TECHNICAL & FINANCIAL FILE

UBUZIMA BURAMBYE (LONG HEALTHY LIFE)

RWANDA

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THE BELGIAN DEVELOPMENT COOPERATION .be

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ABBREVIATIONS

ACT	Artemisinin-based combination therapy
AIDS	Acquired Immuno-deficiency syndrome
ART	Antiretroviral therapy
ARV	Antiretroviral
ASM	Maternal Health CHW (Animatrice de Santé Maternelle)
ASRH&R	Adolescent sexual and reproductive health and rights
BCC	Behaviour change communication
BCT/CTB	Belgian technical cooperation / coopération technique belge
CAMERWA	Central Drug Purchasing Agency in Rwanda
CBHI	Community-based health insurance
CBNPs	Community-based nutrition programs
CCA	Common country assessment
CCM	Country coordination mechanism
CCS	Country Cooperation Strategy
CDC	Centers for Disease Control and Prevention
CHUB	Butare University Hospital (teaching hospital)
CHUK	Kigali University Hospital (teaching hospital)
CHW	Community health worker
CORAR	Compagnie Rwandaise d'Assurance et de Reassurance
CoK	City of Kigali
CPAF	Performance assessment framework
CPAF	Common performance assessment framework
CVD	Cardio-Vascular Diseases
DH	District hospital
DHMT	District Health Management Team
DHU	District Health Unit
DGD	Directorate General for Development cooperation & Humanitarian Aid
DPEM	District Plans to Eliminate Malnutrition
DP	Development partners
DPCG	Development partners coordination group
DQA	Data Quality Audit
EAC	Eastern African community
EANMAT	East-Africa organization for fighting malaria
ECD	Early childhood development

EDPRS	Economic Development and Poverty Reduction Strategy
EFU	External finance unit
EICV	Integrated Household Living Conditions Survey
EML	Essential medicine list
FBO	Faith based organizations
FHI	Family Health International
FP	Family Planning
GAVI	Global Alliance for Vaccines & Immunization
GBS	General budget support
GBV	Gender-based violence
GDP	Gross Domestic Product
GIZ	Deutsche Gesellschaft für Internationale Zusammenarbeit
GEWE	Gender Equality and Women's Empowerment
GFTAM	Global Fund for AIDS, TB and Malaria
GMO	Gender Monitoring Office
GoR	Government of Rwanda
HC	Health center
HF	Health facility
HFWG	The health financing working group
HIV	Human immunodeficiency virus
HMIS	Health management information system(s)
HRH	Human resources for health
HSSP	Health sector strategic plan
HSWG	Health sector working group
iCCM	Integrated community case management
IDHS	Interim Demographic and Health Survey
IDSR	Integrated Disease Surveillance and Response
IMCI	Integrated Management of Childhood Illness
IPPS	Integrated Public Performance System
ISQUA	International Society for Quality in Health Care
JSI	John Snow, Incorporated
LLIN	Long-lasting insecticidal nets
MCH	Maternal and Child Health
MDG	Millennium development goals
MDR	Multi drug resistant
MH	Mental health

MINAGRI	Ministry of Agriculture
MIGEPROF	Ministry of Gender and Protection of the Family
MIP	Malaria in Pregnancy
MoH	Ministry of Health
MTI	Medical Technology and Infrastructure
MTR	Mid-term Review
NA	Not Applicable
NCD	Non-communicable disease(s)
NGO	Non- governmental organization
NHA	National health account
NISR	National Institute of Statistics of Rwanda
PBF	Performance Based Financing
PCU	Program Coordination Unit
PEFA	Public Expenditure and Financial Accountability assessments
PFM	Public financial management
PMTCT	Prevention of Mother to Child Transmission
PPP	Public Private Partnership
PSC	Program Steering Committee
PTF	Pharmacy task force
RAFi	Responsable Administratif et Financier de l'Intervention
RAMA	Rwanda's medical insurance agency
RAC	Rwanda Accreditation Council
RBC	Rwanda biomedical center
RDC	Republic Democratic of Congo
RDHS	Rwanda Demographic and Health Survey
RHSS	Rwanda Health System Strengthening
RSSB	Rwanda Social Security Board
RFMA	Rwanda Food and Medicines Authority
SAMU	Service d'aide médicale d'urgence
SBS	Sector budget support
SGBV	Sexual and Gender-Based Violence
SPIU	Single project implementation unit
SRHR	Sexual and reproductive health
SRHR	Sexual and reproductive health and rights
SWAP	Sector Wide approach
TB	Tuberculosis

TFF	Technical and Financial File
TFR	Total fertility rate
THE	Total health expenditure
TPR	Test Positivity Rate
TWG	Thematic working groups
UCL	Université Catholique de Louvain
UNCT	United nations country team
UNDAF	United nations development action framework
UNDAP	United nations development plan
UNFPA	United Nations Population Fund
UNICEF	United nations children's fund
USAID /USG	US Agency for International Development/ United States Government
VCT	Voluntary Counselling and Testing
WHO	World Health Organization

EXECUTIVE SUMMARY

The sector support intervention 'Ubuzima Burambye' ('Long Healthy Life') is part of the Indicative Program of Cooperation (ICP) 2011-2014 negotiated between Rwanda and Belgium. The Belgian contribution is 21,000,000 €, the Rwandan contribution is estimated at 7,215,000 €. In order to have sufficient buffer, in particular in view of the planned construction works in this program, the Specific Agreement will be for a duration of 72 months. The duration of the actual implementation phase is set at 48 months. This intervention, focusing on 6 areas of change (See 6 results below), will work in synergy with the two other components of the ICP namely i) the Sector Budget Support (32,000,000 €) using (and reinforcing) existing national mechanisms and focusing on policy dialogue, and ii) the Capacity Development Pooled Fund (CDPF) (2,000,000 €) focusing on a coordinated approach to Human Resource for Health in planning, production and retention of Health workforce across the sector. The coordination of the 3 health components in the ICP will in principle be assured by the public health expert of the Health Sector Budget Support. This program will in its turn be embedded in the Rwandan Sector wide approach dynamic.

'Ubuzima Burambye' ('Long Healthy Life') will build further on the focus, dynamic and lessons learnt from the 2 previous interventions, namely the institutional support program 'MInisanté 4' and the support to Kigali Ville 'PAPSDSK'. Like its predecessors, this intervention will work both at the central level (RBC-SPIU and MOH) and at the decentralized level (both urban and rural districts). There will however be no specific geographical focus anymore, but rather a thematic focus. This implies that depending on the theme certain districts will be targeted as areas of implementation. Equity in the choice of the implementation site of specific activities will be a major criterion.

The general objective of this intervention is "strengthening the quality of primary health care and health services in Rwanda "

The specific objective has been fully aligned with the 3 outcomes described in the Rwandan National Health Sector Policy (2014): "A people-centered, integrated and sustainable health care system with quality essential health care services as close to the community as possible has been reinforced".

On the basis of i) a participative SWOT-analysis of the four components of HSSP III, ii) the lessons learnt from the previous health support program and the remaining challenges, , iii) the scope of the identification file negotiated between the Rwandan and Belgian partners, iv) the complementarity and potential synergy with other development partners, 6 interlinked results have been identified. Each of them contributes to a variable degree to the 3 outcomes of the National Health Sector Policy and to the implementation of HSSP III:

- R1. The quality assurance system is set up and integrated and functional at the level of all hospitals
- R2. The mental health services are accessible at the community level up to the national level in a sustainable way
- R3. The urban health service coverage is rationalized and extended in line with the three guiding principles of the National Health Sector Policy
- R4. The leadership and governance is reinforced, specifically regarding district stewardship, the respective roles of the MoH and RBC and the public private partnership
- R5. Data are generated, analysed and used for evidence-based decision-making in a more correct, integrated, systematic, accessible and effective way
- R6. The asset management system is designed and operational in a cost-effective way

These results will mutually reinforce each other.

A specific attention will be given to the crosscutting issues (environment, gender, Sexual and Reproductive Health & Rights, HIV/AIDS) in the perspective of contributing to the MDG (principally 3,4,5,7). These are integrated in each of the results. However, various mechanisms are foreseen to assure a proper visibility in relation to these themes.

To accompany this process of strengthening the health sector in Rwanda, this formulation document foresees a mix of i) long-term International and National Advisors, and ii) punctual expertise (national and international) for specific issues. They will work together with the SPIU team for the overall management of the intervention and with specific departments of RBC/MoH in relation to the 6 results.

In line with the Paris Declaration, the Aid Agenda of Accra, the Rwanda Vision 2020, this intervention, like all BTC supported interventions, will combine various modus operandi, depending on the management area (scope, procurement, finances). The aim is to come as close as possible to a “fully run by GoR” situation, while taking into account risks and constraints, as assessed by the organizational assessment done in August 2014 and by the formulation mission.

The process of formulation has been a participative exercise with i) a mixed formulation leadership (composed of a BTC formulation manager and an SPIU co-formulation manager) supported by a Formulation Core Team (composed of national staff and BTC International Advisors), ii) an extensive consultation process under the form of workshops and consultations with the involvement of a wide range of actors of both central and decentralized level, public and private sector, and national and international actors.

ANALYTICAL RECORD OF THE INTERVENTION

Title of the intervention	Ubuzima Burambye (Long Healthy Life)
Intervention number	NN 3015102
BTC Navision Code	RWA 13 092 11
Partner Institution	Ministry of Health (MoH)
Length of the Specific Agreement	72 months
Length of the intervention	48 months
Estimated start-up date	01/07/2015
Contribution of the Partner Country	EUR 7,215,000
Belgian Contribution	EUR 21,000,000
Sector (DAC codes)	12110 – Health – Health Policy - Administrative management 12220 – Health – Primary Health Care 12281 - Health – Primary Health Care – Training Health Professionals
Brief description of the intervention	Continued support to the health care sector in Rwanda with specific emphasis on institutional strengthening, integration of mental health care and the concept of urban health.
Overall Objective	“Strengthening the quality of primary health care and health services in Rwanda”
Specific Objective	A people-centred, integrated and sustainable health care system with quality essential health care services as close to the community as possible has been reinforced”
Results	R1. The quality assurance system is set up and integrated and functional at the level of all hospitals R2. The mental health services are accessible at the community level up to the national level in a sustainable way R3. The urban health service coverage is rationalized and extended in line with the three guiding principles of the National Health Sector Policy R4. The leadership and governance is reinforced, specifically regarding district stewardship, the respective roles of the MOH and RBC and the public private partnership R5. Data are generated, analysed and used for evidence-based decision-making in a more correct, integrated, systematic, accessible and effective way R6. The asset management system is designed and operational in a cost-effective way

1 SITUATION ANALYSIS

1.1 General context

1.1.1 Some facts on demography, urbanization, socio-economics, poverty and education

Demographical facts: Rwanda is a landlocked country with an estimated population of 10.5 million (Rwanda Population Census 2012). Compared with a population of 8.1 million in the 2002 Census, this implies an **annual population growth rate of 2.6%**. Living within an area of 26,338 km², p**opulation density** has thus increased from 321 to 416 persons per sq.km between 2002 and 2012, one of the highest in Africa. Between DHS 2005 and 2010, the total fertility rate has decreased from 6 to 4.5 children per woman of reproductive age. At the current population growth rate, it is estimated that Rwanda will attain a population of 13 million by 2020.

The rate of **urbanization** is 4.4% with 19.1 % of the population living in urban areas. The population is essentially young, with more than half (52%) of all Rwandans under the age of 20 and 52 percent of the population is female. Nearly all Rwandans speak the same language, Kinyarwanda (spoken by over 99 percent of the population), which is the country's first official language, followed by French and English.

Socio-economical facts: Rwanda has made remarkable **socio-economic progress** during the past decade. Economic growth for the EDPRS 1 period 2008–2012 exceeded ambitious expectations. Real GDP growth averaged 8.2% annually, which translated into GDP per capita growth of 5.1% per year. The economy grew strongly, and significant poverty reduction was achieved.

Economic activity was driven by a large increase in agricultural output, robust exports, and strong domestic demand. Fortunately, Rwanda has remained relatively insulated from the slowdown in the advanced economies. Though inflation rose sharply in 2011, it has still remained in single digits and has been the lowest in the region. In 2012, high growth was sustained and inflation remained relatively modest, although risks from instability in commodity prices and aid flows remain.

According to the World Bank's Doing Business Report for 2012, Rwanda progressed from 58th to 45th position in the ease of doing business rankings worldwide. This performance makes Rwanda the second most reformed economy in the world over the last five years and the second easiest for doing business in Africa, as well as being the first in the East African community (EAC). Rwanda also ranked 45th out of 175 in the world and 3rd best in Africa in the Corruption Perceptions Index assessing the governance and legal environment for the fight against corruption.

Agriculture is the backbone of Rwanda's economy and the majority of households in Rwanda are engaged in some sort of crop or livestock production activity. The agriculture sector is therefore widely regarded as the major catalyst for growth and poverty reduction. Agricultural growth was 3.2% in the year 2010/11 (NISR 2011). As a share of GDP, the agriculture sector makes up 31% (MINAGRI 2011).

Poverty in Rwanda: Although poverty is still a major concern in Rwanda, the rate of people living under poverty threshold decreased from 56% in 2005 to 45% in 2010 according to the EICV3. Notwithstanding the fact that well-designed pro-poor programs such as Vision 2020 Umurenge, reduced poverty for female-headed households with 13% from 60.2% (2005/6), Rwanda's poverty profile indicates that women remain more affected by poverty than their male counterparts, with 47% (2010/11) of female headed households being poor compared to 44.9% of all households. A key challenge is, therefore, to ensure sustained growth and poverty reduction nationwide and among all groups, particularly in rural areas. High level of inequality is also a continuing challenge, as measured by the Gini co-efficient, fluctuating around 0.50 since year 2000 (0.507 in 2000, 0.52 in 2005 and 0.49

in 2010). To put this in perspective, a Gini co-efficient of 0.40 is regarded as high inequality: when China reached this in 2000, it rapidly changed its policy from one focused only on economic growth to "growth with equity".

Education: Rwanda is on track to achieve universal access to primary school education by 2015 with a primary net enrolment rate of 95.4 per cent (97 per cent for girls). The qualified teacher/pupil ratio at primary level is 1:58, with over 90 per cent attendance. All children are entitled to 12 years of free education; education is compulsory for children aged 7 to 16 years. Challenges remain regarding the underrepresentation of women in Sciences & Technologies and tertiary education in Public Institutions (33.4%). It should also be noted that there is still an important illiteracy gap, since 35% of women (15+), against 28% of men (15+) are not able to read and write in at least on language.[1]

1.1.2 Rwanda Health System

The Rwanda Health System is a pyramidal structure made of 6 levels: National, Province, District, Sector, Cell and village. Table 1 provides a summary of existing administrative structures and related health facilities.[2]

Table 1. Administrative structures by level, with their health facilities

Levels	Admin Structures	Health Structures	HF Numbers
1. Villages / imidugudu	14,837	CHW	45,011
2. Cells / akagari	2,148	Health Posts / FoSaCom[3]	56
3. Sectors / imirenge	416	Health Centers	472
4. Districts	30	District Hospitals District Pharmacies District Health Management team (DHMT)[4] District Health Unit (DHU)[5]	35 30 30 30
5. Provinces (including City of Kigali)	5	(DH to be upgraded to ProvHosp)	4
6. National	1	Nat. Referral Hospitals[6]	8

[1] Rwanda, Country report, Report on the implementation of the Beijing Declaration and Platform for Action (1995) and the outcomes of the Twenty-Third Special Session of the general Assembly (2000), June 2014, p. 11.

[2] In the HMIS, Health Facilities (HF) are defined as all public sector facilities that provide health services, from Health Centers (including the health posts = FoSaCom in their catchment area) up to the National Referral Hospitals. In the private sector, there are dispensaries, (poly)clinics, hospitals and specialized clinics such as lab and dental facilities. Currently, there are 157 registered private dispensaries / clinics.

[3] There are also 15 prison dispensaries, part of the public health sector, but managed by MINTIR

[4] DHMT is composed of all main health sector agents at district level

[5] DHU is composed of 3 health officers for planning and coordination, prevention and promotion and M&E

[6] These are KFH, CHUK, CHUB, RMH (Rwanda military hospital), and Ndera, Kibungo, Kibuye and Ruhengeri.

Levels	Admin Structures	Health Structures	HF Numbers
Referral systems		Ambulances / SAMU	154
Registered Private HFs			157[7]
Total Public + "Agree" HFs (= in bold, being HC + DH + Nat Ref Hospitals)			519

Source: HMIS and QA desk, March 2012

The following figure expresses the Health pyramid with the most important health structures:

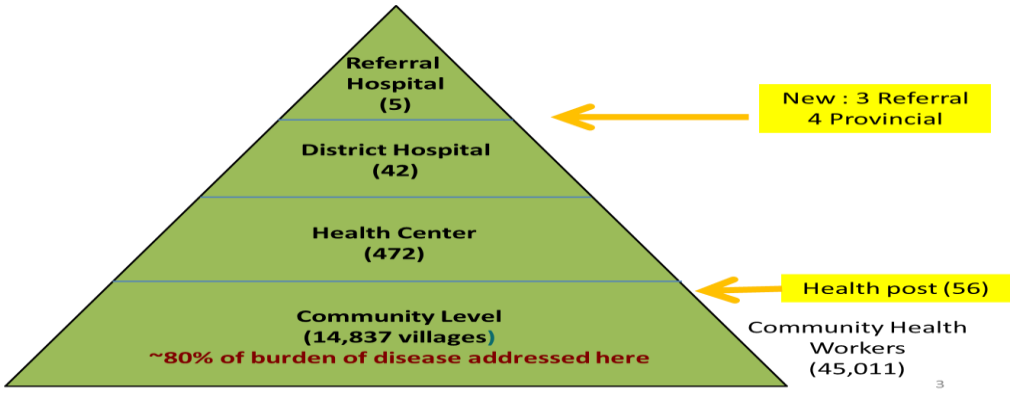


Figure 1: Health Pyramid

The health sector is led by the Ministry of Health (MOH), with its implementation arm, the Rwanda Biomedical Center (RBC).

The **MOH** supports, coordinates, and regulates all interventions whose primary objective is to improve the health of the population (see Annex 7.4 for current organization chart of MOH).MOH has the primary mandate of developing, monitoring and evaluating policies & strategies; capacity building of its implementing entities and resources mobilization for the sector.

RBC is the main public implementation body of sector policies and strategies coordinating with other stakeholders including NGOs, private sector and development partners (see Annex 7.5 for current organizational chart). In the ongoing institutional reforms, some MoH departments and or desks like Maternal and child health, Health management information system, E-Health are transferred to RBC. The Single project implementation unit (SPIU) managing externally funded projects has also recently been integrated into Rwanda Biomedical Center.

Although the MOH has overall stewardship on health issues, 15 **other national ministries** implement activities that either directly or indirectly impact on the health of the Rwandan people.

Rwanda is divided in 5 administrative regions: Four **provinces** and the City of Kigali (CoK). The four provinces do not have a health coordination structure, but CoK, as a decentralized level, has a health and environment unit.

[7] This includes 127 Dispensaries & Polyclinics, about 20 specialized clinics (ophtalmo, dental care, kine, nutrition…) as well as centers of traditional medicine. Not included are about 50 pharmacies and 5 clinical laboratories.

Services are provided at all levels of the health care system: community health, health posts [HPs], health centers [HCs], district hospitals [DHs], provincial hospitals and referral hospitals and by different types of providers (public, confessional, private-for-profit, and NGO). At all levels, the sector is composed of administrative structures (boards / committees) and care providing structures.

The agencies at the **district level** are district hospitals, pharmacies, Community-Based Health Insurance (CBHI), and HIV/AIDS committees. For clinical services, they report to the director of the district hospital. For administrative matters, however, the agencies are under the supervision of the party responsible for social affairs of the district, the District Health Unit (DHU). This is an administrative unit in charge of the provision of health services in the district and responsible for planning, monitoring, and supervision of implementing agencies. It is part of the intersectoral collaboration and coordination with DPs and civil society through the Joint Action Development Forum (JADF). The DHU is composed of a district director of health with three technical staff members (District M&E officer, District health promotion/disease prevention officer, District planning and coordination officer) and reports to the vice-mayor for social affairs or to the District Council directly, if necessary. The District Organizational Structures are presented in Annex 7.6.The current district health monitoring and evaluation [M&E] officer is not in the district structure but the MOH has judged necessary to maintain this position financially supported by SPIU.

The District Health Management Team (DHMT) is composed of the district director of health, the hospital director, the director of CBHI, the director of pharmacy, and a representative of the health center managers. It is chaired by the vice-mayor for social affairs. The role of the DHMT revolves around planning and management, supervision, coordination, financial and resource oversight, regulation, and increasing participation on the part of the local community in the delivery and management of services.

The figure below presents the organizational chart of DHMT and DHU with the composition of these district health coordination bodies:

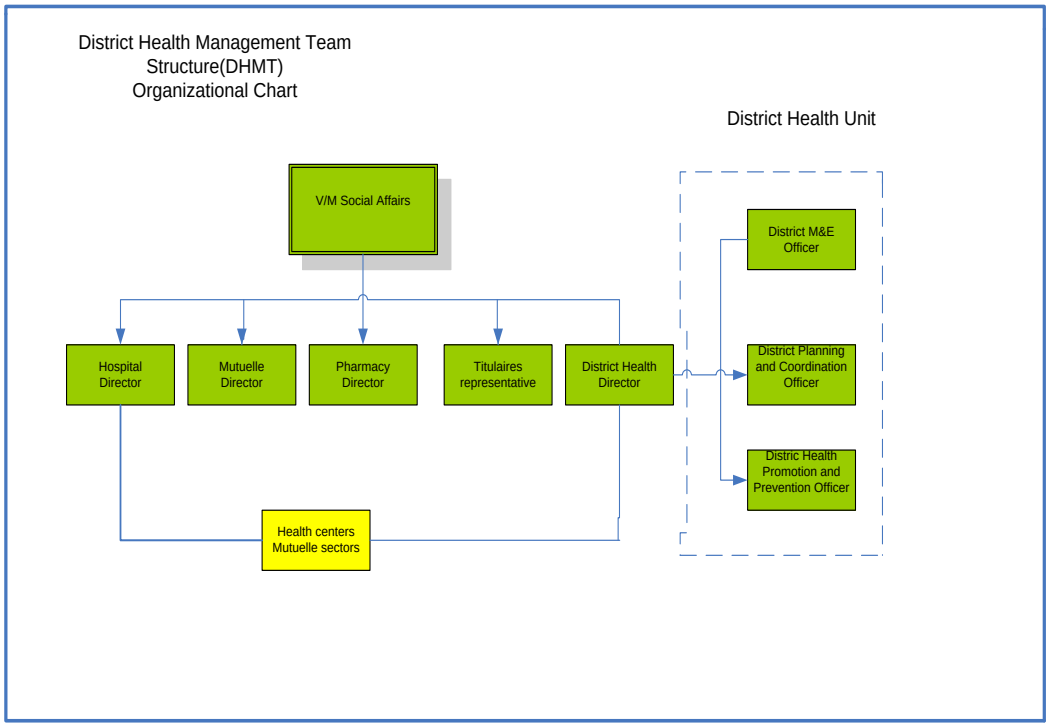


Figure 2: Organizational chart of DHMT and DHU

At the **sector level**, HC committees provide oversight of the work of the various units in the health

center, its outreach and supervision activities, and general financial control.

At the **village level**, community health workers (CHWs) are supervised administratively by those in charge of social services and technically by those in charge of health centers. CHWs receive compensation for their work from performance-based financing (PBF) through formally established local cooperatives.

The health sector is also **supported** by development partners (DPs), faith-based organizations (FBOs), nongovernmental organizations (NGOs), professional associations, and regulatory bodies.

1.1.3 National Health Policies and strategies

1.1.3.1 Health sector Policies and related Strategic plans

The Ministry of health has recently undertaken a comprehensive review and update exercise of all its policies and strategic plans to align them with the current EDPRS II (2013-2018). The EDPRS maintains a strong focus on improving the sexual and reproductive health status of the population and commits to sustain efforts towards the achievement of the health related Millennium Development Goals Moreover, the EDPRS II identifies the fight against HIV and AIDS as one of the crosscutting issues to be mainstreamed throughout all sectors, as well as gender equity – including the prevention of and response to gender-based violence -, environment and climate change and social inclusion.

Here are the main policies and strategic plans that represent the body of reference documents guiding the health sector, addressing also the cross-cutting issue HIV/AIDS.

Table 2. Summary table for Health sector policies and strategic plans

Health sector Policy (2014)	Health Sector Strategic Plan (HSSP III 2012-2018) Health Sector M&E Strategic Plan (HSSPIII 2014-2018)
Maternal and Child Health Policy Child Health Policy (April 2009) National reproductive health policy (July 2003) Family Planning Policy (2012) National ASRH&R Policy (2011)	Roadmap to reduce Maternal and new-born mortality (2013-2018) Child Health SP (2013-2018) FP strategic plan (2012-2016) ASRH&R SP (2012-2018) National Accelerated Plan for Women Girls Gender Equality and HIV (2010 to 2014) National Manual for ASRH in Rwanda (2010) Ministry of Health. Standards des services de santé sexuelle et de la reproduction adaptés aux adolescents et aux jeunes du Rwanda (s.d.) National Guidelines for HIV Prevention Interventions among Sex Workers (2011) City of Kigali. Strategic Plan for HIV and AIDS Response in the City of Kigali (2013-2016)
Nutrition Policy (2007)	Nutrition Strategic Plan (2013-2018)
Infectious disease policy (in finalization process) National HIV/AIDS Policy (2005) TB/HIV Policy (2005)	HIV/AIDS strategic plan (2013-2018) TB strategic plan (2014-2018) Malaria strategic plan (2012-2017) Strategic plan for the control of neglected tropical diseases 2012-2017 Vaccine and preventable diseases Strategic Plan (2013-2017)
Vector Control Policy (ready for validation)	Integrated Vector Management Strategic Plan (2012-2017)
Non Communicable Diseases Policy (2014)	NCD SP (draft ready for approval)
Mental Health Policy (2014)	Mental health SP (2013-2018)
Health Care services Access Policy (draft ready for validation) National Blood Transfusion Policy (May 2006) National Medical Laboratory Policy (July 2005) National Policy for Quality Management (2012)	National Reference Laboratory Strategic Plan (2010-2014) SAMU Strategic Plan (2010-2013) National Strategy for Quality Management (2008-2012) Rwanda Healthcare Accreditation Strategic Plan (2013-2018)
Pharmaceutical Policy (draft ready for approval)	National Pharmaceutical Strategic Plan (2012- 2017) National Supply Chain SP (draft ready for approval)

HRH Policy (2011)	HRH strategic plan (2011-2016)
Community Health Policy (Draft ready for approval)	Community health strategic plan (2013-2018)
Health Financing Policy (2009) is currently updated National Health Insurance Policy (April 2010)	Health Financing Strategic Plan (draft ready for approval)
Health Promotion Policy (2010)	
Health Research and Information Policy (2012)	Medical Research Center Strategic Plan (2012-2017)

1.1.3.2 The HSSP 3

The Third Rwandan Health Sector Strategic Plan (HSSP III) provides strategic guidance to the health sector for six years, between July 2012 and June 2018. HSSP III has been inspired and guided by the VISION 2020, which will make Rwanda a lower-middle-income country by 2020; the Rwandan Health Policy of 2005; and it has recently been reviewed to align to the priorities set out by the Economic Development and Poverty Reduction Strategy (EDPRS II 2013–2018).

At the international level, the most important policies and commitments providing direction to the HSSP III are the Millennium Development Goals (MDGs), the Abuja Declaration, the African Health Strategy (2007–2015), the Paris Declaration (2005), and the Accra Agenda for Action (2008). Recently, the Rio Political Declaration on Social Determinants of Health (October 2011) has strengthened the Ministry of Health (MOH) political commitment to reduce health inequities.

An extensive situation analysis conducted in the second half of 2011, together with a comprehensive Mid-term Review, provided the information about Rwanda's burden of disease and the epidemiological profile needed to determine the five overall priorities of HSSP III, as follows:

- Achieve MDGs 1 (Nutrition), 4 (Child), 5 (Maternal and Child Health) and 6 (Disease Control, including HIV/AIDS) by 2015;
- Improve accessibility to health services (financial, geographical, community health)
- Improve quality of health provision (quality assurance, training, medical equipment, supervision)
- Reinforce institutional strengthening (especially towards District Health Services & Units)
- Improve quantity and quality of human resources for health (planning, quality, management)

In view of achieving MDGs 1-4-5-6 HSSP III keeps a particular focus on : 1) maternal and child health; 2) sexual and gender-based violence; 3) adolescent sexual and reproductive health and rights; 4) family planning; and 5) HIV and AIDS.

Against the background of the situation analysis and in line with the conceptual framework, HSSP III provides a detailed account of the objectives, priorities, interventions, and innovations that (1) all the major programs, (2) all the health support systems, (3) the various levels of service delivery, and (4) the governance institutions are planning to continue, initiate, or roll out in the coming years. All four components have defined the essential indicators they intend to monitor annually (see section 2.3 of this document for more information on the HSSP III conceptual framework).

1.1.4 Rwanda and the health related MDGs

Rwanda has made great progress since 2000 towards socio-economic development as measured by

the MDGs and is on course to achieve its MDGs targets by 2015. Specific information is presented below for the MDGs directly related to health.

1.1.4.1 MDG 1 : Eradicate extreme hunger and poverty

Rwanda has made tremendous strides in eradicating extreme poverty and hunger. The success of EDPRS 1 has reduced poverty by 12% points from 57% to 45%, lifting a million people from poverty. On top of that extreme poverty dropped from 35.8% in 2006 to 24.1% in 2011. However, the level of malnutrition remains high, as showed by the prevalence of stunting among children under 5 measured during DHS 2010 at 44 per cent, with higher rates in the rural areas of Northern Province (60 per cent). Food insecurity and chronic malnutrition are closely linked, with poverty as the root cause. The Government has acknowledged the importance of nutrition to the development of young children and made the elimination of malnutrition a national priority.

1.1.4.2 MDG 3: Promote gender equality and empower women

The Rwandan Government is committed to Gender Equality and Women's Empowerment (GEWE). In the health this reflected through 3 main entry points:

1) the National Gender Policy (NGP) (July 2010) includes a specific component for the health sector. The NGP aims at strengthening efforts regarding family planning, ensuring that women, men, boys and girls are provided with adequate information on reproductive health and also ensuring that the reproductive health services delivery system is gender sensitive and easily accessibility to both men and women. Efforts also address rural health systems and referrals, in order to ensure that women and men have equal access to HIV related information for prevention, treatment & care with a special attention to women. These efforts also facilitate access to health facilities for both women and men and ensure that trained medical personnel, appropriate equipment and medical supplies are available. Finally, there are measures to address GBV by tackling the different influencing factors (involving the men) and by ensuring continued revision, dissemination and enforcement of GBV laws.

2) the HSSP III stipulates specific objectives to improve GEWE. In particular, since there continues to be a high level of tolerance by both men and women regarding of domestic violence (NISR 2011), HSSP III is committed to establish 42 One-Stop-Centres for sexual and gender-based violence (SGBV) in all districts with a standardized minimum package of activities.

3) the national program on Gender Responsive Budgeting, headed by MINECOFIN in collaboration with MIGEPROF, imposes all sector ministries to draft Gender Budget Statements following the budget cycle. The Gender Budget Statement for the health sector (2014/2015) focuses on 3 programs: 1) Maternal and child health, 2) Health and quality improvement and 3) Disease prevention and control.

1.1.4.3 MDG 4 : Reduce infant mortality

Over the last decade, Rwanda has recorded significant improvements in health outcomes. Infant mortality has reduced from 86/1000 live births (RDHS 2005) to 50/1000 live births (RDHS 2010). The under-five mortality rate has significantly reduced from the 2006 rate of 152 per 1,000 live births to 76 per 1000 live births in 2011. Improvements in vaccination coverage over this period have contributed significantly with the number of children vaccinated increasing from 75% in 2006 to 90% in 2011.

1.1.4.4 MDG 5 : Improve maternal health

Maternal mortality also decreased, from 750 per 100,000 live births in 2005 to 476 per 100,000 live births in 2010 but still short of the MDG target of 325 per 100,000 live births. This improvement is attributed to the percentage of delivery assisted by skilled providers which increased from 39% in 2006 to 69% in 2011. Two of the main pillars to achieve MDG 5 are the improvement of adolescent sexual and reproductive health (ASRH) and improved accessibility of family planning (FP) services.

The latter should also be integrated in services for HIV and AIDS, maternal health and child health.

1.1.4.5 MDG 6 : Combat HIV-AIDS, Malaria and other diseases

The national HIV prevalence in people between 15 and 49 in Rwanda has remained stable over the last five years (3.0% in both DHS 2005 and 2010). HIV prevalence is higher among women (3.7%) than among men (2.2%) and higher in urban areas (7.1%) than in rural areas (2.3%). The differences in HIV prevalence among men and women are particularly striking in the 20-24 age group where the HIV prevalence for women is five times higher (2,4%) than among men (0,5%)

However, there has been a decline in the HIV prevalence rate amongst pregnant women tested as part of routine antenatal care between 2006 and 2011 from 4.4% to 2.4% respectively. Mother-to-child transmission rate has also declined from 21.5% in 2006 to 2.6% in 2011. Most new infections occur among key populations, such as sero-discordant couples (SDC), young people, men having sex with men (MSM) and male and female sex workers (MSW/FSW). Improving prevention of and response to sexual and gender-based violence is one of the priorities in the National HIV/AIDS Strategic Plan 2013-2018.

There has been a decline in malaria and Tuberculosis cases. The death rate associated with TB has decreased from 6% to 4% between 2006 and 2011. Ownership of at least one long lasting insecticide treated bed net has risen from 15% in 2006 to 82% in 2011. A similar trend is observed in the number of five year olds sleeping under a treated net from 16% in 2005 to 70% in 2011.

1.1.4.6 MDG 7: Ensure environmental sustainability

Household access to safe drinking water has increased from 64% in 2006 to 74.2% in 2011 which is on track for the MDG target of 82%. There have also been gains in access to sanitation from 58.5% in 2006 to 74.5% in 2011.

1.2 Health Sector SWOT Analysis

This SWOT analysis is based on the participative workshop organized during the formulation process and complemented by review of reference documents produced in the last few years: the situation analysis conducted in preparation of HSSP III (2012), the EDPRS health sector self-assessment conducted in preparation of EDPRS II (2011) and the Mid-term review of HSSP II (2011).

Table 3. Health Sector SWOT Analysis

Strengths	Weaknesses
- Review of responsibilities of central MoH and RBC to ensure a strong potential to react to emerging/challenging issues - Strong sector and sub-sector policies and strategic plans in place - Functional HSWG and TWGs for strategic orientations and joint monitoring of health sector performance - Effective decentralization in health sector - Increased geographical accessibility to health services (42 DH and 450 HC) - Packages of service delivery at different level of HF are well defined with good referral and counter referral system - Community health workers have a well-defined/organised package of services - Ongoing strategies (e.g. accreditation, PBF, integrated supervision) to improve the quality of services - Innovations such as Mutuelles, PBF, and decentralisation of funds and services - Development of R-HMIS: data collection and sharing system - Existence of District Gender Statistical Frameworks - Active faith-based organizations	- Insufficient number of health staff - Limited skills of staff in some areas regarding clinical care and health management at the various levels - High turnover of health professionals - Insufficient mental Health Ambulatory services - Lack of tools to operationalize DHMT - Poor mentorship of the DHMT - No HC/DH in some sectors/districts (including urban districts in Kigali) - Lack of standard norms of medical equipment and infrastructure - Lack of standard maintenance workshops at DHs - Insufficient horizontal integration of health programs (in HF and with CHWs) - Insufficient continued capacity building for the health professionals (Health care providers, Biomedical engineers and technicians) - Insufficiency of integrated supervision - Lack of accreditation Body or agency to coordinate the accreditation process - Limited management capacity at decentralized level - Limited coordination at decentralized level - Poor budgeting process at decentralized level - Insufficient integration of health information systems (E-LMIS,EMR,R-HMIS) - Insufficient use of (sex-disaggregated) data in decision making - Insufficient capacities to integrate gender as a cross-cutting issue

Opportunities	Threats
- Inter-sector coordination among social Ministries through the Social Cluster (GoR) contribute to a comprehensive health system (link with education, agriculture, transport, WASH) - EDPRS II and Health Financing Strategic Plan (2014) encompass private sector involvement - Existence of HRH and CPD programs to strengthen health workforce - Transfer of CBHI (mutuelles) financial management to RSSB (2014) - Strong process of empowering local government (districts) - Existence of Performance contracts/ Imihigo - Zero tolerance policy against mismanagement of public funds - 'Medicalized' centers in urban centers - Integration of Mental Health services in the HC package for people centered care - Well-functioning Gender Monitoring Office, collecting, analysing and reporting disaggregated data for all sectors - Strong political will to work on gender equality and women's empowerment, including gender responsive budgeting	- Lack of predictability of donor funds & risk of declining external resources for the health sector - In spite of efforts to decentralise, most of the decision-making power is still at central level - limited capacity of districts (inadequacy between decentralisation of functions vs. resources)

1.3 Specific context

On the basis of the country context and the SWOT analysis presented above, and in line with the identification file previously agreed on between the Rwandan and Belgian governments, six main intervention areas have been selected. A more detailed analysis of background, achievements and challenges has been conducted regarding these six priority areas. The challenges related to these 6 main intervention areas will be the basis to define the activity clusters under chapter 3.

1.3.1 Quality of services

The Rwanda Ministry of Health (MoH) selected healthcare facility (hospitals and health centers) accreditation as one of several strategies to improve quality of services. This approach is in line with institutionalizing the process of continuous quality improvement of health care services targeting a range of comprehensive services provided by health facilities.

1.3.1.1 Background: The accreditation process between 2006 and 2014

"International" accreditation in Rwanda started in the three national referral hospitals: King Faisal Hospital (KFH), University Teaching Hospital of Kigali (CHUK) and University Teaching Hospital of Butare (CHUB) in 2006. The MoH contracted an external assessor, the Council for Health Services Accreditation of Southern Africa (COHSASA) to start the international accreditation process according to international standards. In 2011 King Faisal Hospital was the first to be accredited by COHSASA. CHUK attained in July 2014 the pre-accreditation level with a score of 83 % and will probably be accredited in 2015, whilst the program in CHUB has stalled reportedly due to lack of technical assistance.

Inspired by this initiative of international accreditation, the intention to develop a "national" accreditation for all health facilities was born, through the Rwandan Accreditation Program. The Minister of Health officially launched the national accreditation program in 2012 and an accreditation steering committee was set up with the mandate to develop the structure for the accreditation agency. The steering committee developed and approved the initial draft of the standards and a Rwanda Healthcare Accreditation Strategic Plan 2013-2018. Some key elements of the strategic plan are listed in the table below. The Rwanda Accreditation Program has been broadly supported by the Integrated Health System Strengthening Project (IHSSP) run by MSH (USAID funding), by BTC/Minisante4 and by Joint Commission International (JCI).

Table 4: The Rwanda Healthcare Accreditation Strategic Plan 2013-2018

General objective:
To continuously improve safety and quality of care provided to the Rwandan population through accreditation of health facilities that supports quality improvement in the health care system.
Specific objectives:
To institutionalize continuous quality improvement of health care services in Rwanda
To build institutional capacity of the health sector to manage the accreditation program for health facilities at all levels
To develop national accreditation standards that are based on current evidence, which will be used to measure quality improvement of health services delivered by healthcare facilities
To develop a fully functional accreditation body that can support the accreditation process within the country
To coordinate and mobilize the required resources to support the accreditation program

1.3.1.2 Achievements

The main achievements for the national accreditation program in Rwanda are the following:

1. **Rwanda Essential Hospital Accreditation Standards developed:** The process started with the adaptation of the International Essentials of Health Care Quality and Safety designed by Joint Commission International (JCI) to address the five following risk areas to patients in hospitals: 1) Leadership Process & Accountability, 2) Competent & Capable Workforce, 3) Safe Environment for Staff & Patients, 4) Clinical Care of Patients, 5) Improvement of Quality & Safety.

2. **Rwanda Healthcare Accreditation Strategic Plan 2013-2018 developed and approved**
3. **The Rwandan accreditation surveyors training launched:** 38 accreditation surveyors have been trained and only 10 were certified by JCI; 25 surveyors are still pursuing the training for the certification, while 3 surveyors dropped out of the training.
4. **Rwandan Accreditation Facilitation System installed and 40 Rwandan accreditation facilitators trained:** The accreditation facilitators were categorized into two categories, 10 are external and 30 are internal facilitators. The 10 external accreditation facilitators came from the Ministry of Health and RBC and provided mentorship, technical assistance, and on-site consultations to assist healthcare facilities to improve quality of care and services by meeting accreditation standards. The 30 internal facilitators came from hospitals under full accreditation program to keep their hospitals on the path of implementing and complying with accreditation standards.
5. **Accreditation baseline conducted in all district hospitals and progress assessments conducted in 15 hospitals: t**he accreditation baseline assessment was conducted in all 43 hospitals, but progress assessment was conducted in 15 hospitals only. However, only 5 new referral and provincials hospitals are in full accreditation program. New referral hospitals are Kibungo and Ruhengeri and the new provincial hospitals are Bushenge, Rwamagana and Ruhango. Also Kibuye is a new referral hospital but not in full accreditation and Kinihira is a new provincial hospital that is not also in full accreditation.
6. **Established Rwanda Annual National Quality and Patient Safety Goals:** The Rwanda Annual National Quality and Patient Safety Goals have been developed to bring 37 District hospitals on board to the Rwanda accreditation process. These National Quality and Patient Safety Goals (Goal 1: responsive customer care, Goal 2: incident management and reporting, and Goal 3: surgical site infections), are in the Rwanda Essential Hospital Accreditation standards framework.
7. **PBF linked to accreditation:** The main purpose of linking accreditation process and existing PBF mechanism is to effectively support quality improvement of health care and services and patient safety and to avoid duplication in assessment mechanisms.
8. **Training on continuous quality improvement**
9. **Policies and Procedures were disseminated and communicated in all 43 hospitals**
10. **Established Accreditation support Committees in all hospitals:** The hospital accreditation support committees are responsible for the oversight of the implementation of the accreditation standards and progress toward achieving and maintaining accreditation.

1.3.1.3 Challenges

In spite of the key achievements described above, the National Accreditation Program is still in its early stages of development and the challenges are numerous and important to reach maturity. Here are the main challenges currently identified and strategies proposed to address these challenges:

1. At the present time, the program is managed by MOH, which makes it judge and party in the technical assessment of quality of services in health facilities. The creation of an autonomous accreditation body is necessary for the impartial and objective management of the accreditation process.
2. Innovative strategies have been identified to strengthen the accreditation process and expand the number of facilities involved (linkage of accreditation to the PBF management mechanism and to integrated supervision, establishment of public/private partnership for accreditation of private health facilities), but national models, norms and standards need to

be developed to guide the implementation of these innovations;

3. At present, only a few hospitals, at the referral and provincial level, are involved in the full accreditation program. The extension of the full program to all hospitals, and eventually to health centers, will necessitate important additional financial and human resources. A comprehensive capacity building plan and resource mobilization strategy will be developed and implemented. Specific training programs are needed for technical aspects identified as assessment criteria for the accreditation process (cardio-pulmonary resuscitation, infection prevention and control);
4. Quality management is still a new concept for a majority of health care providers and managers, an intensive awareness raising program is needed to establish a strong culture of quality and safety of care and services in hospitals and in health centers;
5. The basic assumptions underlying the establishment of the accreditation program as a major strategy to improve quality of health care and services need to be documented and investigated with scientific methods. Operational research studies are necessary to guide policy and implementation of the National Accreditation Program.

1.3.2 Mental health

Rwanda today still faces an exceptionally large burden of mental disorders. Rates of depression and post-traumatic stress disorder (PTSD) among adults have been reported at levels that exceed by far the international averages for a large part related to the genocide in 1994. Up to one in four adults is estimated to suffer from post-traumatic stress disorder (PTSD) (Munyandamutsa et al. 2012) and prevalence of major depression was estimated at 15.5% (Bolton et al. 2002).

1.3.2.1 Background: Policy and institutional environment

In response to the burden of mental disorders, the Government of Rwanda (GoR) has taken steps to provide people-centered services for all people with mental health problems (WHO 2010). In 2005, mental health was identified within the health sector policy as a priority area for intervention (Government of Rwanda, MoH, 2005). This policy called for the integration of mental health services at all levels, down to the community level. In 2014, the National Mental Health Policy in Rwanda revised in 2011 was published by the MoH. It is structured around 10 fields of intervention, as presented in the following figure.

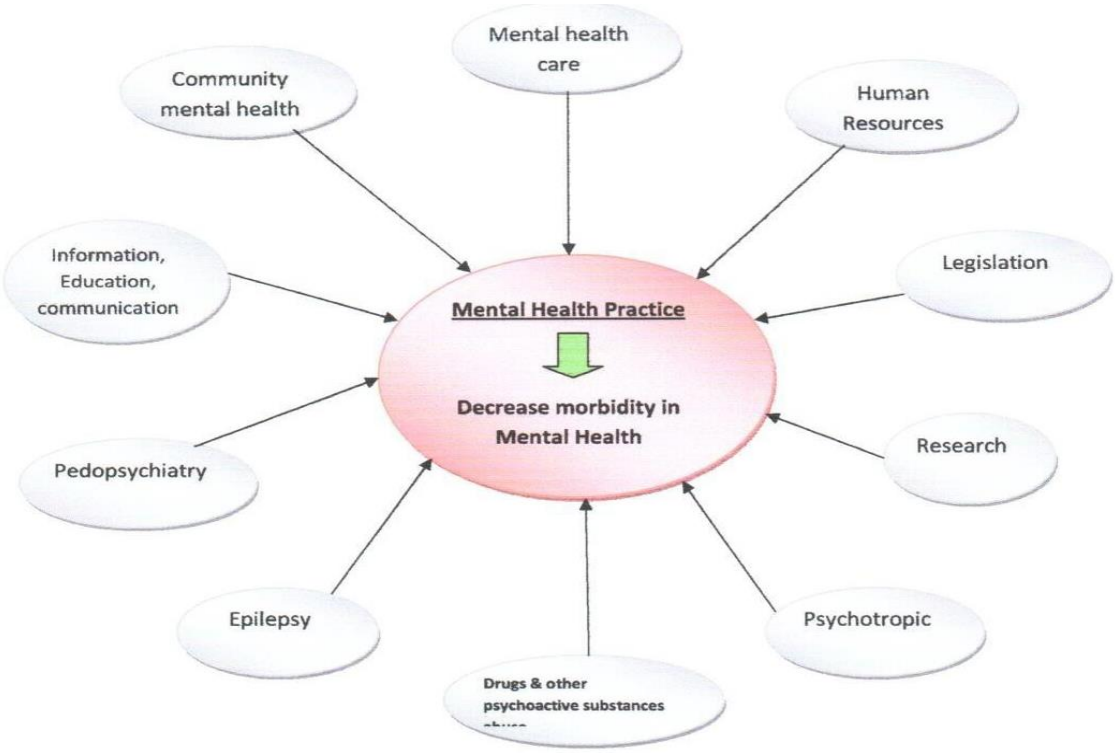


Figure 3: The National Mental Health Policy 2011- 10 intervention fields

At central strategic level, there is a Mental Health Division in Rwanda Biomedical Center (MHD-RBC). Its mission is to implement the mental health policy through the development and implementation of a strategic plan linked to the Health Sector Strategic Plan (HSSP III 2012-2018). The MHD-RBC is composed of 3 units, as shown in the following figure. The 2014 restructuring of RBC has adopted 2 units for the MHD. The first unit will be in charge of the mental health care development, the second will be in charge of community interventions.

