



VOLUME 25 ISSUE 2

Administratio Publica



ASSADPAM

Journal of the Association of
Southern African Schools and Departments
of Public Administration and Management

Contents

Editorial	1
<i>Compiled by C J Auriacombe</i>	
Sextortion in South African Public Sector Institutions	7
An Ethical and Moral Dilemma	
<i>P Hlongwane</i>	
Network Theory	26
The Bricks and Mortar of Integrated Public Service Systems (IPSSs)	
<i>F M Uys and F Jessa</i>	
Employability of Public Administration Graduates	49
An Empirical Exploration	
<i>T S P Mbhele, T I Nzimakwe and V Naidoo</i>	
Equality for People with Disabilities in the South African Public Service	69
<i>S B Kahn</i>	
Contextualising Gender Mainstreaming in Integrated Development Plans (IDPS)	100
<i>S Vyas-Doorgapersad</i>	
INTERNATIONAL FORUM	
Social Development Policy Implementation in Rwanda	117
Challenges of the Implementation of the Community-Based Health Insurance Policy in Local Government	
<i>O Nzirera</i>	
Towards a Model for Assessing Performance of Public Sector Organisations (PSOs) in Uganda	135
A Rapid Assessment	
<i>B C Basheka, A Byamugisha, J T Luba</i>	

POST GRADUATE FORUM

Promoting a Culture of Organisational Learning 157
A Case Study of the Department of Science and Technology

P S Tomolomo and W N Webb

The Management of Health Risks in the 175
KwaZulu-Natal Department of Education

G B Sithole and G van der Waldt

Social Development Policy Implementation in Rwanda

Challenges of the Implementation of the Community-based Health Insurance Policy in Local Government

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ABSTRACT

This article aims to highlight the Social Development Policy Implementation in Rwanda in general and the challenges of the implementation of the Community-based Health Insurance (CBHI) policy in local government in particular.

The article provides conceptual clarifications of the context of the CBHI policy, the regulatory framework of CBHI policy in Rwanda and the stakeholders involved to ensure the successful implementation of the community health insurance scheme. The Rwandan districts adopted several strategies to implement the national policy on community health insurance in order to promote social welfare. The article aims to find out whether local governments are strategically equipped to effectively and efficiently develop strategies to implement CBHI.

Finally, the article will discuss the challenges that local governments have to implement strategies to promote the health insurance scheme. Through a review of literature, official documents, and related editorials, the article utilises a desktop conceptual and documentary analysis of the units of analysis. A qualitative approach was adopted by way of interviews with relevant stakeholders as a unit of observation to determine the challenges of the implementation of the health insurance scheme in local governments.

INTRODUCTION

In Rwanda, the health policy adopted in 2005 and revised in 2014 set the overall goal of ensuring universal accessibility (geographical and financial) of equitable and affordable quality health services (preventive, curative, rehabilitative and promotional). The law governing the Community-Based Health Insurance (CBHI) is a policy instrument adopted by the government to enable healthcare service affordability. The role of local governments in the management of the CBHI scheme is mainly to mobilise the community to pay premiums (mobilisation committees created at village, cell and sector level) (Prime Minister's Office 2015:22).

Despite that most local governments (districts) in Rwanda pledged regularly to reach 100% CBHI enrolment in recent years, this target is very seldom achieved and variations are observed in districts' performance. As an example, the Institute of Policy Analysis and Research (IPAR) reported that for the financial years 2014–2015 and 2015–2016 the average enrolment rate was 78% (2016:24) against 86% in 2009 (Ministry of Health 2010:6).

A number of scholars like Kalab and Krishna (2004), Ekman (2004), Gottret and Schieber (2006), Bennet, Kelley and Silvers (2004), Collins, Kalisa, Musange, Saya and Kunda (2016); have researched the CBHI schemes in a bid to understand the characteristics of such plans and the factors that contribute to its success especially in the developing countries. Most of these scholars recognised that the CBHI has a good effect on increasing the utilisation of health care services and universal coverage by extending financial protection to the poor. They also highlight some weaknesses like overall low income due to the fact that most members are not the well-off members of the community hence cost recovery challenges. Despite that these scholars demonstrated the strengths and weakness of such a scheme based on a number of agreed indicators, limited literature exists on such a policy implementation strategy by local governments especially in Rwanda where the CBHI is enhanced by government policy.

This article seeks to elucidate how the local governments in Rwanda are currently equipped in terms of strategies to effectively implement the CBHI as an important social development policy and highlights the challenges faced therein. The scope of the study presented by this article is limited to the analysis of the local government strategies for the implementation of the CBHI scheme in a policy analysis perspective; hence the study findings generalisations need to be limited to this stage of the CBHI policy process. The period covered by the study is 2010 (date of the CBHI policy adoption) until June 2016.

