. NGOs, churches and UNICEF assisted a large number of primary schools by providing food, construction and school materials. Externally financed projects

9 In 1998 and 1999, this amounted to about US$1.80, with the exchange rate of about FRW300 per US$1.0.

10 This information was obtained from district education offices. The data from the city of Kigali (PVK) was not available for both years and for the province of Umutara for 1998/99

also provided support for the rehabilitation of damaged school buildings and the construction of new ones and, through the DEOs, textbooks and other supplies. Unfortunately the record-keeping at the schools and districts did not permit an assessment of the flows from these ad-hoc sources.

Table 7: Main Sources of Revenues in Primary Schools Across Provinces
(Amounts in FRW)

Province	No of DEOs	1998/1999			1999/2000		
		A	B	C	A	B	C
Butare	20	734647	101325	41920	668439	143445	36105
Byumba	15	101794	na	160100	137491	na	na
Cyangugu	12	1576456	42312	na	1810491	619586	na
Gikongoro	13	499281	101615	na	684520	54120	93125
Gisenyi	12	806833	na	127290	1331004	na	208717
Gitarama	17	1088495	76165	24114	1335971	474805	16847
Kibungo	11	1012373	na	81667	725001	na	231332
Kibuye	9	2990614	na	57800	16349904	na	162800
Kigali-Ngali	16	2927160	380287	29300	1798647	na	442676
PVK	3	na	na	na	na	na	na
Ruhengeri	16	1539384	167735	120025	1419229	296398	179005
Umutara	10	na	na	22500	877350	na	122120
Total	**154**	**13277037**	**869439**	**664716**	**27138047**	**1588354**	**1492727**

Source: data collected at district level.

Key: **A:** Fees collected by the schools**;**
B: Total of other funds;
C: School fees spent on District Education Officers by primary schools.

Flow of funds

The flow of resources to provinces in the education sector was similar to that of the health sector. The funds went through the same institutional nodes (MINECOFIN, NBR, commercial banks) to the provincial level. Wages were released on a monthly basis and paid directly to the bank account of the staff member. The operational costs of the administration of schools (provincial and district offices) in MINEDUC's budget were paid directly to the bank accounts of provincial education authorities. MINEDUC triggers the flow process through a simple letter, each quarter, requesting disbursement for release of RWF 1.250M to PEOs. While these funds are supposed to be released quarterly as in the case of the health sector, authorization of the release of funds by MINECOFIN was contingent on the availability of resources. Thus, although the budgeted amounts for the year were eventually released in full, actual releases did not follow the quarterly schedule and were often delayed. Furthermore, the provincial offices claimed that the little amount of money received only permitted them to provide the district education offices with a few office supplies. Primary schools did not receive any funds from this budget.

Financial management.

Most education officials interviewed (92 percent) indicated knowledge of instructions on the utilization of public funds but 25 percent found these instructions less than clear. Many of the school administrators could not provide any copy of the instructions

during the survey. Only two of the 11 provincial officers indicated that they had elaborated any budget for their operations.

Implications for Educational Outcomes

The relatively low level of funding education has implications for many aspects of the provision of educational services including the quality and quantity of educational facilities, the affordability of education, the quality and quantity of the teaching staff, and the lack of scholastic materials. These have tended to restrict access and impair the provision of quality education and undermine the overall education attainment. The school environment was poor: with about 4200 temporary classrooms in 1999/2000, lack of drinking water and latrines, and inadequate supply of school materials, according to the headmasters. However, despite the poor state of education facilities and infrastructure and poor education outcomes, a large proportion of headmasters interviewed (78 percent) indicated that their schools were offering services of good quality. This lack of despair was probably an indication that these officials were seeing some improvements in the system and expected more in the future.

Fees: Many households could not afford the school fees. However most schools surveyed (95 percent) provided fee exemptions for pupils from very poor households. In some provinces such as Ruhengeri, all schools provided exemptions. Since exemption is national policy, albeit an unfunded mandate, it is not clear why some schools did not have exempt pupils.

Teachers: The pupils-to-teachers ratio increased from 55 to 58 between 1998 and 1999 for the total population of teachers. The ratio of pupils to qualified teachers is much higher, reaching over 100 in 1998 and 1999. This implied that about 50 percent of pupils enrolled are most likely taught by unqualified teachers. The average number of untrained teachers per school even increased between 1998/99 and 1999/2000 in a number of regions (Gikongoro, Gisenyi and Umutara). The lack of qualified teachers was especially desperate in some provinces; the qualified teacher/pupil ratio was 1/44 in the City of Kigali (PVK) and 1/140 in Kibungo in 1999/2000.