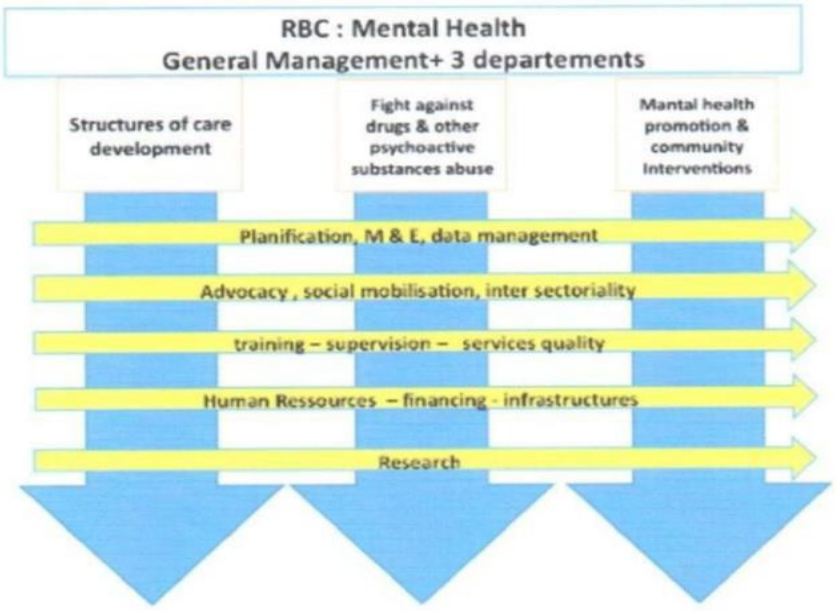


Figure 4: The Mental Health Division

1.3.2.2 Achievements

Structures of care development

For the operational delivery of mental health care, Rwanda has different levels. There is one 3rd level referral hospital in mental health: the neuropsychiatric hospital of Ndera. A Mental Health department of the Kigali University Teaching Hospital is currently serving as a referral service for outpatients.

At District level, there are 43 general district hospitals which include each a mental health unit as specialized service. Six have specific hospital beds for mental health. 462 out of 468 health centers have at least one general nurse trained to handle the common mental health disorders. At community level, 15,000 CHWs have been trained in 2014. The effort is further pursued by targeted training for nurses of the health centers and for community health workers in order to reinforce the integration of mental health care in PHC.

Decentralized hospitals and health centers across the country are now capacitated to provide mental health care. Community-based health insurance includes mental health care services and drugs; and systematic sensitization campaigns reach every village in Rwanda.

Substance abuse prevention and control

Drug abuse is a new public health concern identified in Rwanda. According to a recent study (KHI &Miniyouth 2012) more than half of the youth, considered by the sample, declared already to have used substance/drug (52.4%). Among them are users with a serious dependency problem: 7.46 % are dependent on alcohol, 4.88 % on tobacco and 2.54 on Cannabis. The age of onset is as low as 11 years. To face this concern, an extensive Preventive & sensitization program was launched by MHD-RBC and a rehabilitation center for drug/HIV has been constructed in Huye district. The Center needs to be equipped and the prevention program needs to be strengthened. The rehabilitation center for chronic drug users and HIV (Huye District) will provide inpatient and outpatient care for those suffering from disorders resulting from abuse of alcohol or/and drugs. The center will also provide a forensic component by supporting persons detained or awaiting trial in order to preserve their health and rights by preventing withdrawal syndrome effects.

Mental health promotion and community interventions

At community level, the most important focus is on promotion of healthy behaviour and prevention of mental illnesses. 15,000 CHWs have been trained in 2014. The effort is further pursued by targeted training for nurses of the health centers and for community health workers in order to reinforce the integration of mental health care in PHC.

Mental health and HIV/AIDS

Over the past years the Mental Health Division at the Ministry of Health has made huge efforts to improve the quality of the psychosocial counselling of people living with HIV and AIDS (PLHIV) and created a Technical Working Group on HIV and Mental Health in 2009. One of the main challenges for the near future will be to ensure the effective integration of mental health and HIV psychosocial counselling services at all levels of the health system.

Mental health and gender

One-Stop-Centres providing integrated assistance for girls and women suffering from SGBV, have an important impact on individual and community level and should be further supported, in close collaboration with MIGEPROF and CSO, while taking into account the lessons learned from other organizations like UN Women. However, these CSO focus mainly on the ‘victim-component’ and neglect the transformational roles women and girls can play in their society. Initiatives supporting (economic) empowerment for women is therefore one of the main challenges.

1.3.2.3 Challenges

In spite of the achievements outlined above, several critical challenges still remain:

1. Stigmatization of people living with mental disorders remains important;
2. There is still lack of qualified human resources
3. The number of specialized clinicians does not meet the burden of disease;
4. The mental health department of the Kigali University Teaching Hospital is currently serving as a referral service for outpatients but it has never been provided with adequate infrastructure.
5. Insufficient sharing of people-centered approach of MHD with general health professionals
6. The integration of mental health and HIV psychosocial counselling services at all levels.
7. The Mental Health Department needs a real unit to coordinate drug abuse issues;
8. Persisting needs on gender approaches in mental health, more precisely regarding awareness-raising and capacity building, care of victims of GBV, and coaching of girls and women as agents of change;
9. Foreign aid for mental health care is limited;

1.3.3 Urban health

1.3.3.1 Background: Population growth in CoK

Rwanda is still predominantly rural, with 19.1% of population living in urban areas. However Rwanda is one of the fastest-urbanizing countries in Africa. The urban population share increased from just 5% in 1995 to 17% a decade later and forecasts suggest that the urban population will reach 30% of the national population by 2020. The City of Kigali (CoK), by far and away the largest city in the country, is representing 44% of the urban population. It presently covers three of the Rwanda's thirty districts: Gasabo, Kicukiro and Nyarugenge, and 35 administrative sectors. Data about Kigali's population growth reveal an initial increase from 6000 at independence in 1962 to 600,000 by 2000 and the population continued to grow quickly and reached 1,132,686 in 2012. Statistics indicate that population of Kigali is expected to double by 2020 to around 2 million inhabitants and by 2040 is proposed to reach 4.2 million.

1.3.3.2 Achievements: Health care offer in CoK

Health related preventive and Promotional services

The Vision of the CoK is to be a model of a "Clean, Green & Safe City with a High quality of service". The hygiene & environment component is a key area. At each level of Local Government there is an Officer in Charge of public hygiene responsible for the coordination of hygiene inspection in public places and in the community. Twice a year the CoK organizes a hygiene campaign in collaboration with local government level, MoH and various stakeholders in order to strengthen the culture of hygiene & environmental protection.

There are many other initiatives related to health related prevention and promotion, focusing on specific target groups such as adolescents and social vulnerable groups. A major challenge is to more effectively coordinate these initiatives.

Health coverage of Public Health Centers

Table 5: Current mapping of Health Centers in the three districts in CoK

	Kicukiro District	Nyarugenge District	Gasabo District
Population	319,661	284,860	530,907
Administrative Sectors	10	10	15
Operational HCs	9	11	16
Sectors without HCs	Kigarama: 44, 610 inhab. Kagarama:14, 054 inhab.	Rwezamenyo:16,888 inh. Gitega: 28,870 inhab.	Kimihurura: 20,704 inhab. Gatsata: 36,897 inhab. Kimironko: 59,312 inhab. Gisozi: 44,075 inhab.
HCs with uncompleted PHC package	'Solaces Ministries': lack of maternity and room for hospitalization	Biryogo and Rwampara: lack of maternity and room for hospitalization	Women Network in Kinyinya sector (no hospitalization); AVEGA HC in Remera (no maternity & hospitalization)

Currently the minimum requirement for Rwanda is to have 1 HC for each Sector. Table 5 shows that 8 sectors don't have a functional public HC. This must be linked to the fact that the majority of the population of CoK (> 80% of the population) is covered by the Community Health Insurance scheme, giving only access and reimbursements for services in the public health facilities. 80 % of the population in CoK has therefore only access to public structures and no access to private-for-profit HFs. A sound "public" health offer is therefore an important determinant for the health of the population of CoK. Regarding the CoK hospital facilities, the situation is documented under Table 7.

Hospital coverage

Table 6: Inventory of hospitals in CoK

Level	Institution	Number of beds
National referral	King Faycal Hospital	154
National referral	CHUK	473
National referral	Rwanda Military Hospital Kanombe	400
Referral	Kacyiru Police Hospital	62
National referral	Ndera	288
Referral	KMH	234
District Gasabo	Kibagabaga DH	186
District Kicukiro	Masaka DH	145
District Nyarugenge	Muhima DH (MCH nat. Excellence center)	162
TOTAL		**2,104**

Achievements and lessons learnt from the intervention PAPSDSK

The CoK and its districts efficiently adapted their health and environment management instances to respond to its fast development through the creation of a functioning Health and Environment Unit and by providing support to family and Child Protection Unit in each of three urban districts. Annual planning for health is institutionalized in the 3 districts of CoK and informed by the 5-year strategic health development plan of the City of Kigali and HSSPIII. A more clear division of roles and tasks between CoK and the MOH has been established.

The Health and Environment Unit of CoK is currently instrumental in the coordination of Health and environment initiatives including the supervision and technical support to Districts' staff in charge of health. However, a Health Environment Platform which was supposed to be created to translate the strategic orientations into concrete plans and to follow up their execution did not materialise.

In order to increase geographic accessibility to healthcare services in the CoK, four new medicalized health Centres were constructed, equipped and staff were deployed to make them functional. These health centres intend to serve a population of 300.000 (almost 27% of the population of the CoK) with an upgraded medical package. Questions remain however at the level of payment of the services and the optimisation of the complementarity between the existing teaching hospitals, provincial, district hospitals and health centres.

In terms of Public-private partnership, achievements so far consist in a successful reform of the health management information system including high coverage of reporting by the private sector. Future attention needs to be directed to quality issues. In addition to continue provision of promotional and preventive interventions by private health facilities, there is a clear and apparently felt need for norms, standards and trainings in the use of clinical guidelines and overall oversight.

Other achievements include development of master plans for the District Hospitals of Muhima and Kibagabaga, clinical support and specialist training in the CHUK, assistance to national hospitals to obtain international accreditation, research activities on unmet obstetric needs, referral and counter-referral, continued support for a computerised patient and hospital management system in the CHUK, support to the central maintenance workshop (ACM), biomedical maintenance contracts for the district hospitals and the CHUK; financial and material support for the functioning of district hospitals; drainage networks and waste water treatment in Kigali district hospitals, mapping of the health care coverage (supply side) with public and private services, including detailed geographical information system (GIS) based maps, specific thematic training sessions for District Hospital teams, including ETAT ('Emergency Triage-Assessment-Treatment for children and neonates), support to supervision activities by District Hospital teams and introducing 'systemic clinical audits, support to the management of the Performance Based Financing (PBF) system, external scientific support (provided by the School of Public Health of Kigali and the Université Libre de Bruxelles -ULB) accompanying action-research and other initiatives; clinical support and training of specialists at the CHUK by project ITAs, contributions to the City's campaign 'Beautifying my Kigali', 'Green, Clean and Secure City' and participation in 'Health Open Day'; development of a school health strategy and a protocol to study the feasibility of medical screening in primary schools.

These achievements have also prepared the ground for issues to be tackled in the future such as completing supply side primary care according to the 3 dimensions of universal coverage as disseminated by WHO, thinking through the complementary functions of (different level) hospitals/new HCs, developing a more explicit policy on urban health, supporting the development of human resources through formalised training-for-qualification in the area of mental health, and supporting the development of a coherent governance response to drug abuse among youths and HIV focusing on most at risk group.

1.3.3.3 Challenges

1. Evolution in the overall burden of disease:

Urbanization provides opportunities but it is also associated with many health challenges. Traditional health issues remain present, and new ones emerge, characterized by the simultaneous occurrence of a quadruple burden of diseases: (i) Non-communicable diseases – such as diabetes, rheumatic and congenital heart diseases, malignancies, asthma, epilepsy, and hypertension –and conditions fuelled by environmental air pollution, tobacco use, unhealthy diets, physical inactivity, and harmful use of alcohol; (ii) Infectious diseases exacerbated by poor living conditions; (iii) perinatal and maternal morbidity and mortality; (iv) road traffic or workplace injuries, violence (including SGBV) and crime. Moreover, there is a high concentration of people affected by diverse mental illnesses like epilepsy, post-traumatic syndrome disorders, psychic or psychosomatic and other neurologic diseases.

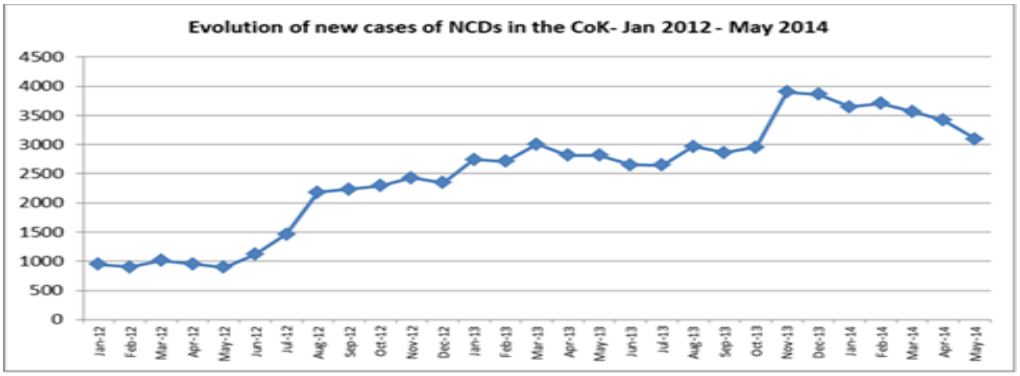


Figure 5: Evolution of NCDs in CoK (2012-2014)

Public HFs (HCs and DHs) in the CoK are not dealing adequately with NCDs, road traffic injuries, environmental, mental health disorders and disaster preparedness. Another particular trait in the City of Kigali relates to mental health problems.

2. High prevalence of HIV/AIDS in the CoK:

One of the greatest urban health threats is HIV/AIDS, which is associated with several social determinants characteristic of urban settings. Having to cope with the highest HIV prevalence of the country (7,3%) the CoK developed a “Strategic Plan for HIV and AIDS Response in the city of Kigali 2013-2016” and identified vulnerable populations and key populations for whom specific outreach programs are to be developed, including young girls (15-24 years), sex workers, men having sex with men, domestic workers and people living with a disability. A recent study revealed that 56% of the female sex workers in the CoK is HIV positive.

3. Environmental issues in the CoK:

Today, air pollution is important in Kigali mainly due to road traffic contributing for 58%. This is to a great extent responsible for the increase in asthma.

Waste management is another big challenge for CoK, with open dumpsites at Nyanza and Nduba. Sanitation is a key challenge for CoK as well. Access to flush toilets is only 7 %, with a target of 100 %. The current water production in Kigali is 70,000 m3 per day which is insufficient compared to the current demand of 100,000m3 per day.

4. Insufficient offer and regulation of first line health care in the CoK:

Private-for-profit facilities (>160 in CoK) are mostly offering curative services and are mainly located in

urban areas of the CoK. 39% of clinical consultations are done in private clinics. Their installation is not based on the needs of the population, but rather on the capacity to pay. This sector is not yet optimally organized, only partially controlled and its articulation with the public sector is not yet fully defined. The private sector is fairly well utilized, especially by patients who are more economically affluent and those who have contracted private medical insurance such as RSSB (RAMA).

On the public side the spectrum of providers, not all sectors are nowadays having a health center. Combined with the absence of reimbursement of the services in the private clinics and dispensaries by the CBHI, this leads to an inequitable and inhomogeneous coverage of first line health care services in the CoK.

5. Insufficient coverage of the District Hospital network in the CoK:

Lack of District Hospitals in the CoK leads a high number of patients to directly use CHUK causing congestion at this national reference hospital, resulting in long waiting lists. CHUK therefore cannot adequately play its role of national reference in health services, teaching, supervision and research. Muhima District Hospital already became a national center of excellence in MCH care under CHUK. If Masaka DH is set to become a national referral and university teaching hospital replacing the current CHUK, this means Kibagabaga DH is going to remain the only district hospital in the whole city of Kigali leaving two of the three administrative districts without a District Hospital for a population of more than 1,300,000 inhabitants.

6. No effective collaboration between all hospitals in CoK:

Though an attempt to start a CoK hospital network was conducted with the intervention PAPSDSK, nowadays there is no formal framework for exchange and resource sharing between hospitals in Kigali. Each hospital has autonomy and functions as an isolated service provider. There is little exchange of information and expertise or joint activities among these hospitals. There is no pooling of resources with high inefficiency as a consequence. Networking of healthcare institutions would provide an opportunity for reorganization and rationalization of care in urban areas bringing better services to the populations and reducing the costs by more efficient use of resources.

1.3.4 Governance

1.3.4.1 Background

The Rwandan Ministry of Health has the primary mandate of developing, monitoring and evaluating policies & strategies; capacity building of its implementing entities; regulation, coordination and resources mobilization for the sector.

All responsibilities related the implementation of sector policies and strategies will be delegated to the Rwanda Biomedical Center. This body will also assure the operational coordination of various stakeholders including NGOs, private sector and development partners. In the ongoing institutional reforms, some MoH departments and or desks like Maternal and child health, Health management information system, E-Health are expected to be placed under the responsibility of RBC. The Single project implementation unit (SPIU) is also expected to move from Ministry of Health to Rwanda Biomedical Center. During restructuration, attention should be given to gender equality and to professional opportunities for women.

The local governance structures at district level have been explained under 1.1.2.

1.3.4.2 Achievements

Establishment of District Management structures

At the District level, Management Committees and board of Directors of public health facilities, District pharmacies and community health insurance have been established ensuring the voice of the

population and its participation. In 2011, a coordination organ called District Health management team (DHMT) has been established (See. 1.1.2). This is a very young organ, and its functioning dynamics varies across Districts. In the District administration, a health unit (DHU See. 1.1.2) has been established to coordinate all stakeholders. However it is understaffed.

National coordination structures[8]

The national health strategy, HSSPIII, has been developed together with all stakeholders. The policy dialogue is organized through the bi-annual Joint Health Sector Review, the Health Cluster meetings and through the organization of Technical Working groups and taskforces. The functionality of these groups and meetings varies however.

National health insurance coverage

One of the health sector policy objectives is universal health coverage (UHC) of quality health care services. Rwanda is advanced on UHC agenda, almost 90% of the population is covered by a health insurance. However, a decline of 10% in Community based Health Insurance membership was noted in 2012/13 and little is known on financial and non-financial barriers to health care among specific and uninsured population.

1.3.4.3 Challenges

1. Weak overall steering and management capacities at district level:

DHMTs need capacity and coaching, peer learning for them to better take over their roles and responsibilities. The process of planning, budgeting and financial management, monitoring and evaluation at the District level needs to be more integrated and inclusive (with all stakeholders). District hospitals are not fully playing their roles of mentorship and technical support towards health Centers. District Hospitals are in the process of becoming budget entities, but their staff has limited capacities in planning, financial management systems (costing, accounting, expenditure tracking, internal and external audits). Insufficient information is available on financial barriers to health insurance by specific groups.

2. Specific working points with regard to stewardship at the central level

There are a few points of attention: i) the capacity of the Ministry to develop evidence-based policies and strategies and monitor their implementation is limited; ii) the participation of civil society and private sector in policy discussions and the level of private investment in the health sector are not yet at the desired level; iii) 3 out of 4 professional regulation and coordination bodies (professional councils) are young and need support to grow, to better deliver on their mandate and to become self-reliant in the future; iv) the division of roles & tasks between MOH and RBC needs to be rolled out in practice.

3. Mainstreaming gender in health policies and strategies:

A concrete challenge could be to develop a specific gender policy for the health sector. There is the political will: the 11th Leadership Retreat Resolution (LLR)[9] no. 9 (March 2014), instructed all Institutions to ensure gender is also mainstreamed in the budget preparation. In a similar way, support to the GRB processes (including the forthcoming assessment of the Gender Budget Statements) is an excellent opportunity to meet national commitments towards integrating gender in the budgetary processes of the health sector.

[8] The sector coordination is described at length in the Belgian Sector Budget Support Technical Note.

[9] The LRR is an important government event that takes place every year. The Government leaders retreat, chaired by the president, share and discuss their visions on the priorities for the next year.

1.3.5 M&E

1.3.5.1 Background

Rwanda began using a national health management information system in 2000 and was supported by BTC at Central level. In 2007 the MoH changed the data collection forms and data base shifting to SQL Software. Since January 2012, the HMIS has been redesigned and transferred to a web-based open source platform called DHIS-2 (District Health Information System).

1.3.5.2 Achievements

Installation of DHIS-2 (District Health Information System)

A new initiative to implement a national data warehouse and the HMIS software platform has been launched in January 2012. This web-based system improves access to data at all levels of the health system and serve as a sustainable platform for integrating additional modules. All health facilities are now reporting using the new HMIS monthly reports and data entry is done through the internet. Each health facility has a data manager who is in charge of entering the data from data collection form to the central level web-based system. IT equipment has been distributed to all Health facilities to facilitate data management. Access to internet is increasing in the country and use of mobile phones by CHW has contributed to improve reporting.

Data quality assurance

As far as data quality is concerned, in 2009, the Ministry of health reinforced quality of data by recruiting data managers, enhancing their capacity by trainings in different fields of data management (data entry, data checking, and data analysis and data quality assessment). Now every health facility has a data manager and HMIS is receiving monthly data from health facilities (Public, Private) and community. M&E staff has also been recruited at district and health center levels.

Utilization of data

In HSSP III and its M&E plan, programs indicators have been defined with relevant baseline and targets and in most cases, HMIS is the source of data for outcomes and outputs indicators. Different registries have been established for integrated system of data collection, storage and exploitation at all levels from Public and Private sector. Data sharing has been promoted at all levels.

So far, every year HMIS publish an annual booklet and since 2013/2014 FY, HMIS is publishing also quarterly bulletin.

Integration of a gender approach in M&E by the Gender Monitoring Office (GMO)

The mandate of the GMO is to monitor the implementation of gender principles. The provide support such as i) availability of sex and gender disaggregated data, ii) development of sector specific tools for monitoring the implementation of quantitative and qualitative gender indicators (also regarding HIV/AIDS), iii) assist in production and dissemination of sector gender sensitive indicators and analysis, iv) technical assistance in processes leading to gender sensitive planning, monitoring and assessment, v) assistance in fighting GBV and promoting GRB.

The District Planning Officer and the District M&E Officer, have an important role to play in collecting, reviewing, analysing, interpreting data and to provide feedback and reports to stakeholders.

1.3.5.3 Challenges

The main role of M&E/HMIS is to provide data for clear evidence based for policy and decision making so that all partners can agree where progress has been achieved and where there are still constraints.

1. Integration of different information systems is not finalized:

Other health information systems, particularly the electronic medical record, MEMMS (See. output 6 on asset management), the Resource Tracking Tools, other e-health systems, information of the private actors, as well as non-routine data are not yet integrated.

Modules and user manuals for training and guidance of the M&E staff at central and decentralized level need to be developed as well.

2. Still some gaps in the quality of data:

The planning process is not sufficiently evidence-based with unreliable figures, not always sex/gender disaggregated and there is no common understanding of key M&E concepts. HMIS needs tools for data collection (standardized and harmonized registers). There is further need to strengthen data quality assessment and monitoring at decentralization level

3. Insufficient culture of utilization of data:

Use of data at the local and district levels for decision-making and action-research is limited. There is need to build capacity in routine data analysis by private health facilities and district administrative level (Mentorship, Supervisions, Trainings for new HFs). At central level, strategic analysis and research capacity needs to be strengthened.

Specifically regarding gender, close collaboration between the HMIS team and the GMO office will facilitate impact assessments on a series of topics (effectiveness/efficiency of health budgets, financing for GEWE, SGBV, ….).

1.3.6 Asset management

1.3.6.1 Background

The Medical Maintenance Centre (MMC) recently named Medical Technology and Infrastructure (MTI) is the division within Rwanda Biomedical Centre in charge of all aspects of maintenance. MTI Division is composed of 3 units: Infrastructure unit, Medical Equipment Engineering Unit, and Health technology and Infrastructure Planning Unit. The Mission of MTIs Division is to carry out the Healthcare technology management and the supervision or assistance in Engineering of infrastructure for health facilities in the whole country. The Vision is to contribute to the improved accessibility to quality health services, with interventions focusing mostly on health infrastructure development, i) providing technical, capacity building of Provincial and District Hospitals curative and Maintenance workshop ii) engineering assistances to all levels of Health facilities and iii) assuring the management of the healthcare assets across the country.

1.3.6.2 Achievements

The main **Health infrastructures project constructed** under the supervision & coordination of MTI:

- The construction of Health Facilities (Ntongwe Provincial Hospital, Kinihira Provincial hospital, Bushenge Provincial hospital, Kibuye hospital phase I)
- The construction of various maternity blocks and mortuaries in different health facilities
- The construction of incinerators in various health facilities
- The ongoing construction works: Kirehe District hospital phase III, Remera-Mbogo DH, Rutare HC, Nyabikenke DH, Maternity block at Nyagatare DH
- Validation of Architectural design, technical and bill of quantity of Nyabikenke, Ntongwe, Kinihira, Byumba hospital

- The ongoing architectural design of Kibuye, Ruhengeri and Munini
- Architectural design and bill of quantity of a typical health Center

Management of medical and non-medical equipment:

- Providing technical support in procuring medical & non-medical equipment for all health facilities.
- Execution of maintenance services of Lab equipment in all health facilities across the country including Lab equipment of National Reference Laboratory (NRL).
- Execution of preventive maintenance of medical and non-medical equipment across 4 provincial hospitals, 35 district hospitals and 502 health centers.
- Execution of corrective maintenance in Health Facilities.

1.3.6.3 Challenges

The Organizational Assessment done by the intervention Minisanté IV (OAG report) emphasizes the poor maintenance of medical equipment and infrastructure. In relation to that, some key-challenges can be identified:

1. Imbalance between operational role of MTI and role in preparing policy making & strategy development:

   MTI is constantly overburdened with purely operational interventions of all kinds, and therefore not able to correctly work on policy making, regulations, normalization, and standardization. And the lack of these institutional mechanisms is the origin of new operational challenges. For example, in the absence of a policy on donations coming in the country, the MTI is constantly requested to intervene on issues linked to donation. A good policy on donation should regulate this.

2. Operational gaps in relation to procurement & maintenance of health infrastructures & equipment:

- No harmonization system of medical equipment.
- Inadequate norms and standards for national healthcare technology.
- Lack of standardized medical and non-medical equipment list for different health care levels.
- Database for medical equipment not complete and not well used (MEMMS)
- Lack of standard maintenance workshops space, tools, equipment and human resource at 35 DHs and 4 provincial hospitals.
- Inadequate standard workshop and spare parts at central level (MTI)
- No Standardization of health infrastructure design for hospitals
- Radiation protection in HF is not according to international radiation safety standards

3. Lack of a comprehensive approach towards waste management

   The audit on waste management in health sector has recommended to formulate a law, national policy and an operation strategy. A baseline is lacking as well.

4. Budget and Finance gaps:

- Insufficient budget (both at the level of national budget and the level of the budget entities) allocated to spare parts for critical equipment
- Insufficient budget for higher education, practical trainings, technical seminars, exhibition and workshops
- Insufficient budget for capital expenditure like procurement of tools, equipment.

5. Gaps in relation to Human Resources for Health:

- Inadequate number of qualified staff for administrative, management, regulatory and technical functions at central level

- Lack of sufficient human resources in Provincial and District hospitals
- Inadequate technical training for Infrastructure engineers, biomedical engineers and technicians at central level and health facilities

6. Constraints in relation to quality assurance
- No technical staff at central level
- Due to lack of staff, MTI is not able to participate in accreditation process
- Inadequate and incomplete quality control instruments and tools at central level (MTI)

1.4 Belgian Cooperation Support to the Health Sector

The overarching rationale of the longstanding partnership between the Kingdom of Belgium and GoR is the alignment with Country priorities, respecting MoH ownership, whilst abiding by the global principles of aid effectiveness, the Paris, Accra and Busan declarations emphasizing on results, harmonization, coordination, inclusive development partnerships, predictability and mutual transparency and accountability.

In the framework of the I**ndicative Cooperation Program (ICP) 2007-2010**, complementarities and specificities of two aid modalities Sector Budget Support and project modality were gradually built with a double anchorage at district and central level. Belgium Support to the Rwanda Health Sector has evolved towards a program approach by strengthening coordination, synergies, documenting experiences and action research. Under 2007-2010 ICP the following interventions were identified:

1. Health Sector Budget Support: 13,000,000 €
2. Institutional Support Program to the Conception and Implementation of the Strategic Health Development Plan of the city of Kigali (PAPSDSK): 15,000,000 €
3. Institutional Strengthening Support Program to MoH (Minisanté IV): 12,000,000 € focusing on supporting on the one hand the central level (especially the planning and clinical services directorates within MOH, and the Mental Health Division and the Medical Infrastructure and Technology Division in RBC) in its function of policy, strategy, norms and procedures development; supporting on the other hand the decentralized level to implement these policies, strategies and norms, and reporting back (using quality data) to the decision-making level at district & central level.

Through the current **Indicative Cooperation Program (ICP) 2011-2014**, the Belgian Cooperation has allocated 55,000,000 € for providing support to the health sector through a comprehensive program approach. This program consists of:

1. Sector Budget Support (Joint Health Sector Support-JHSS): 32,000,000 € focusing on the policy dialogue relating to sector priorities and the two other programs
2. Basket Funding (Capacity Development Pooled Fund-CDPF): 2.,000,000 € focusing on a coordinated approach to Human Resource for Health in planning, production and retention of Health workforce across the sector by increasing the numbers and quality of trained HRH and their equitable distribution.
3. Improving the quality of primary health care and services in Rwanda program: 21,000,000 €.

These 3 components of the program are implemented with the support of International Technical Advisors (ITAs) from BTC. A clear division of roles and responsibilities are shared between the Embassy of Belgium (lead of the political dialogue), BTC representation (member of the Steering Committee) and the ITAs (policy and technical dialogue).

The ITAs are actively involved in several Technical Working Groups established at national level by

the MoH. So far the Belgian Cooperation did not actively participate in the MDG related Technical Working Groups, i.e.: Maternal and Child Health, Prevention of Diseases (incl. HIV) and Social Mitigation (incl. orphans and vulnerable children) nor in the Gender working group[10], to which the Embassy of Belgium has given its support.

[10] In the agricultural sector, BTC has taken initiatives to coordinate efforts on gender mainstreaming.

2 STRATEGIC ORIENTATIONS

2.1 The general objective

The identification file has defined the general objective of the support program as follows: « Strengthening the quality of primary health care and services in Rwanda »

Primary Health Care will be interpreted largely as complementary interlinked packages of promotional, preventive, curative & rehabilitative services at the different levels of the health care pyramid. In this document the 'essential health care and health services' will be used.

2.2 National Health Sector Policy guiding principles as specific outcomes

The mission of the Rwandan health sector, as retained in the Rwandan National Health Sector Policy (2014) is "to provide and continually improve affordable promotional, preventive, curative and rehabilitative health care services of the highest quality, thereby contributing to the reduction of poverty and enhancing the general well-being of the population."

Three guiding principles are defined in the National Health Sector Policy:

People-centered services: "i) ensuring universal demand and access to affordable quality services, ii) focusing on the well-being of individuals and communities in particular women and children, iii) encouraging and valuing community inputs to identify health priorities and needs expressed by the population; iv) fostering equity and inclusion and integrates marginalized groups. "

Integrated services :" i) aligning the health system with national goals, among which Vision 2020 and EDPRS overarching goal of poverty alleviation; ii) leveraging and building on existing assets in terms of infrastructures and human resources, but also on cultural values and institutional bodies; iii) developing and strengthening decentralized services whenever possible while remaining coordinated (between actors, between levels of care); iv) involving all sectors of the Rwandan population, including the private sector and civil society."

Sustainable services: " i) building the capacity of people, communities and institutions to assure the quality of services, ii) prioritizing value for investment, seeking cost effectiveness, using appropriate technology and adopting creative innovations to maintain the achievement of outcomes in a context of scarce resources, and prioritizing health promotion, communication and prevention, iii) promoting rigor and transparency of outcomes and ensuring the collection and dissemination of quality information so that decisions and choices are based on evidence, iv) developing self-reliance of organizations and individuals by mobilizing domestic resources, advocating for greater financial ownership by the public sector and promoting investment and involvement by the private sector and civil society."

The specific objective defined on the basis of the identification file of the Health Program elaborated in the context of the Indicative Cooperation 2011-2014 between Rwanda and Belgium aligns with these three guiding principles: "A people-centered, integrated and sustainable health care system with quality essential health care services as close to the community as possible has been reinforced".

These three guiding principles will therefore be taken as the three outcomes of this health support program. The various results and related activity-areas defined in this program will contribute to these outcomes in a synergetic way. Progress markers and indicators to appreciate the contribution of the health program will be identified in chapter3.

2.3 .Selection of HSSP III as outputs & justification

The **Health Sector Strategic Plan III** has developed a strategic framework, based on 4 components:Leadership & governance, Health Support Systems, Programs and Service Delivery Systems as shown in Figure 6. The HSSP III document insists on the fact that the "the interrelated components together will improve the desired outcomes" (See. p15 point 3.1 in HSSP III document).

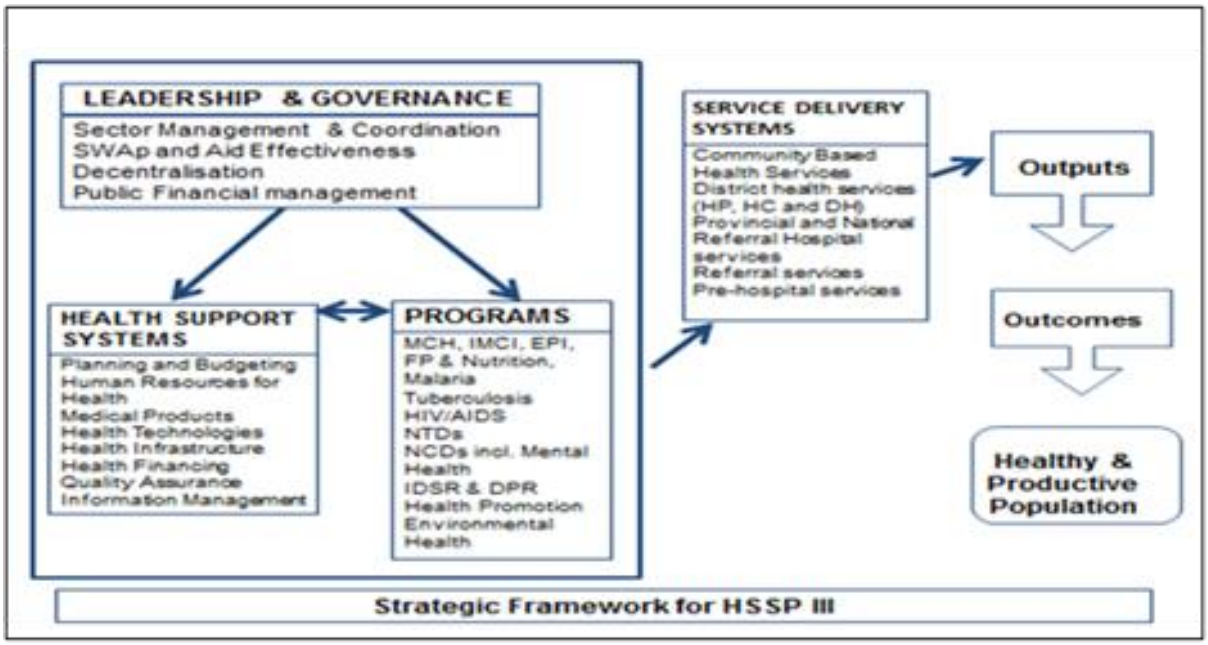


Figure 6 : The conceptual framework of HSSP III

The selection of the intervention areas presented below are based on i) a SWOT-analysis of the four components of HSSP III with the three guiding principles as benchmark during the first formulation mission, ii) the lessons learnt from the previous health support program (Minisanté 4), iii) the remaining challenges of the result areas initiated in the Minisanté 4 program, iv) the objectives and scope of the identification file negotiated between the Rwandan and Belgian partners, v) the complementarity and potential synergy with other development partners (most of them work on specific vertical programs which justifies a focus on strengthening selected key-components of the health system). A focus on selected areas of the HSSP III framework have been identified for this intervention: Quality Assurance, Mental health, Service Delivery with a focus on district health services, Leadership & Governance, Information management, and Health Technology & Infrastructure.

On this basis 6 interlinked results are identified. Each of them contributes to a variable degree to the outcomes (guiding principles).

Outputs (results)	Outcome (Guiding principles)		
	People-centredness	Integration	Sustainability
1. The quality assurance system is set up and integrated and functional at the level of all hospitals	+++	++	++
2. The mental health services are accessible at the community level up to the national level in a sustainable way	+++	++	++
3. The urban health service coverage is rationalized and extended in line with the three guiding principles of the National Health Sector Policy	+++	+++	++
4. The leadership and governance is reinforced, specifically regarding district stewardship, the respective roles of the MOH and RBC and the public private partnership	++	+++	++
5. Data are generated, analyzed and used for evidence-based decision-making in a more correct, integrated, disaggregated, systematic, accessible and effective way		++	+++
6. The asset management system is designed and operational in a cost-effective way	+	+	+++

Figure 7 : 6 outputs leading to 3 outcomes

Each result will also reinforce the others and will keep some balances:

Result 1 (at least its component at operational level) will mainly focus on improving services in hospitals in rural districts. This keeps the balance with result 3 which meets the challenge of rapid growing urbanization and the need to extend urban health services (with a focus on some of the poorest sectors in the City of Kigali).

Result 2 is a nice example of how a specific program (in this case Mental Health) can be integrated in the 'horizontal' health care services. The people-centered approach of the Mental Health Care program will be mainstreamed in the general services (synergy with result 1 & 2).

The support to the accreditation in all hospitals and the integration with other Quality Assurance systems such as for example Performance Based Financing and integrated supervision (Result 1) will help to create the necessary conditions for quality care (synergy with results 1,2,3) and support services (result 5,6).

Result 4 on Leadership & Governance has its place in this program because proper steering & management is an absolute condition for a rational health system. The main focus will be on strengthening the stewardship[11] capacities at district level (including district hospitals) where the management systems are still very fragile. But also steering & management capacities at national level will be reinforced. These capacities will be useful for making progress within the different results: i) a smooth collaboration between the Ministry of Health and Rwanda Biomedical Centre – RBC based on the new division of their roles and tasks (result 4), ii) the development and implementation of a Public Private Partnership policy (result 3, 4 &6), iii) the creation of an autonomous accreditation

[11] Stewardship refers to the fact that health systems are pluralistic, implying the need for steering in order to valorise the contribution of the various actors (including civil society and private sector). This with the objective to improve health in the most effective way and to generate downward and upward accountability. In this way, the implementation of the principles of the Dakar Declaration on Local Health Systems (2013) will be promoted.

body (result 1), iv) the creation of a functional inter-hospital-network (result 3), and v) evidence-based decision-making based on correct data (result 5).

Result 5 on Data Systems is an absolute prerequisite to take rational decisions and continuously improve the system at all levels. It will thus affect the implementation of all other results.

Result 6 on Asset Management constitutes an emergency because of i) the huge needs regarding procurement & maintenance of equipment and buildings , and ii) the need to decrease dependency from external resources. Result 6 will have a direct impact on all results where constructions are planned (results 2, 3, 6). Synergy with result 1 (accreditation processes regarding asset management), result 4 (financial management hospitals) and result 5 (integration of the MEMMS, the asset management data system, in the overall data system) is obvious as well.

This illustrates how all the results are imbricated (for more details see chapter 3). They intervene at some of the key-components of the health system which work in a synergetic way to reach the outputs in terms of services and systems. This will contribute to create a conducive environment ('the nest') for client-centered, concerted & rational decision-making as a health professional or health system manager in line with the 3 outcomes.

2.4 Learning cycles for sustainable sector development

This health program supports activities both at the central level (Ministry of Health, RBC/SPIU) and the decentralized level (districts). There is however no confined geographical focus on specific districts but a thematic focus. Some activities will have a nation-wide scope (ex: mental health program), other activities will improve specific services in specific districts (rural/urban); still other activities will test particular strategies in specific districts (rural/urban).

This presence at both operational and strategic level (double anchorage) is reflected in each of the 6 results. Within each result are defined activity-clusters (for detailed description See. chapter 3). These are situated at two levels. Each result contains activity-clusters which are situated at the strategic level, where policies, strategies, norms, standards and guidelines are developed and disseminated. Each result contains as well activity-clusters which are situated at the operational level, where these strategies and norms are translated into practice in order to produce services, either health services or support services (e.g. maintenance services). Figure 8 shows the two levels for each of the results and the way they interact with each other and with activity-clusters of the other results.

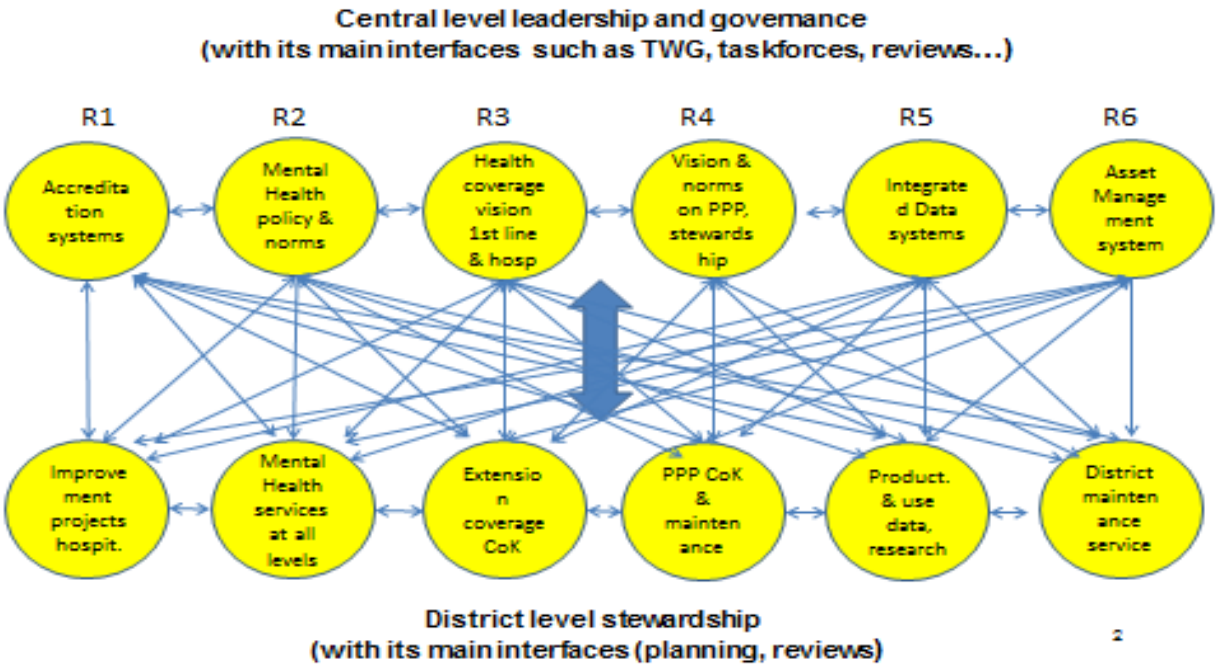


Figure 8 : A health intervention on strategic and operational level

The arrows in the scheme are bidirectional (top-down & bottom-up). Interesting experiences at the operational level will be documented in an evidence-based way and communicated back to the strategic level. So lessons from practical experience can be taken to further improve the national policies, strategies and norms. The hypothesis is that this active interaction between strategic and operational level will lead to a continuous learning cycle at sector level (as illustrated 9) and ultimately to a sustainable sector development based on rational decision-making.

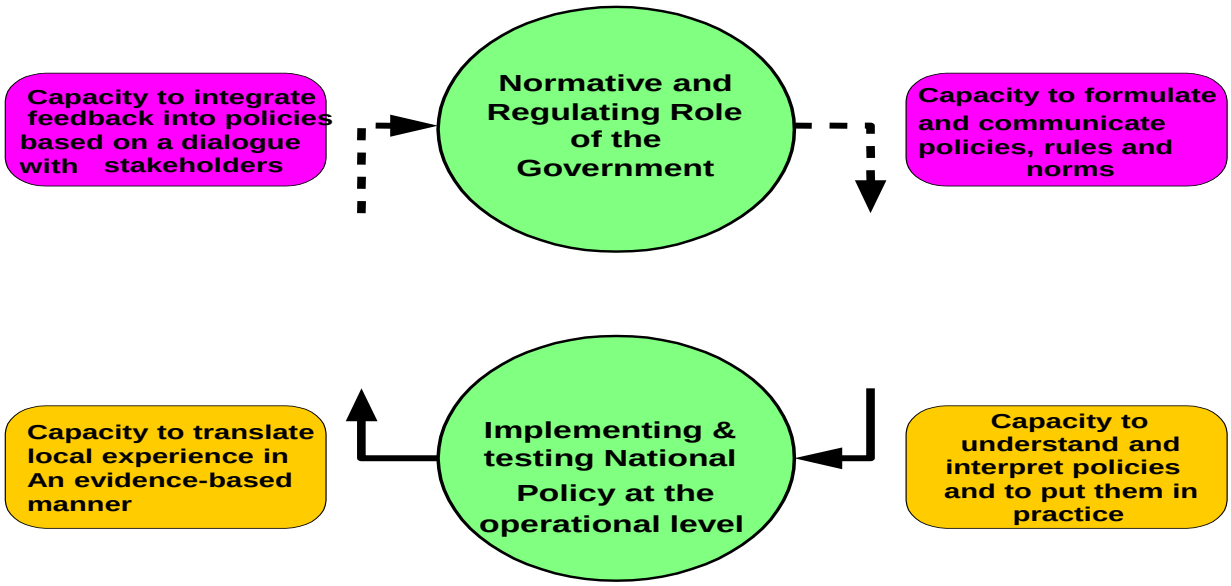


Figure 9 : Double anchorage of a sector intervention

This cycle reflects the core strategy of this health program. It aims to reinforce i) the capacities of the strategic level to develop and communicate policies, strategies and guidelines which are based on

evidence and on field level reality; ii) the capacities at operational level to translate policies into concrete actions and services, to learn from experience and to provide a structured and evidence-based feedback to the strategic level. Since these are not spontaneous processes, the interaction and communication channels between the two levels need to be reinforced as well. This learning cycle does not only apply to sector level management but to management teams at all levels.

2.5 Other principles guiding implementation

Assure equity: each strategic decision in this program will be measured by its positive effect on equity such as i) priority to the services for the poorest communities, ii) balance between rural and urban development, and iii) inclusiveness for all types of vulnerable groups. The mainstreaming of the cross-cutting issues (see below) also implies that due attention will be given, in the actions developed throughout this program, to the health needs and rights of vulnerable populations (such people with a disability, adolescents, men having sex with men, sex workers, drugs consumers, etc.).

Assure flexibility in implementation: given the complexity of a health system and its continuously changing context, the non-linear character of reforms and transformation, as well the very nature of capacity development processes of persons, organizations and systems, this formulation document cannot be prescriptive. Changes in activities and utilization of the budget are possible.The intervention logic, outcomes and principles however will guide decision-making for achieving the results.

Embed the intervention in a long term process: accompanying a sustainable change process goes beyond an intervention cycle of 4 years. This support program will built on the relevant result areas initiated in the current/previous intervention and further extend, strengthen and sustain their outputs & outcomes. The recommendations & lessons learnt from the midterm and final evaluations of the current intervention as well as sector-wide studies and evaluations will be taken into account.

Embed the intervention in the Sector Wide Approach: it should align with the planning and M&E mechanisms within the health sector, strengthen the implementation of national policies & strategies, reinforce the platforms of dialogue between the various actors within the sector and the synergy between them. Parallel procedures & structures should be avoided as much as possible.

Reinforce the complementarity between the other interventions of the Belgian Cooperation: this means i) the other components of the Belgian health sector support portfolio in Rwanda being the Health Sector Budget Support program (policy dialogue) and Capacity Development Pooled Fund, ii) the interventions in the other sectors (decentralization, infrastructure), iii) other cooperation mechanisms such as study funds and grants, and iv) the interventions of the indirect bilateral actors.

Orient utilization of resources of the intervention for activities leading to change and to the desired outcomes: this implies that i) the financing of the routine functioning of the health system will be avoided as much as possible, ii) investments (constructions & equipment) will be embedded in a strong conceptual framework & conditioned by a preparatory roadmap and should illustrate good practices and desired change according to policies & norms, iii) technical expertise will focus on the structural elements of the health system and will not be used to substitute routine tasks.

Define technical expertise in partnership with the staff of the Ministry of Health (MoH) & RBC and in complementarity with the sector budget support & the interventions of the other Development Partners: all long term technical expertise are BTC staff[12] but will be anchored at MoH& RBC. Together with the partner they will co-operate to achieve the desired change & outcomes as defined

[12] With primary accountability to BTC

by the TTF, which is to be considered as a contract with mutual responsibilities. The whole intervention team will have a collective responsibility towards all results (which are anyhow interlinked), and will be evaluated in that way. For specific technical services, short term or longer term national or international expertise can be hired on a consultancy-basis. Technical and scientific backstopping will be available as well.