The researcher opted for analytical methodology using the available secondary data on the CBHI scheme in Rwanda and a review of authoritative literature on social development and CBHI schemes worldwide. Kothari (2004) says that with analytical research, the researcher has to use facts or information already

available, and analyse them to make a critical evaluation of the material; hence the study will primarily focus on desk research. A qualitative approach was applied through semi-structured interview techniques to collect complementary data on key points under study from key informants.

CONCEPTUAL CLARIFICATIONS

Social development

According to Midgley (2014:xii) there is limited scientific work focusing on social development theoretical framework and practice and no common agreement exists among scholars on the exact definition of social development. According to the World Bank (2005:2), social development promotes local, national and global institutions that are responsive, accountable and inclusive and it empowers poor and vulnerable people. This definition seems to describe some characteristics of social development and its goals but does not clarify its content and the indicators for its measurement. The World Bank identifies five goals of social development that are: participation and civic engagement; social analysis; community driven development; conflict prevention and reconstruction; and social safeguards.

According to Midgley (2014:1), social development refers to government policies and programmes concerned with social aspects of development such as reducing poverty, increasing literacy, combating malnutrition and improving access to health and education, eradication of poverty and hunger, improving education and literacy, reducing infant and maternal mortality, ending gender discrimination, enhancing participation in the political process, increasing access to improved sanitation; and others.

In Rwanda, social development state responsibility is enshrined in the country's Constitution and also integrated in the national development policies and the government vision policies like Vision 2020, government's seven year programme (2010–2017) and EDPRS2 (2013–2018). According to Article 48 of the National Constitution adopted in 2003 and revised in 2015, the state has the duty to put in place development strategies for its citizens who also have the responsibility to participate in the country's development. Articles 20 and 21 provide that each Rwandan has the right to education and to good health (Prime Minister Office 2015).

The Vision 2020 and EDPRS2 seek to fundamentally transform Rwanda into a middle income country by 2020 which implies average economic growth of 11.5%, GDP per capita of US\$ 1,240 and reducing poverty below 30%. One of the main pillars of Vision 2020 is human resource development and a

knowledge-based economy which implies investment in general peoples' welfare programme, education and health services (Ministry of Finance 2000:14).

In the same context, the government agenda programme for 2010–2017 Pillar IV focuses on social well-being with the goal to have skilled, knowledgeable, healthy and wealthy citizens (Prime Minister's Office 2010:48). Other specific social development programmes and social sector policies exist like the health sector policy (2014), education policy (adopted in 2005 and revised in 2010), the social protection strategy (adopted in 2013) including a number of programmes like Ubudehe, Vision 2020 Umurenge or VUP. Such poor empowerment programmes consist of offering to the identified poor direct material or financial support like shelter, health insurance, providing the active poor with paid jobs in labour intensive projects or microfinance support schemes with low interest loans or via labour intensive paid work.

Public policy

A number of definitions of public policy were proposed by different scholars. According to Clarke E. Cochran *et al.* (1999) cited by Birkland (2011:8) the term public policy always refers to actions of the government and the intentions that determine these actions. The same scholars add that it is the struggle of the government over who gets what. Guy (1999), proposed a simplified definition saying that public policy is the sum of government activities whether acting directly or through agents as it has influence on the life of citizens. These definitions focus much on the initiator of public policy which is the government but do not clarify the goals and involved processes.

Cloete and De Coning (2011:7) suggest that public policy is government's statement of intent, including sometimes a more detailed programme of action to give effect to selected normative and empirical goals in order to improve or resolve perceived problems and needs in society thereby achieving desired changes in a given society.

Birkland (2011:9) put it correctly that public policy has common attributes such as: policy being made in response to some sort of problem, policy is made on public behalf, policy is oriented towards a goal or desired state such as the solution of a problem, policy is ultimately made by government, policy is implemented by public and private actors who have different interpretations of problems, solutions and motivation, policy is what government decides to do or not to do (meaning that no action is also a policy option or decision).

Regarding public policy types, Cloete (2016:31) says that different typologies of policies can be identified like, sectoral policies, macroeconomic policies, institutional policies, regulatory policies or vision policies. Such policies can be described also as inducing (carrots); punitive (sticks); persuasive (sermons). The

drivers of policy according to Cloete (2016:33) include rationality, emotions, ideology, a combination of these factors, or organisational objectives.

According to Parson (1995:77) cited by Cloete (2016:31), any policy evolves as a cycle starting with a policy problem recognition and analysis (issue structuring), policy option and goal formulation or policy design, policy decision-making, policy implementation, policy evaluation and review.