Educational Materials: School headmasters pointed out that lack of books and teaching materials continued to be a major constraint for schools. The majority of pupils did not have textbooks. The basic teaching aid available in most schools at the time of the survey was the chalk. However, even this basic material was not provided regularly by the DEOs and hence most schools used PTA funds for its purchase. The situation was the same for stationery. Provincial education offices often did not receive the promised scholastic and teaching materials from MINEDUC and what they received was not systematically distributed.

Facilities: Between 1998 and 1999, enrolment rates rose sharply but there was no increase in the number of schools and classrooms. Headmasters and district school officials expressed the need for urgent rehabilitation of school infrastructure, especially in the provinces of Gisenyi, Ruhengeri and Byumba. The pupils-to-classroom ratio increased between 1998 and 2000, from an average of 54 pupils per classroom to over 58. The provinces of Umutara (from the large increase in population due to the influx of pre-1994 refugees, and Gisenyi (destruction and dislocation of population due to insurgency in

1997/1998) were the most affected by the shortage of classrooms, with ratios averaging 75 and 60 pupils per classroom, respectively.

Table 8: Exemptions from paying school fees and number of children not admitted to the first year of primary school in 1999/2000 because of overcrowding in classrooms

Province	N° of schools responding	N° of schools with exempt children	N° of schools without exempt children	N° of children not admitted for lack of space
Butare	31	29	3	192
Byumba	30	28	2	252
Cyangugu	32	30	2	415
Gikongoro	27	23	4	0
Gisenyi	43	41	2	341
Gitarama	42	40	2	430
Kibungo	29	28	1	60
Kibuye	39	38	1	580
Kigali-Rural	40	39	1	248
PVK	9	7	2	322
Ruhengeri	45	45	0	400
Umutara	12	10	2	30
Total	379	358	22	3270
Percentage	**100.0%**	**94.5%**	**5.8%**	

Source: data collected in the field

The survey found that in 1999, 3270 children were not admitted to school because of lack of space and shortage of desks. In the sample schools interviewed, an average of 8.6 pupils per school could not be admitted in the first year. In Ruhengeri, where all schools had provisions for exemption of school fees for children from poor families, the lack of space was cited as reason for not admitting 400 children to the schools sampled during the academic year 1999/2000 alone. The highest rate of denial of admission was in the poor province of Kibuye where about 580 children were not admitted. The rejection rate was also relatively high in other poor regions, including Kigali-Rural (see Table 8).

VI. RECOMMENDATIONS OF FIELD OFFICIALS AND FACILITY HEADS

The specific recommendations are in the Tables A.2-A.6 in the Annex. Table A.2 and A.3 represents the study team's summary of the recommendations on the health and education sector based on the responses from the survey. Tables A.4, A.5 and A.6 summarize the problems identified and recommendations from provincial officers, district health and education officers, and facility heads respectively. These cover a broader set of issues that are germane to the challenges that these administrators face. For instance, the recommendation to improve infrastructure is not an issue for health and education but it, in many ways, affects the operation of the facilities.

VII. SUMMARY OF FINDINGS AND CONCLUSIONS

The study is based on a survey of local administrators and managers of public facilities in the health and education sector during the period, 1998-1999. Its primary objective was to assess the flows of public spending from the center to facilities and primary beneficiaries with a view towards identifying possible delays and leakages, and to the extent possible propose recommendations for improving efficiency of flows and use of public funds. Another objective was an assessment of process of service delivery and the constraints to its effectiveness from the point of view of the providers of the services. In this context, the study assessed the roles of other stakeholders, parents, donors, NGOs in managing and improving services in primary education and primary health.

The survey covered all 11 regional and 40 district health offices and all the 351 health centers. In the education sector, all 12 provincial and 154 district education offices were surveyed and the 400 primary schools surveyed were selected using multi-stage stratified random sampling. The survey collected information on the flows of funds from the central to local administration, education and health facilities, the overall financing of these facilities, the systems in place for managing public funds in local offices and facilities as well as the state of the facilities. The response rate was relatively high, over 99 percent. The findings below reflect the budget practices in 1998 and 1999. The nature of the challenges facing the budget process have changed, with the institutional reforms undertaken since 1998. Actions taken in recent years on the budget include capacity building, budget process reforms, the introduction of the MTEF process for the budget, and the decentralization of government and the fiscal framework. Efforts to strengthen budget execution, including the systems of accountability, in the line ministries and decentralized district administrations are underway.