Achieve concrete, visible results with regard to the cross-cutting issues gender, HIV/AIDS and environment will be mainstreamed as crosscutting issues throughout the program cycle. The focus on gender and HIV/AIDS will be linked to the protection and promotion of sexual and reproductive health and rights in general and of vulnerable and key populations in particular. SRHR also includes the SRHR of youth and adolescents and stigmatized populations. In relation to gender, collaboration with the MIGEPROF, the GMO and MINCOFIN will be strengthened in line with the National Gender policy. The focus on the crosscutting issues is particularly important in view of supporting the GoR in its efforts to achieve the MDGs.

The cross-cutting issues will be dealt with in an integrated way. This implies that no separate activities are defined and that the activity-groups are designed in a manner that takes these dimensions into account in an explicit way where relevant, as illustrated in the table below. This does not exclude that (following the twin-track approach) gender specific actions can be designed during implementation, addressing specific groups with specific needs or experiencing gender inequalities/discriminations and reaching out for their rights and longing for empowerment.

Table 8 : link crosscutting issues and 6 outputs

Outputs	Crosscutting Issues		
	Environment	Gender	HIV/SRHR
R1. Quality assurance	+ (norms)	+ (norms)	+ (norms)
R2. Mental health services	+ (construction)	++ (PCC)	+++ (drug abuse, HIV, GBV, PCC)
R3. Urban health service coverage	+++ (construction)	++ (PCC)	+++ (PCC, SDH, vulnerable pop. CoK)
R4. Leadership & governance		+++ (equity, female leadership)	+ (equity)
R5. Data management	++ (reduce use of paper)	+++ (sex and age disaggregated data, vulnerable pop.)	++ (vulnerable populations)
R6. Asset management system	+++ (rationalisation system, waste management, construction)	+ (training opportunities)	+ (safe work environment)

Integration inevitably entails a risk of lack of visibility. In order to ensure visibility and to facilitate the capitalisation of experiences in the mainstreaming of each of the crosscutting issues the program will encourage specific studies and/or action-research initiatives related to the crosscutting issues. A limited number of specific indicators are identified as well to ensure the crosscutting issues are also

taken into account during monitoring and evaluation.

2.6 Coordination & synergy with other development partners

2.6.1 Coordination in Health and policy dialogue

The **DPCG** (Development Partners Coordination Group) is the highest-level coordination body in Rwanda responsible for overseeing the entire aid coordination system and policy dialogue on development. The Ministry of Finance and Economic Planning (MINECOFIN) is the lead government and the health Sector Working Group (HSWG) reports directly to MINECOFIN through its Chair.

The **HSWG** (Health Sector Working Group) chaired by the Permanent Secretary of the Ministry of Health (MoH), is an inclusive platform for dialogue and coordination that brings together Central and Local government institutions, Development Partners (DPs), Civil Society and the Private Sector involved in the Sector. It enhances coherence and ownership regarding policy formulation & implementation and strengthens accountability through regular reviews. Currently the 3rd Health Sector Strategic Plan (HSSPIIII) 2012-2018 is the reference for Development Partners (DPs) supporting the Health Sector. Therefore this program is embedded in the HSSPIII framework.

In 2007, a Memorandum of understanding (MoU) establishing the Health Sector Wide Approach (**SWAp**) was signed by MoH and ten DPs as a starting point defining a general system for partnership collaboration. Then a roadmap and manual of procedures to strengthen Health SWAp were developed in 2010. In 2013, a District Swap reference guide was designed and disseminated to enhance the Swap at District level. Through these mechanisms, DPs have adopted a common approach for coordination and harmonization of planning, implementation, M&E under MoH leadership.

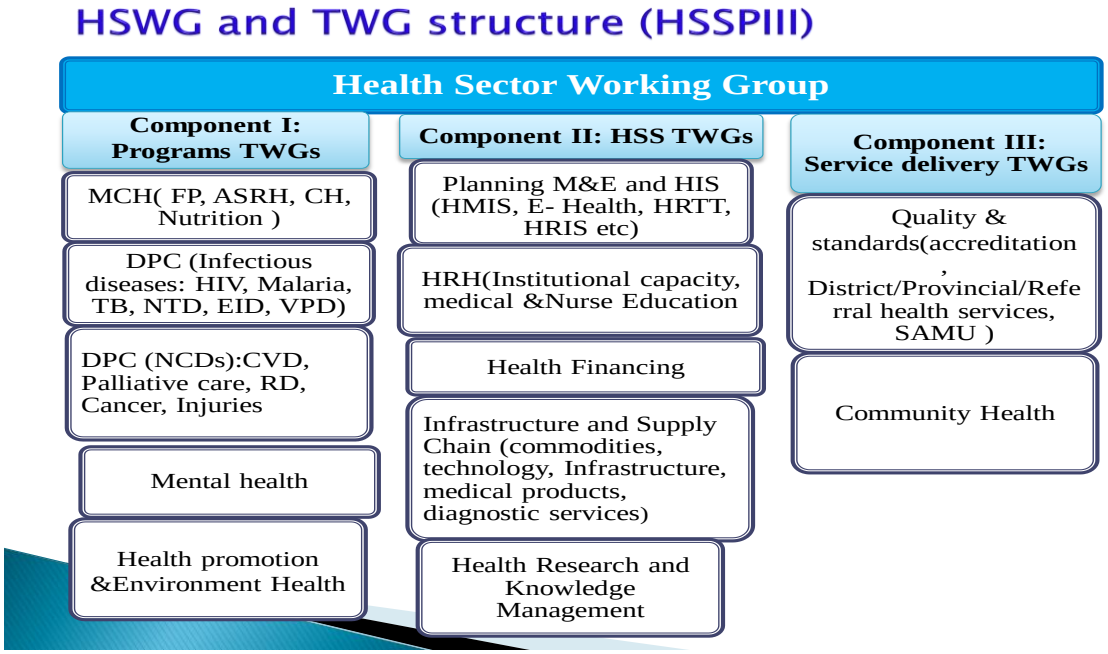
At this time, the Development Partner Group in Health (**DPG**) has reinstated the dialogue on partnership accountability mechanism between GoR and DPs in the Health Sector by jointly revising the current MOU in order to align it to EDPRSII, HSSPIII and the seven behaviours promoted by the International Health Partnership (IHP+) **COMPACT**, more precisely i) support to a single national health strategy, ii) record all funds for health in the national budget, iii) harmonize and align with national financial management systems, iv) harmonize and align with national procurement and supply systems, v) use one information and accountability platform, vi) support South-to-South and triangular cooperation and vii) provide well-coordinated technical assistance.

Since 2012, US Government (USG) is the lead-Donor of the DPG and the Co-Chair of the HSWG with WHO. According to the 2012 division of labour, the **main DPs** in the health sector are USG, Belgium, Swiss Development Cooperation for the bilateral Cooperation and the Global Fund to fight AIDS, Tuberculosis and Malaria and ONE UN (WHO, UNICEF, UNFPA,UNAIDS) for multilateral cooperation. Other active International NGOs are especially Management Sciences for Health (MSH), Rwanda Family Health Project, FHI 360, Clinton Health Access Initiative(CHAI), Access Project, Partners in Health, Catholic Relief Services, Fracarita and Handicap International.

Coordination with the DPs in the implementation of the ongoing Institutional Support to MoH-Phase IV is always sought both at the national and operational level. This will continue under this new program and the **Technical Working Groups** (TWG) will remain the main forum for facilitating multilevel coordination, information sharing, and policy dialogue at the sub-sector level while ensuring interface with the HSWG via both “top-down” and “bottom-up” approaches. The “Top-down”, Sub-sector policies and strategic directions determined at the HSWG level and agreed upon in the Joint Health Sector Reviews are passed down to the TWGs for support in operational planning and execution, and to develop relevant guidelines and tools to be used by the implementing agencies. Then the “Bottom-up”, by virtue of their knowledge of the context, realities, successes and challenges of the health

system in Rwanda, and the specificity of their technical expertise, the TWGs recommend evidence–based policy and strategic modifications, and propose innovations to the HSWG. Since Belgium is the Co-Chair and active member of 7 out of the 12 TWGs namely i) Quality and standards, ii) Mental Health, iii) Health Financing, iv) Infrastructure and Supply Chain, v) Planning, M&E, HIS TWG, vi) HRH and vii) Health research and Knowledge management, the linkages and synergies as well as the learning cycle with other actors at all levels will always be at the heart of the program.

This new program will also seek opportunities for creating more synergies with other health DP who are specifically active in the area of **gender and health, SRHR and HIV/AIDS**. This will include as well the multilateral agencies such as UNFPA, UN Women, UNICEF and UNAIDS who are also important partners of the Belgian Cooperation. Ideally this collaboration is organized within the TWGs for Maternal and Child Health and Disease Prevention.



2.6.2 Areas of synergies with this intervention

The comparative advantages of (and synergies between) the 3 aid modalities of Belgian cooperation support to the health Sector, namely Sector Budget Support, Capacity Development pooled fund and this intervention will always be considered during implementation. Together they constitute the BTC supported Health program.

Synergies with DPs providing support to the health Sector as well as the sector of decentralisation and good governance will be sought through active participation of Belgium in the related SWG and TWGs. The table below summarizes the main synergies to maintain and strengthen during implementation based on the current mapping of key actors in Health.

Table 9: Synergy with other interventions and Development Partners

Belgian actors	Areas of Synergies
BC (Belgian Cooperation) - Rwanda Decentralization Support	- Use of common approaches for cross cutting issues (gender SRHR/HIV and environment) in both sectors - Decentralization and Health. - Harmonization of capacity building approaches at national and sub-national levels regarding training, coaching and interpersonal and management skills (Link with R4: Stewardship)

Program	- Cross-sectoral dialogue for Evidence based, Planning and M&E in Local Government through participation in SWG and TWGs (Link with R5: Quality data use)
BC-Study Fund	- May provide funding for studies linked to the intervention
Other inter-ventions of the Belgian Cooperation in the health Sector (Budget support and Capacity Development Pooled Fund)	- Support from SBS experts in multilevel coordination, information sharing and analyses, and policy dialogue through active preparation and participation to HSWG/ Joint Health Sector Reviews, TWG, Steering Committees, field visits (Link with all the 6 Results of the program) - Joint action research and capitalization focusing on 'top down' and 'bottom up' approaches (Link with the learning cycle for sustainable sector development) - Advocacy for adequate resources allocation for continued training/upgrading of health workforce (Midwives, Nurses, Lab Technicians, Hospital Managers, Medical Maintenance Technicians) in Rwamagana, Kabgayi, Byumba, Nyagatare and Kibungo Schools of Midwifery and Nursing, Kigali Health Institute and University of Rwanda (Link with the 6 results) - Use of the CDPF Steering Committee as a forum for dialogue with Ministry of Education for integration of 'People Centered Care' in training Curriculum development and equitable redeployment of trained staff (Link with R1 and R3)
Handicap International	- Training of occupational therapists and taking into account quality of care for vulnerable groups (in particular people with disability-PWDs) in accreditation (link with R1) - Community based Mental Health program with focus on Gender based Violence prevention and management for PWDs, in Rutsiro, Rubavu and Gasabo districts (link with R2) - Accessibility norms and standards in infrastructure design for people with disability (link with R2, R3 and R6) - Disability disaggregated data collection and use (link with R5)
Médecins Sans Vacances (MSV)	- Capacity strengthening in MSV partner-hospitals (Kabgayi, Gatagara, Rilima, Murunda,Cyangugu, Ndera in relation to (para)medical services (link with R1, R2) - support services (maintenance, laboratory, radiology) (link with R1, R6) and hospital management –auto-evaluation (link with R4)
Fracarita	- Management of Mental health cases at Ndera Referral Hospital - Clinical Training of Health workforce in Mental Health and formative supervision-Opportunity for integration of 'People Centered Care' – (Link with R2)
COOPAMI	- Training in Social Protection Management for Rwanda Social Security Board and MoH (link with R4)
Because Health Platform (www.be-causehealth.be)	- Support to exchange and capitalization of experiences of interventions supported by actors of the Belgian cooperation (Link with all 6 results) - Technical support through the TWG of Because Health - Contribution to the implementation of the Because Health & EU charter in relation to Human resources in Health
QUAMED	- International Platform for quality procurement of medicines especially psychotropic drugs where Rwanda can become a registered member (Link with R1, R2 & R3)
Coopération universitaire ARES (CUD)	- Reinforcement of capacities of the Rwanda University (UNR) through i) reinforcing masters/doctorate thesis's, ii) improving the quality of training of teachers and technicians, iii) reinforcing UNR revenue, iv) improving laboratory equipment and their use, v) improving quality of services, vi) support

	to training and research activities (Link with R2, R5 and R6). - In particular, there is the clinical mentoring of paediatricians by Rwandan, American and Belgian (through CUD) paediatricians in collaboration with hospitals offering the opportunity for practical training (CHUK, Hôpital Roi Faycal, Hôpital militaire de Kanombe et Hôpital Universitaire de Butare)[13].
Other Develop. partners	
Swiss Cooperation (SDC)	- Strengthening the use of HMIS and the functioning of the District Health Management team in Karongi, Nyamasheke and Rutsiro Districts (Link with R4 & R5) - Funding Integrated approach towards Gender Based Violence (implemented by Handicap International) - Action Research (Link with the learning cycle)
USG and Implementing Agency	New program in planning stage for Health System Support-Implementing agency not selected yet. This program will target mainly the following areas: - Leadership, Advocacy, Governance and Policy and Planning (Central and decentralization) (Link with R4) - Management, Coordination and implementation in Health financing for revenue generation and mobilization and strengthening regulatory bodies for quality assurance (link with R1) - M&E, learning and Knowledge-based practices (link with R5) - Quality improvement, M&E system strengthening (link with R 5) This is one of the interventions were identification of synergies at the planning stage is important otherwise duplications are likely to occur during implementation.
Management Sciences for Health (MSH)	- Quality Assurance and accreditation nationwide (Link with R1) - Strengthening HMIS through Technical Assistance (Link with R 5) - Strengthening Planning, M&E at District level(Link with R4-) - Strengthening management of health facilities capacity at decentralized Levels (Link with R6) This intervention is winding up.
Rwanda Family Health Project	- Quality Assurance and accreditation (Link with R1) - Planning, M&E, Management (Link with R4)
UNICEF	- Technical Support for new-born and paediatric care, IMCI and PMTCT and training on EMONC in 7 Regions.
UNFPA	- Technical Support to Reproductive Health services and Family Planning - Technical support to Adolescent Reproductive Health Services specifically - Support to action research (Link with learning cycle)
UNAIDS	- Support to Health Resource tracking Tool upgrade (Link with R 5)

[13] A concrete collaboration with BTC for clinical mentoring has already been established since 2010 with the assistance of Samuel Van Steirteghem (ITA pediatrician) and Rwandan colleagues during the PAPSDSK intervention

GFATM	- Support to HIV, TB, Malaria programs & Health System Support (Link with R1)
GAVI	- Support to immunization program and introduction of new vaccines.
WHO	Support the Ministry of Health through technical assistance for: - strengthening capacity in health system governance and stewardship (link with R4), quality assurance service delivery (link with R1), Human Resources for Health production & management (link with R1) - Developing an Integrated disease surveillance and response (IDSR) strategy (link with R1) - Promotion of Health and Social Determinants of Health including healthy lifestyles addressing NCDs risk factors such as tobacco, alcohol, substance abuse, physical inactivity and proper nutrition in school institutions, and targeting other vulnerable groups (Link with R2 and R3) - Promotion of health system information and evidence, monitoring of trends, data generation and analysis of health priorities, e- Health, research for health and knowledge sharing (Link with R5) - Promotion of access to health products and health-care technologies based on primary health care needs (Link with R6-Cost effective asset management)
Partners in Health	- Primary Health Care and Community health - Quality Assurance in District Hospitals at Burera and Kirehe (Link with R1) - Clinical Training- Medical Education of health professionals and Research (Link with the learning cycle)
CHAI	- Technical Assistance for Medical Equipment Management and Maintenance Tool development (link with R6) - Support to RBC leadership (Link with R4)
COOPAMI	- Training in Social Protection Management for Rwanda Social Security Board and MoH (link with R4)
Because Health Platform	- Platform for reflecting on the changes in urban and Rural District for advancing Universal Health coverage with the Community of Practice on Service delivery in Rwanda (Link with R3 and R4)
QUAMED	- International Platform for quality procurement of medicines especially psychotropic drugs where Rwanda can become a registered member (Link with R2 & R3)
Partners in Gender	- Multilateral UNWOMEN, UNICEF, UNFPA - Bilateral: GIZ, USAID, SDC - Civil Society: RAMREC, Girls Hub Rwanda, Rwandan Women's Network

3 INTERVENTION FRAMEWORK

3.1 General objective

“Strengthening the quality of primary health care and health services in Rwanda “

3.2 Specific objective

“A people-centred, integrated and sustainable health care system with quality essential health care services as close to the community as possible has been reinforced”.

3.3 Expected results

R1. The quality assurance system is set up and integrated and functional at the level of all hospitals

R2. The mental health services are accessible at the community level up to the national level in a sustainable way

R3. The urban health service coverage is rationalized and extended in line with the three guiding principles of the National Health Sector Policy

R4. The leadership and governance is reinforced, specifically regarding district stewardship, the respective roles of the MOH and RBC and the public private partnership

R5. Data are generated, analysed and used for evidence-based decision-making in a more correct, integrated, systematic, accessible and effective way

R6. The asset management system is designed and operational in a cost-effective way

3.4 Activity-clusters

3.4.1 The quality assurance system is set up and integrated and functional at the level of all hospitals

Table 10 : Activity Clusters for output 1 in relation to Outcomes (with budget in euro)

	The quality assurance system is set up and integrated and functional at the level of all hospitals	*1,704,500*	People-centredness	Integrated services	Sustainable services	link with other results
01	Progress towards the creation of an autonomous accreditation body	0		+	++	R 4, 5, 6
02	Update & disseminate norms, standards and models (MOH)	225,000	+	+++	+++	R 4, 5, 6
03	Facilitate and implement the accreditation process at all hospitals	283,500	++	++	++	R 2, 3, 4, 5, 6
04	Finance people-centered improvement projects	1,100,000	+++			R 2, 3, 4, 5, 6

USAID will also support the accreditation process in their new program. Through the Accreditation Taskforce presided by the MOH, the support of different actors (amongst which the Belgian Cooperation and USAID) will be coordinated to assure complementarity.

3.4.1.1 Progress towards creation of an autonomous accreditation body

Rwanda opts for the creation of a sustainable in-country accreditation system of its health services. Accreditation per definition is an external assessment by an organization that still has to be created in Rwanda. This organization will be called RAC (Rwandan Accreditation Council) in this document. This council normally has to be accredited itself by an international agency like the International Society for Quality in Health Care (ISQUA). The process of getting this RAC will, according to experiences in other countries, take several years, starting with the recruitment of a core team as well as the set-up

of standards, guidelines, measuring tools and reporting methods. Only after this process, accreditation of the RAC itself can be strived for.

There will be a need for recruitment of the core team, recruitment and training of the surveyors, and for the first few years, the logistical aspects for the surveys will have to be dealt with. The current and future USAID intervention has foreseen the resources for the creation of the RAC (recruitment of the core team, recruitment and training of the surveyors, and the logistical aspects to conduct the surveys in the initial phase). The Belgian cooperation will not contribute to the investment part of RAC but rather to the functional set-up of the RAC and the further development of an integrated, cost-effective and people-centered accreditation design through the medium term technical assistance. If needed the steering committee of the program will decide on specific additional support in the creation process of the RAC.

3.4.1.2 Update & disseminate norms, standards and models

Parallel to the creation of the RAC, MOH will continue to develop standards, guidelines, norms and strategies. RBC will support the development of more operational guidelines. The various national programs within the MOH will gradually integrate their standards & tools in the accreditation process. Setting the quality standards for the health services clearly remains under the responsibility of MOH. The role of the RAC is to assure its application.

This program foresees long term national consultancies for the development of the standards. An important focus will be put as well on the integration of the various mechanisms for assuring quality health services existing in Rwanda: PBF, insurance schemes, QA, integrated supervision mechanisms through specific consultancies.

Research funds are also foreseen to assure scientific validation and backup of the standards &tools developed, as well as the funds for the organization of workshops and meetings to update and disseminate these standards & tools.

A particular activity concerns the quality of medicines procured. To ensure, Rwanda (Medical Procurement & Production Department) will register as member of Quamed network, an international organization promoting the adoption of regulations and procedures for quality assurance of medicines.

3.4.1.3 Facilitate the implementation of the accreditation process at all hospitals

- A critical condition for the roll out of the accreditation process is the availability of trained internal and external facilitators. The Belgian cooperation will assure their training[14]. Internal facilitators are based in the hospitals (all district hospitals, and future provincial and regional hospitals; in total 43 at the moment): every hospital needs 6 internal facilitators to cover the full scope. The external facilitators will come from academic or teaching institutes. They coach, guide, monitor, and reorient the internal teams on a continuous basis. Beside individuals to be trained, group sessions are equally important. Considering that a hospital easily employs more than 100 employees, funds for collective training of targeted departments are foreseen in this intervention.
- The sound articulation between the pool of accreditation facilitators, surveyors, (integrated) supervisors, mentors of specific programs, peer-reviewers, the PBF teams and hospital staff will be supported as well. This should lead to a comprehensive quality approach beyond procedural quality, with a focus on patient care.

[14] This training is independent from the creation of the RAC

3.4.1.4 Finance people-centered improvement projects

Following the recommendations of the ongoing accreditation exercises, there is need for concrete improvement initiatives to improve the quality of the health services. The program will provide an envelope for execution agreements to create the space for dynamic health facilities to work out improvement initiatives. The envelope will be managed by a selection committee of max 10 persons (composed of max 5 selected members of the Accreditation Taskforce, 2 peer-members from the district level, the ITA Program Coordinator, and minimum one DP other than BTC).The initiatives will be funded on the basis of a set of criteria which will be further refined during the implementation phase of this program by the Accreditation Task Force, based on the findings from the Health Facility assessments. Indicative criteria may be: i) priority to rural health facilities (in order to balance with the support to urban health services defined in output 3); ii) link with the recommendations from the accreditation reports; iii) contribution to one or more of the 3 Health Policy Outcomes, being people-centeredness, promotion of an integrated approach (between levels, programs & departments), and sustainability; iv) joint proposals by several actors/departments; v) link with hospital business plan, vi) promotion of cross-cutting issues, vii) use of action-research methodology. During the formulation mission some relevant improvement initiatives were already identified. Some examples: installation of practice of systemic clinical audits[15], follow-up of Chronic Non-communicable Diseases, reduction of neonatal and maternal mortality, burn care, fracture treatment (See. annex 7.8 for more details). The selection committee will present to the Steering Committee more detailed selection criteria for the execution agreements. In annex 7.12 is included the list of the hospitals with which execution agreements can be made based on concrete proposals for the utilisation of this envelope.

3.4.2 The mental health services are accessible at the community level up to the national level in a sustainable way

The activity-clusters to meet the challenges identified in the SWOT-analysis (See. chapter 1) are organized according to the 3 departments within the Mental Health division: Mental Health Promotion & Community Interventions, Structures of Care development, and Fight against drugs and other psychoactive substances abuse. Their respective contribution to the outcomes and their link with the other results is highlighted in the following table 11.

[15] Jef Van den Ende (ITM) had already initiated this approach in the target hospitals/districts in the interventions PAPSDSK and MInisanté 4

Table 11: Activity Clusters for output 2 in relation to Outcomes (with budget in euro)

	The mental health services are accessible from the community level up to the national level in a sustainable way	*3,258,400*	People-centredness	Integrated services	Sustainable services	link with other results
01	Strengthen community interventions on mental health	250,000	+++	++	+	R3
02	Consolidate Mental Health Care Services & a people-centred approach at the level of health Centres & hospitals and extend referral outpatient & inpatient Mental Health Care at the level of the provincial and national referral hospitals	1,786,400	+++	++	++	R1,3,5,6
03	Develop multidisciplinary strategies and actions with regard to the fight against abuse of psychoactive substances and with regard to mental health issues related to HIV/Aids and Gender Based Violence (GBV)	600,000	+++	++	++	R3

3.4.2.1 Strengthen community interventions on Mental Health

- To assure Mental Health services at community level there is a need to have a second Community Health Worker (CHW) at the level of each village, according to MOH norms. 15000 CHWs will be trained. Their tasks will be on Mental Health promotion, prevention and fight against discrimination, but also early detection of mental health disorders and the follow-up of therapeutic compliance with regard to psycho-tropic medicines (e.g. for epilepsy). In the 2 sectors of the City of Kigali where a new first line approach will be developed (with new Health Centers), a close collaboration between Health Centre staff and CHWs trained in Mental Health will be organized with a focus on specific Mental Health problems such as Mental Health & HIV, Gender/Age/Disability Based Violence and drug abuse.

- Specific training materials and diagnostic tools to early detect Mental Health disorders will be set up. Mental Health discussion groups within communities under the supervision of psychosocial health workers will be initiated as well.

3.4.2.2 Consolidate Mental Health Care Services & a people-centered approach at the level of Health Centers & Hospitals and extend referral outpatient & inpatient Mental Health Care at the level of the provincial and national referral hospitals

- 500 General Nurses of Health Centers as well as 70 General Nurses (GN) and 70 General Practitioners (GP) at District, Provincial and National referral hospitals will be trained with regard to the Mental Health protocols. They will however also be trained and coached with regard to people-centered care and related techniques in general health care services, with a particular focus on the management of chronic Non Communicable Diseases (See. R3 link with the 'medicalized' package for Health Centers in the City of Kigali). Beyond the specific Mental Health program components, the expertise of the Mental Health division will thus be mobilized to introduce a more people-centeredness approach into general health services, which is by the way one of the National Safety Goals in the accreditation process. This innovative process will be explicitly documented. This capacity building will not only reinforce the quality of general care but fits as well into an integrated strategy of early detection of Psychological and Mental Health disorders. Mentorship and monthly (pooled) formative supervisions to the district hospitals will be assured by the central level.

- To assure proper Mental Health referral services and the domestic capacity to run the Mental Health Care program on the longer run, the training of 14 psychiatrists will be supported. This program will cover the costs (scholarship, tuition fees, coordination fees, and teaching missions) to complete the training of the 6 psychiatrics which already have started their 4 year training (of which 2 years in Belgium – Switzerland and 2 years in Rwanda) and the costs for the full training of 8 new psychiatrists. This training, as well as the other trainings, should be completed before the end of the Specific Agreement.

- At the level of 4 newly appointed provincial (Ruhango, Bushenge, Kinihira, Rwamagana) and 3 national (Kibungo, Ruhengeri, Kibuye) referral hospitals, a specialized Mental Health department will

be set up[16]. These departments will assure both outpatient and inpatient care (including emergency care) and as well provide mentorship to the district hospitals within their respective catchment areas according to their general mandate. An internship for 2 general practitioners and 2 general nurses per hospital will be assured. At term the departments will be led by the psychiatrists currently in training. Ndera Hospital employs one child psychiatrist. He will be supported in order to ensure training and mentorship regarding his specialty in referral and provincial hospitals. Paediatric Mental Health care

- A national Day-Care Centre in the City of Kigali will be constructed and equipped. This center will :i) assure outpatient Mental Health & Neurologic Care for adults as well as for adolescents and children (by a child-psychiatrist), ii) organize a limited inpatient service for short-term observations and emergencies, iii) offer rehabilitation services for Mental Health patients, iv) be a national (and at term a regional) academic training center on Mental Health as well as on People-centered approaches, v) be a research center on Mental Health, with the availability of data of Mental Health Care Services in Rwanda integrated in the data-warehouse of HMIS (See. R5) and with disaggregated data concerning specific vulnerable groups. This center may contribute to the sustainability of Mental Health services in Rwanda and at term in the wider region. As for all constructions in this program, the construction of this center will be conditioned by a roadmap with preliminary steps prior to construction such as: 1) a long-term vision on the development of the health care coverage for CoK, 2) a detailed business-plan, 3) the functional link with the other (referral) hospitals, 4) a design of a construction (See. R6) sustainable in the long run, based on internationally accepted unit prices for construction (review by Tractebel), in line with environmental requirement, and taking into account access of vulnerable groups, 5) an overall sustainability plan for the Mental Health program in Rwanda on the long term.

- The development of accreditation norms for Mental Health will be integrated and rolled out through the accreditation process. This will also include quality norms for the procurement of psychotropic drugs. The international platform for quality procurement of medicines (Quamed) can assist this specific process.

3.4.2.3 Develop multidisciplinary strategies and actions with regard to the fight against abuse of psychoactive substances and with regard to mental health issues related to HIV/AIDS and Sexual and Gender Based Violence (SGBV)

- Prevention of drug & alcohol abuse is becoming a priority in Rwanda. Drug and alcohol abuse has been identified as the main risk factor for child, domestic, disability & gender based violence and the spread of HIV. Moreover, it is associated with mental health problems. A budget for national sensitization campaigns, in particular in schools and prisons is foreseen. This will be done in coordination with the inter-ministerial commission on drug abuse. The process will be supported by Prevention & Treatment of Substance Abuse Disorders specialist. Attention should be given not to criminalize this problem but to take into account the social determinants of health. The topic will also be part of the in-service training of general health professionals (See. 3.4.2.2). The new health Centers in 2 sectors in the City of Kigali (See. R3) will also integrate this component in their tasks related to health prevention & promotion Action-research will be included to map the problem and to document interesting initiatives in these sectors.

- Referral services to rehabilitate patients with a chronic drug & alcohol addiction using a multi-disciplinary, non-criminalizing[17] approach will be supported as well. The police drug and alcohol forensic medical rehabilitation center in Huye will be equipped to allow medical and psychosocial

[16] The intermediate structures 'Pôles opérationnels Santé Mentale' are phased out

[17] The support to this activity will depend on a clear policy and strategy incorporating this type of approach

consultations for outpatients, to organize hospitalization for max 50 patients and to provide laboratory and psycho- &arts-therapy services. The center will benefit for a training and regular mentorship of its mental health staff.

- Particular attention will be given to mental health and its link with HIV/AIDS and SGBV. An action-research approach will be used to learn more about the need and the use of services as well as their quality and impact related to this field. This could lead to a kind of "Centre of excellence" in Rwanda for addressing the mental health of people with HIV and survivors of SGBV. On the one hand the program will pay attention to the vulnerability of people with mental health problems to HIV/AIDS and all forms of Sexual and Gender-based violence through the development of programs aimed at prevention (reducing their risks for infection with HIV and of becoming a victim of SGBV) as well as response (adequate support for improvement ARV adherence, adequate services for people with a mental health problem who have survived acts of SGBV; support to the One Stop Centers for SGBV). On the other hand the program will also develop the necessary tools for improving the quality of psychosocial counselling of PLHIV and of SGBV survivors. The specific needs of vulnerable groups such as children, adolescents or people with a disability will be taken into account.

3.4.3 Urban health service coverage is rationalized and extended, in line with the three guiding principles of the national health sector policy

The support to urban health services will cover i) health promotion activities, ii) a rational design for urban health centers and a strategy of extension of the coverage, iii) a functional hospital network ,iv) development of a model urban hospital.

Table 12: Activity Clusters for output 3 in relation to Outcomes (with budget in euro)

	The urban health service coverage is rationalized and extended in line with the three guiding principles of the National Health Sector Policy	*7,198,200*	People-centredness	Integrated services	Sustainable services	link with other results
01	Develop promotional activities on social determinants of health in CoK	110,000	+++	++	+++	
02	Develop and validate a sound concept and equitable coverage plan for HC	82,000	++	+++	++	R1, 4, 5 & 6
03	Support the implementation of the coverage plan through various strategies : upgrades of the existing HF, construction of new HC or PPP initiatives in the most vulnerable sectors of CoK	1,656,000	++	+++	+++	R1, 4, 5 & 7
04	Create a functional, autonomous and efficient hospital network	373,200	++	+++	+++	R1, 4, 5 & 8
05	Design, build and equip a 300 beds Hospital in Kicukiro District articulated with the CoK coverage plan	4,065,000	+++	+++	++	R4,5,6

Activity cluster3.4.3.1 is highly important to bring change towards people-centered health services: generating evidences on determinants contributing to health in urban zones is the entry point for actions leading to higher awareness on how to guarantee better health at community level.

With 3.4.3.2 and 3.4.3.3 the change to be generated is crucial for a universal and equitable access to health in CoK: in a highly dynamic urban context with a multitude of care providers at different levels and with different characteristics, sound mapping and inclusive planning of the health care offer in CoK is key, with as cornerstone the reasonable and timely access to predefined service packages for the urban populations.

With 3.4.3.4 the idea is to change the fragmented approach of the hospitals in CoK, leading to inefficiency and difficult access for the people. Creating a functional efficient and comprehensive hospital network for the urban populations, with adequate pre-hospital orientation, intake, efficient quality care and transparent financial flows oriented to sustainable services.

With 3.4.3.5 the aim is the development of a model hospital – designed as a reference for future

infrastructure works in terms of organization and patient flowing, healthy working conditions, respect for environmental priorities, sound management of liquid, solid and gaseous waste, etc.

3.4.3.1 Develop promotional activities on social determinants of health in CoK

Health as a human right, be it in urban or in rural settings, is not just an issue of quality service delivery or a good health system. As shown in annex 7.7, there are 12 core determinants of health: employment and working conditions; education and literacy; physical environments; social support networks; personal health practices and coping skills; social environments; healthy child development; biology and genetic endowment; culture; financial and social status; gender; and health services. An alternative way of presenting the determinants is shown in the same annex. Whatever the way of looking at health and its determinants, it is very clear that to improve the health of the urban populations, it will all start with the in-depth analysis of the determinants of health, to create evidence about the critical factors related to the health condition of the populations of Kigali. This analysis will further lead to the development of a health promotion plan for the CoK.

This program will i) invest in the analysis of the urban socio-cultural determinants of health through the funding of studies, ii) assist the CoK in the development of innovative promotional activities (including through channels as social media where input[18] can be given), iii) and contribute to the communication related to health promotion. Health promotion activities will not forget to take into account the changing epidemiological profile in CoK (with increase in Chronic Non-Communicable Diseases).

3.4.3.2 Develop and validate a sound concept for the urban HC and an equitable coverage plan for primary health care offer in CoK

The health service providers in the CoK are composed of a heterogeneous mix of public and private providers. All contribute in a considerable way to the offer of health services.

The importance of the private providers has grown progressively over the last decade. However their access is not covered through the community based health insurance (CBHI) schemes. Though activity reports of the private providers show an important amount of services delivered, little data exist on the population covered. On the public side the spectrum of providers, not all sectors are nowadays having a health center. Combined with the absence of reimbursement of the services in the private clinics and dispensaries by the CBHI, this leads to an inequitable and inhomogeneous coverage of first line health care services in CoK. Confusion grew in recent years with the construction of 2500m2 urban health centers. These constructions are far bigger than the usual HC and have induced an intense debate on the medicalization of the public health centers and their complementarity with the role the urban district hospitals. An issue also was the discrepancy between their design and the mission of Health Centers to offer holistic promotion, preventive and curative services close to the population.

The intervention PAPSDSK started the geographical mapping of health facilities and their activity profiles. This program proposes in the first place to actualize the mapping of the health facilities in CoK combined with a baseline assessment on the activity profiles and needs inventory. An agreement must be sought regarding the minimal packages to be offered in the first line urban health facilities, with an emphasis on assuring an equitable access to health services in all sectors. Medicalization can indeed be part of the package if this proves to be an economically defendable option. This

[18] from f.e. civil society organizations like Girls Hub Rwanda

process will be conducted in close consultation with the urban districts and the CoK.

The Belgian cooperation will fund the baseline, the studies, the consultancies, and the workshops for the development of the coverage plan. It will also support diffusion and communication of this plan to all stakeholders.

3.4.3.3 Support the implementation of the primary health care coverage plan through various strategies : upgrades of the existing HF, construction of new HC or PPP initiatives in the most vulnerable sectors of CoK

After the development of the coverage plan, as detailed under paragraph 3.4.3.2, support will go to the implementation of the plan.

- Firstly, funds will be made available for initiating initiatives in public private partnership (PPP). Given the capacities of the private actors in CoK, integrating them in the local health system of CoK makes sense. The ways forward are multiple: i) contracting private providers (with a focus on starting private providers) for service delivery in small public health facilities (existing or new space offered by government)), ii) purchasing services by MOH or CoK in the private facilities at competitive fees, iii) development of insurance mechanisms covering both public and private services even for the CBHI-insured, iv) including the private actors in the PBF schemes and v) accrediting the private facilities in the longer term.
- Secondly, the construction of maximum 2 new public health facilities (HF) is considered, conditioned by the presence of a long-term health coverage plan for CoK and a proper follow-up by Ir. experts in infrastructure. The aim is to demonstrate and document the functioning of 'first line medicalized' centres, which will be different from the large urban health centers constructed under PAPSDSK. In order to be complementary to the package at the district hospitals and to assure people-centered services close to the population, the focus will be on ambulatory services. This means offering a package promotion (including topics related to environmental and socio-cultural determinants), preventive and first line curative services. The package will include as well NCD (Non-Communicable Diseases), HIV and PMTCT, ASRH, One-Stop-Centers for SGBV, nutritional services, dental care and in a later phase ophthalmological services. The exact content of the package will be finalized in the implementation phase of this program. The construction will focus on the most backward sectors in CoK (Gatsata, Kimironko), being sectors with no or weak offer of public HC, a poor private offer and critical health parameters of their population. This program will provide funds for elaboration of the architectural concept (taking into account the principles of waste management and access of vulnerable groups) for the cofounding (around 90%) of the construction & rehabilitation of HC, the follow-up of the constructions, the acquisition of standardized equipment as prescribed through MTI (see 3.4.6). An alternative option, to be confirmed after development of the coverage plan, is to adapt existing public Health Facilities based on the same architectural and functional design.
- Thirdly, a specific emphasis will go to the waste management: a gender sensitive baseline analysis on the practices of solid and liquid waste in the health sector will be done, in order to develop healthy strategies for solid waste management.

3.4.3.4 Create a functional, autonomous and efficient hospital network

Having an efficiently organized and integrated hospital offer in an urban context is only possible if all actors work together. The intervention PAPSDSK invested in the development of a formal hospital network in CoK. However, up to now this network is not functional.

It is evident that sharing the resources (human, financial, logistical), installing one unique procurement unit of drugs, consumables, and equipment for the hospital network and merging technically complex services (maintenance of heavy equipment, sterilization, production of medical gases and liquids) can

considerably reduce the costs and improve the efficiency.

Secondly, it is expected that a functional hospital network will automatically generate better services for the populations, because of the better articulation between all actors, the assurance of the essential packages for all, the development of specificities per site, and the concentration of "labour- or resource-intensive" services at the best possible location in the network. Beds will be occupied in a more rational way and patient information will be dealt with in harmonized information systems, guaranteeing better continuity of care.

This program is determined to make the CoK Hospital Network succeed. One of the major lessons of PAPSDSK is that from the start it is critical to install a secretariat (hosted by one of the hospitals) which will specifically support the piloting of the hospital network. The human resources and logistics required to run this secretariat will pay themselves back for the reasons mentioned above. The network concept will be further developed and systematically documented, including organizational framework, regulations, roles and responsibility development for the managers of the newly created structure. A shared understanding of the key actors of this concept will be an important task. The capacities of key actors will be developed with a study fund. If needed a study tour can be conducted to convince the key actors and to raise their know-how about the set-up of such a network. A critical and essential element for the CoK Hospital Network success will be the integration of all ICT systems to one global architecture and software package, allowing permanent interaction and exchange in the network, permanent monitoring at all sites of activities and performances, as well as joint research. This is also a condition to develop tele-medicine.

3.4.3.5 Design, build and equip a 300 beds Hospital in Kicukiro District articulated with the CoK primary health care coverage plan

The construction of a district hospital at Kicukiro (KDH) in Cok is considered provided that a set of accompanying measures, summarized in Table 13, are elaborated. These measures should be worked upon (as much as possible in the context of the current program 'Minisanté 4') already before the start of this new program so that no time is lost and the preparations of the construction can be started as early as possible in the implementation phase (within the first year). The plot for the construction is already acquired and the hospital design will be done by the Minisanté 4 intervention in order to gain time. The actual construction should start at the latest 2 years before the end of the planned implementation phase of the intervention.

Table 13 : preliminary supporting measures for the construction of the Kicukiro DH (and other constructions foreseen in this program) (with budget in euro)

- ***The development of the hospital is embedded in a global coverage plan for (primary) health care coverage for CoK, developed in close collaboration with the urban districts, CoK and MoH***: the idea of blindly putting a "district" hospital, only because there is a "district" without a hospital, is not a sufficient argument.
- ***The Kigali hospital network is formally set-up and functioning[19] and explicitly foresees the integration of this future hospital in its plans***: hospital offer in urban areas cannot be modelled as in rural zones, as the environment is totally different. The construction of a new hospital should be an additional booster for the dynamic of the hospital network, by the definition of

[19] This means there is 1/ a formal secretariat, 2/ meetings with minutes, 3/ evidence of initial steps in formal collaboration and joint initiatives

complementary service packages, shared resources and shared management functions.

- ***The hospital is designed in such a way it constitutes a model, in terms of architectural, technical and functional design, for future hospitals in Rwanda in order to implement the national health policy principles of people-centeredness, sustainability and integration***. Proper standards with regard to access to vulnerable groups, clinical care & related, quality assurance mechanisms, environment, materials to be used, low energy consumption, recuperation of rain water, waste management, etc… will be applied. Implication of urban districts and CoK in this process as well as follow-up of the construction by Ir. experts in infrastructure is mandatory.
- ***Asset management policies and guidelines developed under RBC and its principles are applied in the architectural and functional design of KDH as well as in the future business-plan* of the hospital:** all new constructions in this program will need to be accompanied by an asset management plan and sufficient budget foreseen in the Mid Term Expenditure Framework.
- ***The construction of KDH is done in a perspective of Health System Strengthening***
- ***A preliminary gender analysis is done,*** regarding i) the architectural plan (safety, accessibility) and ii) the HR policy in the business-plan (equal opportunities between sexes, work floor policy on sexual harassment, capacity building), iii) disaggregated data-management (gender/vulnerable groups)
- ***The plots for the construction are acquired[20] before the implementation phase:*** in the case plots are unilaterally changed by the partner, BTC will no longer be committed to Finance the related constructions.
- ***The appointment of the constructor based on a public tender*** should be ***taken at the latest 4 years before the end of the Specific Agreement (***as for all other constructions in this program)

This construction offers a test case to put in practice principles of modern leadership & governance, better utilization of health information, and cost-effective application of asset management guidelines (see Table 12: Activity Clusters for output 3 in relation to Outcomes).

This program will fund the development of the concept and master plan for the district hospital. For the infrastructure works and equipment an adequate amount of resources is made available (see budget chapter 4.1 and logical framework 7.1). A national architectural firm will be contracted in order to guarantee external quality control at the essential and critical phases, funds are reserved for the international quality checks. In order to have good waste management practices, a budget for hiring highly qualified international expertise is set aside. An International technical expert with an expertise and experience in public health, hospital networking and urban health (Terms of Reference in annex 7.3) will be contracted to support these processes.

Finally, halfway the construction, a joint process (with RBC and the hospital Network) of identification of required staff and equipment will be conducted by MoH.

3.4.4 The leadership and governance of the health pyramid is reinforced specifically regarding district stewardship, and the respective roles of the Ministry of Health and RBC

The main focus will be on the district stewardship.

[20] See specifications of plots in annex 7.12

Table 14: Activity Clusters for output 4 in relation to Outcomes (with budget in euro)

	The leadership and governance is reinforced, specifically regarding district stewardship, the respective roles of the MOH and RBC and the public private partnership	*1,230,000*	People-centredness	Integrated services	Sustainable services	link with other results
01	Strengthen stewardship capacities at the level of the local health system (districts)	850,000	++	+++	++	R3,5,6
02	Provide support to MoH and RBC with regard to their respective roles (separation of regulatory/coordination/ M&E, and implementing role)	380,000	++	+++	++	R1,3,5,6

3.4.4.1 Strengthen stewardship capacities at the level of the local health system (districts)

District health management teams have to deal with a lot of actors contributing to health such as local communities, civil society, private sector, development partners, the other sectors at district level, and district authorities. This complex, pluralistic environment requires district health managers to strengthen their capacity as stewards of the local health system and hereby promoting a district SWAp dynamic. This requires that the Ministry of Health and its partners help district offices to become learning organizations. District Health Units (DHU) and District Health Management Teams (DHMT) (see annex 7.6) have to put more effort in listening to people, respecting their autonomy, but they also need to gather quantitative and qualitative information on their health needs, identifying what could be done together to address these needs. They also need to gather information on the performance of the different components of the local health system and on the bottlenecks which constrain them. The Dakar Declaration on Local Health Systems (October 2013) provides useful recommendations to assist this process of stewardship and the development of learning cycles (planning – implementation – analysis and M&E) at district level. In this program, based on a specific capacity gap assessment, the focus on districts will be to enhance their capacity related to joint planning, developing locally adapted strategies and joint M&E. A gender perspective will be conducted during capacity needs assessments and planning activities and if needed, a specific gender audit can take place in a pilot setting. The district capacity building will have a national scope and will work in synergy with the USAID Health Systems Strengthening Program. The presence of the Decentralization Support Program 'Enhancing the capacities of districts' supported by the Belgian Cooperation which allows a closer follow-up of the results at the level of 8 districts in particular. The district learning management cycle will be boosted through following activities:

- The planning process at district level needs to be a flexible instrument of coordination and alignment of all actors. DHU & DHMTs, instead of being mainly an authority, should become conveners, organizers and process facilitators. Training and coaching related to these capacities will be provided. Apart from working on the process, a focus will be put on the result, meaning district plans of good quality. Following criteria to appreciate progress of the quality of the district plans will be used: i) integrated district health plans based on individual plans of the district hospitals, the aggregated plan of the health sectors in the district, the specific health programs as well as the plans of non-state actors; ii) evidence-based plans adapted to local needs and based on correct data (link with R5); iii) result-based, customer-oriented plans with a monitoring framework according to national norms; iv) a transparent and comprehensive budget taking into account both public and non-public financial resources. In that regard the plans should contain specific initiatives to strengthen the financial management system in hospitals and DHMTs; v) plans & budget taking into account proper asset management (replacement budget for investment costs, budget for maintenance; link with R6); and vi) gender responsive budgeting. The support program will not contribute directly to the implementation of the plans though the development of operational strategies to tackle specific challenges (reflective action process) will be encouraged

(See. R5).

- The district M&E capacities, not only of the district M&E focal points[21] but also of the other members of the DHU & DHMTs will be reinforced in following areas: i) similar to planning, M&E should bring together the wide range of actors in the district contributing to health. Through training and coaching the stewardship capacity of district health managers towards the preparation, facilitation and follow-up of existing review platforms (such as health district bi-annual reviews, the health commission of the JADF) will be improved; ii) specific skills on developing learning loops, conducting (innovative) reflective action and action-research(with a particular focus on equitable access to quality services for vulnerable groups & crosscutting issues in general), sharing best practices & lessons and scaling up interesting experiences will be built at the level of the DHU & DHMTs; iii) comprehensive district financial district reports (including financial reports of the hospitals) with upward but also downward accountability will be developed and institutionalized; iv) monitoring of effective funding of gender and SRHR/HIV related issues because external funding very often targets specific activities ('vertical funding'), neglecting more system-oriented activities such as supervision, continuous training and support to HIV & gender focal points.
- A third focus will be on training and coaching in relation to interpersonal and management skills to i) enhance teamwork at the level of the DHU and DHMT on the one hand, and ii) to stimulate collaboration and to clarify roles & accountability lines between DHU, DHMT, Board of Directors, PBF steering committee, District councils and the District executive Committee on the other hand.

3.4.4.2 Provide support to MoH and RBC with regard to their respective roles (separation of regulatory/M&E/coordination and implementing roles)

- MoH and RBC (see annex 7.4 & 7.5), through their respective roles, will support teambuilding and organizational learning (through improved stewardship in planning and M&E) at the level of the DHU and DHMTs as mentioned under 3.4.4.1. The program will assist the MoH in i) developing, disseminating and facilitating use of adapted guidelines & tools in relation to the above mentioned topics, ii) better linking district planning with sector planning and expenditure frameworks (MTEF) and working on gender responsive budgeting, iii) stimulating a systematic evidence-based input from the districts to the Technical Working Groups and bi-annual Sector Reviews with the objective to pick up lessons from the field level and scale up interesting operational strategies, iv) regular coaching of the district teamwork and management through supportive field-visits by MoH staff and the facilitation of district peer reviews. RBC will be supported in their mentorship role towards the districts through i) effective, integrated, formative supervisions and ii) participation and guidance in district planning and review sessions.
- The program will support the function of strategic steering by the MoH through the following activities: i) training on policy and strategy formulation based on learning loop mechanisms within the health sector which are to be institutionalized, ii) training on strategic purchasing, contracting and regulatory practices, iii) the preparation and follow-up of the joint health sector reviews together with the districts, development partners and non-state actors (~ stewardship by MoH), iv) revision of current legal and regulatory documents to align them to the standards of the East African Community, iv) facilitation of the annual inter-professional review of the professional councils and support to specific research & studies conducted by the councils in particular in relation to the accreditation process (See. R1), the public-private partnership (PPP) (See. R3 & R4) and the quality procurement of medicines (link with Quamed See. R6).