As regards policy implementation, scholars like Meter and Horn (1975) cited by Hill and Hupe (2014:48) proposed a theoretical framework for policy implementation success. They proposed a model of six variables linked dynamically to the production of the outcome of performance assuming that policy implementation success will be likely in a situation where marginal changes are required with high levels of goal consensus. The variables include: policy standards and objectives, the resources and incentives, the quality of inter-organisational relationships, characteristics of the implementing agency (organisation control or relationship with the policy-making or policy enforcing body), the economic, social and political environment, the disposition of the implementers (involving elements like their cognition/understanding of the policy, their attitude vis-à-vis the policy like acceptance, rejection, indifference, etc.) and the intensity of such response. Such approach may be qualified as top-down as the element of flexibility of procedures and processes is limited and perceived as a source of inefficiency.

In another perspective Cloete (2016:84) says that the variables that influence the degree of success of policy programmes are mainly the degree of control over the implementation process (and the degree of dependence on factors outside your direct control), the adequacy of resources for implementation and the quality of management of the implementation process.

In Rwanda, policies are put in place by the government (the Executive or the Legislature) by virtue of exercising the state's constitutional responsibility of putting in place development strategies for its citizens according to Article 48 of the Rwandan Constitution. The source of policies are mainly the necessity to implement the national development Vision 2020, the government programme, the economic development and poverty reduction strategy, internationally agreed upon objectives or programmes, the President's priorities as stated in his speeches or otherwise communicated, or the desire to address new challenges or tap new opportunities (Prime Minister's Office 2013:43). The policymaking process in Rwanda starts within ministries where policies and strategies are formulated and the cabinet is the ultimate decision-making organ. The Cabinet Manual suggests that good policy proposals must have clear objectives, consider all options, be evidence-based, be deliverable (realistic and achievable), be joined up (stakeholders consultation) and be well communicated (Prime Minister's Office 2016:47). Regarding local governments, by virtue of the decentralisation policy in

force since 2000, they can make local policies in the form of by-laws and local strategies which must be consistent with national policies.

Community-based Health Insurance Scheme

According to Gottret and Schieber (2006: 96) the CBHI can be defined as not for profit prepayment plans for health care, with community control and voluntary membership. They generally spread risk from the healthy to the sick but if the prepayments are based on income can also be risk sharing from the better-off to the poor. A variety of CBHI forms exist such as those community organised and managed mutually (mainly observed in francophone West Africa), hospital organised and managed community financing systems (mainly observed in the East Africa region); or plans that are closely associated to the government health care financing policy (observed in countries like Tanzania and Rwanda).

The international interest in the CBHI is substantiated by a statement by the World Health Organization (WHO) on sustainable health financing structures and universal coverage issued in 2011. The statement urged all member states to: "...ensure that health-financing systems evolve so as to avoid significant direct payments at the point of delivery and include a method for prepayment of financial contributions for health care and services as well as a mechanism to pool risks among the population in order to avoid catastrophic health care expenditure and impoverishment of individuals. The members were also encouraged to aim for affordable universal coverage and access for all citizens on the basis of equity and solidarity" (WHO 2011).

Jakab and Krishna (2004) cited by Gottret and Schieber (2006:97) identified three common features of most CBHI plans which are that the affiliation is based on community membership (though some community members may not be part of the plans especially the extreme poor who cannot pay premiums) and the community is strongly involved in the system management. Another characteristic is that the beneficiaries are excluded from other forms of health coverage (as the CBHI regroup the poor who cannot afford other forms of financing). The last characteristic is that the members share a set of social values such as voluntary participation, participation and solidarity.

Regarding the strengths of CBHI, Ekman (2004:249) cited by Gottret and Schieber (2006:99) analysed the merit of such schemes considering a number of criteria like resource mobilisation, quality of care, provider efficiency, moral hazard, financial protection, out-of-pocket spending and access to care. He found that there is strong evidence that the CBHI provides some financial protection by reducing out-of-pocket spending but there is evidence of moderate strength that CBHI improves cost recovery.

Gottret and Schieber (2006:99) say that CBHI may complete or fill the gaps of other financing schemes or may be a first step towards a larger scale system. According to Bennett, Kelley and Silver (2004) cited by Gottret and Schieber (2006:100) the CBHI can help to meet the needs of a specific category of people such as rural middle class and informal workers; this being the reason why some governments like in Rwanda launch the CBHI scheme.

Regarding the weakness of CBHI, Gottret and Schieber (2006:101) say that the main challenge of such schemes is that they are limited by the low overall income of the community hence they have to complement their basic resources with user fees, government subsidies and donor assistance. They add also that sometimes the protection offered by such a scheme is hindered by the small size of the pool and that schemes are affected by problems of adverse selection inherent in voluntary prepayment schemes.