Main Findings

The major findings of the study are (i) the very limited funding of the central government for primary education and primary health care; (ii) the provision of supplies to education and health facilities from the government, through the districts, and the donors and NGOs, is sporadic and uncoordinated; (iii) the processes for the release of funds to ministry level and the payments of salaries work in systematic and largely predictable ways through the banking system; (iv) while the processes for the release of operational funds to the provincial/regional education and health offices are systematic, the actual releases were irregular and often delayed; (v) the release of funds from the provincial/regional offices to the district offices was unsystematic, the amounts and timing appeared to be at the discretion of provincial/regional officers; (vi) there were no systems and requirements for accountability for the budgetary resources provided to regional/provincial and district health and education offices; and (vii) the strong local involvement in managing education and health facilities which bodes well for decentralization efforts.

The lack of accountability in the administrative offices is in contrast with efforts at facility level to be accountable, presumably due to local involvement. However, the almost total reliance on local efforts in education and health services creates disparities among communities in the access and quality of education and health services. Evidence from the parallel CWIQ survey of beneficiaries indicated the underutilization of existing health care facilities as the high cost of health care was limiting access of the poor to health services.

Funding Operations and Maintenance at Facility Levels

The most startling finding of the study is the very limited funding by the central government of primary education and health services. Although the budget allocations to the health and education ministries were relatively large and increasing rapidly compared to other ministries, these budgets did not fund the operations and maintenance (O&M) costs of primary education and health at facility levels. As a result, the facilities relied on fees for services and, in the case of primary schools, other contributions by parents. The Parent Teachers Associations (PTAs) became a significant source of support for primary schools. In the health sector, with the introduction of the cost-recovery policy in accordance with the Bamako Initiative, the facilities have relied mainly on the consultation fees and sales of medicines.

NGOs, donors and other development agencies through externally funded government projects, provided support for education and health facilities in the form of construction and rehabilitation of facilities, books and other school supplies for primary schools, and equipment, medical supplies and medicines, for health centers. Nevertheless, the support was sporadic, and often in quantities inconsistent with the needs and priorities of the facility. Government distribution of donor-funded text books to provincial education offices and the subsequent distribution to the schools did not seem to follow a systematic plan.

The facility heads and other health and education officials pointed to the low level of public funding as well as the systemic inefficiencies in funding and provision of public support as the causes of low quality of public services and level of provision. The CWIQ survey found that the lack of textbooks and teaching materials was regarded by beneficiaries as the most serious constraint to improving the quality of primary education. The reliance on fees and household contributions tended to increase the disparities in the level of access between poor and non-poor households as well as between urban and rural communities. [11]

Poverty was cited as one of the leading causes of low level of schooling and access to health facilities. The cost of health services was also a major deterrent to using them, with evidence from the accompanying Core Welfare Indicators Questionnaire (CWIQ) survey indicating that about 95 percent of respondents who needed to see a health provider but did not do so cited the high costs, and among those that consulted a health provider, 80 percent were dissatisfied with the costs. The government has responded to some of these concerns with the introduction of exemptions from fees for poorer households, determined at local levels. The evidence is that the system is operational in many districts but does not appear to be working well for the very poor.

Local funding and management of primary education is an appropriate approach, and the decentralized cost-sharing arrangement in the health services in Rwanda is conceptually sound. However, the evidence from the PETS and CWIQ is that cost-recovery for social services has been an obstacle for the recovery of the population impoverished by the genocide and its legacies. Thus the full cost recovery policies were, at the early stage of post-genocide recovery, at odds with the Government's objective of rapid socio-economic

[11] The recent household expenditure survey (HLSS) indicates that income distribution has considerably worsened in Rwanda, with the Gini coefficient rising for 0.29 in 1985 survey to 0.45 in the 2001 survey. Most well-off households live in urban areas (see Rwanda HLSS, (2002) for further details on the distribution of income).

recovery and reintegration of the population and its priority on human resource development. While a system of exemption of very poor people from fees in education and health was in place, it has been an unfunded mandate that created an additional financial burden for the local authorities managing the facilities.