[21] developed in the current Minisanté 4 program and yet to be institutionalized

- A policy, operational strategy and operational roadmap will be developed to regulate and coordinate the private sector and create a conducive environment to attract private actors in effective, long-term PPP. Through specific consultancies, studies, training and study tours innovative institutional arrangements to contract and incentivize the private sector will be worked out. The strategy can build on existing tools such as i) performance-based financing and accreditation (See. R1), ii) the data-warehouse in the sector in which the data of the private sector can be integrated (See. R5). Concrete PPP initiatives will be tried out at the level of the first line health care services in the City of Kigali (contracting-in of private doctors See. R3), and at the level of contracting-out maintenance where appropriate (See. R6). Finally, an annual forum between MoH and the private providers will be supported in order to assure a good dialogue and to assure a proper follow-up of the progress of the roadmap.

3.4.5 Data are generated, analysed and used for evidence-based decision-making in a correct, disaggregated[22], integrated, systematic, accessible and effective way

Rwanda has made important gains in recent years in the area of health Information management. These have included achievements in the automation of systems (such as HMIS, SISCom, Rapid SMS, LMIS) that are operational at all levels of the health system. The most important challenge identified in the M&E system is the insufficiency of dissemination and use of data, particularly at the decentralized level. MOH is currently in the process of harmonizing the different health data sources and establishing an integrated system where all existing databases are interoperable within a comprehensive health system data warehouse.

The next USAID program will principally focus on the further development of the data system at national level. This support program of the Belgian cooperation will contribute to strengthen the national M&E system through three main interventions: i) support together with USAID the data integration process to ensure all the necessary tools are in place, ii) address the gaps in relation to the quality of data, iii) build capacities to ensure effective data utilization for decision making at central and decentralized level. An international expert in Epidemiology/biostatistics will be recruited to support the MOH M&E team to assure these processes.

[22] At least for age and sex

Table 15: Activity Clusters for output 5 in relation to Outcomes (with budget in euro)

	Data are generated, analysed and used for evidence-based decision-making in a more correct, disaggregated, integrated, systematic, accessible and effective way	*1,330,000*	People-centredness	Integrated services	Sustainable services	link with other results
01	Assure the integration of different systems of information and further develop HMIS tools, methods and guidelines	120,000		+++	+++	R3,4,6
02	Assure the production of quality data	140,000		++		R1,4,6
03	Develop strategies for effective utilization of data for monitoring, evaluation decision making and action-research	350,000	+++	++	+++	R1,2,3,4,6

3.4.5.1 Assure the integration of different systems of information and further develop HMIS tools, methods and guidelines

- With the establishment of the comprehensive health system data warehouse comes a need to update and adapt the different Modules and user Manuals for M&E and HMIS used for training and guidance of the M&E staff at central and decentralized level. One of these important M&E tools is the Metadata dictionary providing clear definition of each of the indicators of the M&E system which has to be regularly updated and disseminated.
- Resources will be foreseen for ad hoc technical assistance to accompany the continuous integration process of other health information systems, particularly the electronic medical record, MEMMS (See. output 6 on asset management), the Resource Tracking Tools, other e-health systems as well as non-routine data.
- The progressive integration of the private actors will be enhanced through following activities: i) training on reporting, ii) the creation of specific incentives to report (such as logistic support, access to trainings, PBF type of incentives), and iii) supervision by the district M&E officers.

3.4.5.2 Assure the production of quality data

The health sector has improved reporting compliance with the HMIS to nearly 100 percent (partially thanks to PBF incentives). It has addressed as well issues of data quality by introducing a standardized data quality assessment methodology at national and district levels. All Data Quality audit tools have been developed and districts trained.

- The program will support mechanisms for regular review of data quality (semester data quality audits). These mechanisms are in place but must be implemented systematically and become part of the standard operations of health facilities and health staff. The role of the district M&E officers will be supported in particular. In addition, the USAID program will support the application of an error-checking and quality control system for identifying missing and inaccurate data. USAID will introduce as well a user-friendly and practical methodology to identify and correct gaps in the quality of data collected and reported.
- The conclusions of these data audits need to be disseminated and discussed with the people in charge of data collecting and reporting. This will be done through regular restitution sessions that will take place at the end of the data audit exercise in the 30 districts. These sessions will be essential to develop the culture of striving for quality data and will sensitize the health care workers on the importance of good quality data for appropriate decision-making.
- All data should be at least sex and age disaggregated. Ideally they should also allow to identify the evolutions of the health indicators of the most vulnerable populations.

3.4.5.3 Develop strategies for effective utilization of data for monitoring, evaluation, decision making and action-research

- First of all, relevant data need to be available to all agents who can assess their performance and identify gaps in service delivery. Dissemination of data will be systematized through publication of

quarterly bulletins presenting routine key health information at central and decentralized level. The USAID program will work on a new Data Sharing agreement with simpler procedures to access the more specific data in the data warehouse.

- Once data are regularly available, the capacities of central level staff and training of DHMT, DHU and others in 30 districts need to be strengthened on how to use this data. These training sessions will focus on the use (analysis, processing and dissemination of processed data) of HMIS data in decision making for Senior Managers and on how to evaluate programs and strategies implementation.

- To ensure that these newly acquired capacities do not remain theoretical but are applied in the daily work of health staff at decentralized level, funds will be available to promote reflective action and action-research initiatives with a particular focus on the capacities at district level (USAID primarily concentrating on the national level). M&E officers and district staff will be trained in reflective action and action-research. Initiatives eligible for funding will be prioritized on the basis of a set of criteria which will be refined during the implementation phase of this program. Amongst the criteria to be included are: i) important challenges in the health status and health service provision to the local population, ii) link with the recommendations of the accreditation exercise, iii) link with the 6 outputs of this program or with the crosscutting themes (gender, environment, HIV/SRHR), iv) the formulation of a clear research hypothesis and methodology, v) a multi-actor approach in the research set-up (ex: collaboration between districts, between actors in the district, between central and decentralized level, collaboration with a scientific institute or a joint research of a hospital network), vi) a link with existing TWG or the preparation of Joint Health reviews. The objective is to have a better understanding of problems at the operational level and find locally adapted solutions useful to be communicated to other districts (through peer-review) and the national level (through existing platforms of exchange and dialogue at national level). A scientific committee of about 10 persons will be formed (including representatives from the central level actors involved in action-research, from national/international public health related researchers, from both rural and urban districts and from the hospital network, as well as from the technical experts in support to this program depending on the topic). For specific gender related questions, representatives from GMO and MIGEPROF will be consulted and invited on ad hoc basis (regarding tools, indicators, assessments, analysis, research,…).. Funds are foreseen to support action-research initiatives and to hire national and international academic expertise to guide this process.

3.4.6 An asset management system is designed and operational in a cost-effective way

Rwanda has made significant progress in increasing the quality & quantity of health services and in improving the health status, as many medical centers & hospitals are in place. Modern medical equipment is becoming gradually available in these health facilities in line with the standard packages at each level. With the current government programs the standards will only become higher in future. It is therefore imperative that national expertise in Biomedical Engineering is generated in order to guarantee the sustainability of medical services standards through an appropriate and cost-effective design & maintenance of assets at every level of health care and their maintenance. However, there are still gaps in: i) standardization of infrastructures & equipment, ii) adequate maintenance of existing infrastructures & equipment, leading to improper use of these assets, iii) functional waste management systems in many health facilities, iv) sufficient resources to fund needed investments & maintenance at HF level, and v) sufficient and competent staff to ensure asset management.

This program will support interventions to address these different gaps and henceforth contribute to a more efficient service delivery system and better quality of health services, and thus also contribute to the improvement of the Rwandan population health status. The position for an international technical

expert in asset management will be extended for 4 years to consolidate past achievements and support the transformation process to develop a strong asset management system. National technical expert positions will also be supported for project management and data analysis.

Table 16: Activity Clusters for output 6 in relation to Outcomes (with budget in euro)

	An asset management system is designed and operational in a cost-effective way	*3,724,500*	People-centredness	Integrated services	Sustainable services	link with other results
01	Develop, validate and disseminate policies, technical standards for HF in infrastructure and equipment, acquisition standards including donation, procurement & replacement standards, collaboration with private sector…	66,000	+	+	+++	R1,2,3,4
02	Develop a functional procurement & maintenance system at operational level	1,021,500	+	++	+++	R2,4
03	Develop a waste management policy, strategy and baseline	80,000			+++	R4
04	Finance strategic improvement projects with impact on the asset managment	1,300,000	+	++		R1,2,3
05	Develop domestic human capacity with regard to asset management	465,000			+++	R1,4

3.4.6.1 Develop, validate and disseminate policies and technical standards for HF in infrastructure and equipment

- The first step in strengthening the national asset management system is to update and complete the national policies and standards regulating the construction or rehabilitation of health infrastructures and the acquisition of health equipment for the different levels of health care. The production of acquisition standards will include regulations concerning donation, procurement and replacement of health equipment to ensure the quality and standardization of equipment by level of HF. Guidelines for the collaboration with the private sector will also be established in these reference documents on the basis of the recommendations of a study. All these standards and guidelines will have to be integrated in the accreditation process (See. output 1). An envelope is provided to hire external consultants to support this process.
- These policies and standards will be officially approved through a validation workshop, disseminated and communicated to all concerned staff for appropriate implementation.
- An active involvement of key MTI staff both in the Technical Working Group of asset management and in the accreditation steering committee (maintenance is part of the five priority risk areas identified by the accreditation program) is important for the development, dissemination and implementation of standards and guidelines.

3.4.6.2 Develop a functional procurement & maintenance system at operational level

- The maintenance system for medical equipment in Rwanda is coordinated by the Medical Maintenance Center (MTI) at central level and is operationalized at decentralized level by maintenance workshops in District hospitals. In order to strengthen the operational functioning of these institutions, upgrade of MTI at central level will be supported by refurbishment of ten work benches for biomedical technicians and engineers and maintenance workshops will be installed (or upgraded) and equipped with required tools in the most remote15 Districts .
- A call centre for health facilities with a registered intervention-request and follow-up of the response (and the delay) will be set up. It may be a good marker for the functionality of the system.
- There is a huge need (further details will be provided by the study on asset management foreseen to be conducted in the current program 'Minisanté 4') for financial resources for the rehabilitation of buildings and procurement of spare parts & new equipment. Strategies to increase financial resources will include amongst others i) advocacy and monitoring to increase the budget line for maintenance and asset management in the national budget, ii) sensitization & training of hospital

managers to allocate more funds to asset management in their budget, iii) grouped purchases at national level (by pleading for a recentralisation of the purchase of costly spare parts and drug procurement) and at the level of the hospital network in CoK, iv) innovative incentive mechanisms. In that perspective, an asset management fund will be set up (See. 3.4.6.4).

- The MEMMS (Medical Equipment Maintenance Management System Database) is functional at the level of all hospitals However, there is a need to i) train hospital technicians to enter their data, ii) assure MTI staff is making analyses of the data, and iii) integrate MEMMS into HMIS (See. R5).

3.4.6.3 Develop a waste management policy, strategy and baseline

- When building or rehabilitating health infrastructures, an important element to take into account is the management of sanitary waste produced by health services, to avoid contamination or dispersion of toxic products in the environment. Rwanda has the ambition to develop a national policy and strategy for sanitary waste management and this program will provide technical assistance to support this process. This support will align with national gender intentions (e.g. regarding WATSAN, where the intention is also to develop a water and sanitation gender policy).
- As a preliminary exercise for the elaboration of this national policy, the Hygiene desk of MOH will hire a consultant to conduct a gender sensitive baseline study of the current situation of waste management and hygiene & infection control in the national health facility network. The recommendations will be integrated in the short-term trainings of technicians (See. 3.4.6.6).

3.4.6.4 Finance strategic improvements projects with impact on the asset management

A functional asset management support system is not enough. A dramatic increase in domestic funding of asset management to enable health facilities to implement the policies and invest in the purchase & maintenance of their infrastructures and equipment is necessary as well. Such an exponential increase on the short term is however unrealistic. Nevertheless, a lot of recommendations of the accreditation process are related to infrastructure & maintenance. In order to (very partially) meet the most urgent needs while working on longer term mechanisms, and improve health care services to the population in a concrete and equitable way, this program will support the establishment of execution agreements to support investment for infrastructure & equipment maintenance (See. 3.4.6.2).

- This program will support the start-up phase of the envelope, by establishing the mechanisms and selection criteria for application for investment. These will be validated by the Steering Committee. The envelope and subsequent execution agreements will be managed by MTI; A selection committee of about 10 persons (composed of representatives of MTI and district health technicians, MOH, the ITA biomedical engineer and the concerned international experts attached to this program) will select proposals submitted by health facilities on the basis of a set of criteria that will be further refined during the implementation phase of this program. Following criteria (amongst others) will be included: i) priority to rural health facilities (in order to balance with the support to urban health services defined in output 3), ii) link with the recommendations from accreditation, iii) degree of contribution to people-centred services (in that regard a demand coming from the clients will be valued), iv) degree of contribution to sustainability (ex: proposals with an important degree of revenue-generating maintenance' will be valued), v) joint proposals by several actors is a plus, vi) health facilities with a long term asset management strategy have priority, vii) presence of co-funding mechanisms, viii) link with national priorities, ix) a gender assessment of planned provisions and expenses. Most of these criteria are not absolute but increase the chance of a proposal being funded.
- An envelope to fund selected proposals through execution agreements is foreseen. This system is strategically linked with output 1 on accreditation of health facilities where a similar system is

proposed to support initiatives for people-centred services. The two need to be coordinated to increase synergies in order to support health facilities both in improvement of organization of their services and in strengthening of their infrastructures. A list of the health facilities and districts with which execution agreements can be concluded is included in annex 7.12.

3.4.6.5 Develop domestic human capacity with regard to asset management

Capacity building of human resources is certainly one of the most important, if not the most important intervention area to strengthen the asset management system. Several strategies will be used: short term training, long term training and the establishment of a program for bio-engineering bachelor degree in the College of Science and Technology.

Otherwise, the emphasis will be on the exploitation of in house expertise, with the organization of

- Short term trainings for district technicians and MTI staff: all opportunities during the regular functioning of MTI will be used as capacity building activities: regular clinical/professional meetings in MTI, preventive maintenance trips with experienced technicians and engineers, occasional visits to MTI by professors from reputed universities. A yearly training workshop (4 in total) will be organised where senior staff will transfer knowledge and skills to junior staff through theoretical as well as practical training. A library will be installed offering reference textbooks from different engineering faculties and using ECRI software. Technical staff will follow short courses offered by specialized institutions and online courses to build specific capacities (including on the cross-cutting issues). Collaboration will be developed with private companies manufacturing and installing specialized equipment to conduct training on their equipment.
- Short term training for hospital managers: with the aim to sensitize them on the importance of maintenance, to teach them to plan for preventive and curative maintenance, and to provide resources in the hospital budget (at least 5% of the revenues according to ministerial instructions prepared). Specific attention should be given to the creation and the maintenance of a safe, hygienic and secure working environment for health and non-health staff as well as for the patients. Such trainings should also include aspects related to HIV workplace policies and to gender.
- Long term training for two civil engineers from the Infrastructure unit of MTI: they will be sent abroad to be trained in health infrastructure design. The condition is that they sign a retention contract with refund modalities if the contract is not honoured.
- CST Bachelor degree in biomedical engineering: There is a growing need of skilled Engineers that will organize preventive and curative care of medical equipment. There is however no other academic institution offering this opportunity in the region. This confirms the pertinence to develop this program in the Rwanda College of Science and Technology. The Bachelor program will offer certification, under graduate (BSc degree program) and maybe later graduate level courses (MSc degree program). The Biomedical Engineering Program will develop strong capacities to understand, design, trouble shoot and maintain all medical equipment used in Rwandan health facilities. It is multi-disciplinary and will incorporate knowledge from both the engineering and medical domains as well as computer science. The support program of the Belgian cooperation will include soft support (practical trainings, tutors, revision of curriculum), a contribution to the library, and a participation in the inscription fees. However, MOH should clarify with Mineduc about the necessary budget to run this program with domestic funds on the longer run.

3.5 Indicators and means of verification

The indicators selected to monitor the progress of the 6 results of the program as presented above are partially taken from the list of national indicators identified in the HSSP III M&E Plan. Additional

indicators are proposed for specific intervention areas not covered by these national indicators.

The indicators will be disaggregated as much as possible in order to make a specific follow-up of the vulnerable groups (minimally per sex and per age).

3.5.1 Scheme of indicators & progress markers for this program

The indicators & progress markers for the program are situated at 4 levels:

Level	Sources for National Indicators ('the what')	Progress markers ('the how')
General objective (~sector performance)	Impact indicators from the HSSP III M&E Plan, Demographic Health Survey (4° et 5° DHS)	
Specific objective (~influence of program)		Progress markers linked to the 3 outcomes of the National policy
Results (~influence of program)	HMIS Indicators, subsector policies and plans	Indicators and Progress markers per result and per actor to be defined in implementation phase
Activity clusters (~influence/control of program)	HMIS Indicators, subsector policies and plans	Indicators and progress markers linked to action-research protocols

3.5.2 Indicators for General Objective

The General objective of the program is "Strengthening the quality of primary health care and services in Rwanda ". Impact indicators from the HSSP III M&E Plan are presented in the following table:

Table 17: Impact Indicators from HSSP III

Maternal mortality ratio/100,000
< 5 mortality rate/1000 live births
Neonatal mortality rate/1000
Infant mortality rate/1000 live births
Total Fertility Rate
Utilization rate for modern contraceptive methods among women of 15-49 years
HIV prevalence 15-49 years

3.5.3 Indicators and Progress markers for the Specific Objective

The specific objective ("A people-centered, integrated and sustainable health care system with quality essential health care services as close to the community as possible") specifically refers to the 3 outcomes in the national policy: people-centeredness, integration and sustainability. However, the national strategy doesn't include specific indicators to monitor the progress towards these outcomes. Therefore, the program will propose a few i) measurable outcome related indicators, ii) most significant changes (MSC) expected through this program. The MSC defined here are exemplary, not exhaustive, and will need to be completed during the outcome-mapping exercise at the start of the

implementation phase of the program. They will orient the development and validation of progress-markers for each of the 3 outcomes during the same outcome-mapping workshop. Representatives (max 25) of the different actors concerned directly by this program (such as the planning department and clinical services department at MOH; the involved units of RBC; health districts of CoK; the hospital network at CoK; selected representatives from rural districts and hospitals; Minaloc; representatives from the civil society, private sector and professional councils; BTC & Development partners) will be involved in this process. They will express their respective engagements[23] to contribute to the realization of the 3 national outcomes through the focus agreed upon in this program.

3.5.3.1 Indicators & Progress markers in relation to the Outcome 'people-centeredness'

Outcome related indicators:

- The degree of satisfaction of both users – all types including vulnerable groups - (in relation to quality services) and health professionals (in relation to a conducive working environment) (Source S: satisfaction surveys disaggregated according to vulnerable group, accreditation reports, reports of pooled supervision).
- The inventory of initiatives at the level of a hospital (within the accreditation process) or at the level of the targeted health sectors in Cok which reinforce the autonomy of local communities with regard to their health (S: accreditation reports, BTC program reports).

Most significant changes expected through this program:

- The health professionals at the health facilities (in particular at hospitals within the accreditation process, the institutions supported within Cok ,and the staff involved in Mental Health Care) as well as the health managers (in particular at hospitals, DHMT, and central level staff involved in sector review mechanisms and Technical Working Groups/Taskforces related to this program) have acquired improved interpersonal skills in one of more (according to need) of the following fields: listening, dialogue, communication, facilitation, coaching, negotiation, leadership, teamwork, conflict management and networking. These skills are essential in a pluralistic working environment. Through regular coaching with regard to these skills, this will lead to changes in the relations with i) patients (from a mere technical towards a more comprehensive approach), ii) communities (from a focus on offer towards institutionally integrating the demand side), and iii) health professionals and actors inside/outside the sector (from directive leadership towards more stewardship & coaching).
- There is a greater equity within the health system, through the inclusion and particular attention to vulnerable groups (~age, gender, disability, marginalized groups in CoK, rural populations) in all activities.

3.5.3.2 Indicators & Progress markers in relation to the Outcome 'sustainability'

Outcome related indicators:

- The inventory of (scientifically) validated action-research initiatives in relation to the development sustainable operational strategies, which are communicated to the decision-making level, and disseminated and/or published (S: action-research papers, scientific

[23] "According to the approach used in Outcome mapping: 'Expect to see, llke to see, love to see"

articles, reports of Technical Working Groups, presentations at international conferences, capitalization seminars)

- The inventory of (scientifically) validated action research initiatives related to the improved integration of each of the crosscutting issues (environment, gender including GBV and SRHR/HIV/AIDS) (S: action-research papers, scientific articles, reports of Technical Working Groups, presentations at international conferences, capitalization seminars)

Most significant changes expected through this program:

- The actors directly concerned by this program (whether at health facility level, at district level and central level) make a shift from 'intuitive' to more evidence-based decision-making. They will engage themselves in a participative, reflective process around key-questions, document their experiences with coaching (from the central level and/or research experts), and assure feedback to the decision-making level (whether at central or decentralized level). This in the perspective a creating institutional learning loops within the health system.
- Technical and environmental norms for health infrastructure and for equipment according to the health package at every level of health care are available and applied; systems for rational life cycle management of infrastructure and equipment are in place and are reflected in plans and budgets; and, in the targeted areas, a culture of preventive maintenance is taking shape.

3.5.3.3 Indicators & Progress markers in relation to the Outcome 'integration'

Outcome related indicators:

- The quality of team meetings (related to the RBC/SPIU teams involved in the 6 results) and multi-actor spaces of dialogue (district health reviews, Technical working groups related to the 6 results, health sector reviews) measured in terms of representation, regularity, leadership, communication, preparation, conduct, outputs and follow-up of utilization of outputs (S: minutes, invitation with agenda and preparatory documents, technical documents as outputs)

Most significant changes expected through this program:

- The district and central level authorities make a shift from a more institutional logic (confined to public actors only) to a more multi-actor (systemic) approach. The Dakar Declaration on Local Health Systems (October 2013) promotes stewardship at district level which valorises and coordinates the contribution of all actors at the district level (such as local communities, civil society, private sector, development partners, the other sectors at district level, and district authorities) towards health and health management (joint planning, implementation, M&E and action-research) activities. The same applies to the central level: in particular MOH will reinforce its stewardship role through better regulation of the private sector and health councils, a clear separation between the role of MOH and RBC and a more effective sector coordination/M&E (joint sector reviews, Technical Working groups, taskforces).
- The referral and counter-referral mechanism between the various levels of care (in particular in relation to the hospital network at CoK and mental Health services) is more effective.
- The standards & norms of support mechanisms (in particular with regard to quality assurance through accreditation, data management and asset management) and specific programs (in particular Mental Health) are integrated in the overall accreditation process.

3.5.4 Indicators for the Results

The following table presents the indicators for each of the six results of the program, taking into account the proposed activity clusters. Where possible the proposed indicators are taken from the National M&E Plan (marked with an asterisk *)[24]. *S = Source of verification*

R1. The quality assurance system is set up and integrated and functional at the level of all hospitals
• An independent accreditation body is set-up and is accredited by ISQUA (S: ISQUA report) • The number of national programs who integrate their norms & checklists (existing or new ones) into the ongoing accreditation process[25] (S: accreditation checklists and guidelines) • * % District Hospitals with a functional (= regular meetings, analysis of reports, issues addressed, recommendation reported to the Hospital administration management) QA team (S: minutes meetings) • Number of external facilitators trained compared to required number (S: training reports) • * % District Hospitals and provincial hospitals using one standardized assessment tool for accreditation and PBF (S: accreditation report) • * % District Hospitals (> 70%) and provincial hospitals (100%) eligible for accreditation (>70%) by 2018 (S: accreditation report) • % of DH and provincial hospitals with accreditation for the full package of SRHR/HIV/ASRH/ SGBV related services (S: accreditation report) • Progress in implementing the recommendations of the hospital accreditation reports, measured by the list of improvement initiatives which are people centred and which increase client satisfaction (including environment, gender, SRHR/HIV/ASRH/SGBV when appropriate) (S: accreditation report, survey) • Satisfaction rate of the users in relation to the quality of care (S : surveys, focus-group discussions)
R2. The mental health services are accessible at the community level up to the national level in a sustainable way
• % of CHWs, General Nurses , General Practitioners and psychiatrists compared to the targets[26] trained in early detection & treatment of Mental disorders as well as in people-centred related techniques (S: training reports) • * Proportion of Health Centres providing integrated Mental Health Care (S: HC reports) • % Mental Health cases referred from HC to DH MH services as a proportion of all DH MH cases (S: hospitals annual reports) • % of all MH cases referred from DHs to provincial (4) and national (3 plus Ndera Hospital and MH Day Care Center) mental health referral structures (S: hospitals annual reports) • A National Mental Health Day Care Center constructed (according technical and environmental standards), equipped and operational (S: business-plan; annual report Day Care Center)

[24] Indicators marked with a '*' are national indicators taken from the National M&E plan

[25] The purpose is to arrive at a comprehensive accreditation process which covers all the components of the functioning of a health facility. As a consequence, all national programs have to integrate their norms and checklists into the accreditation process

[26] The % is measured against the targets set for: CHWs (target: 15000), General Nurses (target: 570), General Practitioners (target: 70) and psychiatrists (target: 14)

- The operational strategy for integration of drug and alcohol abuse prevention (with active involvement of community actors) in 2 new Health Centre related Sectors of the CoK is documented, published and disseminated' (S: publication of article)
- Multidisciplinary strategies and action with regard to mental health and psychoactive substance abuse are in place and operational at the rehabilitation center of Huye (S: annual report Huye)

R3. The urban health service coverage is rationalized and extended in line with the three guiding principles of the National Health Sector Policy

- Inventory of innovative activities of CoK in relation to health promotion taking into account the socio-cultural determinants and changing epidemiological profile (S: annual report health unit of CoK Council)
- Availability of a long-term comprehensive coverage plan for 1st and 2nd line health care (including private facilities) within CoK (S: coverage plan)
- * % of registered private clinics and dispensaries reporting routinely to HMIS
- An article documenting the experience of the public-oriented (whether private or public Health Centres), medicalized Health Centres is published and disseminated' (S: publication of article)
- Functional Hospital network in CoK (criteria and S: functional secretariat, mission statement and organization, minutes meetings, inventory of joint initiatives)
- A new district hospital is constructed and equipped in Kicukiro District according to an architectural, technical and functional design & business-plan supporting the 3 outcomes of the national policy (people-centeredness, integration, sustainability) and proper asset and waste management (S: hospital design, business-plan)
- A comprehensive medical waste management plan for CoK is available (S: medical waste plan)

R4. The leadership and governance is reinforced, specifically regarding district stewardship, the respective roles of the MOH and RBC and the public private partnership

- * % DHU operational (at least 3 DHMT meeting held per year under the secretary of DHU, using quality health information for decision making) S: comprehensive participative district annual planning, budgeting, reporting timely)
- * % GOR funds disbursed to districts (grants: national health budget plus district transfers) (S: national accounts, district and hospital financial reports)
- % districts with regular district reviews meeting quality standards (participation of all stakeholders in health, representative taking into account gender-balance, regularity, well-prepared, concrete action points & recommendations (S: review report, DHU+DHMT meetings)
- % of district/provincial hospitals accredited for their financial management processes
- * (from the Health Financing Strategic Plan) % of health facilities (District and provincial hospitals) providing comprehensive financial reports in a timely manner (S: hospital reports)
- % of DHU having conducted a gender audit (S: audit reports)
- * % of Development Partners providing resources through the Health Resource Tracking Tool
- MOH and Private sector providers Forum is functional (S: bi-annual meetings)
- Number of new contracts (for maintenance or with private health facilities) signed based on the public-private partnership policy and roadmap developed (S: roadmap)

R5. Data are generated, analysed and used for evidence-based decision-making in a more correct, disaggregated (age/gender), integrated, systematic, accessible and effective way

- A gender assessment of the Gender Budget Statement is published (S: assessment report)

- Number of specific information systems integrated in the global health information system in Rwanda compared to the baseline at the start of the program (S: data-warehouse)
- * % of DH using open MRS or individual electronic recording Systems (S: open MRS)
- * % of DH/DHU preparing their annual staff census using computerize IHRIS (S: IHRIS)
- * % districts (which received a data audit) receiving a quarterly feedback report from HMIS on the data quality audits (S: minutes restitution session)
- Quarterly publication and dissemination of the National and District epidemiological profiles with age & gender disaggregated data (using quality HMIS data and accreditation assessment results) (S: quarterly bulletins)

R6. The asset management system is designed and operational in a cost-effective way

- Number of new health infrastructures built according to approved norms and standards, taking into account access/quality & environmental issues ((S: national policy & guidelines regarding health infrastructure, architectural plans, physical inspection)
- A standardized and rationalised medical equipment procurement & replacement system, taking into account environmental standards, is in place (S: medical equipment policy/guidelines/procedures, integration in HMIS)
- * % District Hospitals with effective maintenance workshops (S: annual report MTI)
- * % of HF with online tracking system for all procurement entities (e-LMIS) (S: e-LMIS)
- Number of intervention-requests collected by the maintenance/asset management call-centre handled with adequate response (S: register and requests and responses, satisfaction surveys)
- % of the national health budget and hospital budget allocated to asset management (S: hospital budgets, national budgets)
- Availability of a national policy and strategy on waste management (S: policy and strategy documents)
- * % of Health Facilities with effective waste management Systems (S: annual report MTI)
- Inventory of improvement projects (through program fund) in districts/district hospitals related to a secure working environment or asset management with documented increased satisfaction of the benefitting institution and/or their clients (S: program-related reports)
- The % of health facilities in the accreditation program complying with the minimum standards for a safe, hygienic and secure working environment
- Number of biomedical engineers who started their Bachelor Degree at CST (S: inscriptions CST of candidates)

3.5.5 Indicators and progress markers in the context of action-research

Since the program will focus on improving the system (not financing routine activities), a number of action-research protocols will be initiated. These protocols will develop specific indicators (and eventually progress markers) with a specific baseline. This will allow to monitor the progress in an evidence-based way based on a clearly formulated action-research hypothesis

3.6 Hypothesis, risk and opportunity Analysis

The risks threatening the achievements of the program and the hypothesis are presented by result. Each risk is identified according to the category it belongs to: Implementation, Management, Effectiveness, Sustainability or Fiduciary. For each risk, mitigating measures are also identified to minimize it.

Table 18: Risks and mitigating measures

Risk	Probability	Impact	Mitigating measures
Risks related to the specific objective: A people-centered, integrated and sustainable health care system with quality essential health care services as close to the community as possible			
1/ The support program insufficiently generates evidence-based operational strategies contributing towards the outcomes (sustainability risk)	MEDIUM	HIGH	The M&E mechanisms linked to the intervention will keep the focus and have specific indicators for this type of work; reflective action and action-research will be part of the development circles of the BTC experts; scientific guidance throughout the intervention (such as support from academic institutions, thesis students, GMO) will be assured; each counterpart-expert will have at least one publication by the end of the intervention and will be monitored; presentation of results at national and international conferences will be encouraged and inventoried
2/ Some development partners are supporting interventions which are not contributing to an integrated and sustainable system (sustainability risk)	LOW	HIGH	The SPIU will continue to play its role; the Embassy of Belgium and the BTC sector budget experts will promote in the TWG and joint sector reviews further alignment and harmonization of donor support, using the national health sector policy, the strategic framework HSSP3 and more specific policies and documents as the reference for all interventions
3/ the basic training of health professionals is insufficiently preparing them for a people-centred approach (effectiveness risk)	LOW	HIGH	The policy dialogue needs to focus on that issue; MoH and Mineduc will have to sit together to discuss how to adapt the curriculum so it prepares the students for a more people-centered, gender-sensitive approach
4/ BTC Technical Advisors are involved in some operational tasks (to be conducted by national staff) outside the focus of the program (substitution as an implementation risk)	MEDIUM	HIGH	The various M&E mechanisms linked to the intervention including 'Development circles' will assure that the respective responsibilities regarding the outputs and outcomes of the TFF are kept

5/ The mainstreaming of the crosscutting issues may cause lack of visibility or even neglecting these issues(management risk)	MEDIUM	MEDIUM	Use of sex and gender disaggregated data and specific indicators for crosscutting issues Specific action-research and impact assessments on cross-cutting issues District level initiatives (planning, M&E, capacity building, gender responsive budgeting,..) are assisted by GMO & MIGEPROF focal points
6/ The integration of the financial and procurement management of the program into IFMIS might be delayed (implementation risk)	MEDIUM	MEDIUM	A RAFI will be contracted for 18 months as well as 6 punctual missions to assure the follow-up of the progress compared to the findings and recommendations of the Organizational Assessment of SPIU
7/ The acquisitions of the plots for constructions are not assured	LOW	HIGH	At the time of formulation the procedures to acquire the plots for the different constructions have already been submitted (29/10/2014)
8/ The constructions encounter delays	MEDIUM	HIGH	2 national TA for infrastructure will be contracted (BTC obligation) combined with backstopping from a construction expert of BTC Brussels and by Tractebel
Risks related to Result 1: 'The quality assurance system is set up and integrated and functional at the level of all hospitals'			
1/Autonomous Accreditation body is not established (management risk)	LOW	MEDIUM	Advocacy to support the establishment of the Accreditation body
2/ Insufficient funding to respond to accreditation recommendations / needs (implementation risk)	MEDIUM	HIGH	Prioritize on basis of high impact investment for infrastructure and equipment that will make a difference for public health improvement
3/ Inability to standardize equipment coming from multiple donors and suppliers (management risk)	MEDIUM	HIGH	Advocacy for policy to standardize equipment while respecting procurement regulations

4/ Accreditation process focused on quantitative criteria rather than on people centeredness and real improvement of care (effectiveness risk)	MEDIUM	MEDIUM	Ensure qualitative criteria are included in accreditation process; promotion of clinical & systemic audits in health facilities
6/ Quality assurance mechanisms compartmentalized (no linkage between PBF, Accreditation and supervision assessments) (implementation risk)	LOW	MEDIUM	Support integration of different assessment mechanisms
Risks related to Result 2: The mental health services are accessible from the community level up to the national level in a sustainable way			
1/ the domestic training course of psychiatrists is not sustained (sustainability risk)	LOW	HIGH	Hand-over responsibility for payment of coordinator to the University of Rwanda training psychiatrists after 2 years to enhance a sustainable solution together
2/ the newly trained psychiatrists do not stay in the public health sector (sustainability risk)	MEDIUM	MEDIUM	contract to psychiatrists to refund training when leaving prematurely the public sector or alternative solutions Offer attractive contracts upon training completion
Risks related to Result 3: Urban health service coverage is rationalized and extended, in line with the 3 guiding principles of the national health sector policy			
1/ Insufficient resources to build necessary infrastructures (implementation risk)	MEDIUM	MEDIUM	Support resource mobilization efforts by MOH and CoK to ensure funding for infrastructure investment
2/ Hospitals functioning as independent entities and not able to work as a network (management& effectiveness risk)	MEDIUM	MEDIUM	Advocacy with leadership at MoH and hospital direction towards network development; put a formalization of the network (with secretariat) as a condition for the construction of the Kicukiro District Hospital
3/ Inadequate water and sanitation infrastructures in HF (implementation risk)	LOW	MEDIUM	Include water and sanitation infrastructures assessment as important part of planning of construction and rehabilitation of HF

4/ Absence of integration of private services (management risk)	MEDIUM	MEDIUM	Advocacy with leadership at MoH and CoK health services planning for increased integration of private HF
5/ Low interest of private actors to engage in a pilot project of PPP in a public sponsored health facility	MEDIUM	LOW	Advocacy of MOH and CoK towards private actors
6/ Medical approach not taking into account the holistic conception of health (effectiveness risk)	MEDIUM	MEDIUM	Ensure that social determinants of health are taken into account in the planning of health services on CoK and in HF service provision package through awareness raising
7/ Inadequate number of skilled staff in City of Kigali for health planning and management (implementation risk)	LOW	LOW	Technical assistance to the secretariat in charge of coordination of the CoK hospital network
Risks related to Result 4: The leadership and governance of the health pyramid is reinforced specifically regarding district stewardship, and the respective roles of MoH and RBC			
1/ the post of Health M&E officer at district level is not institutionalized (sustainability risk)	LOW	HIGH	Assure continued well-argumented negotiation between MoH and Mifotra
2/ the culture of bottom-up learning is insufficiently institutionalized (sustainability risk)	MEDIUM	HIGH	promote the practice of systematically documenting and including interesting field experiences in the agenda of the TWG; promote the participation of central level staff at the review meetings in the districts; develop coaching skills at the level of the supervisors
Risks related to Result 5: Data are generated, analysed and used for evidence-based decision-making in a more correct, (sex & gender) disaggregated, integrated, systematic, accessible and effective way			
1/ Data quality biased by PBF and accreditation processes (Management risk)	MEDIUM	HIGH	Technical support for integration between different quality assurance systems (PBF, accreditation, integrated supervision)
2/ DQA and Supervision results not implemented (effectiveness risk)	LOW	HIGH	Institutionalize and systematize feedback mechanisms to decentralized bodies and HF to ensure follow up of recommendations

3/ Quarterly bulletins not produced for data dissemination (implementation risk)	LOW	MEDIUM	Technical assistance to M&E department for regular production of quarterly statistics and epidemiology bulletin
4/ Lack of culture of M&E in human resources for health (effectiveness risk)	MEDIUM	MEDIUM	Training for leadership and decentralized HRH on importance of M&E
5/ Low capacity of human resources for data use in decision making (sustainability risk)	MEDIUM	MEDIUM	Training of all levels (central and decentralized) of HRH on data analysis and use mechanisms Collaborate with the GMO (technical advice and capacity building)
6/ Lack of integration of M&E systems (national and externally funded programs) (management risk)	LOW	MEDIUM	Strengthening of Planning and M&E TWG to ensure harmonization of different M&E systems
7/ Poor use of results of action research projects (effectiveness risk)	HIGH	MEDIUM	Dissemination workshops and exchange visits at local level to understand results of research projects and take decisions on implementation of recommendations
Risks related to Result 6: An asset management system is designed and operational in a cost-effective way			
1/ Weak policy for equipment standardization (management risk)	LOW	HIGH	Technical assistance to the Medical Technology and Infrastructure department for policy development
2/ Weak competency of HRH for infrastructures and equipment maintenance (sustainability risk)	HIGH	HIGH	Establishment of strong pre-service and in-service training for MTI and decentralized maintenance staff
3/ Insufficient financial resources for infrastructure development (central & district workshops) (fiduciary risk)	MEDIUM	HIGH	Support MoH efforts for resource mobilization for this strategic investment area
4/ Lack of linkage of MTI with accreditation process (management risk)	MEDIUM	MEDIUM	Advocacy with leadership and technical assistance with MTI and accreditation technicians to facilitate collaboration between the two processes

5/ Health facilities have poor waste management systems (sustainability risk)	HIGH	MEDIUM	Include waste management assessment as a condition when planning a construction or rehabilitation of HF
6/ Risk of non-alignment with gender policies and strategies	LOW	MEDIUM	Coordinate with other initiatives in other sectors on gender (e.g. WATSAN gender policy)
Fiduciary Risks			
1/ Procurement Management: - Delays in intervention implementation due to increased duration of the tender procedures - Implementation of activities not reaching the aimed objectives in terms of quality and value for money	LOW	MEDIUM	- Implication of BTC experts in the drafting of tender documents (technical specifications etc.) - Ensuring that RPPA conducts a regular (annual) audit of SPIU's compliance with Rwandese procurement rules - Increase awareness of and knowledge on the "Value for Money" concept (training) - Assure that BTC technical experts may be part of the internal tender committee
2/ Financial Management: IFMIS not yet properly implemented - Possible impact on the speediness and accuracy of the financial registration and reporting - Lack of understanding of utilization / potential and of the IFMIS-system, possibly leading to delays and shortcomings in financial reporting	MEDIUM	HIGH	- BTC will invest time and energy in getting to know IFMIS: its functionalities, modus operandi, reporting capabilities, and possible shortcomings - A solution needs to be worked out with MINECOFIN in order to solve the issue regarding commitment registration in IFMIS, possibly based on the solutions proposed by the Organisational Assessment. - A financial RAFI profile (ITA) will be foreseen in the budget for at least 1.5 years to follow up the progress towards IFMIS commitments
3/ Incomplete implementation of commitments towards the improvement of the financial management IFMIS: Possible budget overshoots due to incomplete information on commitments	HIGH	HIGH	

4/ Financial Management: Budget execution reports produced by the IFMIS system do not take into account the commitments with respect to outstanding contracts	HIGH	MEDIUM	
5/ Cash management: Use of the normal treasury system, without separate bank accounts - Limited view on the impact on the execution of the intervention of using the normal treasury system - Additional time lag in payments due to involvement of MINECOFIN and reduced capacity of the SPIU in communicating with service providers and in guaranteeing timely payment	MEDIUM	HIGH	Use of specific accounts at BNR

4 RESOURCES

4.1 Financial resources

4.1.1 Rwandan Financial Contribution

The Rwandan contribution during the implementation phase of the program consists in the following elements:

- Plots for the construction of 2 health centres, a mental day care centre and Kicukiro district Hospital for a total estimated amount of 1.57M Euros, Human Resources working in these health Facilities: 580,000 Euros/year or 2.32M Euros for 4 years and roads to be built to facilitate access to the infrastructures: 1.9M Euros for a total of **5.79M Euros;** see also 7.13 for more details.
- Secondment of an Intervention Director and Head of Departments (concerned by the program) for the whole duration of the intervention (between 40% and 70% of salaries and expenses depending on the positions): 185,296 Euros/year or **741,184 Euros** for 4 years;
- Provision of office premises (with Internet connection, water and electricity services and security) for the intervention in Kigali, including at minimum 5 offices at RBC available for the PCU. 15 offices at 400 Euros each per month = 6,000 Euros/month or 72,000 Euros/year and **288,000 Euros** for 4 years;
- Operational costs (rental of vehicles, meeting room, …) of all units RBC supported through the program (vehicles rental, meeting costs, per diems and communication costs for a total of 28,000 Euros/year for 6 units or **112,000 Euros** for 4 years
- 4th year monthly supervisions to District Hospitals/Referral hospital **84,000 Euros** for one year;
- Top up budget for equipment **200,000 Euros** (year 3 and 4)

As agreed upon in the General Development Cooperation convention signed on the 18th of May 2004 between both governments, any tax, including VAT on the supplies and equipment, works & services is covered by the Govt. of Rwanda

The Rwandan contribution for this specific intervention is estimated at minimum **7.215M Euros** and will be reviewed in accordance with the actual investments through the update of an Operation and Maintenance Plan.

Rwanda will report at least yearly to the Steering Committee on the use of this contribution.

The Rwandan contribution after the implementation phase of the program consists of:

Operation and maintenance costs of program infrastructure investments in the Mid Term Expenditure Agreement during at least 15 years construction / 10 years equipment after implementation period for the sake of sustainability (see art 11 of Specific Convention).

4.1.2 Belgian Financial Contribution

Table 19: summary budget

TOTAL BUDGET				total	%
A		**OS**	**A people-centered, integrated and sustainable health care system with quality essential health care services as close to the community as possible has been reinforced**	**18,541,600**	**88%**
A	*01*		*The quality assurance system is set up and integrated and functional at the level of all hospitals*	*1,704,500*	*8%*
A	*02*		*The mental health services are accessible from the community level up to the national level in a sustainable way*	*3,258,400*	*16%*
A	*03*		*The urban health service coverage is rationalized and extended in line with the three guiding principles of the National Health Sector Policy*	*7,198,200*	*34%*
A	*04*		*The leadership and governance is reinforced, specifically regarding district stewardship, the respective roles of the MOH and RBC and the public private partnership*	*1,326,000*	*6%*
A	*05*		*Data are generated, analysed and used for evidence-based decision-making in a more correct, disaggregated, integrated, systematic, accessible and effective way*	*1,330,000*	*6%*
A	*06*		*An asset management system is designed and operational in a cost-effective way*	*3,724,500*	*18%*
X	01		**Contingency**	**159,600**	**1%**
Z			**General means**	**2,298,800**	**11%**
Z	*01*		*Personnel costs*	*1,450,800*	*7%*
Z	*02*		*Investments*	*55,000*	*0%*
Z	*03*		*Functional costs*	*313,000*	*1%*
Z	*04*		*Audit, monitoring and evaluation*	*480,000*	*2%*
TOTAL				**21,000,000**	**100%**

The Belgian contribution for this intervention is 21 million Euro. The detailed budget per year is presented at the end of this chapter.

An amount for contingency of around 160,000 Euro is set to compensate the exchange rate fluctuations and to allow flexibility in the implementation phase of the intervention.

The budget is not fixed for each result. It is flexible and will be allocated on the basis of operational plans in the implementation phase. The coordination of the program will assure the overall coherence of the intervention and, given the context at that moment, the most effective utilization of the budget in order to meet the outcomes of the program through the 6 outputs.

4.2 Human resources

4.2.1 Principles

- The program will be fully integrated into the partner organizations (MoH, SPIU, RBC).
- It will be implemented through the normal structures and procedures of the partner organizations as much as possible. The Program Coordination Unit will be anchored in the Single Project Implementation unit (SPIU) of RBC.
- Considering the nature of the program (change process) and its workload, a mix of technical expertise is foreseen: i) long-term international technical advisors (ITA), ii) long-term national technical assistance (NTA), iii) short-term and periodic technical expertise.
- Although TAs (and their counterparts) are assigned to specific results, they have a collective responsibility to achieve all the results of the intervention and will provide support in a flexible way to specific components of the other results.
- TA will be embedded in a sector approach. This implies that they will coordinate their actions as efficiently as possible with the other expertise available in the sector.
- TA should not substitute MOH or any of its agencies. They must have an added value and therefore should focus on accompanying the change process, described in the TTF, and contribute to the quality of the implementation of the program. This process will mainly be achieved through on-the-job support to MOH, its agencies and Local Governance.

4.2.2 Long-Term expertise - Program Staff

The organisational structure & institutional anchorage of the intervention is shown under section5.3.

The list of the program staff is indicated in the following table (see also organizational structure and description of responsibilities in chapter 5). Detailed Terms of Reference for the ITA, NTA, RAFi experts and key-support staff are found in Annex 7.3.