In Rwanda, according to the CBHI law, the CBHI is defined as a solidarity system in which persons come together with their families and pay contributions for the purpose of protection and receiving medical care in case of sickness (Prime Minister's Office 2015:13). The law provides that CBHI membership is compulsory for all Rwandans who are not covered by other social health insurance systems. Though the law governing the organisation and functioning of CBHI was enacted in 2015, the CBHI as government policy has been implemented since 2005 after the adoption of the CBHI policy which was revised in 2010.

Regarding the coverage of social health insurance for the total population of Rwanda (11.4 million), the National Institute of Statistics of Rwanda (2015:vi) reported that the health insurance coverage rate was 70% in 2014 (with the CBHI accounting for around 65%). Other forms of social health insurance (public and private) cover the remaining percentage.

EVOLUTION AND ACHIEVEMENTS OF THE CBHI SCHEME IN RWANDA

The first form of CBHI scheme emerged in the 1960s in some parts of the country like in Kibungo area (in the East) the scheme was called "Umuwandimwe" and in Butare (South) the scheme was called "Umubano mu Bantu" both aiming at increasing health care service utilisation. In the period that followed the end of the genocide against the Tutsi in 1994 with a huge support of international organisations the access to health care service was free of charge until 1997. As the health care service user charge was reintroduced a significant drop in the health care service was registered with an average 0.28 contacts per year per capita in 1996. In 1999 in order to overcome such constraints the government of Rwanda in three hospitals Kabgayi, Kabutare and Byumba used a pilot phase

which yielded concluding results. In 2005, the government decided to roll out the CBHI scheme to all 30 districts. The guiding policy for the CBHI was adopted by the Cabinet in 2004 and revised in 2014 and the law governing the organisation of CBHI was enacted in 2015 (Ministry of Health 2012:8).

According to the Ministry of Health (2010:5) the CBHI was identified as a privileged channel for the growth of financial accessibility to health services in both rural settings and in the informal sector that complements other social health insurance schemes (public or private covering public servants and other formal sector workers). According to the CBHI law this scheme covers drugs and medical services provided at the health post or health centre; drugs and medical services provided at the hospitals of districts or provinces and drugs and medical services provided at the hospital or referral hospital level (Prime Minister's Office 2015:17).

Regarding premium rates, since 2011 after the adoption of the revised CBHI policy, Rwandans began prepayment based on income or wealth status of households which is determined by the Ministry of Local Government as part of the *Ubudehe* system for more equity (before CBHI members used to pay a flat fee of Frw 1,000 that was supplemented by government subsidy). The Ministry of Health aggregated the four *Ubudehe* categories (initially there were six categories that were reduced to four after a revision by the Ministry of Local Government in 2015) into three CBHI broad categories. CBHI category one that regroups about 27% of the population, is comprised of *Ubudehe* group one (destitute or very poor households). The annual CBHI category one premium amounts to Frw 2,000 (US\$ 3.00) per person and is paid by the government and development partners. CBHI category two group (about 72% of the population), is comprised of *Ubudehe* categories two and three (poor and resourceful poor). The annual premium for category two members is Frw 3,000 (US\$ 4.50) per person. CBHI category three members (about 1% of the population) comprise the better-off (food rich and money rich) they pay an annual premium of Frw 7,000 (US\$10.50). The CBHI beneficiaries also pay a small fixed fee of Frw 200 per visit at health centres (that finances the CBHI units' administration costs), and contribute a co-payment of 10% of the total CBHI bill to the district and referral hospitals. Government policy is that category one beneficiaries do not pay health centre fees or hospital co-payments. Membership of CBHI is family-based and compulsory for all people who do not have other health insurance (Collins *et al.* 2016:12).

Some studies have documented a number of achievements of the CBHI programme in Rwanda. According to the Ministry of Health (2010:6) the CBHI enrolment increased from 7% in 2003 to 74% in 2013. According to Collins *et al.* (2016:22) membership satisfaction is another key indicator of the success of this programme as the majority of CBHI members surveyed stated that the benefits of CBHI membership included lower health care costs (97%) and better access to drugs (73%). It is also noted that more equity in health care utilisation is achieved

by both the well-off and the poor people as a result of the financial protection. Another positive outcome is the incidence of financial catastrophe resulting from out-of-pocket payments for health services that substantially decreased between 2000 and 2010, with the proportion of all households (insured and uninsured) spending over 10% of household consumption falling from 11% in 2000 to 2% in 2010 (UR-CMHS-SPH July 2015 cited by Collins *et al.* 2016: 20).