Health and education are among the budget priority programs and have continued to receive increasing budget allocations and spending. [12] However, the recurrent expenditures on education and health remain, on a per capita basis, very low relative to comparable countries. Most of the recurrent spending is for the salaries of teachers and health workers and as the survey has shown, primary education and health facilities receive no government funding for operations and maintenance, forcing the facilities to rely on the user fees to meet these expenses.

The development budget, at 6 percent of GDP in 1999, is largely financed by external aid. Education and health accounted for about 28 percent of this budget. The survey found assistance to facilities from the development budget was through sporadic provision of in kind assistance (text-books, medical supplies and equipment) from donor funded projects or NGOs funded by donors. Rationalizing the inputs from donors and NGOs so that the assistance is available in a planned and predictable fashion, and meets the priority needs of the facilities, is essential for improving service delivery. This would suggest financial assistance rather than in-kind-support and thus assistance in the form of budget support for these sectors, would be most effective.

Flows of Budget Resources to Provinces

The outcome of the study is consistent across the two sectors. Budgetary flows to the facilities--primary schools and health centers--are limited to the salaries of the staff. The central budget allocation to the provincial/regional education and health offices were to meet the operational and maintenance costs of provincial/regional and district education and health offices. Funds authorized and released by MINECOFIN to the provinces flow through the banking system (BNR and commercial banks) to the accounts of the provincial offices in a commercial bank. This process worked without leakages. However, delays occurred between the submission of a funding release request by the line ministry and the authorization by MINECOFIN. There was a tendency for most of the money to arrive in the fourth quarter of the budget year. These delays in the authorization were attributed to unpredictable pattern of fund inflows to the Government due to the volatility of external budget support, the seasonality of revenues, and poor cash management in MINECOFIN, which relied on a cash budgeting system to manage the uncertainty in resource inflows to the treasury.

Management of Resources at Provincial/District Levels

Once the money got to the provincial/regional offices, the control system broke down as these offices did not have budgets prepared and agreed in advance, and did not keep books and systematic records to account for their receipts and spending activities. These local offices did not seem to have been required by law or practice to account for

[12] Recent surveys including the CWIQ survey indicate that health and education remain among the top five priorities of the population, with health usually the second major concern after poverty and security.

their expenditures. Instructions governing the utilization of resources either did not exist or were not adhered to by officials. There did not appear to be any mechanisms for enforcing good accountability practices. For instance, regional health offices were required to transfer funds to district health offices. However, without budgets/financial plans agreed in advance stating the amounts to be transferred, and systematic records of transfers, it was not possible to determine the amounts transferred, when they were transferred, and thus, whether the transfers were appropriate. It was thus not possible to conclusively determine the leakages and delays in the flow of funds at the district and provincial levels. However, the absence of, or the non-enforcement of the system of accountability presented the opportunity for leakages and prima facie evidence of the misuse of public funds.

The failure of accountability was not limited to local education and health offices and was probably pervasive in the departments of ministries and other government agencies. The PETS findings have simply highlighted the problem that has been known to exist. The legitimacy, capacity and institutional framework for financial management was destroyed by years of conflict and civil war. Auditing of operations of government agencies and the preparation of financial statements of Government operations were not routinely carried out for periods before, during and after the civil war and genocide. The three institutions with the primary responsibility for financial management functions -- Inspector General of Finance and Audit, the Division of Public Accounting, and the *Cour des Comptes*, were until recently dormant. The Office of the Auditor General, set up in 1999 had begun to take over most of the functions of the *Cour des Comptes* and has since carried out audits of many government agencies, revealing that the challenges of improving financial management are substantial. In 2001, the Inspector General of Finance and Audit and the Division of Public Accounting were revived, audit units were set up in key line ministries. The first financial accounts of government budgetary operations are expected in 2004 for the operations of the 2003 budget.

The Implications of Decentralization for Resource Flows and Accountability

The decentralization introduced in 2001 has changed the institutional framework for budgeting and financial management. Elected district councils acquired the responsibility for local social services while the central government representation and intervention in management and implementation of government programs were consolidated at the provincial level. District councils also have been given some authority of taxation. District and provincial officials have already been plugged into the MTEF system and are being trained by MINECOFIN to prepare and implement their budgets in line with the MTEF. Decentralization does not change the fundamental issues of accountability, equity, and low funding of social services identified in this study. The locus and nature of these problems have changed and they have to be addressed differently. District and other local authorities need enhanced and flexible financial assistance and capacity building to improve social services. Decentralization has brought the issue of public financial management to the fore, not only because the accountability of government to the people is one of the key goals of the decentralization but also due to fears about the capacity of the new local authorities to effectively manage the resources being transferred to them.