Table 20: Program staff

Position	Quantity x Duration	Role and HR Set-up	Budget / Line	
SPIU-RBC Director of Intervention	1 x 48 months	Counterpart of the BTC Co-Manager Under RBC employee contract Funded by the RBC	RBC	**Program Coordination Unit**
National Program Officer (support to the Director of Intervention)	1 x 36 months (FTE first 2y, then ½ time in year 3 and 4)	Support to BTC Co-Manager and Director of Intervention	RBC	
ITA Public Health – Program Coordinator (Co-manager)	1 x 48 months	Program Coordinator and expert responsible for Result 1 BTC International Technical Advisor Under BTC employee contract (full time) Funded by the intervention	100% GM	

RAFi expert (RAFi)	1 x 18 months	Expert responsible for supporting a smooth administrative and financial implementation of the program & the integration of the program financial management in IFMIS BTC International Technical Assistant Under BTC employee contract (full time) Funded by the intervention	100% GM	**Short-term International Technical Assistance**
Procurement Officer Goods & services	1 x 36 months (FTE first 2y, then ½ time in year 3 and 4)	Under RBC employee contract (full time) Funded by the intervention	100% on General Means	**Program Coordination Unit** **Support Functions**
Procurement Officer Constructions	1 x 36 months (FTE first 2y, then ½ time in year 3 and 4)	Under RBC employee contract (full time) Funded by the intervention	100% on General Means	
Administrative & finance responsible (local RAF)	1 x 48 months	Under RBC employee contract (full time) Funded by the intervention	100% on General Means	
Accountant	1 x 48 months	Under RBC employee contract (full time) Funded by the intervention	100% on General Means	
Project Administration Assistant	1 x 48 months	Under RBC employee contract (full time) Funded by the intervention	100% on General Means	
Drivers	5 x 48 months	Under RBC employee contract (full time) Funded by the intervention	100% on General Means	
Expert Mental Health International Technical Advisor	1 x 36 months	Expert assigned to Result 2 but technical input to R1, R3, R5 BTC International Technical Advisor Under BTC employee contract (full time) Funded by the intervention	R2	**Long-term International Technical Assistance**
Expert Health Institutional support International Technical Advisor	1 x 48 months	Expert assigned to Result 3 and 4but technical input to R1, R2, R5, R6 BTC International Technical Advisor Under BTC employee contract (full time) Funded by the intervention	R3	
Expert Health Information, Monitoring and Evaluation International Technical Advisor	1 x 48 months	Expert assigned to Result 5 but technical input to R1, R2, R3, R4, R6 BTC International Technical Advisor Under BTC employee contract (full time) Funded by the intervention	R5	
Expert Health Care Asset Management International Technical Advisor	1 x 48 months	Expert responsible for Result 6 but technical input to R1, R2, R3, R5 BTC International Technical Advisor Under BTC employee contract (full time) Funded by the intervention	R6	

Technical Assistant on Health Care Quality Assurance	1 x 48 months	BTC National Technical Assistant (NTA) Under BTC employee contract (full time) Funded by the intervention	R1	**National Technical Assistance**
Technical Assistant on Infrastructure	1 x 48 months	BTC National Technical Assistant (NTA) Under BTC employee contract (full time) Funded by the intervention	R2,R3,R6	
Technical Assistant Prevention & Treatment of Substance Abuse Disorders	1 x 36 months (FTE first 2y, then ½ time in year 3 and 4)	BTC National Technical Assistant (NTA) Under BTC employee contract (full time) Funded by the intervention	R2	
Technical Assistant for Public Private Partnership	1 x 48 months	BTC National Technical Assistant (NTA) Under BTC employee contract (full time) Funded by the intervention	R3	
Technical Assistant for Governance and M&E	1 x 48 months	BTC National Technical Assistant (NTA) Under BTC employee contract (full time) Funded by the intervention	R4	
Technical Assistant Project Manager in Medical Technology and Infrastructure	1 x 36 months (FTE first 2y, then ½ time in year 3 and 4)	BTC National Technical Assistant (NTA) Under BTC employee contract (full time) Funded by the intervention	R6	

For construction a particular follow-up by BTC contracted construction engineer is an obligation.

The presence of a Mental health expert (expertise which was already available for the last 9 years) is limited to 3 years in order to further increase national ownership and sustainability.

The contract of the RAFi expert is limited to 18 months because it is mainly linked to the improvement of the implementation of Smart IFMIS (See recommendations Organizational Assessment). It is expected that the Smart IFMIS will function smooth enough at the end of that 18 month period.

4.2.3 Short-Term expertise

The technical expertise required to cover specific short-term and periodic technical needs will be solicited either internally either through consultancy contracts (both nationally and internationally):

- There is an envelope for backstopping missions (EST, DO) of (indicatively) 16 weeks related to public health issues, infrastructure follow-up, cross-cutting issues and M&E issues.
- For specific short-term infrastructure expertise, BTC has a framework-contract with Tractebel.
- For environmental issues, BTC also has a framework-contract for short-term consultancies.
- An envelope of 200,000 euro is reserved for international (and eventually national) scientific and methodological support, in order to accompany the process of reflective action & action-research, and the process of capitalization in general.
- A budget of 48,000 EUR for a regular follow-up by an external consultant of the further integration of the finance & procurement management after the departure of the RAFI-expert.
- For specific studies, as well as international seminars there is the possibility to use the Study and consultation fund.
- The link between research questions identified within the program and the theses of university students (national/international) will be actively explored.

4.3 (Indicative) Material resources

The following table provides the overview of the indicative budget allocated to constructions and equipment per result. More details can be found in the budget sheet in this document.

Table 21: overview material resources

In EURO	R2	R3	R6	General means	Total (+ % total budget)
Equipment	448,000	850,000	1,767,500	55,000	3,120,500 (14.6%)
Constructions	692,000	4,480,000	744,000		5,916,800 (28.1%)

The use of Resources, Furniture and Equipment acquired by the intervention will strictly respect the Program Implementation Manual of procedures (PIM). It will be jointly elaborated in the preparation phase of the intervention and based both on the BTC Manual of Procedures in Rwanda and the relevant chapters of the SPIU Procedures Manual. Material resources acquired for program support during Minisanté 4 (in particular the 3 vehicles that were purchased) will be transferred to this Program.

The constructions and equipment will be conform environmental and quality norms and will be embed in a life cycle management strategy.

The unit cost of 400 euro/m² for the construction of the 2 Health Centres and the Day care Centre has been based on the experiences with the constructions within the former intervention PAPSDSK in the City of Kigali.

The unit cost of 500 euro/m² for the construction of the hospital has been based on the unit cost used in the program of Burundi ‘PAISS volet 5‘ (2013) and the cost-study regarding health infrastructures in Niger (2012, GIMH).

Table 21b shows more details about construction costs.

Table 21b: Overview budget lines related to construction

The budget lines in green reflect the details of the costs related to construction.

A		OS	A people-centered, integrated and sustainable health care system with quality essential health care services as close to the community as possible has been reinforced	Detail	Amount in Euro
A	*02*		*The mental health services are accessible from the community level up to the national level in a sustainable way*		
A	02	02	Consolidate Mental Health Care Services & a people-centred approach at the level of health Centres & hospitals and extend referral outpatient & inpatient Mental Health Care at the level of the provincial and national referral hospitals		
			equipment daycare center	Lumpsum	193,000
			equipment RH- Purchase EEG	Lumpsum	75,000
			architectural design & follow up of constructions	10% of the amount for construction (5% for design & 5% for follow-up)	69,200
			construction day care center (1,730 m²)	1 m² @ € 400	692,000
A	*03*		*The urban health service coverage is rationalized and extended in line with the three guiding principles of the National Health Sector Policy*		
A	03	03	Support the implementation of the coverage plan through various strategies : upgrades of the existing HF, construction of new HC or PPP initiatives in the most vulnerable sectors of CoK		
			architect : elaboration of concept (5%)	5% of the amount for construction	48,000
			baseline on practices on waste management		10,000
			construction & rehabilitation (medium plan) Gatsata, Kimironko (2,400 m²)	1 m² @ € 400	960,000
			architect : follow up of works (5%)	5% of the amount for construction	48,000
			international consultancy on health facility construction (20 days)	@ € 1,000	20,000
			Follow-up implementation of waste management (20 days)	@ € 1,000	20,000
			standardised equipments for 2 HC+	@ € 75,000	150,000
A	03	05	Design, build and equip a 300 beds Hospital in Kicukiro District articulated with the CoK coverage plan		
			master plan HD	Lumpsum	50,000
			baseline on practices on waste management (20 days)	@ € 1,000	20,000
			construction & rehabilitation (6,200 m²)	1 m² @ € 500	3,100,000
			architect : follow up of works	5% of the amount for construction	155,000
			international consultancy on health facility construction (20 days)	@ € 1,000	20,000
			Follow-up implementation of waste management (20 days)	@ € 1,000	20,000
			standardised equipments	Lumpsum	700,000
A	*06*		*An asset management system is designed and operational in a cost-effective way*		
A	06	02	Develop a functional procurement & maintenance system at operational level		
			maintennance workshops (1,260 m²)	1 m² @ € 400	504,000
			tools (15 units)	@ € 4,500	67,500

Table 22: Budget[27]

TOTAL BUDGET RWA 13 092 11				modality	Amount in Euro	%	YEAR 1	YEAR 2	YEAR 3	YEAR 4
A		**OS**	**A people-centered, integrated and sustainable health care system with quality essential health care services as close to the community as possible has been reinforced**		**18,541,600**	**88%**	**2,755,050**	**5,976,550**	**5,450,350**	**4,359,650**
A	*01*		*The quality assurance system is set up and integrated and functional at the level of all hospitals*		*1,704,500*	*8%*	*180,500*	*543,000*	*523,000*	*458,000*
A	01	01	Progress towards the creation of an autonomous accreditation body	co-management	0		0	0	0	0
A	01	02	Update & disseminate norms, standards and models (MOH)	co-management	225,000		40,000	75,000	60,000	50,000
A	01	03	Facilitate and implement the accreditation process at all hospitals	co-management	283,500		66,500	94,000	89,000	34,000
A	01	04	Finance people-centered improvement projects	co-management	1,100,000		50,000	350,000	350,000	350,000
A	01	05	Medium term technical assistance in accreditation, quality improvement and quality control	BTC-management	96,000		24,000	24,000	24,000	24,000
A	*02*		*The mental health services are accessible from the community level up to the national level in a sustainable way*		*3,258,400*	*16%*	*799,200*	*1,099,200*	*1,096,600*	*263,400*
A	02	01	Strengthen community interventions on mental health	co-management	250,000		100,000	150,000	0	0
A	02	02	Consolidate Mental Health Care Services & a people-centred approach at the level of health Centres & hospitals and extend referral outpatient & inpatient Mental Health Care at the level of the provincial and national referral hospitals	co-management	1,786,400		395,200	545,200	699,600	146,400
A	02	03	Develop multidisciplinary strategies and actions with regard to the fight against abuse of psychoactive substances and with regard to mental health issues related to HIV/Aids and Gender Based Violence (GBV)	co-management	600,000		100,000	200,000	200,000	100,000
A	02	04	Long term technical assistance in mental health and people centered approaches	BTC-management	622,000		204,000	204,000	197,000	17,000
A	*03*		*The urban health service coverage is rationalized and extended in line with the three guiding principles of the National Health Sector Policy*		*7,198,200*	*34%*	*414,600*	*2,234,600*	*2,153,000*	*2,396,000*
A	03	01	Develop promotional activities on social determinants of health in CoK	co-management	110,000		25,000	40,000	40,000	5,000
A	03	02	Develop and validate a sound concept and equitable coverage plan for HC	co-management	82,000		32,000	40,000	10,000	
A	03	03	Support the implementation of the coverage plan through various strategies : upgrades of the existing HF, construction of new HC or PPP initiatives in the most vulnerable sectors of CoK	co-management	1,656,000		48,000	605,000	655,000	348,000
A	03	04	Create a functional, autonomous and efficient hospital network	co-management	373,200		36,600	131,600	160,000	45,000
A	03	05	Design, build and equip a 300 beds Hospital in Kicukiro District articulated with the CoK coverage plan	co-management	4,065,000		45,000	1,190,000	1,060,000	1,770,000
A	03	06	Long term technical assistance in public health, hospital networking and urban health	BTC-management	912,000		228,000	228,000	228,000	228,000

[27] Though the program will use the Rwandan system for the budget lines 'co-management', with either full or joint responsibility depending on the procedure used (See. chapter 5), the term 'co-management' is mentioned in this *table* because scope management is always a joint responsibility. For more information on the BTC definition of 'National Execution', please refer to Chapter 5 (in particular p. 94) // for budget lines A_ 03_03 and A_ 03_ 05 see p87-88 for more details

A	*04*		*The leadership and governance is reinforced, specifically regarding district stewardship, the respective roles of the MOH and RBC and the public private partnership*		*1,326,000*	*6%*	*376,500*	*396,500*	*296,500*	*256,500*
A	04	01	Strengthen stewardship capacities at the level of the local health system (districts)	co-management	850,000		242,500	212,500	197,500	197,500
A	04	02	Provide support to MoH and RBC with regard to their respective roles (separation of regulatory/coordination/ M&E, and implementing role)	co-management	380,000		110,000	160,000	75,000	35,000
A	04	03	Long term technical assistance in (district) capacity building	BTC-management	96,000		24,000	24,000	24,000	24,000
A	*05*		*Data are generated, analysed and used for evidence-based decision-making in a more correct, disaggregated, integrated, systematic, accessible and effective way*		*1,330,000*	*6%*	*302,500*	*382,500*	*372,500*	*272,500*
A	05	01	Assure the integration of different systems of information and further develop HMIS tools, methods and guidelines	co-management	120,000		45,000	25,000	25,000	25,000
A	05	02	Assure the production of quality data	co-management	140,000		35,000	35,000	35,000	35,000
A	05	03	Develop strategies for effective utilization of data for monitoring, evaluation decision making and action-research	co-management	350,000		42,500	142,500	132,500	32,500
A	05	04	Long term technical assistance in HMIS development and M&E	BTC-management	720,000		180,000	180,000	180,000	180,000
A	*06*		*An asset management system is designed and operational in a cost-effective way*		*3,724,500*	*18%*	*681,750*	*1,320,750*	*1,008,750*	*713,250*
A	06	01	Develop, validate and disseminate policies, technical standards for HF in infrastructure and equipment, acquisition standards including donation, procurement & replacement standards, collaboration with private sector…	co-management	66,000		66,000			
A	06	02	Develop a functional procurement & maintenance system at operational level	co-management	1,021,500		290,500	440,500	290,500	0
A	06	03	Develop a waste management policy, strategy and baseline	co-management	80,000		30,000	50,000		
A	06	04	Finance strategic improvement projects with impact on the asset managment	co-management	1,300,000			500,000	400,000	400,000
A	06	05	Develop domestic human capacity with regard to asset management	co-management	465,000		91,250	126,250	126,250	121,250
A	06	06	Long term technical assistance in maintenance of biomedical equipments and in construction of health facilities	BTC-management	792,000		204,000	204,000	192,000	192,000

X	01		**Contingency**		**159.600**	**1%**	**0**	**0**	**0**	**159.600**
X	01	01	contingency CO-MANAGEMENT	co-management	109.600					109.600
X	01	02	Contingency BTC-management	BTC-management	50.000					50.000
Z			**General means**		**2.298.800**	**11%**	**692.450**	**628.450**	**451.450**	**526.450**
Z	*01*		*Personnel costs*		*1.450.800*	*7%*	*481.200*	*391.200*	*289.200*	*289.200*
Z	01	01	ITA Public Health – Program Coordinator (co-manager)	BTC-management	720.000		180.000	180.000	180.000	180.000
Z	01	02	Program manager	co-management	72.000		24.000	24.000	12.000	12.000
Z	01	03	Finance and admin team	co-management	388.800		97.200	97.200	97.200	97.200
Z	01	04	Technical team	co-management	0					
Z	01	05	RAFi / PFM expert	BTC-management	270.000		180.000	90.000		
Z	*02*		*Investments*		*55.000*	*0%*	*55.000*	*0*	*0*	*0*
Z	02	01	cars	BTC-management	0					
Z	02	02	Office equipment	BTC-management	25.000		25.000			
Z	02	03	IT equipment	BTC-management	30.000		30.000			
Z	02	04	Office refurnising	BTC-management	0					
Z	*03*		*Functional costs*		*313.000*	*1%*	*66.250*	*82.250*	*82.250*	*82.250*
Z	03	01	Functioning costs cars	BTC-management	60.000		15.000	15.000	15.000	15.000
Z	03	02	Tele communication	BTC-management	40.000		10.000	10.000	10.000	10.000
Z	03	03	Office material	BTC-management	40.000		10.000	10.000	10.000	10.000
Z	03	04	Missions	BTC-management	40.000		10.000	10.000	10.000	10.000
Z	03	05	Representation costs and external communication	BTC-management	40.000		10.000	10.000	10.000	10.000
Z	03	06	Training (including on HIV workplace policy)	BTC-management	30.000		7.500	7.500	7.500	7.500
Z	03	07	Consultancy costs - PFM support	BTC-management	48.000		0	16.000	16.000	16.000
Z	03	08	Financial transaction costs	BTC-management	5.000		1.250	1.250	1.250	1.250
Z	03	09	Costs VAT	BTC-management	0					
Z	03	10	Other functioning costs	BTC-management	10.000		2.500	2.500	2.500	2.500
Z	*04*		*Audit, monitoring and evaluation*		*480.000*	*2%*	*90.000*	*155.000*	*80.000*	*155.000*
Z	04	01	M&E costs (baseline, 1 EMP + 1 EF)	BTC-management	130.000		30.000	50.000		50.000
Z	04	02	Audit	BTC-management	50.000			25.000		25.000
Z	04	03	Capitalisation	BTC-management	40.000		10.000	10.000	10.000	10.000
Z	04	04	Backstopping expert department BTC	BTC-management	60.000		15.000	15.000	15.000	15.000
Z	04	05	Scientific support	BTC-management	200.000		35.000	55.000	55.000	55.000
TOTAL					**21.000.000**	**100%**	**3.447.500**	**6.605.000**	**5.901.800**	**5.045.700**

BTC-management	**5.126.000**	**1.435.250**	**1.371.250**	**1.187.250**	**1.132.250**
CO-MANAG.	**15.874.000**	**2.012.250**	**5.233.750**	**4.714.550**	**3.913.450**

5 IMPLEMENTATION MODALITIES

5.1 Introduction

This chapter describes how the intervention will be managed, from start-up until closure, in all its management areas (strategic steering, coordination, technical content management (scope), procurement management, financial management, human resources management, quality management & audit) and is intended to enable stakeholders directly involved in the intervention to:

- Understand which **management system** applies to which intervention management area. There are two possibilities:
    - Use of the Rwandan system (or of an harmonized donor system recognized by Rwanda as its system),
    - Use of the BTC system.
- Be aware of their **responsibilities** and of those of the other stakeholders in the various intervention management areas. There are three modes:
    - Rwandan responsibility: the Rwandan partner is responsible. For the finance and procurement management areas, the term “national execution” is used.
    - Joint responsibility: both the Rwandan partner and BTC are responsible. For the finance and procurement management areas, the term “co-management” is used.
    - BTC responsibility: BTC is responsible. For the finance and procurement management areas, the term “régie or direct (BTC) management” is used.

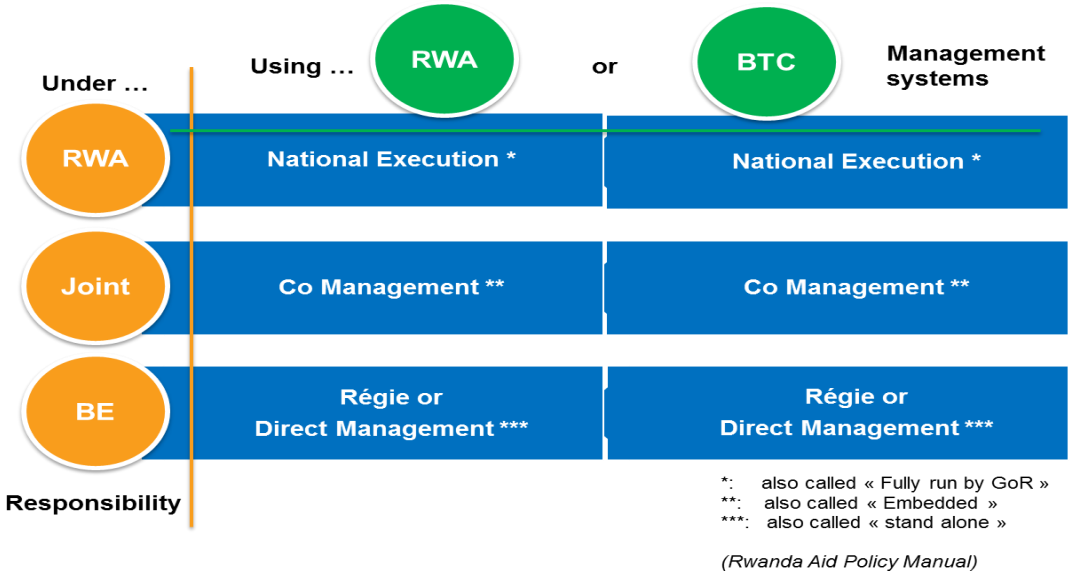


Figure 10: Types of implementation modalities

These possibilities in terms of system and responsibility mode can be related to the three modus operandi for intervention support as introduced in the Rwanda Aid Policy Manual of Procedures:

- A “**Fully run by GoR**” intervention is an intervention where the Rwandan system is used under Rwandan responsibility.
- An “**embedded**” intervention is an intervention where there is a **joint responsibility**, regardless of the system used (from Rwanda or from BTC).
- A “**stand-alone**” intervention is an intervention run under **BTC responsibility**, usually using the BTC system.

The Belgian “Guidelines for National Execution in Projects” (2010) details on its page 20 the definition of National Execution that BTC applies: “A project is said to be under national execution when the national partners of the project implement at least one of the management systems of the project. So, in this note, a project under national execution is a project of which at least a part of financial management and/or procurement management is under national execution”. The above quotation implies that a project or program labelled as being “under national execution” may still combine different execution modalities for different parts of the program.

It should thus be noted that the Belgian definition of the term “National Execution” only relates to finance & procurement management, not to scope management (Production of technical specifications and technical follow-up of the procurement contract), as is shown in the figure below:

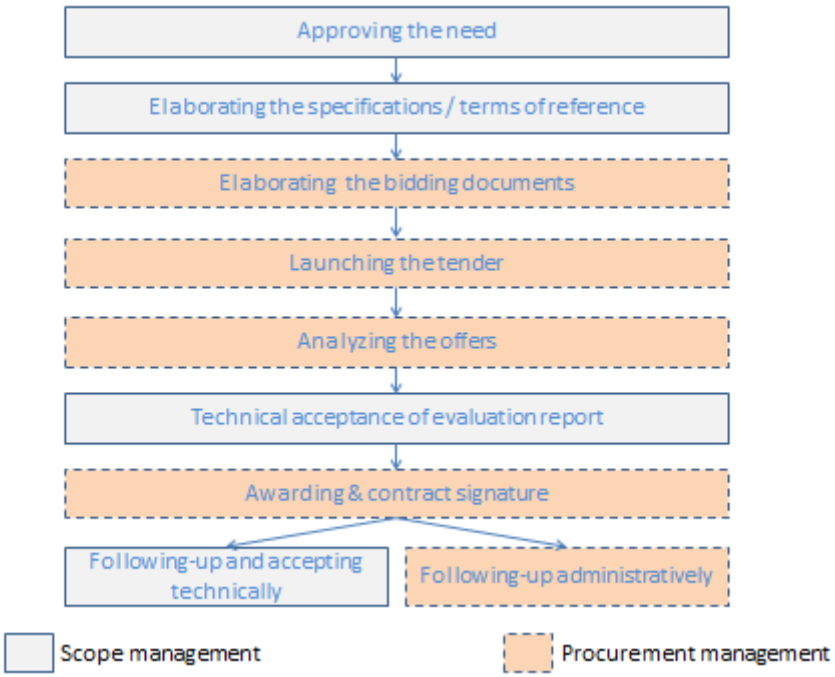


Figure 11: Scope, procurement and financial management

When national execution is used, BTC remains responsible for the good use of the funds: i) Ensuring an adequate risk analysis, ii) Defining risk mitigating measures, iii) Verifying that the agreed risk-mitigating measures are properly implemented, and delivering an annual report on that matter, iv) Auditing the project every year and delivering a report, v) Taking measures, seeking solutions with the partner and possibly using sanctions in case of a negative audit report, including recuperation of misused funds, vi) Informing adequately and timely the Belgian State. These responsibilities must be described explicitly in the specific agreement.

In line with the Paris Declaration, the Aid Agenda of Accra, the Rwanda Vision 2020, this intervention, like all Belgian supported interventions, will combine various modus operandi, depending on the management area. The aim is to come as close as possible to a “fully run by GoR” situation, while taking into account risks and constraints, as assessed by the organizational assessment done in August 2014 and by the formulation mission.

The selected responsibility mode for each management domain will be outlined below. It has been envisaged to use the Rwandan systems as much as possible, based on the Organisational Assessment that took place in August 2014.

Technical assistance, backstopping, audits, MTR, ETR, capitalization services are under Belgian

responsibility.

No matter the choices made in terms of systems and responsibility modes, partnership, collaboration, transparency and mutual information will apply in managing the intervention.

5.2 Specific Modalities: Execution agreements (EA)

Key partner institutions are directly responsible to achieve certain results and take responsibility for implementation of the related activities. These key actors are the district hospitals (43 in total, see list in annex 7.11).

To allow the intervention to collaborate with these key actors in respect with public expenditures regulations of Republic of Rwanda and the Kingdom of Belgium, the intervention will use a specific modality to contract public actors: execution agreements. The Specific BTC guide applies:

"An Execution Agreement is a contract that allows an intervention to delegate to an exclusive public third-party partner the execution of part of the activities described in the logical framework of the TFF, one or more results, or an objective or a combination of results to be met by the intervention. The delegated activities must match with the missions assigned by law to the public entity contracted".

The contract can be directly elaborated with the partner without having to use procurement process under the sole conditions to meet the 3 specific requirements below:

- No participation to private capital
- Real collaboration to execute jointly a common task
- Public interest.

Such collaboration with key partner institutions (43 District Hospitals) is foreseen to achieve Results A_01_04 ("Finance people-centered improvement projects") and A_06_04 ("Finance strategic improvement projects with impact on the asset management"). Their statutes of public agencies and their mandate make them eligible to this specific modality.

Taking into account the elevated number of eligible hospitals, and the rather small envelope that will be availed to each one of them (+/- 50k EUR, spread over 4 years of implementation period, resulting in an average envelope of 12.5k EUR per hospital per yearly action plan), no formal organisational assessment will take place. However, where several district hospitals present similar activities in their action plan, it may be decided for cost-efficiency reason that the tenders related to those activities be managed at the level of SPIU-RBC (for which an organisational assessment took place in August 2014).

5.3 Intervention duration and lifecycle

The duration of the Specific Agreement (SA) will be 6 years (72 months).

The actual execution phase of the intervention is 4 years (48 months) and is preceded by a start-up phase (3 months) and followed by a closure phase (9 months)[28]. All intervention activities must be terminated at the end of the 4 years execution period.

The effective start date of the intervention is the date of signature of the specific agreement.

[28] Reference is made to BTC's start-up & closure guides, and its procedures manuals

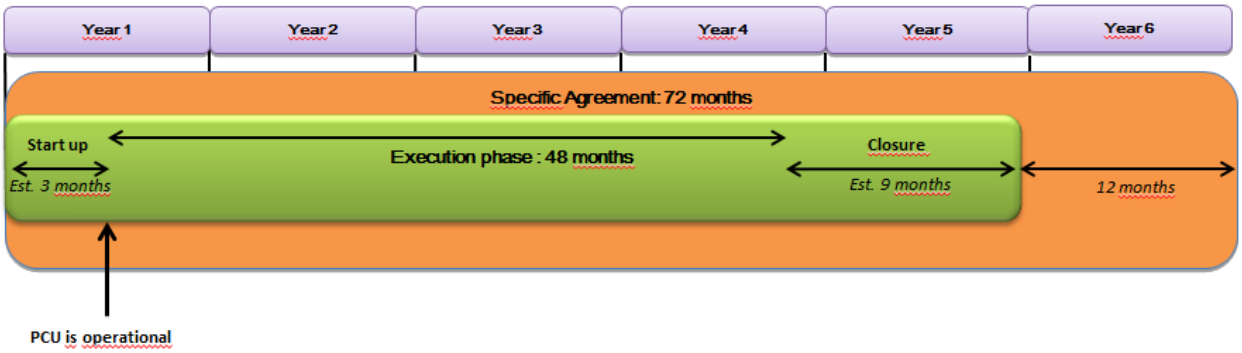


Figure 12: Overall chronogram of the program implementation

5.4 Organizational structure and institutional anchorage

The intervention integrates its support functions into the Single Project Implementation Unit (SPIU) of RBC which has been established to coordinate all external donor funding.

At the time of formulation and drafting the present TFF, the Program Coordination Unit organizational structure, anchored in the SPIU was defined as mentioned in the organogram below (figure 13).

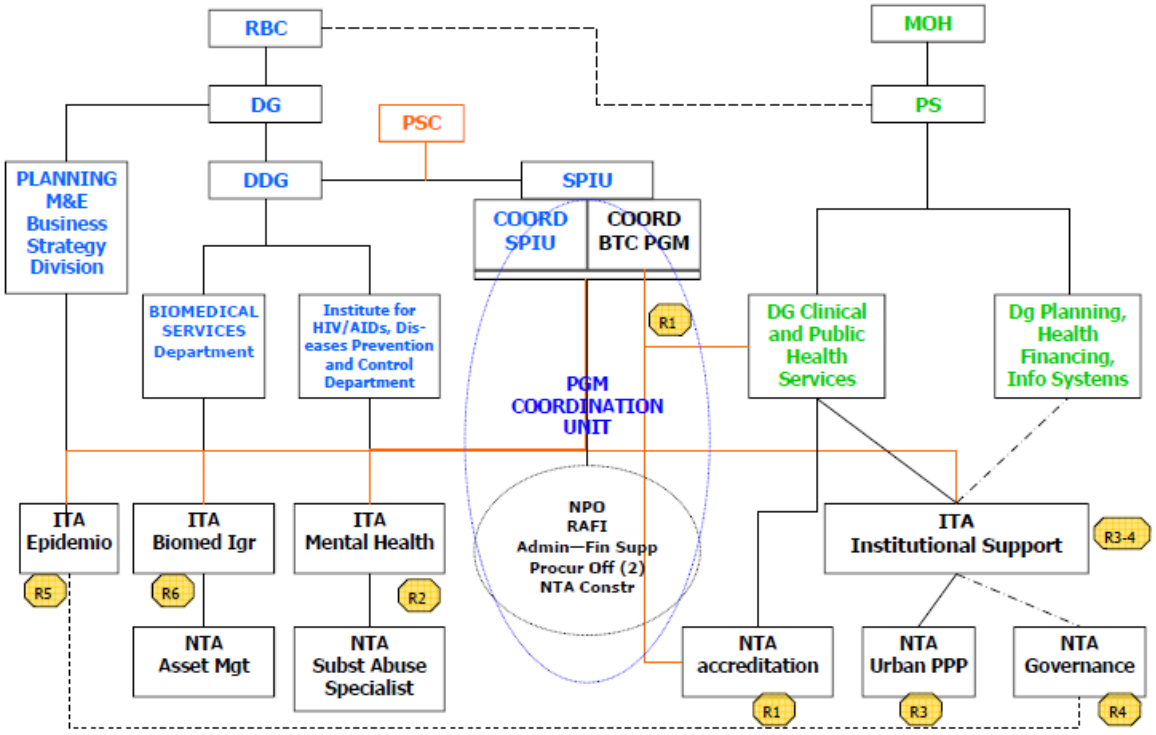


Figure 13: Organogram

5.4.1 Program Steering Committee (PSC)

5.4.1.1 Role

The PSC is the highest level of decision in the intervention. It is in charge of the strategic steering of the intervention. The main responsibilities of the PSC are:

- Defining the intervention strategy, validating main changes in the intervention strategy and

ensuring their alignment to the also evolving overall MINISTRY OF HEALTH strategy (strategic planning, annual planning and budgeting),

- Assessing the development Results obtained by the intervention (strategic quality assurance and control) and approve intervention reports and planning, including the Rwandan contribution to the intervention
- Managing strategic changes on overall and specific objectives, on total intervention budget and/or on duration) and other important changes like budget line and intermediate Results changes, changes on implementation modalities as well as the adaptation of the intervention organization and anchorage to SPIU RBC,
- Solving problems that cannot be solved at the operational level and management level in the Program Coordination Unit (PCU),
- Enhancing harmonization among donors.

5.4.1.2 Composition

The **voting members** of the PSC (who will also sign the minutes of SC) are:

- The Permanent Secretary or the Minister of State (MoH) will be the Chair of SC
- The DDG of RBC will be the Chief Budget Officer)
- The BTC Resident Representative, or his delegate, is the co-chair of the PSC
- The Vice mayor of Social Affairs-City of Kigali
- A representative of the MINECOFIN

Non-voting members of the PSC can be invited:

- ITA
- Representatives of the other DPs involved in the Health sector
- A representative of each result area (Head of Divisions) at MoH, RBC and CoK

The members of the Intervention Management Unit participate as regular observers and informants. The PCU acts as the secretariat of the PSC. Other actors can be invited to the PSC on an ad hoc basis depending on the need.

5.4.1.3 Operating rules of the PSC

The direction of the intervention will elaborate specific 'Internal Working Regulations' at the beginning of the intervention ; those operating rules will be established in accordance with the provisions of the SA where signing parties agree to entrust the monitoring of the project to a Steering Committee.

5.4.2 Program Coordination Unit (PCU)

5.4.2.1 Role

The PCU is the operational level in the intervention. It prepares strategic decisions for submission to the PSC and implements decision taken by the PSC. At operational level, the PCU takes operational decisions and manages intervention activities on a day to day basis in order to fully implement the intervention strategy, in time and within budget, as approved by the PSC. The main responsibilities of the PCU are to:

- Perform the necessary analysis in order to prepare strategic decisions by the PSC
- Implement decisions taken by the PSC

- Develop, propose & implement the intervention strategy and corresponding operational plans
- Prepare consolidated quarterly and annual reports for the stakeholders,
- Coordinate and provide quality assurance and quality control in the processes of procuring the capacity building services and any other services, goods or works requested by the intervention (content management), as well as proper monitoring and evaluation of the intervention.
- Ensure proper management and apply stringent accountability arrangements for the management of the financial resources allocated to the intervention,
- Ensure that procurement processes and procedures used by the intervention are conform to the applicable procurement guidelines,
- Ensure proper human resources management practices conforming to the applicable guidelines,

The PCU will be located in the SPIU RBC premises.

5.4.2.2 Composition

- The SPIU-Coordinator - will be the Director of Intervention (DI), acting as a sponsor and as an authorizing officer for the Rwandan side for all matters executed using the Rwandan systems, whether in joint or Rwandan responsibility (and for the joint responsibility in case the BTC system is used). He will report to the RBC Chief Budget Officer.
- A SPIU/RBC appointed Program Manager (PM), directly under the Director of Intervention. He's acting as a day-to-day intervention manager.
- A BTC appointed Technical Assistant and Coordinator (co-manager). He oversees and guides overall change brought about by the intervention by ensuring global coherence, focus and coordination. This person will be acting as authorizing officer for the Belgian side for any commitment > 25,000 EUR[29] (5.6.2.2). The Co-manager coordinates the PCU together with the DI.
- A BTC appointed RAFi, in charge of ensuring proper integration of the intervention into the Rwandan financial and procurement systems. This person will be acting as authorizing officer for the Belgian side for any payment > 25,000 EUR (5.6.3.1).
- Support staff: 2 procurement officers, RAF, accountant, administrative assistant, 5 drivers

5.4.2.3 Operating rules of the PCU

The intervention will elaborate a Project Implementation Manual at the beginning of the intervention; reference will be made to the BTC Rwanda Procedures Manual and SPIU RBC Manual of procedures.

5.5 Technical content (Scope) management

5.5.1 Scope management

Technical content management (or scope management) encompasses the processes that transform the intervention strategy into activities that must be properly defined, executed and monitored. It also

[29]BTC's mandate structure makes a clear distinction between the commitment and payment responsibilities, which may not be held by one single person (in compliance with the generally accepted principle of 'segregation of duties'). It is considered that the commitment responsibility is the most important one since it entails a legally binding impact.

includes possible backstopping by BTC HQ.

5.5.2 Operations definition, execution and monitoring

System:	Not defined, as these processes are not really formalized
Responsibility:	Joint responsibility[30]

The definition and writing of the specifications (terms of reference) and the technical follow-up (including provisional and final technical acceptance) for all services, goods or works to be procured by the intervention; and the definition, execution and follow-up of the activities lead by the intervention team, are a joint responsibility of the DI and the Co-manager, except if stated otherwise hereunder.

The DI and the co-manager are supported by the other members of the intervention team, by other Ministry of Health and RBC staff, depending on the activity.

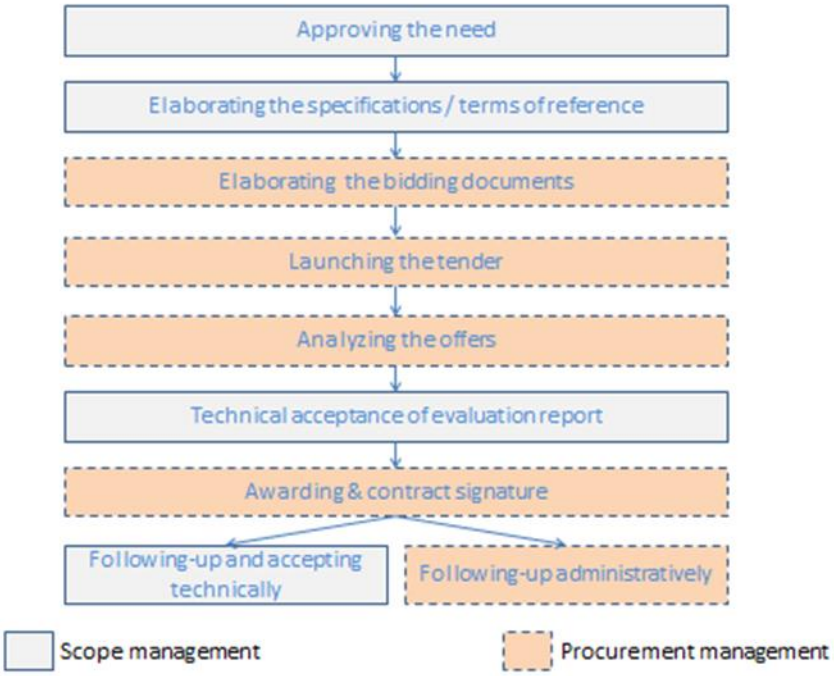


Figure 14: Scope and procurement management

[30] According to the new Rwandan Manual of Projects (2014 Edition), Joint Responsibility will be guaranteed in the following way: "BTC gives NO at the major technical steps of execution of the contract". See Manual.

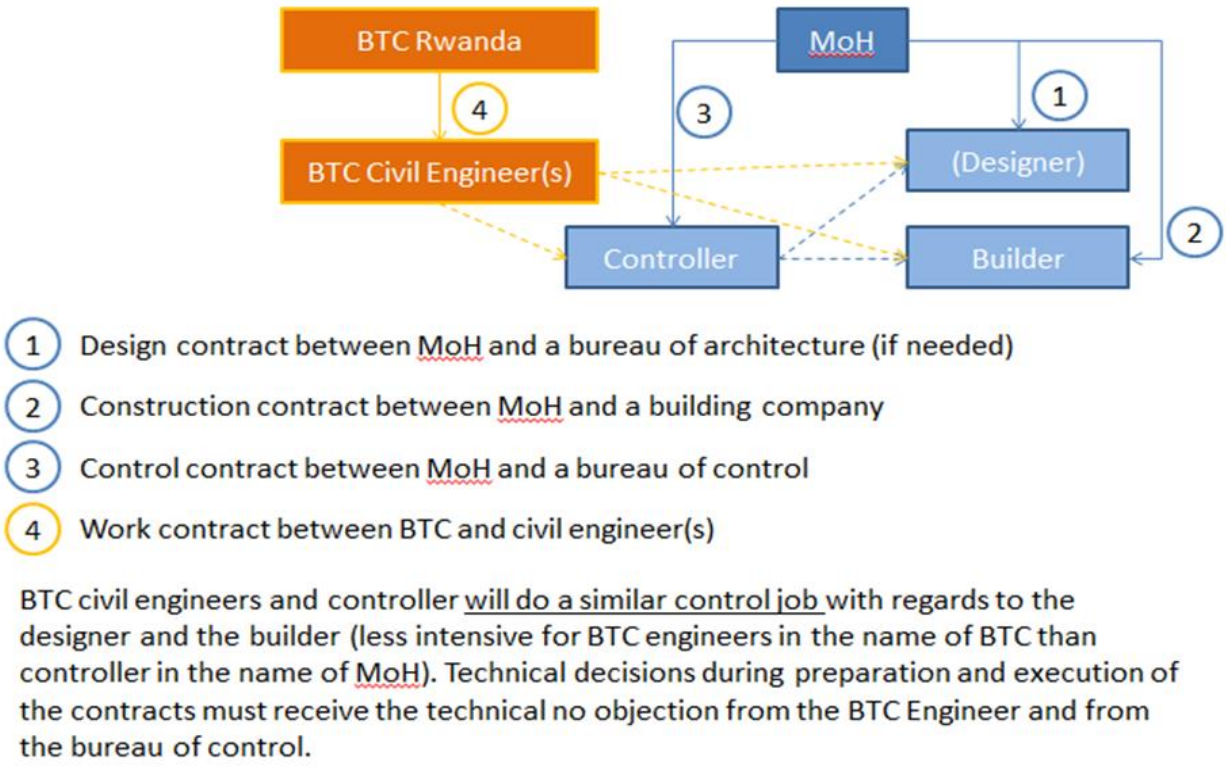


Figure 15: Technical follow-up of construction tenders

5.5.3 Operations coordination

System:	Not defined, as these processes are not formalized
Responsibility:	Joint responsibility

The PCU meets formally at least once a month, in order to review intervention progress, identify issues and risks and proactively take actions.

5.5.4 Technical backstopping

System:	BTC system
Responsibility:	BTC responsibility (or Direct Management) or joint responsibility

Technical backstopping is the possibility for the intervention or the PSC to ask the support of experts (in health, governance, infrastructure & asset management, crosscutting issues) at the level of BTC HQ.

A backstopping mission can also be decided by BTC representation or BTC HQ.

Backstopping findings and recommendations are presented to the PSC.

5.6 Financial & Procurement management

As has been the case with other programs implemented by BTC in Rwanda, the Health programme MINISANTE 4, with an initial budget of 12 million for the period mid-2010 till mid-2015, is being jointly

managed.

Thanks to the positive experience BTC has gained in working with(in) the Health SPIU, the time is ripe to move a step forward regarding the use of national systems for the implementation of its new Health program. However, the Belgian definition of “national execution” limits this alignment effort to the management domains of procurement (use of Rwandan system and full Rwandan responsibility except for scope management) and financial management (use of Rwandan system Smart IFMIS; full Rwandan responsibility for expenses below 25,000 euro).

The table below summarizes the systems that will be used for each domain, and the corresponding responsibility mode. The next paragraphs will provide further detail on the implementation.

	Rwanda System	**BTC system**
Rwanda responsibility	- Procurement management (administrative part) - Financial management (budget, accounting, reporting) and payments < 25.000 EUR	
Joint responsibility	- Financial management : payments > 25.000 EUR - Cash management (BNR)	Asset management
BTC responsibility	Financial management: validation of IFMIS accounting & reports	Audit

For RBC, the Chief Budget Officer is the RBC DDG or his delegate. For BTC, the Resident Representative is the principal Chief Budget Officer[31].

5.6.1 Procurement

In addition to the use of the Rwandan Procurement System (according to the regulations of the RPPA), which Belgian supported interventions have used since many years, procurement management in this intervention will be under Rwandan responsibility. It needs however to be clear that this relates only to the administrative procedures, and not to the scope (drafting of ToR and/or technical specifications, technical acceptance, etc. => see figure 15) which will remain under co-management.

5.6.1.1 Procurement planning

System:	RWA system and BTC system
Responsibility:	Rwandan responsibility for the RWA system Joint responsibility for the BTC system

BTC requires a quarterly procurement plan (through its MONOP-tool). This BTC tool has been aligned to the planning tools of GoR in order to avoid duplication of work.

Procurement planning is performed by the BTC Co-manager and the SPIU/RBC Program Manager, with the support of the procurement services of SPIU/RBC and of the Procurement officers.

[31] Refer to BTC Mandate definition for further details

The DI and the BTC Co-Manager both approve the quarterly procurement plan in joint responsibility.

5.6.1.2 Procurement execution

System:	RWA system by default, BTC system for some clearly defined activities (see below)
Responsibility:	RWA responsibility when the RWA system is used BTC responsibility when the BTC system is used

Use of the BTC procurement system under BTC responsibility:

- Consulting services for supporting BTC backstopping, if required
- Audit services for intervention audit on behalf of BTC
- Consulting services for the mid-term and end-term review
- Capitalisation services (BTC framework contract)
- Other procurements validated by the PSC

5.6.2 Finance management

Regarding the Financial Management domain, BTC has observed that one of the conditions of the Rwanda Overall Assessment (carried out in preparation of the ICP) for the use of national systems has recently been complied with at SPIU: the implementation of the Smart IFMIS.

BTC welcomes the fact that IFMIS implementation has started, and would like to contribute to its further roll-out. There remains however some risks related to its use. The Organisational Assessment report of SPIU-RBC (August 2014) states that "The following recommendations are essential to allow Belgium to use the IFMIS system for the new BTC program, this is, under SPIU management and with program-specific bank accounts and treasury management:

a) SPIU should considerably enhance its capacity in budget monitoring and budget execution reporting (See. recommendation §4.2.1-2).

b) SPIU should collaborate with MINECOFIN as to allow full commitment registration and enhanced budget execution reporting with the Smart IFMIS system (See. recommendation §4.2.1-4).

c) The SPIU needs to enhance its capacity of using the IFMIS system and tapping into its potentials, while avoiding potential pitfalls as described above in §3.4.2 (See. recommendation §4.2.1-8)."

Therefore, BTC proposes to use the Rwandan system for the financial management of its program (excluding expenses under own-management modality), while maintaining specific bank accounts at BNR and implementing other risk mitigation measures (to be followed-up by a RAFi). The BTC system will still serve to enable BTC to report on the total intervention budget to its HQ and to the Belgian authorities. However, the finance management in the BTC FIT-system will be simplified concerning the part of the budget managed in the Rwandan system: consolidated figures of the part of the budget managed through IFMIS will be integrated in FIT after verification, correction (if necessary) and approval of the relevant reports.

This will allow BTC to get to know better this system, which may facilitate the integration of future programs. Furthermore, BTC proposes that the integration of program activities into the Rwandan financial management system will be accompanied by a RAFi[32] expert. This person will also be able

[32] Responsable Administratif et Financier de l'Intervention

to follow-up on the improvements of IFMIS that address the drawbacks mentioned above.

5.6.2.1 Budget preparation

System:	RWA system and BTC system
Responsibility:	Joint responsibility for the RWA system Joint responsibility for the BTC system

The budget attached to the TFF sets out the budgetary limits within which the intervention must be executed. It also indicates expected disbursements per year. This budget is however indicative and can be updated during the implementation phase according to the changing needs but remaining within the scope of expected outcomes.

Budget planning processes have to be implemented both in the:

- Rwandan system in order for Rwanda to be able to track intervention progress in IFMIS
- BTC system in order to allow BTC to have a view on planned disbursements.

Budget proposals have to be approved by both parties

5.6.2.2 Budget execution, monitoring and reporting

The intervention expenses cannot exceed the total budget of the intervention and the budget per responsibility mode may not be exceeded neither.

Any change to the budget must be approved by the PSC on the basis of a proposal that is drawn up by the PCU, according to the BTC rules in this respect.

The use of the budgetary reserve requires a budget change proposal to be validated by the PSC.

Quarterly reports on budget execution are produced by the RAF, as part of the financial reporting.

The verification of budget availability will be done at the occasion of the Technical Validation of the Tor/Technical specifications by the by the ITA in charge of the domain to which the activity relates. [33]

Works, supplies or services with an estimated cost below 25,000 EUR can be committed as soon as a Technical Non-Objection (concerning the Tor/Technical specifications) will be available.

For commitments above 25,000 EUR the budget verification also needs to be approved by the BTC Program Coordinator.

5.6.2.3 Accounting, financial planning and reporting

Accounting is done on a monthly basis according to Rwandan rules for the part of the budget managed in IFMIS, and BTC rules for the rest of the budget that is managed in FIT. Accounting tasks are performed by the intervention accountant under supervision of RAF. The DI and the BTC Co-Manager both approve the monthly accounting in joint responsibility. Thus, only after the approval of the accounting in IFMIS can the consolidated figures be fed into the BTC FIT-system. After approval, the monthly accounting must be transmitted before the 15th of the next month to MINECOFIN regarding IFMIS and the BTC representation regarding FIT.

The PCU elaborates a quarterly financial plan, according to both the Rwandan system and BTC rules and regulations, to inform the PSC. Financial planning is based on the quarterly action and procurement plans. Financial planning tasks are performed by the RAF, based on the operations

[33] This refers to the description of the scope management process - see 5.5

planning. The DI and the BTC Co-Manager both approve the quarterly financial plan in joint responsibility. The quarterly financial planning done in IFMIS will also be copied into the financial planning module of FIT. This will allow BTC HQ to provide the needed disbursement timely to the specific accounts of the program in Rwanda. This plan must be forwarded to the BTC representation.

Financial reporting processes have to be implemented using the Rwandan system for the part of the budget managed in IFMIS, in order for Rwanda to be able to track intervention progress in its own financial reporting system, and in BTC system (global consolidation).