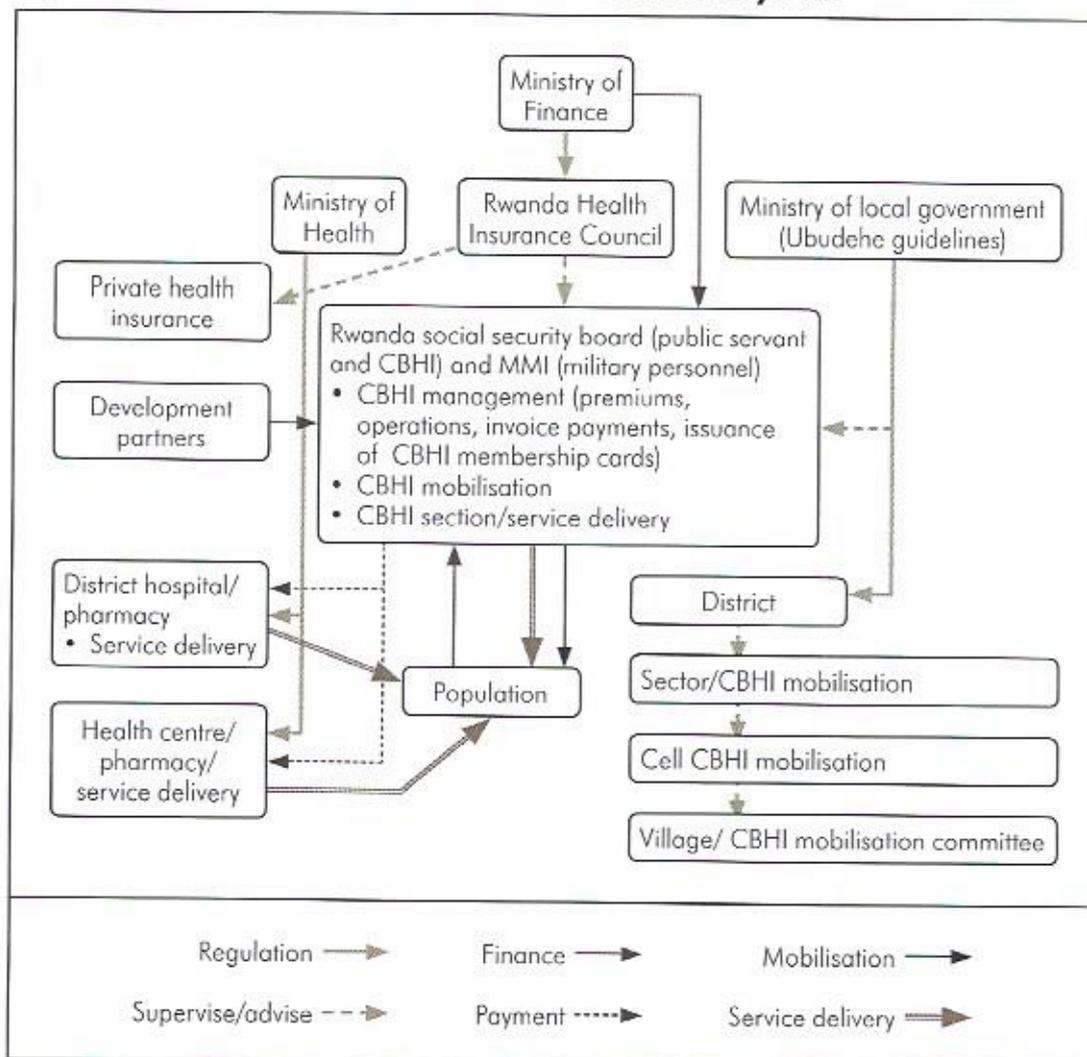
Despite these positive outcomes, some research revealed a number of challenges in the CBHI implementation especially regarding enrolment. The results of the 2013 household survey indicated that the majority (67%) of category two households (which is the largest as 76% of all eligible population are in this category) felt that the payment of premiums was not easy and a significant portion (22%) said they would not re-enrol in CBHI in the following year, mostly because they could not afford the premiums and/or co-payments. 21% of category two households said that they had to pay their premiums in instalments and 67% of them reported not being able to access services before completing the payments. Another challenge highlighted is that despite the introduction of the graduated premiums reducing inequity in general, some inequity persisted among category two members who cannot afford the rate fixed for their category (for prepayment and co-payment). Also, the application of a flat co-payment is regressive since poorer category two and three members pay the same co-payment as better-off members in those two groups (Collins *et al.* 2016: 23).

The health care service providers' cost recovery in line with the CBHI scheme is done in two ways in Rwanda: The first approach is called fee-for-service payments. It implies that the provider receives a payment from the CBHI contributions after producing an invoice. The second approach is called capitation payment where the health care service provider receives a fixed amount for each enrolled member for a given reference period (Ministry of Health 2010).