The emerging fiscal decentralization paradigm in Rwanda recognizes the need to address disparities in incomes and endowments across provinces and districts. Given the low revenue bases of most of the new local authorities, transfers from the central

government will continue to be important for these entities to carry out their responsibilities. Budget support from the donors to the central government will support these transfers. The central government will have an important role in monitoring the flows to the appropriate facilities and the impact of central and local public expenditures on service provision to the population. Under the decentralized structure, the public expenditure tracking survey will be an important instrument for the central ministries to assess the impacts of decentralization on the flows of resources to the facilities, and on service delivery and financial management by both the central and local authorities. The Rwanda PRSP included the PETS as one of its main poverty-related monitoring instruments and preparations for the next PETS survey are underway.

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ANNEX

Table A.1: Comparison of Social Indicators

	Rwanda	Burundi	Kenya	Tanzania	Uganda	SSA
Infant mortality rate in 2000 (x 1000)	123	105	76	95	88	92
Under five mortality rate (x 1000)	203	1763	118	152	162	159
Maternal mortality rate (x 100.000)	1300	1300	590	529	550	844
Crude Death Rate in 1998	21	20	12	16	20	15
Life Expectancy in 1998	40	42	51	47	42	50
Child Immunization (DPT) in 1995-98	85	63	79	82	51	48
Population per physician in 1990-98	24967	17684	27672	23895	24973	--
Adult Illiteracy: Male (%) in 1998	27	44	12	16	23	31
Adult Illiteracy (Female (%) in 1998	41	61	25	34	45	47
Gross Primary School Enrolment (%) in 1997	88[a/]	51	85	67	74	78
Gross Secondary School Enrolment (%) in 1997	10[a/]	7	24	6	12	27

Source:World Bank, ***African Development Indicators***, *2002, and* ***World Development Indicators*** *2000.*

a/ For 1999/2000

Table A.2: Key findings and recommendations for the health sector.

FINDINGS	RECOMMENDATIONS
1. Access and quality of health care The majority of population di d not go to health centers when ill due to high costs and poor quality of medical infrastructure and services.	Reinforce mutual health schemes Examine the feasibility of creating a collective of mutual health schemes; Provide budget resources to primary health facilities to reduce fees and/or increase exemptions.
2. Financing and utilization of resources Public funds took very long to reach regional health offices	Funds for regional health services are among the budget priorities. They should be released on time in accordance with the policy of timely release of funds for priority programs.
The public funds were transferred on the basis of resolutions at meetings in the MINISANTE and not on budgetary principles basis.	Regional and district health offices and facilities should prepare budgets in consultation with MINISANTE and other related bodies and ensure that these budgets are mutually consistent. Budgets will provide the basis for the assessment of financial and physical outputs and the flow of funds. MINISANTE should establish clear policies and principles and prepare a manual of budgetary procedures to be followed by all the parties.
There was a lack of accountability in the use of public funds	Systems for accounting and related record-keeping for the use of public funds should be introduced at all levels of the health system. This will require substantial training for staff at regional and district offices and facilities. Regular audits of these accounts should be undertaken. MINISANTE should prepare a manual of procedures for accountability at regional and district levels and facilities. The manual should also require health offices and facilities to account for financial and in-kind contributions from all sources. The latter is likely to be significant.
Investment expenditures were largely supported by foreign assistance in the form of construction and rehabilitation, equipment and logistics. However, foreign assistance in the health sector did not take into account regional disparities.	There should be a coordinated program of investment that will aim to reduce existing regional disparities in quality and access to health services.
Contact and supervision of health centers by health district officials (DHOs) were weak. While the study noted an improvement in logistical support in 1999, supervisory visits to health centers by DHOs were few and far between.	Supervisory visits need to be regular and formalized and not left entirely to the discretion of the DHO.
Communication between health centers and district and provincial health services was a problem.	Create communication links between health centers and districts, and between districts and provincial health services. Improve ambulance services for health centers.

Table A.3: Key findings and recommendations for the education sector.