5.6.3 Cash management

5.6.3.1 Managing intervention accounts and payments

System:	RWA system and BTC system
Responsibility:	Joint responsibility for the RWA system BTC responsibility for the BTC system

Supporting documents for all payments must be kept in the intervention office.

Accounts in joint responsibility:

As soon as the specific agreement has been signed, an account in EUR (main account) and one operational account in Rwandan Franc will be opened at the National Bank of Rwanda (NBR). Payments above 25.000 EUR from these accounts require a double authorization (BTC and RWA), according to the following specifications:

Authorizing Officer for RWA	**Authorizing officer for BTC**[34] *(according to BTC mandates)*	**Threshold (EUR)**	**Type of account**
Director of Intervention or delegated	N/A (no BTC signature required)	< 25,000	Operational
Chief budget officer or delegated	Manager Administration & Finance at the BTC representation (or ATI RAFi for the first 18 months)	> 25,000	Main
Chief budget officer or delegated	BTC Resident Representative	> 200,000	Main

For logistical reasons, other accounts in joint responsibility may be opened with the approval of the "chief budget officer" and the resident representative.

Account in BTC responsibility:

For local expenses under BTC responsibility, an intervention account will be opened at BTC, with double BTC authorization.

5.6.3.2 Managing cash and transfers

System:	BTC system
Responsibility:	Joint responsibility or BTC responsibility

[34] According to BTC systems and the segregation of commitment and payment duties (see BTC mandate structure)

First transfer on the main account:

Once the signed specific agreement has been notified to BTC, a first cash call can be sent by the PCU to the BTC representation, per responsibility mode. The requested amount must correspond to the needs for the first three months of implementation.

Following transfers on the main account:

The main account is replenished quarterly according to BTC rules and regulations.

Cash management tasks are performed by the intervention accountant. The Intervention coordinator and the ITA RAF both sign the quarterly cash calls in joint responsibility. The first cash call can be signed by the BTC Program Officer if the RAF has not been appointed yet.

5.6.4 Assets and inventory management

System:	BTC system for PCU's assets Rwandan system for assets officially transferred
Responsibility:	Joint responsibility for PCU's assets Rwandan responsibility for assets officially transferred

According to the intervention's objectives, the PCU can acquire infrastructure, equipment and goods to support the partner organization. Assets acquired by the PCU for its own use must be registered in an inventory updated on a quarterly basis according to BTC rules and regulations and its own administrative system. Their use is strictly limited to the activities of the intervention. At the end of the intervention, PCU's assets can be transferred to a partner institution after decision by the PSC. It must be formalized by an official transfer statement signed by all parties.

Transfer of equipment, infrastructure and goods to a partner institution has to follow rules and procedures from Rwanda in terms of inventory management.

5.6.5 Expenses before the signature of the specific agreement

The following expenses can be incurred by BTC [35]before the signature of the specific agreement, in order to speed up the start of the intervention:

- Investment costs: IT equipment and vehicles;
- Costs for the recruitment of the international and national staff for:
  - intervention management
  - administrative and financial management
  - support functions

Table 23: Expenses before the signature of the specific agreement

Activity	**Amount in Eur**	Period and Comments
Recruitment costs	10,000	National & International staff
Capital Investment	25,000	Office equipment
	30,000	ICT equipment
Total	**65,000**	

[35] This possibility helps to speed up the start of the implementation. These expenses will be reimbursed by the Program on its budget in BTC-management after the signature of the Specific Agreement.

5.6.6 Financial closure

5.6.6.1 Financial balance

From six months before the end of the intervention execution phase, the PCU must elaborate each month a financial balance forecast according to BTC procedures

The PSC will be responsible to implement the closing process according the guideline “Closing procedures” of BTC. One year before the end of the project the PCU will draw up a closing action plan which needs to be presented to and validated by the PSC (C-1).

5.6.6.2 Closure of specific accounts execution & financing agreements

The intervention commits itself to close the specific accounts at the end of the execution & financing agreements of the project.

5.6.6.3 Destination of balances at the end of intervention operations

According to the modalities of the Specific Agreement, balance allocation is decided by mutual agreement between Rwanda and Belgium during the last PSC.

5.6.6.4 Expenses beyond the end date of the specific agreement

No commitment can be made in the last six months of validity of the specific agreement without prior approval of the PSC and on exclusive condition that activities close before the end of the specific agreement. After the end date of the specific agreement, no expenditure will be authorised except if it is related to commitments signed before the end of the Specific Agreement and mentioned in the minutes of a PSC. Operational expenditures after the end of the Specific Agreement will not be accepted.

5.7 Human resources management

System:	BTC system for BTC Staff RWA system for non BTC Staff
Responsibility:	Rwandan responsibility for SPIU RBC employees BTC responsibility for BTC employees

The following modalities apply:

For the HR-management, the IPPS-tool of GoR will be used (IPPS stands for ‘Integrated Public Performance System’, and is a generic MIFOTRA tool).

Additional remarks:

- All positions are open for men and women. Female candidates will be encouraged to apply.
- If the ToR defined in this TFF must be revised before advertisement, the revised ToR need to be approved by the PSC.
- The local staff of the intervention will be trained by BTC as they will use some aspects of the BTC management system, in addition to their duties in the Rwandan management system.
- No training other than on the use of the BTC systems is foreseen for the co-manager, except on explicit request from the steering committee.
- Intervention objectives are included in the performance contracts of both the SPIU/RBC Director of intervention and the National Program Officer.

5.8 Quality management : monitoring, review and consolidation

The intervention will establish an M&E framework that is to be used for **accountability** and, **systematic learning**, and for **steering purposes** at all levels of the intervention, up to the specific objective**.** Indicators (See. section 3.5) will be aligned to the specific activities developed through the annual work plans presented to the Steering Committee.

The monitoring system consists of the components described and pictured below.

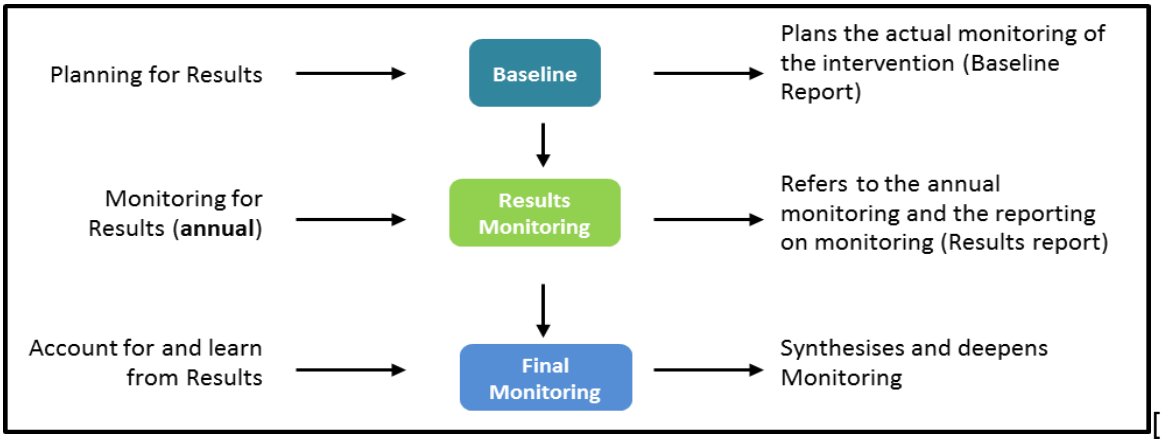


Figure 16: Monitoring processes

5.8.1 Monitoring

The different processes are briefly explained in annex. For every Monitoring process, both the Co-manager and the DI (with the support of the PCU team) are responsible for the delivery and quality of monitoring.

5.8.2 Baseline

System:	BTC system, making use of RWA frameworks systems whenever possible
Responsibility:	Joint responsibility

The DI and Co-Manager are jointly responsible for the elaboration of the Baseline Report. The Baseline Report is presented to PSC for approval.

5.8.3 Operational monitoring (including planning)

System:	BTC system making use of RWA frameworks systems whenever possible
Responsibility:	Joint responsibility

Operational monitoring refers to both planning and follow-up of the intervention's management information (inputs, activities, Results). It is an internal management process of the intervention team and is done every 3 months.

5.8.3.1 Results Monitoring

System:	BTC system making use of RWA frameworks systems whenever possible
Responsibility:	Joint responsibility

Results[36] Monitoring refers to an annual reflective action process in which intervention team reflects on the performance in terms of progress towards the specific objective and delivery of the expected Results, analyses this progress and identifies actions/decisions to be taken in order to ensure the achievement of the specific objective. Results monitoring focuses on the past year and looks forward on the year to come.

The PSC has the mandate to approve or reject the proposed modifications of the PCU.

5.8.3.2 Final Monitoring

System:	BTC system making use of RWA frameworks systems whenever possible
Responsibility:	Joint responsibility

Final monitoring is the final piece of the Monitoring process through which:

- Results achieved at the end of the implementation of an intervention are summarized
- lessons learned are documented after a final reflection on the development process supported by the intervention.

5.8.3.3 Monitoring and Evaluation to support change

The Design of the M&E framework for the RDSP is intended to contribute to the M&E framework of the decentralization sector. By looking at an M&E system in terms of systematic learning and strategic steering, it is clear that M&E cannot be treated as a one shot activity at the end of an intervention.

5.8.3.4 Indicators and Means of Verification

Indicators are described under section 3.5. Result indicators should be included in annual budgets and work plans for accountability purposes in line with good practice in Result based budgeting. This will facilitate alignment with the Rwandan planning, budgeting and IMIHIGO performance contract process on an annual basis.

5.8.4 Evaluation: Mid-term review and End-term review

System:	BTC system
Responsibility:	BTC responsibility

In this context, the term 'review' is used for external evaluations at intervention level. The main function of a review is to offer an external perspective on the intervention's performance as well as to analyse in-depth the on-going or completed development process. In doing so, reviews are used to i) analyse if interventions have to be re-oriented in order to achieve the objective of development, ii) inform strategic decisions, iii) identify and reflect upon lessons learned

Performed by an independent external actor, reviews play an important role in the accountability of the intervention's performance.

[36] Results stands for monitoring the level of expected Results and of the specific objective.

Reviews are organized twice during the lifetime of the intervention:

A **Mid-Term Review (MTR)** will be organized after two years of implementation. In the MTR the focus is on strategic decision making for the intervention. Therefore, special attention will be given to the validity of and functioning of the intervention's Theory of Change.

An **End-of-Term Review (ETR)** will be organized at the end of the intervention. In the ETR, the focus is on learning. Therefore, special attention will be given to expected and unexpected change at the level of beneficiaries by using a Most Significant Change (MSC) methodology.

Reviews are organised twice in a lifetime of an intervention: at mid and end of term. BTC-HQ is responsible for organising the reviews. The ToR of the reviews and their implementation are managed by BTC HQ, with strong involvement of all stakeholders (see chapter 3). The role of the PSC is to approve or disapprove the recommendations made in the reviews.

5.8.5 Consolidation

System:	BTC system
Responsibility:	Joint responsibility

A specific budget line is introduced to allow for consolidation and communication activities during the lifecycle of the intervention.

5.9 Audits

5.9.1 Intervention audits by BTC

System:	BTC system
Responsibility:	BTC responsibility

Audits will be organised by BTC during the intervention implementation period. A qualified external financial auditor selected and contracted by BTC, will execute the auditing. BTC will elaborate the Terms of Reference and select the audit firm. The audit will include the following items:

- verification of the existence and the respect of procedures;
- verification if the accounts of the intervention reflect reality
- verification of the economic and efficient use of funds

The auditor's reports will be presented to the PSC. If necessary, the intervention team will elaborate an action plan in order to improve the intervention procedures and to prove that corrective measures have been taken.

Terms of Reference of BTC audits are a BTC responsibility and will be shared with MINISTRY OF HEALTH for information.

5.9.2 Intervention Audits by External Control Bodies

System:	BTC system or RWA system
Responsibility:	BTC responsibility or RWA responsibility or Joint responsibility

Each year, BTC accounts are audited by the Belgian government auditors, who have the right to audit any intervention implemented by BTC. BTC internal audit chief officer is also free to decide to audit any intervention implemented by BTC.

The Rwandan authorities, either SPIU or its parent ministry MINISTRY OF HEALTH or the Office of the Auditor General for State Finances of Rwanda can also decide to audit the intervention. In this instance, the Director of Intervention is the primary respondent to the auditor's requests. An annual audit is recommended from the Ministry of Finance.

Intervention audits reports are mutually shared and presented to the PSC.

In case the intervention is audited by the Auditor General Office of Rwanda, it will be clear at the beginning of the audit which systems are to be used. It should be avoided to audit the intervention compliance to the Rwandan system where the TFF clearly states that the BTC system must be used.

Moreover the scope of control will focus on the co-management budget whereas the direct management budget will remain under full responsibility of BTC and therefore governed by the jurisdiction of its external control bodies (Belgian Government auditors). If necessary, information on amounts spent in "direct management" can be provided.

5.10 Modification of the TFF

The present TFF may be amended by mutual consent of the parties. It is essential to install an attitude of expecting and encouraging a practice of regular modifications based on the insights gained during the implementation. The task of the intervention management unit and the PSC is to assess the quality of the argumentation for the suggested changes and to request further explanation if necessary.

Careful consideration must be given not to change the present TFF in a way that would unnecessarily change the Objective and Expected Outcomes of the intervention as originally agreed between the parties. A formal agreement by the Belgian government is needed for the following changes:

- Modification of the duration of the Specific Agreement;
- Modification of the total Belgian financial contribution;
- Modification of the Specific Objective of the intervention.

The request of the above modifications has to be approved and motivated by the Steering Committee. The exchange of letters requesting these modifications shall be initiated by the Rwandese party and shall be addressed to the Embassy of Belgium. The following changes to the TFF will have to be approved by the Steering Committee:

- The execution modalities;
- The program Results and activities and their respective budgets;
- The composition and responsibilities of the Steering Committee;
- The mechanism to change the TFF.

All other changes to the TFF should be approved by the chairman of the PSC and the BTC resident representative. The adapted version of the TFF shall be communicated to the BTC headquarters and to the Embassy of Belgium in Kigali.

6 CROSS CUTTING THEMES

The current EDPRS II points at the importance of mainstreaming environment, gender and HIV/AIDS as crosscutting issues in all sector development programs as well as social inclusion as a key-factor for achieving equitable development. The EDPRS II also points at the need for improving the sexual and reproductive health status of the population for a sustainable development and commits to sustain Rwanda's efforts towards the achievement of the health related Millennium Development Goals. The focus on the crosscutting issues is particularly important in view of supporting the GoR in its efforts to achieve the health related MDGs as well as the MDG3 on GEWE.

Gender and environment are also the two crosscutting issues for the Belgian Development Cooperation, which has identified the promotion and protection of SRHR as one of the key elements of sustainable development. Moreover, the Belgian law on development cooperation (March 2013) explicitly states that HIV/AIDS should be addressed as a crosscutting issue for the interventions in endemic countries and that SRH (which also includes HIV/AIDS) should be an integrated part of the health programs. The Belgian law also demands that the rights of the child should be taken into account as a priority issue.

The mainstreaming of the crosscutting issues should be a continuous concern throughout the program cycle. The cross-cutting issues will be dealt with in an integrated way, implying that no separate activities are defined during the formulation but that the activity-groups are designed in a manner that takes these dimensions into account in an explicit way where relevant. Specific actions can – and should – be taken during implementation, addressing specific groups with specific needs or experiencing inequalities/discriminations and reaching out for their rights and longing for empowerment (the twin-track approach)

Integration inevitably entails a risk of lack of visibility. In order to ensure visibility and to facilitate the capitalisation of experiences in the mainstreaming of each of the crosscutting issues the program will be encouraged to organise specific studies and/or action-research initiatives related to the crosscutting issues.

For each of the crosscutting issues a limited number of specific indicators are identified with the aim to ensure the crosscutting issues are also taken into account during monitoring and evaluation.

6.1 Environment

Environmental issues are identified as one of the **major health related challenges** for the urban population of Kigali (See. 1.3.3.3. Challenges), amongst which air pollution is the most prominent, both in terms of outdoor pollution (mostly due to motorized traffic and industry) indoor pollution (smoke from burning of wood and charcoal). Another major problem is the poor management of surface water and rainfalls within and around the City of Kigali, mostly due to encroachment on the wetlands areas. This leads regularly to deadly floods and negative sanitary consequences especially for populations living in least urbanized sectors of the city. The lack of drinkable water and insufficient sanitation capacity also contribute to urban environmental difficulties in the city of Kigali.

In the health centers and hospitals, the management of **medical waste** is not always dealt with according to standards and is in some cases a cause of air pollution (waste is burned using inappropriate methods) and water contamination (wastes are being stored outside on the hospital premises and exposed to rainfall).

Asset management, such as the construction/rehabilitation of Health infrastructures and the management of medical equipment is also directly related with environmental aspects: i.e. sustainable use of energy, water, procurement of materials used for construction, maintenance of equipment,

methods and equipment used for waste disposal (incineration…). In this respect, health technology and infrastructure has been identified as one of the priorities of the last Health Sector Strategic Plan of Rwanda, supported by the present intervention.

This program has integrated a focus on environment in its strategy, budget and expected results in order to tackle some of the most crucial environmental problems and try to develop appropriate solutions. This integration is being specified concretely the expected results (See Logical framework). Support to the environmental dimension of the program will be provided under the form of short term missions, studies, capacity building and institutional strengthening, hiring of specific expertise and the development of strategies and plans. Specific budget lines and indicators have been devoted to ensure this.

6.2 Gender, SRHR and HIV / AIDS

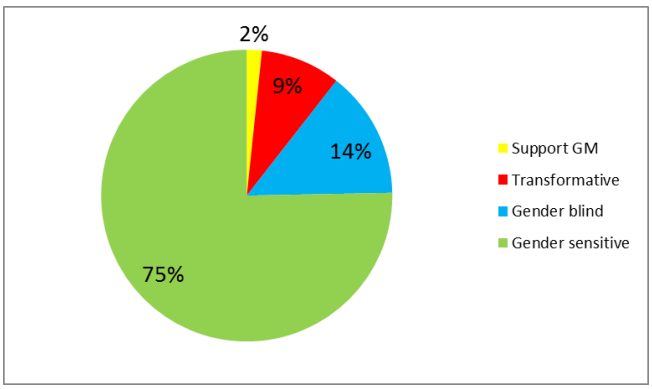
There is a very strong and undeniable link between gender, HIV/AIDS and the broader concept of SRHR. HSSP III explicitly highlights the importance of gender to be mainstreamed as a crosscutting issue. In Annex 8 of HSSP III an overview is given of policy actions addressing gender as a crosscutting issue, i.e.: maternal and child health (including family planning, adolescent and youth health, sexual and gender-based violence), malaria, HIV, health communication and health financing. Maternal and child health and HIV are also taken up in the capacity building component of HSSP III.

6.2.1 Gender

The collaboration with the GMO will be institutionalized. The framework of this collaboration is constituted of 3 reference documents in the area of Gender Equality and Women's Empowerment (GEWE): 1) the National Gender Policy (NGP), 2) the HSSP III and 3) the national program on Gender Responsive Budgeting, headed by MINECOFIN in collaboration with MIGEPROF (imposing all sector ministries to draft Gender Budget Statements following the budget cycle).

This program will mainly focus on activities such as **gender-tranformative/sensitive improvement projects** in relation to accreditation, specific **action-research on gender** topics, prevention and care in relation to **SGBV/drugs and alcohol**, gender-sensitive **health promotion in CoK, gender audits, and age and gender disaggregated data**. These activities are described more in detail in chapter 3.

The graph of the gender budget scan below indicates how much of the budget lines related to the activities are gender blind (14.1%), gender sensitive (72.3%) or gender transformative (8.9%) and support to the national gender machinery, through the Gender Monitoring Office GMO (1.7%).



* An example of a gender transformative activity is A.1.4. 'Finance people-centered improvement projects'. This activity will facilitate the set-up of also gender-related improvement projects, in order to change gender relations between women and men. Another example is A.2.3. 'Develop multidisciplinary strategies and actions with regard to the fight against abuse of psychoactive

substances and with regard to mental health issues related to HIV/Aids and Gender Based Violence (GBV)'. From a gender perspective, this activity will also address violence against men and collect related data. Strategies and actions will avoid stereotypes, discriminations and taboos. The activities will address gender equality as well as equality within the group of women and within the group of men, related to discriminating issues as HIV, age, inabilities, sexual orientation,...).

* A.5.3. 'Develop strategies for effective utilization of data for monitoring, evaluation decision making and action-research' is the only activity that will focus on collaboration with the gender machinery and in particular with the GMO. Even if this activity only represents 1.7% of the total budget, it is however important to valorise national capacities and strengthen ownership regarding gender.

* An example of gender sensitive activity is A.6.3. 'Develop a waste management policy, strategy and baseline'. The policy and strategy will take into account gender issues, practical needs and strategic, long term (transformational) interests. It is to be decided by policy-makers to which degree the policy and strategy will be transformative. Coherence will be respected with the WATSAN gender policy (to be established). As such the activity is initially coded 'green', meaning that it will be done on the basis of a gender analysis.

The recruitment activities are also coded 'green', meaning that legislation and procedures of Human Resources management will be respected with regard to gender (equal treatment equal opportunities and where appropriate positive discrimination.

* Activities coded 'blue' are for example A.6.4. 'Install an application fund for strategic improvements with impact on the asset management', meaning that these activities do not require any preliminary gender analysis. Investment and equipment activities are also coded 'gender blind'.

The details can be found in the detailed gender budget scan in annex 7.11.

6.2.2 SRHR and HIV / AIDS

The achievement of the health related MDGs (4-5-6) are key priorities of the EDPRS II and HSSP III. Moreover, MDG 4-5-6 are closely related to the promotion of SRHR. In the area of SRHR the GoR has identified a series of very specific priorities, such as the further reduction of maternal mortality, the further improvement of under-five health, increased access to and use of modern family planning methods, improved SRH of adolescents, adequate prevention of and response to sexual and gender-based violence and the further reduction the HIV incidence, particularly among the most vulnerable and key populations.

The current program can – and should – make meaningful contributions to the **promotion** of SRHR and the fight against HIV/AIDS. This will be done in a direct way through the organization of SRHR/HIV specific activities, as well as in an indirect way through the explicit follow-up of SRHR/HIV related issues where these have already been integrated in existing systems, tools and mechanisms, such as the **accreditation** procedures and the **asset management** system.

It should be highlighted that the Belgian-Rwandan cooperation in the field of **mental health** creates an important window of opportunity for improving the interaction between mental health and HIV care, treatment and support as well as between mental health and SGBV prevention and response. Explicit attention should also be given to the mental health of children and adolescents affected by HIV/AIDS and survivors of SGBV.

6.3 Link between the crosscutting issues and the results & activity clusters of the program and specific indicators

Table 8 under 2.5 already gave an overview of the areas where activities related to crosscutting

issues are relevant to achieve the 6 results. The following table gives an overview of the specific indicators related to the crosscutting issues. These are already integrated in chapter 3 ('indicators').

Table 24 : Overview indicators of the crosscutting issues environment – gender – SRHR/HIV

Result	Environment	Gender	SRHR/HIV
Specific objective	• Mapping of action research initiatives related to the improved integration of each [37] of the crosscutting issues (environment, gender including GBV and SRHR/HIV/AIDS)		
R1. The quality assurance system	• Number of people-centred improvement projects addressing environment, gender, SRHR/HIV/ASRH/SGBV with documented increased client satisfaction		
			• % of DH and provincial hospitals with accreditation for the full package of SRHR/HIV/ASRH/ SGBV related services
R2. The mental health services		• The integration of drug and alcohol abuse prevention (with active involvement of community actors) in 2 new Health Centre related Sectors of the CoK is documented, published and disseminated'	
R3. The urban health service coverage	• A comprehensive medical waste management plan for CoK is available • Kicokiro district hospital is constructed & equipped in Kicukiro District according to an architectural, technical and functional design & business-plan supporting the 3 outcomes of the policy (people-centeredness, integration, sustainability), and proper asset & waste management	• Inventory of innovative activities of CoK in relation to health promotion taking into account the socio-cultural determinants	

[37] This means that for each of the crosscutting issues at least one action research initiative has to be completed

R4. The leadership and governance		• % of DHU who have conducted a gender audit	
R5. Data management		• A gender assessment of the Gender Budget Statement is available and will be published • Quarterly publication and dissemination of the National and District epidemiological profiles with age & gender disaggregated data	
R6. Asset management system	• Mapping of the improvement projects in districts/district hospitals related to a secure working environment or asset management with increased satisfaction of the benefitting institution and/or their clients • The % of health facilities in the accreditation program complying with the minimum standards for a safe, hygienic and secure working environment		
	• .Number of new health infrastructures built according to approved norms and standards, taking into account access/quality & environmental issues • A standardized and rationalised medical equipment procurement & replacement system, taking into account environmental standards, is in place • Presence of a national policy and strategy on waste management		.

The indicators for gender are in line with the EDPRS II Final Sector Specific Gender Mainstreaming Guidelines indicators.

7 ANNEXES

7.1 Logical framework

	Intervention logic	IOV (See. section 3.5)	sources (See point 3.5)	hypothesis (See point 3.6)
OG	Strengthening the quality of primary health care and services in Rwanda	Impact indicators from the HSSP III M&E Plan, Demographic Health Survey (4° et 5° DHS)		
OS	A people-centered, integrated and sustainable health care system with quality essential health care services as close to the community as possible has been reinforced	5 Progress markers and Most significant changes related to the 3 outcomes 'People-centeredness, integration sustainability"		
R1	The quality assurance system is set up and integrated and functional at the level of all hospitals	9 indicators: 3 HMIS and 6 program-related indicators		
R2	The mental health services are accessible from the community level up to the national level in a sustainable way	7 indicators: 1 HMIS and 6 program-related indicators		
R3	The urban health service coverage is rationalized and extended in line with the three guiding principles of the National Health Sector Policy	7 indicators: 1 HMIS and 6 program-related indicators		
R4	The leadership and governance is reinforced, specifically regarding district stewardship, the respective roles of the MOH and RBC and the public private partnership	9 indicators: 4 HMIS and 5 program-related indicators		
R5	Data are generated, analysed and used for evidence-based decision-making in a more correct, disaggregated, integrated, systematic, accessible and effective way	6 indicators: 3 HMIS and 3 program-related indicators		
R6	An asset management system is designed and operational in a cost-effective way	11 indicators: 3 HMIS and 8 program-related indicators		

The quality assurance system is set up and integrated and functional at the level of all hospitals				Means	Budget
A	1	1	Progress towards the creation of an autonomous accreditation body	surveyors	0
				conduct assessments (5 days per session, 4 persons, 15 per semester) nationwide	
				vehicle rental	
A	1	2	Update & disseminate norms, standards and models (MOH)	national long term consultancies to develop continuously norms	225,000
				national long term consultancies to integrate existing QA mechanisms (PBF, integrated supervision, accreditation) and work on norms & standards by specific national programs and councils	
				research funds 7 researches to be conducted	
A	1	3	Facilitate and implement the accreditation process at all hospitals	43 external facilitators selected and trained	283,500
				43*6 internal facilitators selected and trained	
				trainings on selected topics per hospital site	
				strategy development for the sound articulation between accreditation facilitators, pool supervisors (integrated supervision), mentors specific programs, PBF team	
A	1	4	Finance people-centered improvement projects	funding of specific people-oriented improvement initiatives on service delivery including HIV, SRHR	1,100,000
A	1	5	Medium term technical assistance in accreditation, quality improvement and quality control	international technical assistance	96,000
				national technical assistance	
The mental health services are accessible from the community level up to the national level in a sustainable way				Means	Budget
A	2	1	Strengthen community interventions on mental health	training of second CHW per village	250,000
				set up specific tools to MH disorders early detection	
A	2	2	Consolidate Mental Health Care Services & a people-centred approach at the level of health Centres & hospitals and extend referral outpatient & inpatient Mental Health Care at the level of the provincial and national referral hospitals	scholarship for training abroad in psychiatry	1,786,400
				Local tuition fees	
				coordination of postgraduate training in psychiatry	
				2 teaching missions per year/ 2 Prof	
				training 70 GP and 70 GN in patient-oriented consultation, protocols and clinical standards and follow up	
				equipment day-care center	
				equipment RH- Purchase EEG	
				architectural design & follow up of constructions	
				construction day care center	
A	2	3	Develop multidisciplinary strategies and actions with regard to the fight against abuse of psychoactive substances and with regard to mental health issues related to HIV/Aids and Gender Based Violence (GBV)	baseline and studies	600,000
				sensitization campaigns	
				equipment HUYE rehabilitation center	
A	2	4	Long term technical assistance in mental health and people centered approaches	international technical assistance	622,000
				Prevention & Treatment of Substance Abuse Disorders Specialist	
				Appui perlé (1 mission of 10 days)	
Health Service Coverage in CoK is improved				Means	Budget
A	3	1	Develop promotional activities on social determinants of health in CoK	studies fund: at least 3 studies to be conducted (hygiene, social protection, key populations,…)	110,000

				communication campaign	
				change initiatives on hygiene and sanitation	
A	3	2	Develop and validate a sound concept and action plan for medicalized HC (HC+) in rural and urban areas and upgrade all HC of CoK to medicalized level (HC+)	Baseline study and needs assessment for all existing HC	82,000
				Consultancy	
				Workshops with all stakeholders 5 days workshop with 50 participants	
				communication	
A	3	3	Support the implementation of the coverage plan through various strategies : upgrades of the existing HF, construction of new HC or PPP initiatives in the most vulnerable sectors of CoK	investments for upgrading and initiate PPP	1,656,000
				architect : elaboration of concept (5%)	
				baseline on practices on waste management	
				construction & rehabilitation (medium plan) Gatsata, Kimironko	
				architect : follow up of works (5%)	
				international consultancy on health facility construction	
				Implementing waste management monitoring	
				standardised equipment for 2 HC+	
A	3	4	Create a functional, autonomous and efficient hospital network	study tour for at least 5 persons to at least 2 different hospital networks	373,200
				develop concept for functional network	
				finance secretariat	
				Build capacities of actors	
				develop dashboard for shared monitoring	
				develop telemedicine	
				Design, build and equip a 300 beds Hospital in Kicukiro District articulated with the CoK coverage plan	
A	3	5	Design, build and equip a 300 beds Hospital in Kicukiro District articulated with the CoK coverage plan	master plan HD	4,065,000
				Multidisciplinary conceptualization framework and follow-up	
				baseline on practices on waste management	
				construction & rehabilitation	
				architect : follow up of works (5%)	
				international consultancy on health facility construction	
				Follow-up implementation of waste management	
				standardised equipment	
A	3	6	Long term technical assistance in public health, hospital networking and urban health	international technical assistance in public health	912,000
				national technical assistance PPP	
The leadership and governance (specifically stewardship) is improved				Means	Budget
A	4	1	Strengthen stewardship capacities at the level of the local health system (districts)	Needs assessment consultancy on capacity gaps	850,000
				Development tools for District integrated planning and reporting	
				Management & coaching oriented trainings DHU, BoD, DHMT, health facilities	
				Support DHMTs and BoD for specific operational strategies	
A	4	2	Provide support to MoH and RBC with regard to their respective roles (separation of regulatory/coordination/ M&E, and implementing role)	Organize intensive trainings of MoH staff on policy and strategy formulation, and strategic coaching	380,000
				Training of central level staff on good regulation practices	
				revising current legal and regulatory documents to align them to EAC standards	
				inter-professional annual revues and studies by councils	
				trainings and workshops on PPP	

				local consultancy on development of PPP concept	
				annual forum MoH and Private providers	
				Conduct study on private investment opportunities, social fund	
A	4	3	Long term technical assistance in (district) capacity building	international technical assistance	96,000
				national technical assistance	
Quality data are generated, analysed and used for evidence-based decision-making in a more systematic, accessible and effective way				Means	Budget
A	5	1	Assure the integration of different systems of information and further develop HMIS tools, methods and guidelines	M&E modules	120,000
				Metadata dictionary development	
				consultancy for annual continuous integration of other systems	
A	5	2	Assure the production of quality data	semester data quality audits (1.5) 10 persons for 2 weeks for auditing a set of HF	140,000
				restitution session - dissemination of audit results	
				practical site visits in the districts	
A	5	3	Develop strategies for effective utilization of data for monitoring, evaluation decision making and action-research	training of DHMT, DHU and others in 30 districts	350,000
				dissemination of data	
				training of central level staff in routine HMIS (1.6) (2.5)	
				improving HMIS (2.6)	
				Promote reflective action and action-research initiatives at district level in 30 districts	
A	5	4	Long term technical assistance in HMIS development and M&E	international technical assistance in public health - epidemiologist	720,000
A cost-effective asset management system is designed and operational				Means	Budget
A	6	1	Develop, validate and disseminate policies, technical standards for HF in infrastructure and equipment, acquisition standards including donation, procurement & replacement standards, collaboration with private sector…	consultancy	66,000
				production of standards	
				validation workshops	
				communication	
A	6	2	Develop a functional procurement & maintenance system at operational level	develop sound procurement system for spare parts	1,021,500
				fund start-up phase	
				professional UTD inventory	
				QA procurement medicines (membership Quamed platform)	
				refine MEMMS system (data-analyst)	
				maintenance workshops	
				Tools	
				quality control set for MTIMTI	
				upgrade MTI central level	
				call-center for HC	
				incentive-mechanisms for health facilities to make provisions for procurement & maintenance & MTI support in their budgets	
A	6	3	Develop a waste management policy, strategy and baseline	consultancy for development of baseline (hygiene desk)	80,000
				development of national sanitary waste management policy and strategy	
A	6	4	Finance strategic improvement	NA	1,300,000

			projects with impact on the asset management		
A	6	5	Develop domestic human capacity with regard to asset management	long term trainings	465,000
				short term trainings	
				CST Bachelor's degree in biomedical engineering	
A	6	6	Long term technical assistance in maintenance of biomedical equipment and in construction of health facilities	international technical assistance in maintenance	792,000
				international technical assistance in construction of health facilities	
				national technical assistance asset management	

7.2 Chronogram

	Year 1				***Year 2***				***Year 3***				***Year 4***			
	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
Selection/Installation ITA	■															
Installation at SPIU	■															
Start-up workshop	■															
Baseline exercise	■															
Operational planning		■				■				■				■		
Constructions - Procurement of design - Design - Procurement construction - Construction	■ ■				■		■	■	■	■	■	■	■			
Backstopping missions (EST, DO)	■		■			■		■		■		■		■		■
Mid-term & Final evaluations								■							■	

7.3 ToR long-term personnel

As a general rule, preference will be given to a female expert in case of equal results after selection.

7.3.1 ToRs - International Technical Advisor Public Health – Program Coordination

7.3.1.1 Post

The overall coordination of the program will be provided by an International Technical Advisor (ITA) specialized in Public Health with a solid experience in health care quality assurance system and program coordination.

7.3.1.2 Location and institutional framework

The candidate will be based in Kigali with frequent visits at the operational level country wide. The position will be embedded in the Single Project Implementation Unit (SPIU) of the Rwanda Biomedical Centre (RBC). She/he will work with several departments of SPIU/RBC, and Ministry of Health (MoH) in order to ensure the link between central and all the relevant operational levels of the health System. In close collaboration with his counterpart, she/he will provide technical support in the overall coordination and management of the program. The candidate will also ensure that coherence and synergies are maintained between the six expected results of the program. He/she will provide a particular technical support to quality assurance systems (result 1).

The ITA will work under the leadership of the BTC Resident Representative (ResRep) and in collaboration with other International Technical Assistants, Sector Budget Support experts and the Embassy of Belgium in order to ensure the overall coherence of the Belgian health program.

7.3.1.3 Duration

The position will be funded for four years.

7.3.1.4 Responsibilities

1/ Technical Support component (estimated at a half-time)

The ITA is a change management agent who will be responsible for consolidating past achievements and support the transformation process of a well-functioning and integrated hospital quality assurance system. She/he will work closely with the MoH/Health Services Quality Assurance Unit in order to ensure that Hospitals implement a cost-effective and people-centered accreditation system which is integrated in the Rwanda healthcare System.

2/ Coordination and management component (estimated at a half-time)

The ITA together with his counterpart is responsible for the overall coordination and implementation of the Program. She/he will (co)-approve the expenses as a part of scope management, at a level of expenses as stipulated by the implementation modalities. She/he will contribute to achieving the overall results of the intervention by working in close collaboration with the team involved in the implementation of 'Improving the quality of primary health care and services' program.

7.3.1.5 Tasks

Technical Support

i. Support standard development and the creation of an autonomous accreditation body

- Support the process of setting up a core team and participate in the development/revision and dissemination of quality norms, standards, guidelines and models.

- In collaboration with other Development Partners (DPs) participate in the recruitment and training of accreditation surveyors in order to further develop an integrated, cost-effective and people-centered accreditation system.
- Participate in accreditation steering committee meetings and support the integration process of various mechanisms promoting quality of health services such as Performance Based financing (PBF) and integrated supervision.

ii. Facilitate the implementation of the accreditation process at all hospitals

- Support training of internal and external facilitators from academic or teaching institutes who will coach, guide, monitor, and reorient the hospitals internal teams on a continuous basis.
- Develop and disseminate selection criteria and guidelines to hospitals in order to develop funding proposals for trainings, facilitation of quality assurance initiatives and integrated supervisions.

iii. Finance people-centered improvement projects

- Setting up a fund to support trainings, research initiatives, scientific validation of standards & tools and quality assurance initiatives developed by Hospitals.
- Develop mechanism and modalities for approval of improvement initiatives to be submitted by Hospitals.

Program Management and Coordination

- Ensure smooth implementation of the program during its different phases especially in planning, monitoring, documentation/capitalization and evaluation.
- Ensure synergy and complementarity between the six expected results relating to quality of health care, mental health, urban health, leadership and governance, quality data use and asset management both at operational level and at central levels of MoH, RBC and City of Kigali.
- Ensure a coherent and qualitative approach of all capacity reinforcement activities within the intervention in collaboration with national resource persons for capacity reinforcement.
- Prepare Steering Committee meetings by drafting the agenda, compiling and summarizing progress reports, proposing adjustments and ensure that decisions are implemented.
- Ensure team work within the program team, other DPs working in similar areas of the health sector and contribute to the technical dialogue through active participation in relevant TWGs especially quality and standards TWG and Planning, M&E, HIS TWG.
- Ensure a better flow of information in the sector, within the intervention and the other components of the health program supported by the Belgian Cooperation, and with the BTC representation and the Embassy of Belgium.
- Build staff capacity within the RBC, MoH, City of Kigali and Divisions involved in program implementation.
- Ensure consolidation of narrative and financial quarterly, annual and final reports.
- Ensure (the technical part) of the development circles of ITAs supporting other expected results of the Program and of the National Technical Advisor working on health care quality assurance system .
- Establish and maintain good working relationships with program stakeholders and suppliers.
- Draft the terms- of- reference of studies, consultancies, mi and external evaluations.
- Organize initial briefing and restitution of consultant’s missions and other ITAs.

- Represent the Belgian Health Program in relevant forum and share information with other DPs.
- Pilot and coordinate all activities in relation to the cross-cutting issues (environment, gender, HIV / Reproductive Health and Rights) and assure their visibility.
- Promote action research, capitalization and dissemination of experiences that are relevant to other expected results of the Program and take initiative for research and studies in Health care quality assurance and accompany them.
- Organize coordination meetings in collaboration with BTC representation, other ITAs, BTC experts working on Sector Budget Support and Capacity Development pooled Fund and the Embassy of Belgium.

7.3.1.6 Profile

Education level

Medical Doctor with a Masters in Public health and/or related field

Proven experience*:*

- Professional experience of minimum 10 years, including a minimum of four years in an international context especially in developing countries.
- Experience in change management process for healthcare quality assurance in a complex health Sector
- Experience in Project cycle management within the framework of the international cooperation
- A previous experience of coordination in a similar context within an International Organization is an asset

Skills

- Strong interpersonal, leadership and coaching skills
- Familiar with participatory approaches
- Capacity to work in a multicultural and multidisciplinary context
- Good capacity to conceptualize and conduct action research and surveys
- Good report and scientific articles writing skills for publishing
- Good understanding of mainstreaming cross-cutting issues
- Excellent command of English and good knowledge of French
- Good knowledge of ICT (Word, Excel, Power Point and Database)

7.3.1.7 Mode of recruitment

The recruitment procedure will be launched by the Belgian Development Agency (BTC) in Brussels. The candidate will be selected by the BTC and his Curriculum Vitae will be presented to the Rwandan Partner for approval.

7.3.1.8 Management of the contract

The contract is managed by Belgian Development Agency (BTC) under Belgian Law.

7.3.1.9 Development circles:

Development circles will be carried out by BTC Resident Representative in Rwanda, in collaboration with the Health Unit at BTC Brussels for the technical part.

7.3.2 International Technical Advisor for Mental Health

7.3.2.1 Post

The Mental Health component will be strengthened by an International Technical Advisor (ITA) specialized in Mental Health with a solid experience in program support, personnel capacity development and public health perspective

7.3.2.2 Location and institutional framework

The position will be based in Kigali city in the Ministry of Health, Rwanda Biomedical Center, Mental Health Division with frequent visits to the districts and operational sites.

As part of its mission, the ITA may be required to collaborate with other Ministry of Health Departments, health programs, mental health facilities and health facilities in general. When required, the ITA can also be involved in activities including other sectors than health sector.

The ITA will work in close collaboration with the program under the leadership of the program coordinator and in collaboration with other International Technical Advisors of the Belgian health program.

7.3.2.3 Duration

The position will be funded for three years.

7.3.2.4 Responsibilities

The International Technical Adviser (ITA) will function on a full-time basis as technical advisor of the structure of the Ministry of Health of Rwanda in charge of the implementation of the National Mental Health Policy and the National Mental Health Strategic Plan. Up today, this role is performed by the Mental Health Division under the Rwanda Biomedical Center. He/she will assist the Division in strategic reflections and development in the field of Mental Health and support the effective implementation of policies and guidelines. In continuity with the previous support programs to the Mental Health Division, he/she will further assist in the integration of mental health services in the general services. He/she will contribute to the successful implementation of the postgraduate training in psychiatry in Rwanda. The ITA will monitor implementation of supported activities to assist in the overall M&E of the program and actively facilitate the documentation and action research activities in the domain of Mental Health. She/he will contribute to achieving the overall results of the intervention by working in close collaboration with the team involved in the implementation of 'Improving the quality of primary health care and services' program.

7.3.2.5 Tasks

Technical Support

Specifically, he/she shall:

- ensure further capacity development of the Mental Health Division in strategic and operational planning, accreditation, implementation and monitoring and evaluation
- contribute to develop an annual action plan in mental health which includes the participation and strengthening coordination of partners;
- provide an inventory of mental health interventions at the country level;
- support of decentralized mental health services as well as the national settings in mental health by developing supervision activities and mentorship;
- support other MoH departments to develop and promote healthcare focused on the People-

Centred Care principles ;

- participate in the training of various categories of health professionals in mental health;
- support the coordination structure at University of Rwanda, College of Medicine and Health Sciences in the further development and implementation of a postgraduate specialization program in psychiatry in Rwanda;
- support the start-up of a National Day-care centre
- support the development of multidisciplinary strategies and actions with regard to the fight against abuse of psychoactive substances and Mental Health issues related to AIDS and Sexual and gender based Violence
- propose and conduct operational research or action research within the Program.

Program Support

- Actively participate in planning, monitoring, documentation/capitalization and evaluation sessions during program implementation.
- Work in synergy and complementarity with other ITAs and Partner Staff focusing on expected results relating to quality of health care, mental health, health coverage in the City of Kigali, leadership & governance, quality data use both at operational level and at central levels of MOH, RBC and City of Kigali.
- Contribute to the preparation of Steering Committee meetings by drafting progress reports and proposing adjustments for decision making.
- Work in close collaboration with the program team, other Development Partners (DPs) involved in similar areas of the health sector and contribute to the technical dialogue through active participation in relevant TWGs especially on Mental Health.
- Report regularly (at least every three months) to program coordination and representation of BTC
- Establish and maintain good working relationships with program stakeholders and suppliers
- Draft the terms- of- reference of studies and consultancies
- Organize initial briefing and restitution of consultant's missions in his field
- Represent the program in relevant forum where Mental health and People-centred care is concerned and share information with other DPs
- Lead and accompany action research initiatives, capitalization and dissemination of experiences that are relevant to Mental health and People-centred care.
- Participate to coordination meetings in collaboration with BTC representation, other ITAs, BTC experts working on Sector Budget Support and Capacity Development pooled Fund and the Embassy of Belgium
- Promote and mainstream cross-cutting issues such as environment, gender, HIV / Reproductive Health and Rights in daily work.

7.3.2.6 Profile

Education level

Psychiatrist with a training in public health (ideal) or Public Health Doctor with specific experience in post-traumatic situations and Mental Health services

Proven experience:

- Professional experience of minimum seven years with at least four years of experience in an international setting in the health sector a developing country, preferably focused on mental health
- Work experience in health systems which includes the areas of planning, organization, coordination, supervision, monitoring and evaluation at the national level
- Experience in project cycle management within the international cooperation framework
- Experience with participative methodologies is an asset
- Expertise in management of post-traumatic situations is an asset
- Experience with action-research is an asset
- Previous experience in a similar position or proven experience with organization/institutional development projects is an asset

Skills

- Good knowledge in public health, particularly in the organization of a national health system and its components, integration of care, pharmacology and management of psychotropic medicine;
- Good knowledge and, if possible, work experience in psychiatry, clinical psychology, or management of situations of mass trauma ;
- Proven capacities to work in intercultural team and multidisciplinary team ;
- Strong interpersonal and coaching skills
- Good analytical skills and capacity to conceptualize and conduct operational research or action research
- Good report and scientific articles writing skills for publishing
- Capacity of working with participative methodologies
- Good understanding of cross-cutting issues mainstreaming
- Good knowledge of ICT (Word, Excel, Power Point and Database).
- Good knowledge and writing skills in English and French. Knowledge of Kinyarwanda is an asset

7.3.2.7 Mode of recruitment

The recruitment will be launched by the Belgian Development Agency (BTC) in Brussels. The candidate will be selected by the BTC and his Curriculum Vitae will be presented to the Rwandan Partner for approval.

7.3.2.8 Management of the contract

The contract is managed by Belgian Development Agency (BTC) under Belgian Law.

7.3.2.9 Development circles

Development circles will be carried out by the Program Coordinator (delegated by the Resrep) in consultation with the BTC Resident Representative in Rwanda and the Health Unit at BTC Brussels for the technical part. The program coordinator will report to the Resrep.

7.3.3 International Technical Advisor for Health Institutional Support

7.3.3.1 Post

An International Technical Assistant (ITA), being a Public Health Expert for Institutional Support with a solid experience in the development of Health Districts, and Governance and Stewardship and,

preferably, as well an experience in Urban Health, and Hospital Network will be employed under this program.

7.3.3.2 Location and institutional framework

The candidate will be based in Kigali with frequent visits at the operational level country wide. The position will be embedded in the Ministry of Health (MoH) under the General Directorate of Clinical and Public Health Services. She/he will work with several departments of MoH, Rwanda Biomedical Center (RBC), City of Kigali (Cok) Health Unit and Hospitals. The candidate will also ensure that coherence and synergies are maintained between the six expected results of the program. He/she will provide a particular technical support to the result 3-rational urban health services and result 4-leadership and governance. She/He will report to the overall coordinator of the program.

7.3.3.3 Duration

The position will be funded for four years.

7.3.3.4 Responsibilities

The ITA is a change management agent who will be responsible for consolidating past achievements and support the transformation process of expanding rationalized urban health service coverage in the City of Kigali and ensuring that the governance and leadership at all levels of the health pyramid is reinforced especially at decentralized level. This will be done in alignment with the three guiding principles of the health sector namely people-centeredness, integrated and sustainable services. She/he will contribute to achieving the overall results of the intervention by working in close collaboration with the team involved in the implementation of 'Improving the quality of primary health care and services' program.

7.3.3.5 Tasks

Technical Support

i. Develop promotional activities on social determinants of health in CoK

- Support the process of preparation and commissioning of an in-depth analysis of the core determinants of health for the urban populations
- In collaboration with relevant stakeholders, assist the Cok in developing and communicating on a health promotion plan which include innovative promotional activities

ii. Develop and validate a sound concept for the urban Health Centre and an equitable coverage plan for primary health care services delivery in CoK

- To support the process of updating the mapping (coverage plan) of the health facilities in CoK combined with a baseline assessment on the service profile and needs inventory of each Health facility.
- To organize diffusion and communication activities relating to the updated Health facility mapping to all stakeholders.
- To seek approval of the minimal package of services to be offered in the first line of urban health facilities, with an emphasis on equitable access to health services in all sectors of the City.

iii. Support the implementation of the primary health care coverage plan through various strategies 'upgrading of the existing Health facilities (HF), construction of new Health Centres (HC) or Public Private Partnership (PPP)' initiatives in the most vulnerable sectors of CoK

- To support implementation of CoK coverage plan through various initiatives such as i) contracting private providers for service delivery in small public health facilities, ii) strategic

purchasing of services by MOH or CoK in the private facilities using the Performance based Financing (PBF) and accreditation in the longer term, iii) expansion of the insurance scheme to cover both public and private services for the uninsured and Community based Health Insurance (CBHI) members.