REGULATORY AND INSTITUTIONAL FRAMEWORK OF CBHI IN RWANDA

In Rwanda all health insurance schemes are regulated by the law n° 48/2015 gazetted in early 2016. This law stipulates under Article 3 that: "...any person, whether a Rwandan or a foreign national who is on Rwandan territory shall be required to have health insurance" (Prime Minister's Office 2016:10). Article 7 of this law provides for two types of health insurance; social health insurance and commercial health insurance. The category of social health insurance includes health insurance provided by public entities, the CBHI schemes and the insurance provided by the health insurance association (Prime Minister's Office 2016:12). The law governing health insurance schemes in Rwanda was

Figure 1: Structure of Rwandan Health Insurance System



Source: (Adapted from Ministry of Health 2010:15)

established under Article 26 of the Rwanda health insurance council supervised by the ministry in charge of insurance (The Ministry of Finance and Economic Planning) with the main responsibility of supervising health insurance activities (Prime Minister's Office 2016:24). The health policy adopted in 2005 and revised in 2014's overall goal is to ensure universal accessibility (geographical and financial) of equitable and affordable quality health services (preventive, curative, rehabilitative and promotional). The CBHI scheme is therefore a policy instrument for the achievement of the health policy and the health financing strategy with the ultimate goal to achieve national vision policies like Vision 2020 and EDPRS II.

The CBHI policy was initially adopted by the government of Rwanda in 2004 and revised in 2014 whereas the law governing the organisation of CBHI (law

n° 03/2015) was gazetted in April 2015. The law n° 45/2015 (gazetted in 2015) transferred the mandate of management of CBHI to this entity (initially under the Ministry of Health and the districts). The social health insurance policy institutional framework after the adoption of the CBHI law in 2015 can be summarised as indicated in Figure 1.

LOCAL GOVERNMENT CBHI SCHEME IMPLEMENTATION STRATEGIES AND CHALLENGES

The article's conceptual framework assumes that in the context of decentralisation (especially in Rwanda) the success of the policy implementation process at the local level (sub-national) depends on variables such as a high level of consensus on policy standards and objectives as suggested by Hill and Hupe (2014:48) and the degree of control over the implementation process (and the degree of dependence on factors outside direct control) along with the adequacy of resources for implementation and the quality of management of the implementation process (Cloete 2016:84). The verification of this assumption in the context of Rwandan CBHI policy implementation by local governments was done by applying qualitative research design and related techniques by means of key informant interviews considered as the population of all 30 districts who act as CBHI policy implementers at local level and the central government represented by the Ministry of Health as policymaking organ along with the Rwanda Social Security Board as the national CBHI scheme implementing agency.

The study sample comprises three districts selected based on their performance in CBHI enrolment during the year 2015–2016 (the 1st and 6th that is, Kicukiro in the City of Kigali with 95%; Kirehe in the Eastern province with 90% and Rubavu in the Western province with 70%). The two central level population units were retained in the sample. Each sample unit was represented by a key informant who is in charge of the CBHI policy implementation. The data collected aimed at responding to the question regarding how effective are district strategies to achieve CBHI mobilisation targets as their main responsibility in this policy implementation and what are the challenges faced therein.

By reviewing the local government strategies for CBHI mobilisation, the level of understanding of the national policy regulating the community health insurance programme by local government officials was analysed. It was found that all local government officials interviewed confirmed that they know the main CBHI policy driving principles and objectives. However, except Kicukiro district, other districts' respondents (Kirehe and Rubavu) indicated that they had not yet read the whole text of the CBHI law document (either the former adopted in 2007 or the new one gazetted in 2015) hence they had not mastered all the

details about the law such as the penalties for people refusing or inciting others not to pay CBHI premiums. This situation was observed among technicians and elected leaders. It was also found that the respondents did not have such policy documents at hand. Despite this finding, it was found that the respondents are aware of the districts' responsibilities regarding the CBHI policy implementation. All local government key informants contacted confirmed that their knowledge of district responsibility is due to capacity building workshops on the CBHI scheme organised by the Ministry of Health and the RSSB that they had attended. This was also confirmed by the interviewed official in charge of the CBHI scheme at the Rwandan Ministry of Health. The officer said that the ministry's policy communication strategy privileged consultation workshops after the adoption of the CBHI policy. She added also that consultation during the CBHI policy design process was mainly inter-ministerial but emphasised that local government leaders such as vice-Mayors in charge of social affairs were also associated.

However, the same official added that the ministry is planning new consultation meetings with different stakeholders to discuss observed shortcomings in the implementation of law n° 48/2015 regulating health insurance in general as it seems that the law is not being enforced especially the provision that says that adhering to at least one health insurance scheme is compulsory to all Rwandans and foreigners living in Rwanda; along with the provision that requires that all employers must contribute to premium payments for their employees. According to officials, local governments as the administrative entities that are close to the communities, should play a primordial role in such law enforcement. This shows that policy communication mechanisms exist despite that the level of such communication efficacy may be limited as some policy provisions are not known and not implemented by policy implementers. In view of such limitation, it is evident that more policy briefs may help to address such challenges.