FINDINGS	RECOMMENDATIONS
1. - Access to education Deficiencies in education facilities, including inadequate numbers of classrooms in many districts leading to overcrowding and denial of access.	Accelerate the construction, extension and rehabilitation of primary schools in districts with inadequate and/or poor facilities.
School environment /facilities were considered to be sub-standard, with inadequate sanitary facilities	Rehabilitate classrooms, provide adequate drinking water and build latrines
The FRW300 charged for school fees kept children of poor households out of school	Eliminate school fees and provide primary schools with funds to replace lost fees.
2. Quality of teaching The school system lacked qualified teachers and the situation was especially desperate in some provinces; the qualified teacher/pupil ratio was 1/44 in PVK and 1/140 in Kibungo in 1999/2000..	Efforts to increase the number of qualified teachers needs to take into account the inequalities of the distribution of trained teachers between provinces and districts.
The supply of materials and school manuals by the government and sponsors remained insufficient.	Provide regular budgetary resources for the purchase of scholastic materials and textbooks. Rationalize the supply of scholastic materials now provided in an ad-hoc, sporadic manner from the government, donors and NGOs.
3. Financing and utilization of resources Except for wages, the ordinary budget allocated to the education sector did not reach the schools.	Provide budget allocations for textbooks and other scholastic material and for operations and maintenance of primary schools.
The 5 million RWF allocated to the provincial and district education offices did not take into account the differences in enrolments and administrative needs in the provinces. There was limited supervision by school district education officers, due to limited resources.	Provide budget allocations for school administration in the provinces that is based on the realities and needs in the districts and provinces, including adequate provision for logistics for supervision.
Absence of budgeting system at the level of provincial, district and primary school levels.	Introduce a system of budgets and prepare guidelines and training in the preparation and implementation of budgets at these levels.
Lack of accountability in the use of public funds and other resources contributed by parents, NGOs, donors and other development agencies.	Systems for accounting and related record-keeping for the use of funds should be introduced at provincial and district education offices and in schools. This will require substantial training for staff at regional and district offices and facilities. Regular audits of these accounts should be undertaken. MINEDUC should prepare and enforce a manual of procedures for accountability for the offices and facilities, including the accounting for in-kind contributions from all sources.
Committees for the management of primary schools have been set up; their organization remained weak, however.	MINEDUC should assist to organize the management committees and clearly define its role.

Table A.4: Summary of the Problems and Proposed Solutions by Provincial Health and Education Officers

Problems identified by regional health and provincial education services	Solutions proposed by regional health and provincial education services
Irregularity of public fund transfers	To Institute a system of transfers for public funds.
Lack of standardized procedures of payments of public funds and funds from external assistance.	Adjust systems of payments of funds allocated to health and education sectors
Lack of qualified management personnel	Recruit qualified staff and ensur e continuous training of personnel.
Lack of permanent control mechanisms	Install control mechanisms for the use of public funds.
Insufficiency of operational funds	Provide adequate operational funds.
Non participation in the process of budgeting.	Involve the Regional health and provincial education services.
Lack of planning	Institute systems of planning at all levels of the health and education sectors
Unplanned disbursement of funds	Respect the plans put in place for the disbursement of public funds in the health and education sectors
Lack of transparency in the transactions between the regional health and provincial education services, the NGOs and external development partners in the financial management of health and education programs	Install participatory methods in the choice of programs as well as in their management and evaluation
Wage of health personnel was very low	Raise the wages of the health personnel and teachers
Poor book keeping and absence of accounting records	Institute and to apply conventional standards of keeping accounting records
Impunity of public fund embezzlers	Warn and punish embezzlement of public funds
Inefficiency of the disciplinary function in health and education sectors.	Enforce existing disciplinary measures
Lack of means of communication	Improve means of communication.

Table A.5: Problems and Solutions Identified at District Health and Education offices