- To demonstrate and document the functioning of 'the first line of medicalized' centres by providing guidance on the package of services to be offered in the 2 new public health facilities to be constructed. The package of services will be complementary to the district hospitals and will include promotional activities and ambulatory services, as close as possible to the population in order to assure people-centeredness in service delivery.
- In collaboration with the ITA in asset management and RBC/SPIU staff, design the architectural concept of the construction & rehabilitation of Health Centres, ensure follow-up of the constructions, adapt existing public Health Facilities based on the same architectural and functional design.
- To provide guidance for hiring a consultancy firm for the process of conducting a baseline analysis on the practices of solid and liquid waste management and support the development of healthy strategies in waste management for the health sector.

iv. Create a functional, autonomous and efficient hospital network

- To guide and support the organization of a well-functioning, efficient and integrated hospital network which generate essential packages of services for all, while assuring development of specificities per site, and concentration of "labour- or resource-intensive" services at the best possible location in the network and using patient information in an harmonized information systems to guarantee better continuity of care.
- To systematically document the concept of Hospital Network and continuously seeks a shared understanding of the concept among key stakeholders by building their capacities and raising their know-how about the set-up of such a network.
- Advise and support the ITA in health Information Systems and M&E in relation to the integration of all ICT systems of the hospital network to one global architecture and software package, allowing permanent interaction and exchange in the network, permanent monitoring at all sites of activities and performances, as well as joint research.
- Advise and support the ITA in asset management to install a joint procurement and life cycle management system for equipment within the hospital network.

v. Design, build and equip a 300 beds Hospital in Kicukiro District articulated with the CoK primary health care coverage plan

- To coordinate and advise on the development of the concept and master plan of 'a model Hospital' of 300 beds in the district of Kicukiro and put in practice principles of modern leadership & governance, better utilization of health information, and cost-effective application of asset management guidelines
- To plan and monitor the follow up of the construction works by a national architect company and the external quality control at critical phases by an international Company.
- To provide specifications and quantities of material and equipment to purchase for the Hospital.
- To initiate in collaboration with MoH, RBC and the hospital Network early deployment of well-trained workforce in all departments of the hospital.

vi. The leadership and governance of the health pyramid is reinforced specifically regarding district stewardship, and the respective roles of the Ministry of Health and RBC

- Informed by a specific capacity gap assessment of District Health Unit(DHU) & District Health Management Team (DHMT) and in synergy and complementarity with key stakeholders, enhance district capacities in coordination, evidence based joint planning and budgeting, developing locally adapted strategies and joint customer oriented Monitoring & Evaluation and accountability to further strengthen the Sector Wide Approach (Swap) at decentralized level.
- Build specific skills of district M&E Officers and members of the DHU & DHMTs for developing learning loops, conducting (innovative) reflective action, developing comprehensive district financial district reports (including financial reports of the hospitals) to increase upward and downward accountability.
- Support training and coaching in relation to interpersonal and management skills to enhance teamwork at the level of the DHU and DHMT and to stimulate collaboration and to clarify roles & accountability lines between DHU, DHMT, Board of Directors, PBF steering committee, District councils and the District executive Committee.

vii. Provide support to MoH and RBC with regard to their respective roles (separation of regulatory/M&E/coordination and implementing roles)

- Support the function of strategic steering by the MoH in training on policy and strategy, strategic purchasing, contracting and regulatory practices, preparation and follow-up of the joint health sector reviews, revision of current legal and regulatory documents to align them to the standards of the East African Community, facilitation of the annual inter professional review of the professional councils and support to specific research & studies conducted by the councils in particular in relation to the accreditation process, the public-private partnership and the quality procurement of medicines
- Support MoH and RBC in developing, disseminating and facilitating use of adapted guidelines & tools for organizational learning and improved stewardship in planning and M&E at the level of the DHU and DHMTs in order to better linking district planning with sector planning and expenditure frameworks (MTEF), stimulating a systematic evidence-based input from the districts to the Technical Working Groups and bi-annual Sector Reviews with the objective to pick up lessons from the field level and scale up interesting operational strategies,
- Support regular coaching, mentorship of the district team and management through supportive field-visits by MoH and RBC staff and facilitation of district peer reviews.
- Provide technical guidance for consultancies, studies, trainings and study tours in the process of developing a sound policy, operational strategy and operational roadmap to regulate and coordinate the private sector in a conducive, effective and long-term Public Private Partnership (PPP).
- Support initiatives such as an annual forum between MoH and the private providers to strengthen the dialogue and monitoring trends in PPP roadmap implementation.

Program Support

- Actively participate in planning, monitoring, documentation/capitalization and evaluation sessions during program implementation.
- Work in synergy and complementarity with other ITAs and Partner Staff focusing on expected results relating to quality of health care, mental health, quality data use and asset management both at operational level and at central levels of MOH, RBC and City of Kigali.
- Contribute to the preparation of Steering Committee meetings by drafting progress reports and

proposing adjustments for decision making.

- Work in close collaboration with the program team, other Development Partners (DPs) involved in similar areas of the health sector and contribute to the technical dialogue through active participation in relevant TWGs especially quality and standards TWG and Planning, M&E, HIS TWG.
- Build staff capacity within MoH/General Directorate of Clinical and Public Health Services and other Divisions, City of Kigali/health Unit and Health Facilities involved in program implementation
- Ensure the final responsibility of the procurement and supply of equipment and materials provided by BTC.
- Report regularly (at least every three months) to program coordination and representation of BTC
- Establish and maintain good working relationships with program stakeholders and suppliers
- Draft the terms- of- reference of studies and consultancies
- Organize initial briefing and restitution of consultant's missions in his field
- Represent the program in relevant forum where urban health, hospital Network and Governance matters are discussed and share information with other DPs
- Lead and accompany action research initiatives, capitalization and dissemination of experiences that are relevant to District Swap, urban health and hospital Network.
- Participate to coordination meetings in collaboration with BTC representation, other ITAs, BTC experts working on Sector Budget Support and Capacity Development pooled Fund and the Embassy of Belgium
- Promote and mainstream cross-cutting issues such as environment, gender, children's rights, HIV / Reproductive Health and Rights in daily work.

7.3.3.6 Profile

Education level

Medical Doctor with a Masters in Public health and/or or related field

Proven experience:

- Professional experience of minimum seven years, international context especially in developing countries including a minimum of four years in Health Systems Support
- Experience in coaching health districts
- Experience in Policy and Strategy development
- Experience in hospital management
- Experience in Project cycle management within the framework of the international cooperation
- Experience in change management process and related capacity building is an asset
- Familiar with Public-Private-Private Partnership initiatives in health is an asset
- Experience with a Hospital network, Urban health and/or Health Infrastructure design is an asset
- Experience with action-research is an asset

Skills

- Strong interpersonal and coaching skills
- Experience with participatory approaches
- Capacity to work in a multicultural and multidisciplinary context
- Good capacity to conceptualize and conduct action research and surveys
- Good report and scientific articles writing skills for publishing
- Good understanding of cross-cutting issues mainstreaming
- Excellent command of English and good knowledge of French
- Good knowledge of ICT (Word, Excel, Power Point and Database)

7.3.3.7 Mode of recruitment

The recruitment will be launched by Belgian Development Agency (BTC) Head Quarter in Brussels. The candidate will be selected by the BTC and his Curriculum Vitae will be presented to the Rwandan Partner for approval.

7.3.3.8 Management of the contract

The contract is managed by Belgian Development Agency (BTC) under Belgian Law.

The ITA works under the technical supervision of the overall Program Coordinator and in collaboration with other International Technical Advisor and BTC health Sector Experts.

7.3.3.9 Development circles

Development circles will be carried out by the Program Coordinator (delegated by the Resrep) in consultation with the BTC Resident Representative in Rwanda and the Health Unit at BTC Brussels for the technical part. The program coordinator will report to the Resrep.

7.3.4 International Technical Advisor for Health Information Monitoring and Evaluation Systems

7.3.4.1 Post

An International Technical Advisor (ITA) for Health Information Monitoring and Evaluation Systems with sound experience in epidemiology, data analysis and action research will be employed under this program.

7.3.4.2 Location and institutional framework

The candidate will be based in Kigali with frequent visits at operational level country wide. The position will be embedded in the Planning, M&E, and Business Strategy under the General Directorate of Rwanda Biomedical Center (RBC). She/he will work in collaboration with other International Technical Advisors, Sector Budget Support experts and the Embassy of Belgium. The ITA will report to the Program Coordinator.

7.3.4.3 Duration

The position will be funded for four years.

7.3.4.4 Responsibilities

The ITA is a change management agent who will be responsible for consolidating past achievements and support the transformation process of developing a robust health Information Monitoring and

Evaluation System where data are generated, analysed and used for evidence-based decision-making in a correct, integrated, systematic, accessible and effective way. She/he will contribute to achieving the overall results of the intervention by assisting in the overall M&E of the program (focal point) and actively contributing to the documentation and action research activities relating to the six results areas of 'Improving the quality of primary health care and services' program.

7.3.4.5 Tasks

Technical Support

i. Assure the integration of different systems of information and further develop Health Management Information System tools, methods and guidelines

- Support the functioning of a comprehensive health system data warehouse by updating and adapting the different Modules and user Manuals for Monitoring and Evaluation (M&E) and Health Management Information Systems (HMIS).
- Assist in the development and the dissemination of the Metadata dictionary providing clear definition of each of the indicators of the M&E system.
- Provide guidance in the preparation of trainings on revised Modules and user Manuals for M&E and HMIS at central and decentralized level.
- Advise and provide guidance in the continuous integration process of other health information systems, particularly the electronic medical record, MEMMS (Medical Equipment Maintenance Management System Database), the Health Resource Tracking Tool, other e-health systems as well as non-routine data.
- Support trainings and supervision of private actors on Health Information reporting in order to integrate their data in the National Health Information Systems.
- Support the integration of all ICT systems of the hospital network to one global architecture and software package, allowing permanent interaction and exchange in the network, permanent monitoring at all sites of activities and performances, as well as joint research.

ii. Assure the production of quality data

- Support preparation and conduct regular review of data quality through semi-annual data quality audits.
- Assist the district M&E officers in mastering a user-friendly and practical methodology to identify and correct gaps in the quality of data collected and reported.
- Conduct regular restitution sessions of data quality audits with people in charge of data collection and reporting in order to improve use of quality data for appropriate decision-making.

iii. Develop strategies for effective utilization of data for monitoring, evaluation, decision making and action-research

- Ensure availability of data to all Staff who can assess their performance and identify gaps to address for further improvement in service delivery.
- Support systematic dissemination of data through publication of quarterly bulletins presenting routine key health information at central and decentralized levels.
- Guide in the preparation of training sessions focusing on the analysis, processing and dissemination of processed data from HMIS to be used in decision making by Senior Managers.
- Build capacity of 30 districts District Health Management Team, District health Unit staff and central level staff on effective data and Monitoring and evaluation methods.
- Set up a fund to promote reflective action and action-research initiatives especially at district level. Initiatives could focus on addressing challenges in health status and health service delivery

to the local population, implementation of recommendations from accreditation assessments, hospital network and crosscutting issues especially gender, environment, sexual and reproductive health.

- Facilitate a multi-actor approach in the research and collaboration with renowned scientific institutions while ensuring that bottom-up and top down learning cycle is promoted in technical working groups, during Joint Health Sector Reviews and District Coordination meetings.
- Train M&E officers and district staff in reflective action and action-research while accompanying all the six results of the intervention in developing research hypothesis and methodology, protocols, data analysis and preparation of reports for documenting experiences or/and scientific publications

Program Support

- Ensure synergy and complementarity between activities at the operational level and activities at the central level of MoH and RBC
- Contribute to the technical specifications in the preparation of terms-of-reference for studies and training services and consultancy carried out by national and international experts.
- Take initiatives in action research, capitalization and dissemination of experiences that are relevant to the program.
- Actively participate in steering committees and contribute to Knowledge management and research as well as Planning, Health Information and M&E technical working groups.
- Act as BTC focal point for the M&E system of the program.
- Report regularly (at least every three months) to program and share information about the intervention with other health sector stakeholders
- Establish and maintain good working relationships with program stakeholders and suppliers
- Promote and mainstream cross-cutting issues such as environment, gender, children's rights, HIV / Reproductive Health and Rights in daily work.

7.3.4.6 Profile

Education Level

Epidemiologist or a Public Health expert with large expertise/experience in health information systems

Proven experience

- At least five years of professional experience of which minimum 3 years in providing support to health Management Information Systems as well as Monitoring and Evaluation
- Work experience in conducting evaluations and surveys in the health Sector
- Experience in using Health Information Data base and any electronic medical recording System
- Proven expertise in operational research or action-research
- Scientific publication is an asset

Skills

- Good understanding of the concepts of change management and capacity building
- Strong analytical and reporting skills
- Experience with participatory approaches

- Strong interpersonal and coaching skills
- Ability to conceptualize and conduct action research and surveys
- Good understanding of mainstreaming cross-cutting issues
- Fluent in English and good knowledge of French.

7.3.4.7 Mode of recruitment

The recruitment will be launched by Belgian Development Agency (BTC) in Brussels. The candidate will be selected by the BTC and his Curriculum Vitae will be presented to the Rwandan Partner for approval.

7.3.4.8 Management of the contract

The contract is managed by Belgian Development Agency (BTC) under Belgian Law.

7.3.4.9 Development circles

Development circles will be carried out by the Program Coordinator (delegated by the Resrep) in consultation with the Resident Representative in Rwanda and the Health Unit at BTC Brussels for the technical part. The program coordinator will report back to the Resrep.

7.3.5 International Technical Advisor for Health Care Asset Management

7.3.5.1 Post

An International Technical Advisor (ITA) for healthcare asset management with extensive knowledge and experience in health infrastructure design, health care technology and maintenance systems will be employed under this program.

7.3.5.2 Location and institutional framework

The candidate will be based in Kigali with frequent visits at operational level country wide. The position will be embedded in the Medical Technology and Infrastructure Division (MTI) under the Biomedical Services Department of Rwanda Biomedical Center (RBC). The ITA will work under the leadership of the BTC Resident Representative (ResRep) in collaboration with other International Technical Advisors, Sector Budget Support experts and the Embassy of Belgium in order to ensure the overall coherence of the Belgian health program. She/ he will report to the Program Coordinator.

7.3.5.3 Duration

The position will be funded for four years.

7.3.5.4 Responsibilities

The ITA is a change management agent who will be responsible for consolidating past achievements and support the transformation process to develop a robust cost-effective health care asset management system in Rwanda. She/he will contribute to achieving the overall results of the intervention by working in close collaboration with the team involved in the implementation of 'Improving the quality of primary health care and services' program.

7.3.5.5 Tasks

Technical Support

i. **Develop, validate and disseminate policies and technical standards for Health infrastructures and equipment**

- Support and guide the planning and implementation of activities relating to health infrastructure

and equipment maintenance system in MTI division and at all levels of health care.

- Update, complete and disseminate the national policies and standards regulating the construction or rehabilitation of health infrastructures and the acquisition of health equipment for the different levels of health care including regulations concerning donation, procurement and replacement of health equipment.
- Advise MTI Staff for active participation in relevant technical working groups (TWG) and steering forum e.g. Infrastructure and supply chain TWG, Quality and standards TWG and accreditation steering committee. This support will include advisory role, on-the-job training, coaching and supervision.

ii. Develop a functional procurement & maintenance system at operational level

- Setting up a call center for addressing health facilities maintenance requests and ensuring follow up of the response.
- Support dissemination and implementation of strategies to reduce inefficiencies and increase financial resources at health facility level such as advocacy and monitoring to increase the budget line for maintenance and asset management in the national budget, sensitization & training of hospital managers to allocate more funds to asset management in their budget, grouped purchases at national level and at the level of the hospital network in the City of Kigali and setting up an innovative incentive fund for asset management.
- Support the hospital network at CoK to install a joint procurement and life cycle management system for equipment.
- Training of hospital technicians in the use of MEMMS (Medical Equipment Maintenance Management System) Database and assure MTI staffs are analysing data to inform decision making.
- Support the process of integrating MEMMS into HMIS (Health Management Information System)
- Support registration of Rwanda as a member of Quamed network in order to ensure the quality of medicines procured is up to International Standards.
- Participate in monitoring the performance of the maintenance system.

iii. Develop a waste management policy, strategy and baseline

- In collaboration with the MOH/Health Policy and regulation Unit, contribute to the elaboration of specifications for a consultancy which will conduct a baseline study on ‘waste management and hygiene & infection control in national health facility Network’
- Develop and monitor the implementation of the national policy and strategy for sanitary waste management.

iv. Setting up a fund for strategic improvements with impact on asset management

- Support the start-up phase of a specific fund allocated to Health facilities by establishing mechanisms and selection criteria for screening investment proposals. The fund will be managed by MTI.

v. Develop domestic human capacity with regard to asset management

- Support capacity building of human resources through short and long term trainings and the establishment of a program for bio-engineering bachelor degree in order to develop strong capacities to understand, design, trouble shoot and maintain all medical equipment used in Rwandan health facilities.
- Use in-house expertise for organizing short term trainings of district technicians and MTI staff

during regular clinical/professional meetings in MTI, preventive maintenance trips with experienced technicians and engineers, occasional visits to MTI by professors from renowned universities and yearly training workshops.

- Develop collaboration with private companies manufacturing and installing specialized equipment for conducting trainings
- Install a library offering reference textbooks from different engineering faculties and using ECRI software, promote short courses offered by specialized institutions and online courses to further build specific capacities.

Program Support

- Ensure synergy and complementarity between activities at the operational level and activities at the central level of MoH and RBC
- Work in synergy and complementarity with other ITAs and Partner Staff focusing on expected results relating to quality of health care, mental health, health coverage in the City of Kigali, governance & stewardship (particularly at district level), quality data use and asset management both at operational level and at central levels of MOH, RBC and City of Kigali.
- Contribute to the technical specifications in the preparation of terms-of-reference for studies and training services and consultancy carried out by national and international experts
- Take initiatives in action research, capitalization and dissemination of experiences that are relevant to the area of asset management and accompany them
- Participate in steering committees and technical working groups
- Report regularly (at least every three months) to program coordination and BTC representation and share information about the intervention with other health sector stakeholders
- Advise and contribute to the preparation of the financial, investment and procurement plans
- Establish and maintain good working relationships with program stakeholders and suppliers
- Promote and mainstream cross-cutting issues such as environment, gender, children's rights, HIV / Reproductive Health and Rights in daily work.

7.3.5.6 Profile

Education Level

Master degree in Biomedical or Electronics engineering preferably in the areas of medical technology or infrastructure (or equivalent)

Proven experience

- At least five years of international experience in health care infrastructure and Technology Management
- Previous experience in health care asset procurement and medical maintenance systems
- Experience in Computerized Health Infrastructure and technology maintenance using Reliability Based Maintenance (RBM), Six Sigma, Value Driven Maintenance and other relevant methodological approaches is an asset
- Proven expertise in the field of biomedical waste management is an asset
- Experience in working with the private sector and Governmental organizations is an asset

Skills

- Good understanding of the concepts of change management, institutional development and capacity building
- Experience with participatory approaches
- Strong interpersonal and coaching skills
- Ability to conceptualize and conduct action research and surveys
- Good understanding of mainstreaming cross-cutting issues
- Fluent in English and good knowledge of French.

7.3.5.7 Mode of recruitment

The recruitment will be launched by Belgian Development Agency (BTC) in Brussels. The candidate will be selected by the BTC and his Curriculum Vitae will be presented to the Rwandan Partner for approval.

7.3.5.8 Management of the contract

The contract is managed by Belgian Development Agency (BTC) under Belgian Law.

7.3.5.9 Development circles

Development circles will be carried out by the Program Coordinator (delegated by the Resrep) in consultation with the Resident Representative in Rwanda and the Health Unit at BTC Brussels for the technical part. The program coordinator will report to the Resrep.

7.3.6 National Technical Assistant - Health care quality assurance

7.3.6.1 Post

A National Technical Assistant (NTA) in health care quality assurance system will be recruited to assist the General Directorate of Clinical and Public Health Services mainly in the field of quality Assurance in order to ensure that hospitals implement a cost-effective and people-centered accreditation system which is integrated in the Rwanda healthcare System.

7.3.6.2 Location and institutional framework

The position will be based in the Ministry of Health under the General Directorate of Clinical and Public Health Services.

As part of its mission, the NTA may be required to collaborate with other Ministry of Health Departments, health programs, Rwanda Biomedical Center (RBC) Provincial and District Hospitals.

The NTA will work under the leadership of the International Technical Advisor in-charge of quality Assurance (= also the program coordinator) and in collaboration with other Technical Advisors of the Belgian health program

7.3.6.3 Duration

The position will be funded for four years.

7.3.6.4 Responsibilities

The national Technical Assistant will provide support in the development and the creation of an autonomous accreditation body, facilitation of accreditation process in hospitals and monitoring of people-centered improvement projects. She/will ensures that good practices and successful interventions are documented and disseminated.

7.3.6.5 Tasks

Technical Assistance

- Assist in the preparations on the creation of an autonomous accreditation body ;
- Support the process of setting up a core team and participate in the development/revision and dissemination of quality norms, standards, guidelines and models for Health facility quality improvement ;
- Participate in the selection and training of accreditation surveyors in order to further develop an integrated, cost-effective and people-centered accreditation system;
- Participate in the preparation of accreditation steering committee meetings and support the integration process of various mechanisms promoting quality of health services such as accreditation, Performance Based financing (PBF), integrated supervision and clinical systemic audits;
- Prepare and train internal and external facilitators from academic or teaching institutes who will coach, guide, monitor, and reorient the hospitals internal teams on a continuous basis;
- Disseminate selection criteria and guidelines to hospitals in order to develop funding proposals for ' people-centered improvement projects'
- Develop a Standard operating procedure for the ' people-centered improvement projects' fund which will include trainings, research initiatives, scientific validation of standards & tools and other quality assurance initiatives;
- Organize selection Committee meetings for approving proposals submitted by hospitals to 'people-centered improvement projects'
- Monitor progress in implementation of '*people-centered improvement projects*'

Program Support in Coordination, Planning, Monitoring and Evaluation

- Prepare and actively participate in coordination meetings relating to Quality Assurance;
- Actively participate in planning, monitoring, documentation/capitalization and evaluation sessions during program implementation.
- Work in synergy and complementarity with other NTAs, ITAs and Partner Staff involved in the implementation of expected results relating to quality of health care, mental health, quality data use and asset management both at operational level and at central levels of MOH, RBC and City of Kigali;
- Prepare quarterly progress reports and suggest key issues to bring to the attention of the Steering Committee;
- Work in close collaboration with the program team, other Development Partners (DPs) involved in similar areas of the health sector and contribute to the technical dialogue through active participation in relevant TWGs especially Quality and Standards and in the Accreditation Steering Committee.
- Accompany action research initiatives, capitalization and dissemination of experiences that are relevant to quality assurance, hospital accreditation,
- Assist in promoting and mainstreaming cross-cutting issues such as environment, gender, children's rights, HIV / Reproductive Health and Rights in daily work.

7.3.6.6 Profile

Education level

- Medical Doctor with an experience of at least 3 years in clinic, administration of health services, a Master in Public Health or in Epidemiology or in Health economy.

Proven experience:

- Professional experience of minimum 3 years with experience in an international setting in a developing country, preferably focused in quality assurance, accreditation and Performance based financing
- Work experience in health systems strengthening which includes the areas of planning, organization, coordination, supervision, monitoring and evaluation at the national level
- Experience in project cycle management within the international cooperation framework is an advantage
- Previous experience in a similar position or proven experience with international organization/institutional development projects is an asset
- Have a working experience in managing complex intervention in the Health Sector is an advantage

Skills

- Good knowledge in public health, particularly in the organization of a national health system and quality of care;
- Knowledge of the health sector and the accreditation process of Health facilities;
- Ability to analyse, understand and interpret statistical information (reports and analysis of data/information; highly recommended);
- Good coaching, mentoring , training and facilitation skills;
- Capacity to conceptualize and conduct operational research or action research;
- Teamwork, organizational skills/managerial and ability to work under pressure and meet deadlines;
- Good report and writing skills ;
- Good knowledge of ICT Word, Excel, Power Point and Database);
- Excellent oral and written communication in Kinyarwanda, English and French

7.3.6.7 Mode of recruitment

The recruitment will follow a national recruitment procedure launched by the Ministry of Health in coordination with the Belgian Development Agency (BTC). The candidate will be selected by MOH jointly with BTC.

7.3.6.8 Management of the contract

The contract is managed by the Ministry of Health under the Rwandan Law.

7.3.6.9 Development circles

Development circles will be carried out by the program coordinator.

7.3.7 National Technical Assistant Infrastructure

7.3.7.1 Post

The national assistant will assist the ITA Health Care Asset Management to follow-up all construction works.

7.3.7.2 Location and institutional framework

The position will be based in Kigali city in the Rwanda Biomedical Centre, Medical Technology and Infrastructure Division, under the ITA Program Coordinator. As part of its mission, the National TA may be required to collaborate with other Ministry of Health Departments, health programs, and districts. He/she will also work in close collaboration with the other International Technical Advisors of the Belgian health program.

7.3.7.3 Duration

The position will be funded for four years.

7.3.7.4 Responsibilities

The national infrastructure expert will be responsible for BTC for the follow-up and quality control of all construction works in this program.

7.3.7.5 Tasks

Preparation of works:

- Draws up the planning for all works to be performed under the intervention;
- Is involved in drawing up the technical part of the Call for Tenders File and in the selection of consultants and study bureaus, which are to design the infrastructure/works and follow up the works;
- Advises the Procurement officer on technical aspects of "construction"-related Calls for Tenders;
- Is involved in the detailed analyses of tenders submitted;
- Steers the design of construction or rehabilitation projects until completion of the plans;
- Conducts the technical control of plans and budgets drawn up by the study bureaus for works provided under the sector programme;
- Conceives the Tender Specifications for construction/rehabilitation works that have been identified by the programme components;
- Calculates the value of the works planned;
- Organises visits in view of provisional and final acceptance of the works built, including successive visits to control the corrections brought by the contractor;
- Contributes to reporting about the programme and to appropriately informing the JLCB meetings;
- Promotes the mainstreaming of the transversal themes of the Belgian Development Cooperation – i.e., gender, people with disabilities and the environment – in the design of the works;

Works performance and consultancy:

- Assists in drawing up the technical part of the Call for Tenders File and is involved in the selection of (consultants and) contractors, which are to perform the construction works;
- Validates the control reports of the works;
- Provides technical advice in case of litigation;

- Ensures quality and supports the programme in following up on the works;
- Participates to field visits during construction in order to audit and possibly refocus the assignments of the works supervisor;
- Technically supports the programme with provisional and final acceptances;
- Provides advice to the programme about payments and means of payment;
- Puts in place a construction site monitoring method;
- Provides support with resolving specific problems;
- Is involved in the final acceptance process when the programme is closing.

7.3.7.6 Profile

Education level & Experience

- Has a higher education degree (masters or university degree – in architecture or engineering, or equivalent);
- At least 5 years of relevant professional experience in construction;

Skills

- Has experience with following up and controlling construction works (experience with health infrastructure construction works is an asset);
- Has experience with procurement;
- Has experience with project management;
- Knowledge of the health sector in Rwanda and its structures is an advantage
- Has proved negotiation skills;
- Masters the standard ICT tools;
- Is proficient in English and /French.

7.3.7.7 Mode of recruitment

The recruitment will follow a national recruitment procedure launched by the Belgian Development Agency (BTC). The candidate will be selected by BTC.

7.3.7.8 Management of the contract

The contract is managed by BTC under the Belgian Law.

7.3.7.9 Development circles

Development circles will be carried out by the program coordinator (with input from the ITA Health care asset management).

7.3.8 National Technical Assistant 'Prevention & Treatment Substances Abuse Disorders Specialist'

7.3.8.1 Post

A National Technical Assistant (NTA) specialist of substance abuse disorders will be recruited to assist the Mental Health Division/RBC for the development and implementation of prevention and treatment programs related to these disorders.

7.3.8.2 Location and institutional framework

The position will be based in the Rwanda Biomedical Center (RBC) under the Mental Health Division.

As part of its mission, the NTA may be required to collaborate with all the units under the Mental Health Division, Ministry of Health Departments, other ministries and institutions part of the inter-ministerial committee to fight drug, mental health facilities, Provincial and District Hospitals.

The NTA will work under the leadership of the Manager of the Mental Health Division.

7.3.8.3 Duration

The position will be funded for three years.

7.3.8.4 Responsibilities

The national Technical Assistant will function on a full-time basis and will be in charge of technical coordination and organization of activity implementation related to the development of National policy to fight drug and alcohol abuse. She/he will ensure that good practices and successful interventions are documented and disseminated. The ITA will monitor implementation of supported activities to assist in the overall M&E of the program and actively facilitate the documentation and action research activities in the domain of fighting drug and alcohol abuse.

7.3.8.5 Tasks

Assist the Mental Health Division/RBC by ensuring the technical coordination and organization of the following:

- Development of National policy to fight against drug abuse and alcohol
- Development of Prevention programs for substance use disorders
- Organization of services for treatment of substance use disorders
    - Creation of specific services
    - Integration in the general care at the district hospital level
- Implementation of the law regulating drug abuse, narcotic drugs and psychotropic substances and precursors in Rwanda
- Establishment of Quality Assurance mechanisms of these services
- Development of Capacity building plan and standards and guidelines of treatments
- Reporting methods and research topics
- Sensitization programs against drug abuse for youth and vulnerable groups
- Setting up of inter sector programs to fight against drug abuse at all levels
- Ad hoc programs at all levels
- Integration of drug abuse prevention and treatment in the management training module
- Integration of prevention and psychosocial rehabilitation units at all levels

Program Support in Coordination, Planning, Monitoring and Evaluation

- Prepare and actively participate in coordination meetings relating to services for Substance

abuse disorders;

- Actively participate in planning, monitoring, documentation/capitalization and evaluation sessions during program implementation.
- Work in synergy and complementarity with other NTAs, ITAs and Partner Staff involved in the implementation of expected results relating to quality of health care, mental health, quality data use and asset management both at operational level and at central levels of MOH, RBC and City of Kigali;
- Prepare quarterly progress reports and suggest key issues to bring to the attention of the Steering Committee;
- Work in close collaboration with the program team, other Development Partners (DPs) involved in similar areas of the health sector and contribute to the technical dialogue through active participation in relevant TWGs especially related to mental health.
- Accompany action research initiatives, capitalization and dissemination of experiences that are relevant to quality assurance, hospital accreditation,
- Assist in promoting and mainstreaming cross-cutting issues such as environment, gender, children's rights, HIV / Reproductive Health and Rights in daily work.

7.3.8.6 Profile

Education level

Medical Doctor, Masters in Public Health, A0 Psychiatric Nurse or Clinical Psychologist with an experience of at least 3 years in clinic, administration of health services

Proven experience:

- Work experience in health systems strengthening which includes the areas of planning, organization, coordination, supervision, monitoring and evaluation at the national level
- Previous experience in a similar position or proven experience with international organization/institutional development projects is an asset
- Have a working experience in managing complex intervention in the Health Sector is an advantage

Skills

- Good knowledge in public health, particularly in the organization of a national health system and quality of care;
- Ability to analyse, understand and interpret statistical information (reports and analysis of data/information; highly recommended);
- Good coaching, mentoring , training and facilitation skills;
- Capacity to conceptualize and conduct operational research or action research;
- Teamwork, organizational skills/managerial and ability to work under pressure and meet deadlines;
- Good report and writing skills ;
- Good knowledge of ICT Word, Excel, Power Point and Database);
- Excellent oral and written communication in Kinyarwanda, English and French;

7.3.8.7 Mode of recruitment

The recruitment will follow a national recruitment procedure launched by the Rwanda Biomedical Center in coordination with the Belgian Development Agency (BTC). The candidate will be selected by RBC jointly with BTC.

7.3.8.8 Management of the contract

The contract is managed by the Rwanda Biomedical Center under the Rwandan Law.

7.3.9 National Technical Assistant for Public-Private Partnership

7.3.9.1 Post

The Public-Private Partnership Technical Assistant will assist the Clinical Services General Directorate mainly in the field of public-private partnership

7.3.9.2 Location and institutional framework

The position will be based in Kigali city in the Ministry of Health, Director General of MoH/Clinical Services.

As part of its mission, the NTA may be required to collaborate with other Ministry of Health Departments, health programs, and Rwanda Biomedical Center (RBC). When required, the NTA can also be involved in activities including other sectors than health sector.

The NTA will work in close collaboration with the program under the leadership of the ITA health institutional support and in collaboration with other International Technical Advisors of the Belgian health program.

7.3.9.3 Duration

The position will be funded for four years.

7.3.9.4 Responsibilities

The national Technical Assistant will provide support in the development of policies and strategies for the private health sector. He/she will assist in strengthening PPP for effective coordination with the private sector and initiate mechanisms for collaboration between public health facilities and private medical facilities. He/she will ensure supply of quality health services in private facilities and strengthen the collection of health statistics of the private sector, their integration into the Health Information System, analysis and feedback. He will provide assistance into ensuring that national protocols and guidelines are applied in private health facilities. He will facilitate that good practices and successful interventions are documented and disseminated. Where appropriate, he/she will initiate the process of accreditation of private health institutions.

7.3.9.5 Tasks

Specifically, he/she shall provide:

Technical Assistance, Planning, Monitoring and Evaluation:

- Support and follow the gradual implementation of activities related to the strengthening of the Public Private Partnership;
- Provide technical assistance in the set-up of policies and strategy plans for private clinics, polyclinics and hospitals;
- Provide technical assistance in set up and dissemination of norms and standards for private health facilities;
- Participate in the coordination and ensure the quality of services delivered in private health facilities;
- Organize and participate in activities of capacity building at all levels for a proper quality services delivered;
- Ensure that the supervision channel in the private clinics is properly and timely followed;
- Participate in the process of accreditation of private clinics, polyclinics and hospitals;
- Manage the database for private clinics, polyclinics and hospitals;
- Ensure that the private practitioners report is written timely and through the proper channel and

analyse it;

- Design the tools for supervision and inspection of private clinics, polyclinics and hospitals;
- Support adaptation/updating of operational planning taking into account the emerging needs
- Compile quarterly reports from PHF, analyse and propose a feedback to the DG Clinical services is written timely and through the proper channel and analyse it;
- Support the documentation process of experiences with regard to PPP
- Be involved in any activity related to PPP in consultation with the ITA Institutional Support

7.3.9.6 Profile

Education level

- Medical Doctor with an experience of at least 5 years in clinic, administration of health services, a Master in Public Health or in Epidemiology is recommended

Proven experience:

- Clinical professional experience of minimum 3 years with experience in an international setting in a developing country,
- Experience of min 2 years in health administration
- Have a combined working experience in private health sector is an advantage
- Work experience in health systems which includes the areas of planning, organization, coordination, supervision, monitoring and evaluation
- Experience in project cycle management within the international cooperation framework is an advantage

Skills

- Good knowledge in public health, particularly in the organization of a national health system and its components, integration of care and the private sector;
- Knowledge of the health sector in Rwanda and its structures
- Ability to analyse, understand and interpret statistical information (reports and analysis of data/information; highly recommended)
- Capacity to conceptualize and conduct operational research or action research
- Ability to undertake professional activities using consultative and participatory approaches
- Strong interpersonal skills with excellent ability to communicate, facilitate team work, network and negotiate in a flexible and empathetic manner
- Organizational skills/managerial and ability to work under pressure and meet deadlines
- Good report and writing skills
- Good knowledge of ICT (Word, Excel, Power Point and Database).
- Excellent oral and written communication in Kinyarwanda, English and French

7.3.9.7 Mode of recruitment

The recruitment will follow a national recruitment procedure launched by the Ministry of Health in coordination with the Belgian Development Agency (BTC). The candidate will be selected by MOH jointly with BTC.

7.3.9.8 Management of the contract

The contract is managed by the Ministry of Health under the Rwandan Law.

7.3.9.9 Development circles

Development circles will be carried out by the ITA Health Institutional support in coordination with the Program coordinator.

7.3.10 National Technical Assistant for Governance and Monitoring & Evaluation

7.3.10.1 Post

A National Public health Technical Advisor (NTA) with experience in Governance and Monitoring and Evaluation will be recruited to assist the General Directorate of Planning, Health Financing and Information System.

7.3.10.2 Location and institutional framework

The candidate will be based in Kigali with frequent visits at the operational level country wide. The position will be embedded in the Ministry of Health under the General Directorate of Planning, Health Financing and Information System. She/he will work closely with other Ministry of Health Departments, health programs, Rwanda Biomedical Center (RBC), Professional Councils and District Health Management Teams (DHMT). When required, the NTA will be involved in activities including other sectors especially the Ministry of Local Government in order to enhance synergies.

The NTA will work in close collaboration with the team involved in the implementation of 'Improving the quality of primary health care and services'. She/He will report to the International Technical Advisor (ITA) on health institutional support.

7.3.10.3 Duration

The position will be funded for four years.

7.3.10.4 Responsibilities

The national Technical Assistant will provide support in ensuring that the governance and leadership at all levels of the health pyramid is reinforced especially at decentralized level but also at the central level of the Ministry of Health and RBC in order to strengthen their respective roles. This will be done in alignment with the three guiding principles of the health sector namely people-centeredness, integrated and sustainable services. He/she will provide a technical support in the implementation of result 4- on leadership and governance.

7.3.10.5 Tasks

Specifically, he/she shall:

Technical Assistance

Central Level

- Assist MoH in the preparation of trainings on policy and strategy development, strategic purchasing, contracting and regulatory practices;
- Assist MoH and RBC in the preparation and organisation of trainings and workshops relating to developing, disseminating and facilitating use of adapted guidelines & tools for organizational learning and improved stewardship in planning and M&E at the level of the District Health Unit (DHU) and DHMTs;
- Assist in the preparation and follow-up of joint health sector reviews, revision of current legal and regulatory documents to align them to the standards of the East African Community;
- Facilitate the organisation of annual inter professional reviews of the professional councils;
- Support specific research & studies conducted by the councils in relation to the accreditation process, the public-private partnership and the procurement of medicines;
- Stimulate and support a systematic evidence-based input from the districts to the Technical

Working Groups (TWG) and Health Sector Working Group (HSWG) with the objective to pick up lessons from the field and scaling up interesting operational strategies,

- Plan and assist in the organisation of regular coaching, mentorship of the district team and management through supportive field-visits by MoH and RBC staff and facilitate district peer reviews;
- Support initiatives such as annual Joint Health Sector Review between MoH, RBC and Key Stakeholders in Health including the private providers for strengthening the dialogue and monitoring trends in the Sector.

District Level

- Actively assist in enhancing district capacities in coordination, evidence based joint planning and budgeting;
- Assist in developing locally adapted strategies and joint customer oriented Monitoring & Evaluation and accountability mechanism to further strengthen the Sector Wide Approach (Swap) at decentralized level;
- Conduct specific capacity development activities towards district M&E Officers and members of the DHU & DHMTs for developing learning loops skills and conducting (innovative) reflective actions;
- Assist in developing comprehensive district financial district reports (including Hospital financial reports) to increase upward and downward accountability
- Prepare training and organise coaching sessions in relation to interpersonal and management skills to enhance teamwork at the level of the District Health Unit and DHMT;
- Stimulate the collaboration and support clarification of roles & accountability lines between DHU, DHMT, Board of Directors, Performance Based Financing steering committee, District councils and the District executive Committee
- Participate in seminars and conferences on District Governance and Stewardship (urban and Rural Districts) for experience sharing and learning.

Program Support in Coordination, Planning, Monitoring and Evaluation:

- Prepare and actively participate in coordination meetings relating to Governance and M&E;
- Actively participate in planning, monitoring, documentation/capitalization and evaluation sessions during program implementation.
- Work in synergy and complementarity with other NTAs, ITAs and Partner Staff involved in the implementation of expected results relating to quality of health care, mental health, quality data use and asset management both at operational level and at central level (MOH, RBC) and City of Kigali;
- Prepare quarterly progress reports and suggest key issues to bring to the attention of the Steering Committee;
- Work in close collaboration with the program team, other Development Partners (DPs) involved in similar areas of the health sector and contribute to the technical dialogue through active participation in relevant TWGs especially Planning, M&E, HIS TWG.
- Accompany action research initiatives, capitalization and dissemination of experiences that are relevant to governance and stewardship in order to strengthen the District Sector Wide approach
- Assist in promoting and mainstreaming cross-cutting issues such as environment, gender, children's rights, HIV / Reproductive Health and Rights in daily work.

7.3.10.6 Profile

Education level

- Medical Doctor or Psychologist with a Master in Public Health.

Proven experience:

- Professional experience of minimum four years with at least two years in capacity development on governance and stewardship at the level of decentralized entities and/or Ministries,
- Work experience in health systems strengthening which includes the areas of planning, organization, coordination, supervision, monitoring and evaluation at national and decentralised levels
- Experience in project cycle management within the international cooperation framework is an advantage
- Previous experience in a similar position or proven experience with international organization/institutional development projects is an asset
- Have experience in action-research and capitalization of experience.

Skills

- Good knowledge in public health, particularly in the organization of the Health Sector and service delivery by decentralised entities;
- Ability to analyse, understand and interpret statistical information (reports and analysis of data/information; highly recommended)
- Capacity to conceptualize and conduct operational research or action research
- Teamwork, organizational skills/managerial and ability to work under pressure and meet deadlines
- Ability to undertake professional activities using consultative and participatory approaches
- Good report and writing skills
- Good knowledge of ICT (Word, Excel, Power Point and Database).
- Excellent oral and written communication in Kinyarwanda, English and French

7.3.10.7 Mode of recruitment

The recruitment will follow a national recruitment procedure launched by the Ministry of Health in coordination with the Belgian Development Agency (BTC). The candidate will be selected by MOH jointly with BTC.

7.3.10.8 Management of the contract

The contract is managed by the Ministry of Health under the Rwandan Law.

7.3.10.9 Development circles

Development circles will be carried out by the ITA Health Institutional support in coordination with the program coordinator.

7.3.11 National Technical Assistant Project Manager Medical Technology and Infrastructure

7.3.11.1 Post

The Project Manager will assist the Head of Division mainly Co-ordination of planning, budgeting, implementation and progress measurement and reporting for all domestic and externally funded projects under MTI.

7.3.11.2 Location and institutional framework

The position will be based in Kigali city in the Rwanda Biomedical Centre, Medical Technology and Infrastructure Division, under the Division Manager. As part of its mission, the project manager may be required to collaborate with other Ministry of Health Departments, health programs, and districts. When required, he/she can also be involved in activities including other sectors than health sector.

The project manager will work in close collaboration with the program under the leadership of the ITA health care asset management and in collaboration with other International Technical Advisors of the Belgian health program.

7.3.11.3 Duration

The position will be funded for four years.

7.3.11.4 Responsibilities

The project manager will provide support in the co-ordination of planning, budgeting, implementation, progress measurement and reporting for all domestic and externally funded projects under MTI. He/she will provide recommendations in terms of planning and resource allocation for the Division. He/she will contribute to resources mobilization for the Division, assist management into cost efficiency decisions and actively propose investment plans and income generating ventures for management decision making.

7.3.11.5 Tasks

Specifically, he/she shall:

- Participate in the development of action plans and budget to be funded by different stakeholders
- Follow-up the implementation of action plan and budget execution
- Provide regular programmatic and financial reports to assess the implementation of action plans and budget execution to different stakeholders
- Ensure the implementation of programs and projects are in compliance with local laws and procedures
- Make close follow up of the procurement activities related to the implementation plans and ensure timely and quality execution of the plans and budget.
- Write and pursue opportunities for funding applications
- Participate in sustainable business planning and revenue generation by MTI division, and ensure costs are maintained and MTI implements cost efficiency interventions
- In collaboration with All MOH departments and RBC divisions, especially DG Planning and RBC Planning division:
    - Sectorial level planning and budgeting, including external/donor financing
    - Support in development of business plan / market analysis of Income generating division

- Assess feasibility of potential investment projects in Income generating for MTI division

- Assess, in collaboration with external partners including other GOR and Private institutions/individuals the feasibility of potential investment projects for the MTI Division
- Gather data/provide information to inform the drafting of MoUs, agreements/contracts, etc.
- Contribute to all other activities of the RBC/ MTI, according to the needs.

7.3.11.6 Profile

Education level

- At least a Master's degree in project management, economics, or finance with 3 years of experience in related fields

Proven experience:

- Professional experience of minimum 5 years in project management
- Work experience in health systems which includes the areas of planning, organization, coordination, supervision, monitoring and evaluation at the national level
- Previous experience in a similar position or proven experience with international organization/institutional development projects is an asset
- Experience in income generating projects and savings opportunities and their analysis
- Experience in feasibility studies or financial viability analyses of projects, business or products
- Capacity to provide quality recommendations and actions from cost analysis of MTI operations, market and financial viability
- Knowledge of the health sector in Rwanda and its structures is an advantage
- Have a combined working experience in private sector is an advantage

Skills

- Excellent strategic and operational planning and monitoring skills to assist in effective and efficient management decision
- Capacity to pro-actively propose innovative and efficient ways of working, planning tools and performance measurement
- Teamwork and teambuilding towards achieving common goals
- Organizational skills/managerial and ability to work under pressure and meet deadlines
- Expertise for "on the job" capacity building to grow staff capacity
- Good report and quality writing skills
- Good knowledge of ICT (Word, Excel, Power Point and Database).
- Excellent oral and written communication in Kinyarwanda, English and French

7.3.11.7 Mode of recruitment

The recruitment will follow a national recruitment procedure launched by the Rwanda Biomedical Centre in coordination with the Belgian Development Agency (BTC). The candidate will be selected by RBC jointly with BTC.

7.3.11.8 Management of the contract

The contract is managed by Rwanda Biomedical Centre under the Rwandan Law.

7.3.11.9 Development circles

Development circles will be carried out by the ITA Health care asset management in coordination with the program coordinator.

7.3.12 RAFI Expert Health Program

7.3.12.1 Post

The integration of program activities into the Rwandan financial management system will be accompanied by a RAFi expert.

7.3.12.2 Location and institutional framework

The position will be based in Kigali city in the SPIU (part of RBC).

The RAFI expert will work in close collaboration with the program under the leadership of the ITA program coordinator and in collaboration with other International Technical Advisors of the Belgian health program and BTC.

7.3.12.3 Duration

The position will be funded for 18 months.

7.3.12.4 Responsibilities

During the start of the aligned program, and later during its implementation, the expert will be responsible for the good integration of program activities into the Rwandan financial management system, and also for strengthening the competencies of the program related finance team.

7.3.12.5 Tasks

Technical support

1) The implementation modalities of the program are practically defined, and the new program is successfully integrated into the Rwandan finance and procurement system.

The expert will be responsible for preparing and facilitating the integration process of the health program into the Rwandan financial and procurement management system (at the level of partner SPIU-RBC). To that end, he/she will

- plan this process;
- ensure that the program is integrated into the IFMIS system and define the necessary formats for budgeting, program reporting, etc. that will be used to justify program expenditure to BTC (and ultimately the Belgian authorities);
- assess the integration of activities of the program into the Rwandan financial and procurement management system;
- elaborate concrete measures and necessary adjustments to guarantee this integration and/or propose solutions in order to resolve any problems that occur during the process.

2) The partner SPIU-RBC is supported in achieving its improvement plan.

The expert will be responsible for supporting the partner SPIU-RBC in setting up its improvement action plan for weaknesses in financial management identified during the Organisational Assessment. To that end and on the basis of evaluation report, he/she will

- support the partner in defining improvement points and an improvement action plan;

- support the organisation in implementing the action plan.

3) A focal point with MINECOFIN is set up

As required by the 4th condition of the Rwanda Overall Assessment, the expert will act as BTC focal point regarding the continuous consultation and collaboration with MINECOFIN, in order to continuously improve the integration of the program into the Rwandan financial and procurement system.

- Facilitate the practical utilisation of national financial and procurement systems
- Exchange information on reforms related to Public Financial Management in Rwanda
- Follow-up on the respect of the modalities as defined in the TFF, especially the risk mitigating measures

4) The experiences and lessons learned are documented and shared.