The district responsibility regarding the CBHI policy implementation is mainly community mobilisation for paying premiums. Regarding the degree of control over the CBHI policy implementation process, all district officials interviewed confirmed that the district has full control on deciding the CBHI enrolment target. Generally, all three district officials interviewed say that they always target 100% enrolment as they want to protect all families against catastrophic out-of-pocket health expenditures. The district officials interviewed also maintain that they have control over the enrolment of the communities into the Ubudehe wealth category which serve as basis for determining the CBHI member category and premium rates. As the management of the CBHI premiums was generally assigned to the RSSB since 2015, all district officials interviewed pointed out that the districts do not have a say in the performance of the CBHI section staff who are under the RSSB authority despite that their performance may affect the population's momentum to pay premiums (in case of poor performance).

According to the interview with the Director of the CBHI mobilisation unit at the RSSB, after the change adopted by the government regarding the CBHI management in 2015, some districts manifested a certain decrease of their involvement in the community mobilisation mission whereas the CBHI law stipulates that the CBHI mobilisation committee operates at grassroots level (chapter three of Law n° 03/2015). He pointed out the district should plan for mobilisation as it also has staff in charge of CBHI mobilisation instead of relying on RSSB financial support to facilitate the mobilisation activities. The official indicated also that some districts seem to overload the staff in charge of CBHI mobilisation with other responsibilities even when CBHI enrolment is low. It was found that the RSSB produces on a monthly basis a report on CBHI enrolment progress per district which is shared with the district authorities as support to monitor the CBHI programme. He called for more synergy in the effort to maximise CBHI enrolment as RSSB cannot succeed in this mission with limited personnel.

Regarding the adequacy of institutional and financial resources mobilised by the district for the implementation of the CBHI policy, all the district officials interviewed confirmed that during the CBHI year 2015–2016 no standalone policy document had been elaborated for the CBHI promotion. The review of the three surveyed districts' development plans (2013–2018) showed that the health promotions strategic interventions do not include specific provision on the CBHI promotion. However, all the districts confirmed that they have records of several documented district authorities' decisions (either by the Council or by the Mayor) regarding CBHI scheme promotion. Another key finding is that all three districts surveyed integrated the CBHI enrolment target in their annual district performance contract (Imihigo). Regarding financial resources it was found that not all districts had budgeted for CBHI mobilisation activities in the year 2015–2016. Rubavu district which ranked last in CBHI enrolment performance across the country at the end of the CBHI year 2015–2016 with a 69.51% enrolment rate, had budgeted zero francs for such activities. In contrast, Kicukiro district and Kirehe district whose performance was 95.10% and 90.95% respectively had budgeted 10 million Frw and 3 million Frw for CBHI mobilisation during the same year. This shows that all other things being equal, the pay-off of the allocation of financial resources in support of CBHI promotion activities is evident in terms of the effect on enrolment performance.

The case of Rubavu districts can corroborate the RSSB interviewed official's point of view that he observed a decrease of some districts' involvement in CBHI mobilisation after the transfer of CBHI management's mandate from the districts to the RSSB. However, a positive development in Rubavu was observed since the start of the new CBHI year as the district budgeted Frw 8,676,000 in support of mobilisation activities and this move had encouraging repercussions on the district's CBHI enrolment performance for the first months of the year

2016–2017. Another interesting institutional resource indicated by the respondent is the District Health Management Team (DHMT) headed by the district's vice-Mayor in charge of social affairs which is functional in all districts surveyed. The DHMT regroup district officials in charge of health promotion and health care service delivery including the RSSB representative. They meet on a quarterly basis and are regularly updated on the progress with the CBHI premiums collection and formulate recommendations to address perceived hindrances. The respondents from Kicukiro and Kirehe districts confirmed that they are satisfied by the contribution of the RSSB in the DHMT decisions regarding CBHI scheme promotion whereas the satisfaction is low for the interviewed officials in Rubavu districts. Generally, the complaint regarding RSSB support to the district CBHI mobilisation effort is that they (RSSB) do not systematically support the districts financially to meet their CBHI enrolment targets whereas the community mobilisation is indispensable to meet enrolment targets which effort is costly. All district officials interviewed confirmed that the mobilisation committees at sector, cell and village level were elected and sensitised on the CBHI schemes and their role but no district provided other forms of facilitation to sensitise communities. It appears also that the mobilisation did not include comprehensive training on CBHI law and on mobilisation strategies (they attended a one day workshop to explain the CBHI scheme after their election).