Problems identified by district health and education administrators	Solutions considered at the level of district health and education administrators
Lack of qualified and sufficient personnel	To assess, recruit and upgrade the personnel
Lack of economic and administrative planning,	To institute systems of participatory planning integrating the population and all established structures of health and education services.
Lack of a concrete budgeting system that includes the district health and education services,	To Institute proper budgeting systems.
Distribution of funds and materials inconsistent with the needs of services	To make budget programs and plans of service activities and to respect their implementation schedules
Irregularity of transfers and disbursement of Public funds	To transfer and disburse public funds in conformity with plans and calendars of activities of the services concerned
Lack of statute, and proper attribution of duties within the district health and education services,	To establish statutes that allow for participation and a role for all healthcare and health partners at all levels and set up a framework for collaboration.
Lack of accountability of the district health and education administrators in the management of public funds and equipment assigned to them or passing through them towards lower administrative structures	Institute systems of decentralization at all levels of health and education services and to harmonize a framework for collaboration between all sub-regional and local services
Lack of proper procedures and control in the management of funds	To provide a simple practical manual of management and control for all the structural levels of health and education as well as the other intervening parties
Lack of continuity in the programs supported by external sponsors	To elaborate strategies relating to the sustainability of projects

Table A.6: Problems and Solutions Identified at Health Centers and Primary Schools

Problems identified by health centers and primary school heads	Solutions considered at the level of health centers and primary school
The «BAMAKO» initiative of self- sufficiency and autonomy in management of health centers had not worked very well in the particular context of Rwanda	To put in place adequate monitoring and control measures to ensure access to health care for all.
Apart from paying the wages of the health and education personnel, the government did not support the running of health centers and primary schools.	Provide health centers and primary schools with the necessary financial, technical, material resources to ensure the provision of the best possible medical care and education for the people.
Health centers and primary schools did not have a budgeting system or administrative and financial planning,	Institute in the health sector and primary education at all levels, systems of timely planning and of budgeting so as to satisfy health and education needs especially in the area of disease prevention.
Costs were incurred by health centers and primary education facilities for providing services to civil servants and prisoners.	The government should take care of its employees and prisoners without burdening the meager resources of health centers and primary school
The ratio of the population to number of health centers was growing fast and the centers did not have resources for the needed rehabilitation, construction and extension of facilities, recruitment of new medical and education staff and the upgrading of services.	The state should help technically and financially to solve these problems through planned development of the health sector to help meet the objective of «health for all».
The structural poverty made the population unable to meet the medical expenses.	Put in place systems of solidarity and insurance in the domain of health, notably the mutual schemes and collective medical insurance.
Health centers were not allowed to take care of some illnesses for which they did not possess the technical and material capacity for intervention and yet there were chronic and sometimes life – threatening cases which could be calmed at the level of health centers.	The MINISANTE should redefine policies and strategies so as to rationalize collaboration between health centers and referral hospitals.
Some health centers and primary school were poorly rehabilitated and didn't have adequate facilities to provide, for example laboratory services, maternity care, or even in-patient wards.	The government should proceed to carry out extension work, construct new facilities and provide required equipment to health centers and primary school
Health centers when not capable of providing the required medical care, were often not able to transfer patients to referral hospitals, because these were either too far and /or because the ambulance system was not adequate.	The government should proceed to a quantitative and qualitative improvement of referral hospitals and to deal with the problems of transportation for patients.
Lack of lighting and refrigeration facilities for the preservation of medical products.	The government should provide all centers with lighting, refrigerators and an air conditioned room.
Lack of certain drugs for the treatment of serious and chronic illnesses	The government should review the problem of availability of medicines for health centers.
Irregularity in the payment of wages to health centers and primary school support staff.	The government should regularize wages in general and to pay support staff at health centers and primary school
Health centers and schools function poorly because of lack of financial, technical and material resources.	The government should provide assistance to centers and schools structurally incapable of functioning, while looking for permanent solutions.

Problems identified by health centers and primary school heads	Solutions considered at the level of health centers and primary school
Ignorance, on the part of central services of the real problems of health centers and primary school and even of the population in general	The government should work much closely with the population to enhance its understanding of their problems in health matters
Lack of management autonomy for health centers and primary school functioning under the direct control of referral hospitals and DEO.	The government should enable these health centers and primary school to regain their autonomy
Poverty was paramount and has limited the capacity of poor popul ation to afford access to education and health services.	The government should promote the creation of jobs and encourage people to develop the spirit of enterprise, and/or establish unemployment compensation schemes for the extremely poor as a short-term remedy.
Poor management of health centers and primary schools	The government should hire qualified accounting personnel, provide upgrading courses and ensure the control of management
Lack of staff housing, particularly in rural areas is cited as possible causes for regional disparities.	The government should provide in housing to health and education staff as an incentive to work in many rural areas.
The poor state of public infrastructure.	The government should improve socio-economic conditions of the people, especially by providing clean water, electricity, housing, transport, communication, micro-credit.

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