Lessons learned, about integrating a Belgian program into the Rwandan financial management system that are useful for Belgium and for the Government of Rwanda, are documented, discussed with the Rwandan counterpart and shared with other donors.

The expert will be responsible for reporting about lessons learned and documenting them. To that end,

- He/she will provide a quarterly update on the progress of its action plan and contribute to the annual report of the program;
- He/she will actively participate to the exchange of experiences (with MINECOFIN and other development partners) on the processes and the actions to undertake to allow for the good management of the external programs in the Rwandan financial management system.

5) Support is given to the budget preparation, integration and financial management at service delivery level.

In accordance with paragraph 3.4.4.1 of the TFF, the expert may be requested to provide advice on / support to the drafting of transparent and comprehensive budgets at the service delivery level, and follow-up on the plans containing the specific initiatives to strengthen the financial management system in hospitals and DHMTs.

Financial management of the program

1) Assisting the local finance team in resolving complex finance / procurement issues

The expert will provide advice and coaching on admin-fin problems that may exceed the knowledge or experience of the local staff; he/she may lead or participate in solution-oriented brainstorming sessions and thereby assist the local finance team in finding appropriate answers to complex finance or procurement issues.

2) Capacity building activities for financial management are planned and performed

The expert will assure transfer of knowledge of administrative and finance matters in order to strengthen the competencies of the finance team; and to assure their stand-alone functioning after his/her departure.

7.3.12.6 Profile

Education level

University degree in economic sciences, finances, law or political sciences;

Proven experience:

- At least 5 years of experience and specifically 3 years in financial management of development interventions, preferably with public partners;
- Experience in implementing improvement projects or change processes in financial management and purchase management;

Technical competencies:

- Knowledge of management processes in the public sector: financial management (drawing up the budget, budget execution, accounting, financial reporting and treasury management), public contracts, internal control and audit;
- Good knowledge of Belgian internal management systems;
- Good knowledge of the international evolutions in the domain of using national systems;
- Good knowledge of ICT applications;
- Mastery of English. French is an advantage.

Personal competencies:

- Team work, able to work with colleagues from varying backgrounds;
- Facilitation, coaching and organizational skills
- Strong analytical and assessment skills;
- Excellent writing and oral communication skills;
- Sense of responsibility and initiative;
- Solution and result-focused;
- Proactive and hands-on.

7.3.12.7 Mode of recruitment

The recruitment will be launched by the Belgian Development Agency (BTC) in Brussels. The candidate will be selected by the BTC and his Curriculum Vitae will be presented to the Rwandan Partner for approval.

7.3.12.8 Management of the contract

The contract is managed by Belgian Development Agency (BTC) under Belgian Law.

7.3.12.9 Development circles:

Development circles will be carried out by the Program Coordinator in consultation with the BTC Resident Representative in Rwanda.

7.3.13 National Program Officer

7.3.13.1 Post

The Program Officer will be closely working with Rwanda Biomedical Centre (RBC), MoH Departments and Units, Districts, and all beneficiaries of the Program and Technical Advisors during the process of planning, implementation, Monitoring and Evaluation of the Program. He or she will be preparing the planning exercise, periodic review sessions of program performance and provide technical assistance to implementing institutions in examining and consolidating their reports into one programmatic and financial report.

7.3.13.2 Location and institutional framework

The National Program Officer will be based in the SPIU/Rwanda Biomedical Centre (RBC) in Kigali with frequent visits at the operational level country wide. He/she will work under the supervision of the Director of Intervention (the Single Project Implementation Unit - SPIU Coordinator).

7.3.13.3 Duration

The position will be funded for four years by BTC (100% for the 1st two years and 50% for the 3rd and 4th year).

7.3.13.4 Responsibilities

a. Planning and technical assistance

- Provide necessary expertise and technical support in developing a budgetary and operational plan for program implementation by using the 3 Integrated Financial Management and Information Systems (IFMIS) modules especially planning, budget and accounting / procurement-module under construction.
- Ensure that 'Improving the quality of primary health care and services' program funded interventions are aligned to Rwandan Health Sector policy, sector and sub sector strategic plans as well as national and international standards;
- Ensure that quarterly target and unit costs of funded interventions are in complementing other sources of funding and SPIU managed projects to avoid duplication;
- Contribute in developing actions and budgetary plans of SPIU in its support to implementing 'Improving the quality of primary health care and services' interventions.

b. Operational implementation

- Ensure that program funded activities are implemented in conformity with pre-established calendar, regulations, instructions and procedures of the Government of Rwanda and the Kingdom of Belgium as well as with the Specific agreement signed by both parties;
- Ensure that funds are properly managed and used for intended purposes and that objectives are timely reached;
- Collaborate with program coordination and technical assistance in gathering, analysing and compiling all proposals of budget reallocation by implementers; design budget reallocation and action plan proposals to be submitted by the Program Coordination to the Steering Committee for approval;
- In collaboration with program team, carry out regular field visits to implementers to monitor activities implementation progress and produce related reports;
- Work closely with other SPIU Staff focusing on Health System Strengthening interventions in order to ensure synergies and effective implementation.

c. Monitoring and reporting

- Ensure that all data and information that may affect Program funded interventions are communicated to all implementers in appropriate ways
- Produce quarterly, semester and annual reports on Program funded interventions implementation status and ensure that all implementers are informed on the intervention's implementation progress
- Monitor the implementation of recommendations and decisions as taken by the steering

committee on the budget utilization and achievement of indicators of the of 'Improving the quality of primary health care and services' program funded interventions

7.3.13.5 Tasks

Specifically, he/she shall:

- Closely work with MoH departments and Units, districts health services, implementing entities and development partners (including BTC) in identifying and updating areas of intervention for the operational plan and establishing result-based indicators according to Technical and Financial Files and health System Strengthening objectives;
- Design, Propose and Review programmatic and budgetary data collection tools of 'Improving the quality of primary health care and services' program funded interventions;
- Collect, analyse and present in appropriate manner programmatic, budgetary data and reports on of 'Improving the quality of primary health care and services' program ;
- Provide updates on action plan, implementation status and performance of Program:
    - Identify weaknesses in the course activities implementation and achieving indicators, formulate recommendations as well as tangible solutions for improvement;
    - Carry out field missions with the purpose of quality control of implementers' reported data;
    - Organize quarterly meetings with implementers to crosscheck budget execution status, and performance-based indicators and formulate recommendations for improvement;
- Actively participate in operational research activities and impact evaluation on health system Support in Rwanda and target beneficiaries health status
- Submit to the Program coordination as well as the Technical Advisors, concise weekly reports on program activities
- Prepare with the Coordination team and accountant, quarterly monitoring meetings of the program headed by the Director of Interventions
- Assist the Coordination team and accountant in organizing meetings of the Steering Committee.
- Ensure public relations in disseminating and sharing best practices, lessons learnt and updates on of 'Improving the quality of primary health care and services' program;
- Participate in weekly meetings and share information with the SPIU team on activities' implementation progress status, constraints and proposed solutions
- Participate in workshops, meetings, consultations and midterm review meetings in relation to the Program funded interventions.
- Implement all program related duties as requested by hierarchical supervisors and any other duties related to the SPIU/RBC mission on Health Program and Project management.

7.3.13.6 Profile

The position will be filled by a person of Rwandan nationality.

Education level

Master in Public Health with a background of medical sciences or holding a medical sciences degree.

Proven experience

- Having sound professional experience of five years in Health related projects management, M&E, data collection and analysis
- Having worked with MoH entities at central level, multi/bilateral agencies or other international organizations of sound reputation
- Work experience in project proposal design and funds mobilization.

Skills

- Capacity to conceptualize and conduct operational research or action research
- Teamwork, organizational skills/managerial and ability to work under pressure and meet deadlines
- Good reporting and writing skills
- Good knowledge of ICT (Word, Excel, Power Point and Database)
- Excellent oral and written communication in Kinyarwanda, English and French

7.3.13.7 Mode of recruitment

The recruitment will follow a national recruitment procedure launched by the Ministry of Health in coordination with the Belgian Development Agency (BTC). The candidate will be selected by MOH jointly with BTC.

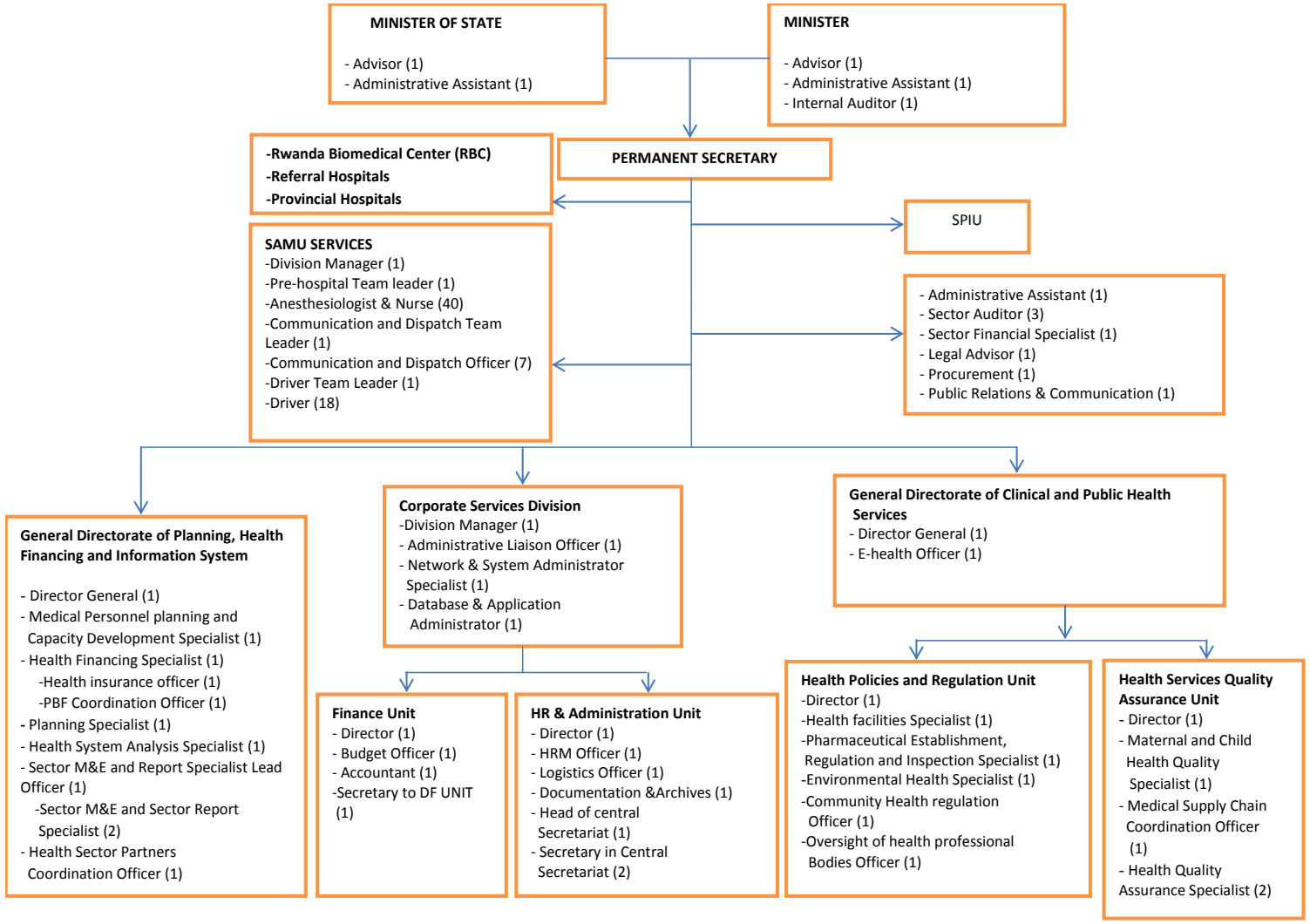
7.3.13.8 Management of the contract

The contract is managed by the Ministry of Health under the Rwandan Law.

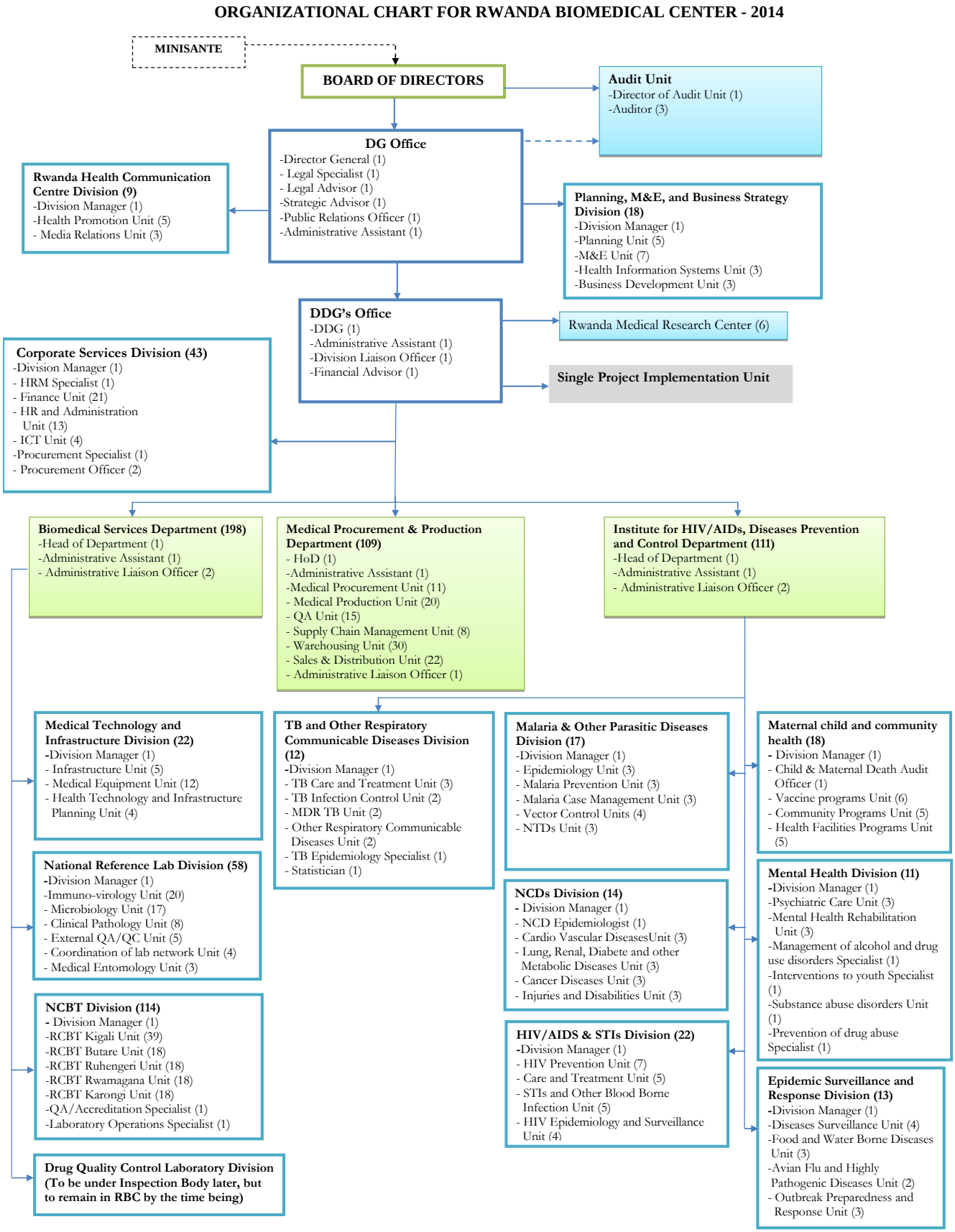
7.3.13.9 Development circles

Development circles will be carried out by the Director of intervention in coordination with the program coordinator.

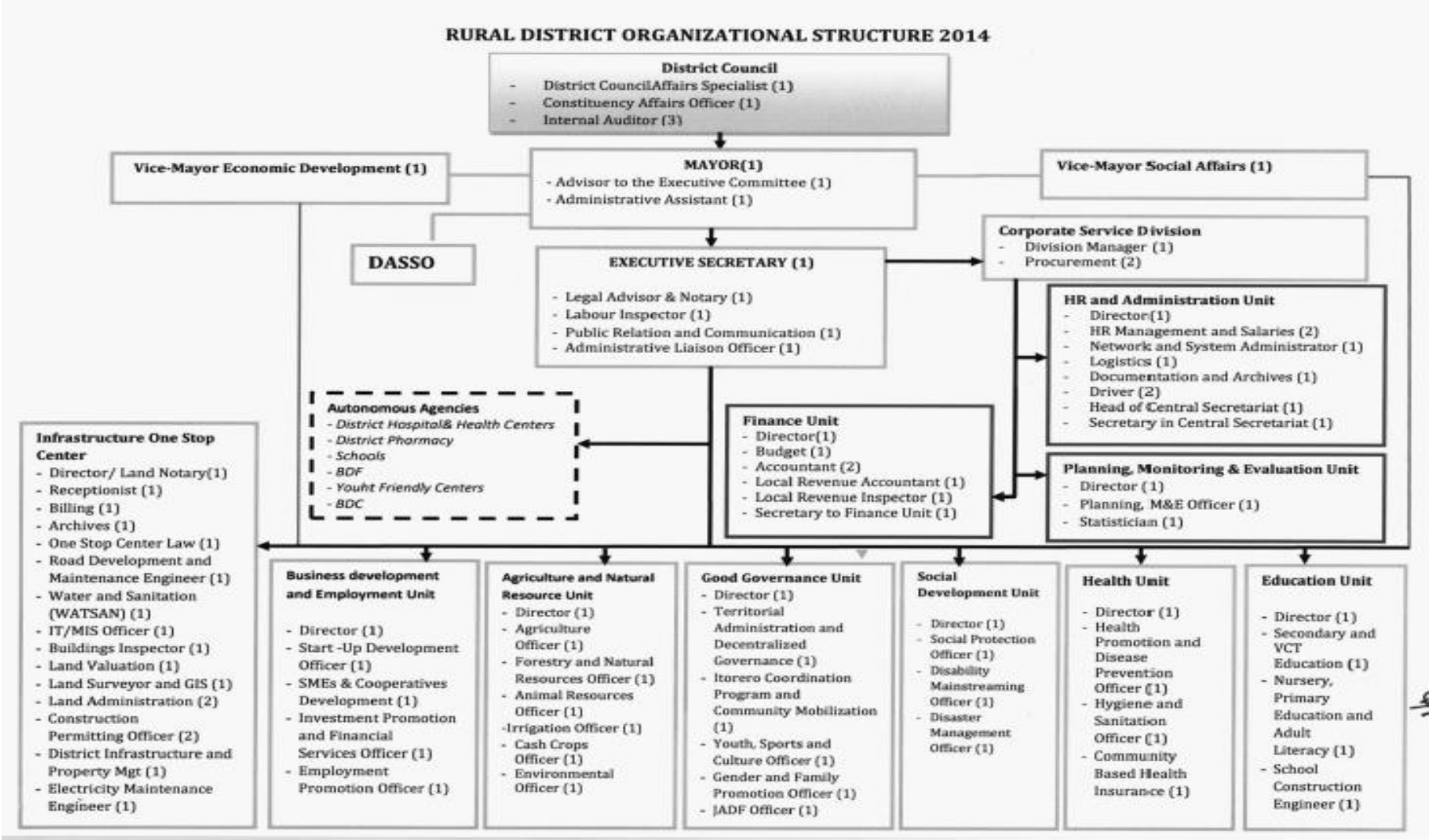
7.4 Ministry of Health Organization Chart

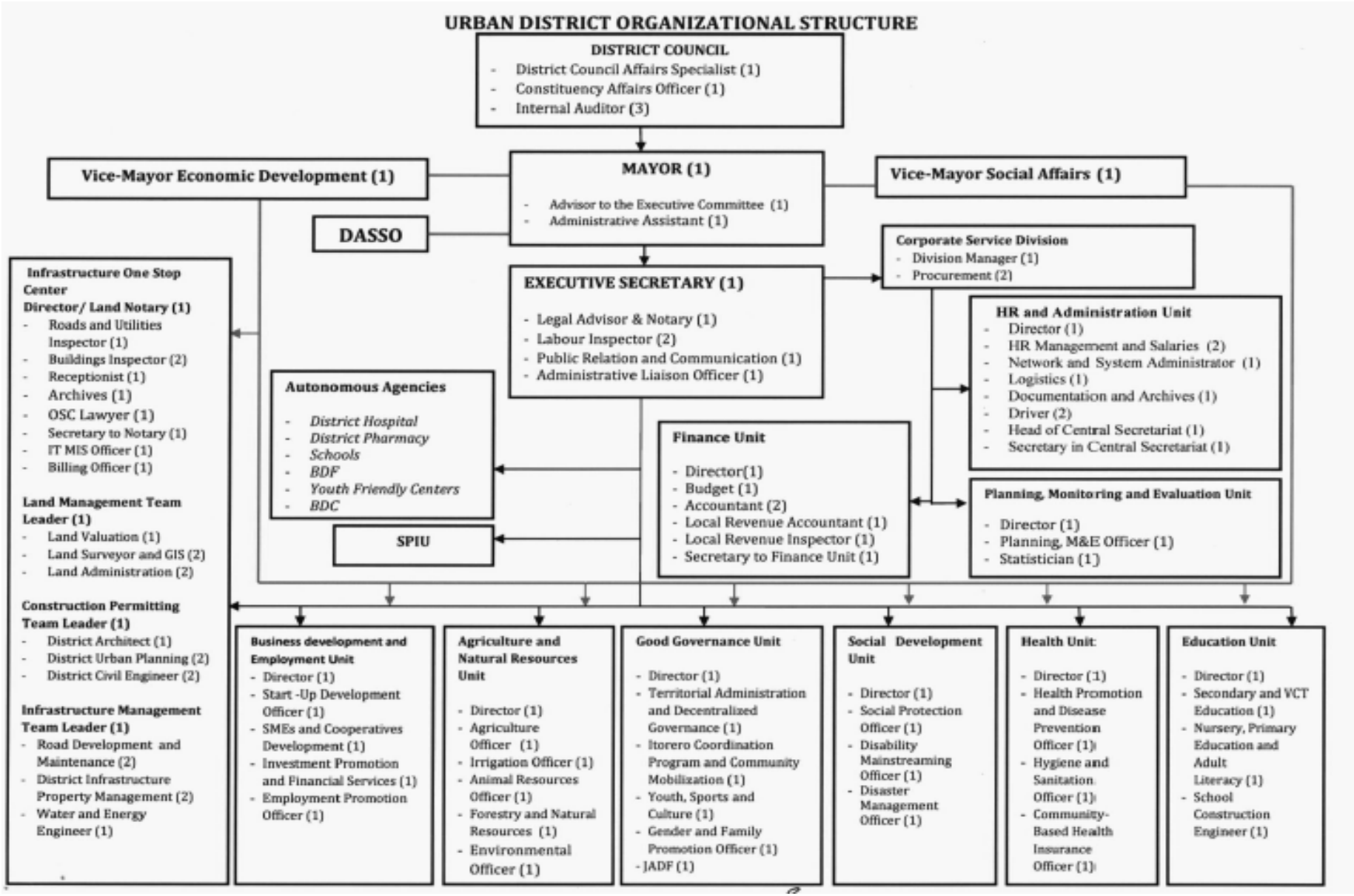


7.5 Rwanda Biomedical Center Organization Chart



7.6 District Organizational Structure 2014




URBAN DISTRICT ORGANIZATIONAL STRUCTURE
DISTRICT COUNCIL
- District Council Affairs Specialist (1)
- Constituency Affairs Officer (1)
- Internal Auditor (3)
Vice-Mayor Economic Development (1)
MAYOR (1)
- Advisor to the Executive Committee (1)
- Administrative Assistant (1)
Vice-Mayor Social Affairs (1)
DASSO
Corporate Service Division
- Division Manager (1)
- Procurement (2)
Infrastructure One Stop Center
Director/ Land Notary (1)
- Roads and Utilities Inspector (1)
- Buildings Inspector (2)
- Receptionist (1)
- Archives (1)
- OSC Lawyer (1)
- Secretary to Notary (1)
- IT MIS Officer (1)
- Billing Officer (1)
Land Management Team Leader (1)
- Land Valuation (1)
- Land Surveyor and GIS (2)
- Land Administration (2)
Construction Permitting Team Leader (1)
- District Architect (1)
- District Urban Planning (2)
- District Civil Engineer (2)
Infrastructure Management Team Leader (1)
- Road Development and Maintenance (2)
- District Infrastructure Property Management (2)
- Water and Energy Engineer (1)
EXECUTIVE SECRETARY (1)
- Legal Advisor & Notary (1)
- Labour Inspector (2)
- Public Relation and Communication (1)
- Administrative Liaison Officer (1)
HR and Administration Unit
- Director (1)
- HR Management and Salaries (2)
- Network and System Administrator (1)
- Logistics (1)
- Documentation and Archives (1)
- Driver (2)
- Head of Central Secretariat (1)
- Secretary in Central Secretariat (1)
Autonomous Agencies
- District Hospital
- District Pharmacy
- Schools
- BDF
- Youth Friendly Centers
- BDC
SPIU
Finance Unit
- Director(1)
- Budget (1)
- Accountant (2)
- Local Revenue Accountant (1)
- Local Revenue Inspector (1)
- Secretary to Finance Unit (1)
Planning, Monitoring and Evaluation Unit
- Director (1)
- Planning, M&E Officer (1)
- Statistician (1)
Business development and Employment Unit
- Director (1)
- Start -Up Development Officer (1)
- SMEs and Cooperatives Development (1)
- Investment Promotion and Financial Services (1)
- Employment Promotion Officer (1)
Agriculture and Natural Resources Unit
- Director (1)
- Agriculture Officer (1)
- Irrigation Officer (1)
- Animal Resources Officer (1)
- Forestry and Natural Resources (1)
- Environmental Officer (1)
Good Governance Unit
- Director (1)
- Territorial Administration and Decentralized Governance (1)
- Itorero Coordination Program and Community Mobilization (1)
- Youth, Sports and Culture (1)
- Gender and Family Promotion Officer (1)
- JADF (1)
Social Development Unit
- Director (1)
- Social Protection Officer (1)
- Disability Mainstreaming Officer (1)
- Disaster Management Officer (1)
Health Unit
- Director (1)
- Health Promotion and Disease Prevention Officer (1)
- Hygiene and Sanitation Officer (1)
- Community-Based Health Insurance Officer (1)
Education Unit
- Director (1)
- Secondary and VCT Education (1)
- Nursery, Primary Education and Adult Literacy (1)
- School Construction Engineer (1)

7.7 Model of Social Determinants of Health

Figure 17: Core determinants of health

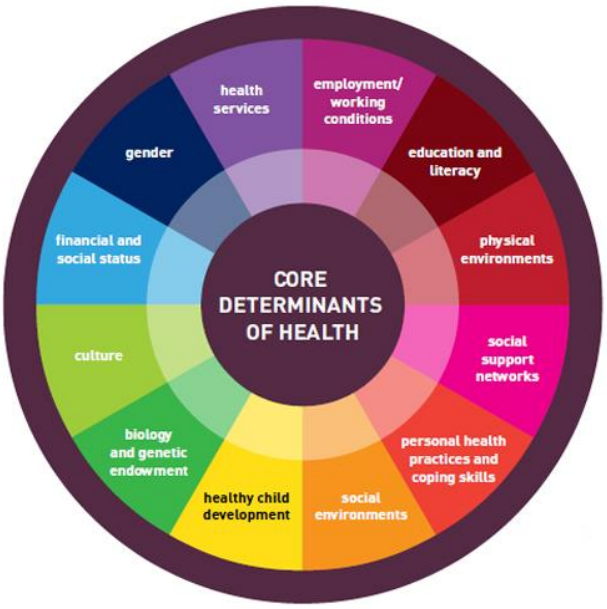
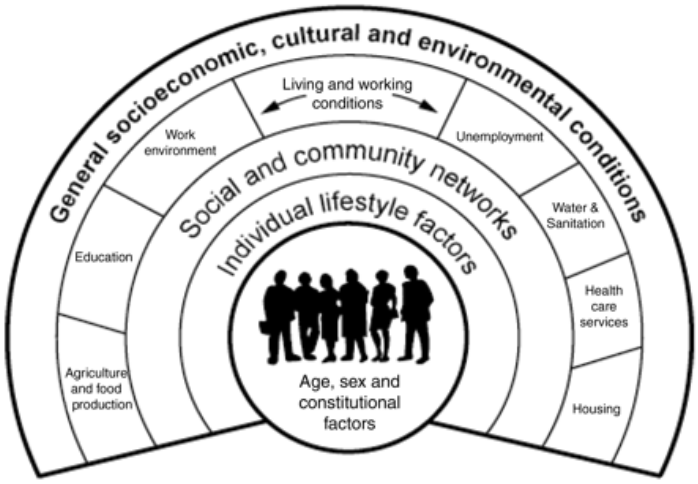


Figure 18: Main determinants of health



7.8 Some examples of people-centred improvement initiatives related to accreditation (R1)

Theme/ problem	Improvement initiative	components
Gaps in referral system and comprehensive approach of patients	Installation of practice of systemic clinical audits	- Agreement on the strategy - Training of Staff - Follow-up through accreditation process - Documentation of experience (action-research)
Increase of Chronic Non-communicable Diseases	Operational strategy for follow-up of Chronic Non-communicable Diseases	- Mapping of situation in catchment area - Development of local adapted operational strategy based on national guidelines - Training of staff - Documentation of experience (action-research)
High neonatal mortality in the Rural HC and DH	Integrated initiative for reduction of neonatal mortality	- Baseline study of the conditions for delivery and resuscitation in the HC and DH - Completion of technical platform : resuscitation bags, oxygen, incubators, - Training of all implicated staff - Monitoring system - Incentivize
Inadequate burn care at primary level	Sensitization and improvement campaign	- Epidemiological study on etiology of burn injuries - Improvement of environment for risk situations - Adequate first line care - Adequate district hospital surgical offer for minor burns - Specialized burn center for major burn injuries
Long delays for fracture treatment at all levels	Improvement of integrated trauma care at first, second and tertiary level	- Situational analysis - Identification of bottlenecks and delays - Baseline of conditions for decentralized trauma care - Upgrade of facilities - Training of specific staff - …
High maternal mortality	Integrated approach to SRH	- Analysis of main causes of MM (including culture, gender, religion) - Development of outreach activities on basis of the analysis results - Availability and quality of adolescent friendly health services - Improved availability of and access to family planning services - Integration of FP services in HIV/AIDS services, maternal health services, child health services, ASRH services - Training of health staff in ASRHR, gender and health - Training of community health workers ASRH, FP, gender and health - Adequate supervision of health staff and community workers - Action research on SRH issues (ASRH and access to modern contraceptives, efficiency of one stop centres for GBV, etc.) - …

7.9 Capacity Reinforcement

Since this program has a focus on capacity building, there is need to have **a clear strategy** in relation to capacity reinforcement. This will include:

- The development of a global vision and coherent approach
- Quality Assurance mechanisms in relation to content and methodological instruments
- The collaboration of the unit responsible for capacity reinforcement within the MOH/RBC in order to institutionalize the strategy
- A good balance between theoretical and practical training and coaching
- Synergy with the CDPF as well as the decentralization Support Program 'Enhancing the capacities of districts' supported by the Belgian Cooperation

The ITA coordinating this intervention will be responsible for this coherent approach.

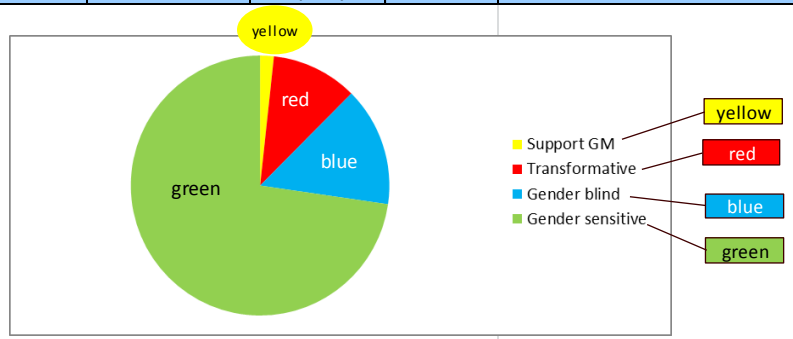
The following **training institutions** (indicative, but no exclusive list) with whom the program will work already have been identified: International Society for Quality in Health Care (ISQUA) for accreditation (R1), UCL – University of Genève – University of Rwanda for training of psychiatrists (R2), CUD (Commission Universitaire au Développement) for the clinical mentoring of paediatricians in collaboration with referral (university) hospitals offering the opportunity for practical training (CHUK, King Faisal Hospital, Kanombe and Butare). (R3), the College of Science and Technology for the training of biomedical engineers (R6), Quamed for quality drug procurement.

7.10 Gender budget scan

					€		
A		**OS**	**A people-centered, integrated and sustainable health care system with quality essential health care services as close to the community as possible has been reinforced**		**18,541,600**	Gender Budget Scan score	**Explanation Gender Budget Scan (GBS)**
A	*01*		*The quality assurance system is set up and integrated and functional at the level of all hospitals*		*1,704,500*		
A	01	01	Progress towards the creation of an autonomous accreditation body	co-management	0	green	Surveys will be conducted taking into account differences between women and men and sex disaggregated data and information (to be included in the ToR). Assessments will be oriented towards women and men, young and old, (dis-)abled and vulnerable groups.
A	01	02	Update & disseminate norms, standards and models (MOH)	co-management	225,000	green	The ToR will also include a focus on gender, however the outcome, e.g. 'develop continuously norms' is not necessarily 'transformative'.
A	01	03	Facilitate and implement the accreditation process at all hospitals	co-management	283,500	green	Taking differences of women and men into account. The ToR will also include a focus on gender.
A	01	04	Finance people-centered improvement projects	co-management	1,100,000	red	Set-up of gender-related improvement projects will be taken into account, in order to change gender relations (intention is to be transformative).
A	01	05	Medium term technical assistance in accreditation, quality improvement and quality control	BTC-management	96,000	green	According to legislation and procedures (equal treatment, equal opportunities) and positive discrimination, under the condition of comparable competencies.
A	*02*		*The mental health services are accessible from the community level up to the national level in a sustainable way*		*3,258,400*		
A	02	01	Strengthen community interventions on mental health	co-management	250,000	green	Specific attention may be given to mental health and HIV, GBV, age, gender and disability (some transformative actions can be developed during implementation). For each target group, attention will be given to the specific needs of women and men.
A	02	02	Consolidate Mental Health Care Services & a people-centred approach at the level of health Centres & hospitals and extend referral outpatient & inpatient Mental Health Care at the level of the provincial and national referral hospitals	co-management	1,786,400	green	Taking practical needs and strategic interests of women and men into account. Possible gender issues on the training agenda. In case of scholarships this will be done in function of competencies, giving opportunities to both women and men. Constructions and rehabilitation take into account specific issues like security, lavatories, menstrual hygiene management (MHM),...
A	02	03	Develop multidisciplinary strategies and actions with regard to the fight against abuse of psychoactive substances and with regard to mental health issues related to HIV/Aids and Gender Based Violence (GBV)	co-management	600,000	red	Gender related studies, also on men experiencing violence. Avoiding stereotypes, discriminations, taboos. Specific topics, aimed and transforming gender relations between women and men, in order to promote gender equality and relations within the group of women and within the group of men, related to other discriminating issues (HIV, age, inabilities, sexual orientation,...) in order to promote equality.
A	02	04	Long term technical assistance in mental health and people centered approaches	BTC-management	622,000	green	In function of competencies, giving opportunities to both women and men and respecting legislation and procedures.
A	*03*		*The urban health service coverage is rationalized and extended in line with the three guiding principles of the National Health Sector Policy*		*7,198,200*		
A	03	01	Develop promotional activities on social determinants of health in CoK	co-management	110,000	green	In studies, gender is systematically taken into account in the ToR. Sex and gender disaggregated data/information are fundamental in each study. In function of the finding of the studies, transformative specific campaigns can be conducted in a later phase of the programme. All communication will avoid stereotypes, discriminations, … and address women and men in different socio-economic and cultural settings.
A	03	02	Develop and validate a sound concept and equitable coverage plan for HC	co-management	82,000	green	Gender is systematically taken into account in the ToR and sex and gender disaggregated data/information are fundamental for the baseline study. Gender and other cross-cutting issues are systematically part of the agenda of workshops and seminars. If needed specific workshops can be conducted to address specific issues. All communication will avoid stereotypes, discriminations, … and address women and men in different socio-economic and cultural settings.
A	03	03	Support the implementation of the coverage plan through various strategies : upgrades of the existing HF, construction of new HC or PPP initiatives in the most vulnerable sectors of CoK	co-management	1,656,000	green	In an initial phase, to be conducted with respect to different needs of women and men. Waste management to be linked with water and sanitation gender policy (to be developed). All ToR include gender dimension.

A	03	04	Create a functional, autonomous and efficient hospital network	co-management	373,200	green	Equal and safe access for women and men (taking practical needs of women and men into account). The ToR will also include a focus on gender, however the outcome, e.g. 'concept for functional network' is not necessarily 'transformative'. When building capacities: taking specific needs of women and men into account, if needed specific gender sessions can be organised. Sex/gender disaggregated data.
A	03	05	Design, build and equip a 300 beds Hospital in Kicukiro District articulated with the CoK coverage plan	co-management	4,065,000	green	Gender analysis will be done. In function of findings, taking specific needs into account.
A	03	06	Long term technical assistance in public health, hospital networking and urban health	BTC-management	912,000	green	In function of competencies, giving opportunities to both women and men and respecting legislation and procedures.
A	*04*		*The leadership and governance is reinforced, specifically regarding district stewardship, the respective roles of the MOH and RBC and the public private partnership*		*1,326,000*		
A	04	01	Strengthen stewardship capacities at the level of the local health system (districts)	co-management	850,000	green	All assessments will be conducted in a gender sensitive way. If possible planning will link up to gender responsive budgeting processes.
A	04	02	Provide support to MoH and RBC with regard to their respective roles (separation of regulatory/coordination/ M&E, and implementing role)	co-management	380,000	green	Gender is an inherent dimension of all ToR and training packages. Support in conducting the gender assessment of the gender budget statements of the MOH in collaboration with GMO. Trainings will be organised taking into account participation of women and men (facilitate participation). Gender studies can be conducted.
A	04	03	Long term technical assistance in (district) capacity building	BTC-management	96,000	green	In function of competencies, giving opportunities to both women and men and respecting legislation and procedures.
A	*05*		*Data are generated, analysed and used for evidence-based decision-making in a more correct, disaggregated, integrated, systematic, accessible and effective way*		*1,330,000*		
A	05	01	Assure the integration of different systems of information and further develop HMIS tools, methods and guidelines	co-management	120,000	green	Gender and sex disaggregated data and information. Gender in ToR.
A	05	02	Assure the production of quality data	co-management	140,000	green	Always reference to gender and sex disaggregated data/information. In function of availability of gender and sex dissagregated data, new related data and information can be collected.
A	05	03	Develop strategies for effective utilization of data for monitoring, evaluation decision making and action-research	co-management	350,000	yellow	This activity also concerns gender and sex disaggregated data and information (avoid stereotypes in communication). If needed gender on the agenda. Trainings will be organised taking into account participation of women and men (facilitate participation). Collaboration with the GMO office for gender related utilisation of data .
A	05	04	Long term technical assistance in HMIS development and M&E	BTC-management	720,000	green	In function of competencies, giving opportunities to both women and men and respecting legislation and procedures.
A	*06*		*An asset management system is designed and operational in a cost-effective way*		*3,724,500*		
A	06	01	Develop, validate and disseminate policies, technical standards for HF in infrastructure and equipment, acquisition standards including donation, procurement & replacement standards, collaboration with private sector…	co-management	66,000	blue	Initially: without a gender analysis. However if during implementation cross-cutting issues are revealed, the code can change from 'blue' to for example 'green' and a gender analysis can be conducted.
A	06	02	Develop a functional procurement & maintenance system at operational	co-management	1,021,500	blue	Idem
A	06	03	Develop a waste management policy, strategy and baseline	co-management	80,000	green	The policy and strategy will take into account gender issues, practical needs and strategic, long term (transformational) interests. It is to be decided by policy-makers to which degree the policy and strategy will be transformative. Coherence will be respected with the WATSAN gender policy (to be established)
A	06	04	Finance strategic improvement projects with impact on the asset	co-management	1,300,000		Without gender analysis
A	06	05	Develop domestic human capacity with regard to asset management	co-management	465,000	green	On the basis of a gender analysis. Always provide gender on the training agenda and measures to facilitate women's participation.
A	06	06	Long term technical assistance in maintenance of biomedical equipments and in construction of health facilities	BTC-management	792,000	green	In function of competencies, giving opportunities to both women and men and respecting legislation and procedures.

X	01		**Contingency**		**159,600**		
X	01	01	contingency CO-MANAGEMENT	co-management	109,600	blue	Without gender analysis.
X	01	02	Contingency BTC-management	BTC-management	50,000	blue	Idem
Z			**General means**		**2,298,800**		
Z	*01*		*Personnel costs*		*1,450,800*		
Z	01	01	ITA Public Health – Program Coordinator (co-manager)	BTC-management	720,000	green	In function of competencies, giving opportunities to both w omen and men and respecting legislation and procedures.
Z	01	02	Program manager	co-management	72,000	green	Idem
Z	01	03	Finance and admin team	co-management	388,800	green	Idem
Z	01	04	Technical team	co-management	0	green	Idem
Z	01	05	RAFi / PFM expert	BTC-management	270,000	green	Idem
Z	*02*		*Investments*		*55,000*		
Z	02	01	cars	BTC-management	0	blue	Without gender analysis.
Z	02	02	Office equipment	BTC-management	25,000	blue	Idem
Z	02	03	IT equipment	BTC-management	30,000	blue	Idem
Z	02	04	Office refurnising	BTC-management	0	blue	Idem
Z	*03*		*Functional costs*		*313,000*		
Z	03	01	Functioning costs cars	BTC-management	60,000	blue	Idem
Z	03	02	Tele communication	BTC-management	40,000	blue	Idem
Z	03	03	Office material	BTC-management	40,000	blue	Idem
Z	03	04	Missions	BTC-management	40,000	blue	Idem
Z	03	05	Representation costs and external communication	BTC-management	40,000	blue	Idem
Z	03	06	Training (including on HIV workplace policy)	BTC-management	30,000	blue	Idem
Z	03	07	Consultancy costs - PFM support	BTC-management	48,000	blue	Idem
Z	03	08	Financial transaction costs	BTC-management	5,000	blue	Idem
Z	03	09	Costs VAT	BTC-management	0	blue	Idem
Z	03	10	Other functioning costs	BTC-management	10,000	blue	Idem
Z	*04*		*Audit, monitoring and evaluation*		*480,000*		
Z	04	01	M&E costs (baseline, 1 EMP + 1 EF)	BTC-management	130,000	red	Specific attention to transformative development processes. All cross-cutting issues are fundamental for EMP & EF, involve a gender expert during EMP and EF.
Z	04	02	Audit	BTC-management	50,000	blue	Without gender analysis.
Z	04	03	Capitalisation	BTC-management	40,000	red	Specific attention to transformative development processes. All cross-cutting issues are fundamental for capitalisation.
Z	04	04	Backstopping expert department BTC	BTC-management	60,000	green	In function of needs / cross-cutting issue
Z	04	05	Scientific support	BTC-management	200,000	green	
TOTAL					**21,000,000**		



7.11 List of public entities eligible for improvement funds

Health Facilities List

Province	District	referral	provincial	District Hospital	Sector	Health Facilities
East	Bugesera District			Nyamata DH	Gashora	Gashora CS
	Gatsibo District			Kiziguro DH	Gasange	Gasange CS
				Ngarama DH	Gatsibo	Camp Nyabiheke CS
	Kayonza District			Gahini DH	Gahini	Gahini CS
				Rwinkwavu DH	Kabare	Cyarubare CS
	Kirehe District			Kirehe DH	Gahara	Gahara CS
	Ngoma District	Kibungo DH		Kibungo DH	Jarama	Jarama CS
	Nyagatare District			Nyagatare DH	GATUNDA	Nyarurema CS
	Rwamagana District		Rwamagana DH	Rwamagana DH	Fumbwe	Nyagasambu CS
Kigali City	Gasabo District			Kacyiru DH	Kacyiru	Kacyiru CS
				Kibagabaga DH	Gikomero	Bumbogo CS
	Kicukiro District			Masaka DH	Gahanga	Gahanga CS
	Nyarugenge District			Muhima DH	Kanyinya	Kanyinya CS
North	Burera District			Butaro DH	Bungwe	Bungwe (burera) CS
	Gakenke District			Nemba DH	Busengo	Busengo CS
				Ruli DH	Coko	Coko (ruli) CS
	Gicumbi District			Byumba DH	Bukure	Giti CS
	Musanze District	Ruhengeri DH		Ruhengeri DH	Busogo	Busogo CS
	Rulindo District		Kinihira DH	Kinihira DH	BUSHOKI	Tare CS
				Rutongo DH	BUREGA	Burega CS
South	Gisagara District			Gakoma DH	Gikonko	Gikonko (Gisagara) CS
				Kibilizi DH	Kansi	Gikore CS
	Huye District			Kabutare DH	Gishamvu	Busoro-gishamvu CS
	Kamonyi District			Remera Rukoma DH	Gacurabwenge	Kamonyi (gacurabwenge) CS
	Muhanga District			Kabgayi DH	Cyeza	Kivumu (muhanga) CS
	Nyamagabe District			Kaduha DH	Buruhukiro	Buruhukiro CS
				Kigeme DH	Cyanika	Cyanika (nyamagabe) CS
	Nyanza District			Nyanza DH	Busasamana	Hanika I (NYANZA) CS
	Nyaruguru District			Munini DH	Busanze	Runyombyi CS
	Ruhango District			Gitwe DH	Bweramana	Gitwe CS
			Ruhango DH	Ruhango DH	Kinazi (Ruhango)	Kinazi CS
West	Karongi District	Kibuye DH		Kibuye DH	Bwishyura	Kibuye CS
				Kirinda DH	Gashari	Birambo CS
				Mugonero DH	Gishyita	Mpembe CS
	Ngororero District			Kabaya DH	HINDIRO	Muramba CS
				Muhororo DH	BWIRA	Gashubi CS
	Nyabihu District			Shyira DH	Bigogwe	Arusha CS
	Nyamasheke District		Bushenge DH	Bushenge DH	Bushekeri	Gisakura CS
				Kibogora DH	Cyato	Yove CS
	Rubavu District			Gisenyi DH	Bugeshi	Bugeshi CS
	Rusizi District			Gihundwe DH	Bweyeye	Bweyeye CS
				Mibilizi DH	Bugarama	Islamic (Bugarama) CS
	Rutsiro District			Murunda DH	Boneza	Iwawa HC

7.12 City of Kigali participation with regard to the infrastructure in CoK

1. **KICUKIRO DISTRICT HOSPITAL**
   - Plot Number: 1348,1359
   - Area: 35110.933sq.m
   - **Cost: 596 885 861 Rwfs**
   - Human resources per year: **485 427 270 Rwfs** (*167 Staff*)

2. **KIMIHURURA PSYCHO SOCIAL DAY CARE CENTER**
   - Plot Number: L.R No 254 (Part B)+ L.R No 693 (Part A)+L.R No499 (Part A) /GAS/KIM
   - Area: 7,253sq.m
   - Cost: 184 110 000+11 960 000+ 21 530 000= **217 600 000 Rwfs**
   - Human resources per year: …….Millions Rwfs

3. **GATSATA HEALTH CENTER**
   - Plot Number: L.R.No:566(Part B)/GAS/GAT
   - Area: 10 632.70 sq.m
   - Cost: **154 000 000 Rwfs**
   - Human resources per year: **39 500 000 Million Rwfs** (*14 Staff*)

4. **KIMIRONKO HEALTH CENTER**
   - Plot Number: L.R.No.1121 (PartA)/GAS/KIM
   - Area: 14 298.757 sq.m
   - Cost: **450 330 000 Rwfs**
   - Human resources per year: **39 500 000 Million Rwfs** (*14 Staff*)

   Total cost for expropriation: **1 418 815 861 Rwfs**

Total salaries budget for 1District Hospital +2Health Center: **524 927 270 Rwfs/Year**

5. **ROADS**

Kicukiro hospital road around 600 Million Rwfs

Kimihurura will be 2 Sides around 1200 m: 700 Million rwfs

Gatsata: 250m: 145 Million Rwfs

Kimironko:450m: 262,5 Million Rwfs

Total: **1,707.5 MIlions Rwfs**