Regarding the CBHI mobilisation strategy adopted by the districts during the year 2015–2016, from the data collected from the surveyed districts we found that that they are diverse but some elements are common. The first finding is that in all districts surveyed no one developed an extensive or summarised written district CBHI mobilisation strategy but rather different decisions (meeting resolutions) were taken in reaction to past performance in CBHI enrollment. The community consultation or participation in such strategies' formulation was also limited or indirect through the District Council. In some districts like Kicukiro as urban district the district mobilisation strategy was based on a preliminary assessment of the socio-economic and cultural condition of the district's population.

The interviewed officials from Kicukiro district pointed out that they had faced in previous years a situation where some people who are ranked among the well-off by "Ubudehe" categorisation had failed to pay CBHI premiums. They conducted house-to-house visits targeting the defaulters and established a list of defaulters who are really poor and those who are not. As the direct support to the poor people through social protection programmes generally is transferred by the central government as fixed budget they tried to find alternative support for paying premiums for the needy not covered by the government transfers. Their strategy consisted of working closely with the district partners mobilised via the Joint Action Development Forum (institutionalised district development partners' forum) to pay for the poor (who were a big percentage of those who were

uncovered). The same spirit of preliminary assessment of the community situation and readiness to pay premiums was also conducted in Kirehe district during the same period. According to the district authorities interviewed, such assessment helped to understand the main sources of revenue of the population and the saving culture in the district so as to adapt the mobilisation to such characteristics. As the main source of revenue identified was farming activities (banana, coffee, cattle) they decided to focus sensitisation on saving for the CBHI scheme during the harvesting period. They work closely with farmers' cooperatives to this effect. They also promoted the informal community saving scheme called "Ibimina" which existed to make sure that the communities can put their savings in a local bank long before the start of the new CBHI year. Like Kicukiro they also promoted partnership with development partners especially during the period of drought which affected many households that lost agriculture production. However, the exact statistics on the district's population who are part of the 'Ibimina' saving scheme could not be found but the district officials interviewed maintain that the majority of households adhere to at least one 'Ikimina'. They suggest also that if the RSSB could open its CBHI premium account as early as possible, like in January, (against current practice of authorising payment starting June) this would facilitate the population even more so that they do not finalise payment for the whole family within the covered year.

In Rubavu district during the year 2015–2016 the mobilisation strategy focused on house-to-house visits by grassroots authorities to encourage all citizens to pay CBHI premiums. The district officials interviewed revealed that for the following CBHI year (2016–2017) more resources were mobilised to make sure that they identified all defaulters and obtained commitments to pay within an acceptable timeframe. They also privilege partnership with civil society organisations and the private sector for the payment of premiums for the poor who are in the CBHI category two (who cannot afford paying Frw 3000 for each family member).

Another finding is that despite the CBHI law providing administrative sanctions to CBHI defaulters (those who refuse to pay premiums while being part of the well-off, not eligible for social protection direct support offered by the government to the indigents) all district officials interviewed said that they never resort to sanctions as they think this approach might be counterproductive. All district officials interviewed maintained that they did not have detailed information about the CBHI law provisions regarding such sanctions.

Regarding the CBHI mobilisation strategy, the official from the Ministry of Health interviewed confirmed that before 2015, the ministry used to devise annual CBHI mobilisation strategies that were adopted by the districts. It was pointed out that the ministry is planning to resume this practice and develop indicative CBHI mobilisation strategies as support to the various CBHI policy implementers along with capacity building activities.

CONCLUSIONS

This article concludes that the CBHI enrolment levels have increased over time in Rwanda as the government and the districts adopted diverse mobilisation strategies to maximise CBHI enrolment. Despite that districts' strategies are not summarised into a single guiding document, most districts select intervention options based on preliminary assessment of the socio-economic and cultural patterns of the concerned target population (saving culture, source of revenues, satisfaction on CBHI section service, etc.) to inform proposed intervention focus. The level of control over the CBHI policy implementation since 2015 has reduced as most responsibilities were transferred to RSSB leaving the local government with the main responsibility of community mobilisation. It is noted that in order to reach enrolment targets set by the local governments during "Imihigo", joint actions and synergies are needed between the former and RSSB especially regarding co-financing mobilisation activities and more consultation with the communities who pay premiums; to promote a bottom-up approach.

It was also observed that there was some limitation regarding inadequate common understanding of the policy objectives between the policymakers (ministry) and the policy implementers (districts). As solution to this challenge improvement in policy consultation and policy communication is needed. Generally, a more bottom-up policy implementation approach may contribute to the improvement of the CBHI policy outcome of limiting out-of-pocket health care related expenditures. Further researches are recommended to shed more light on opportunities and challenges of such social development policies' implementation strategies by local governments using a comparative approach.

NOTE

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