REPUBLIC OF RWANDA

MINISTRY OF HEALTH

FINAL REPORT
INSTITUTIONAL SUPPORT TO MINISTRY OF HEALTH – PHASE 4

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ACRONYMINISANTÉ

ANC	Antenatal Care
ATN	National Technical Assistant
BTC	Belgian Technical Cooperation – Belgian Development Agency
CDPF	Capacity Development Pool Fund
CBHI	Community Based Health Insurance
CHUK	University Teaching Hospital of Kigali
CHW(s)	Community Health Worker(s)
CoK	City of Kigali
CSQ	Chargé de Suivi Qualité – In charge of Quality Monitoring
DG/CS	Director General of Clinical Services
DG/PHIS	Director General of Planning and Health Information System
DH(s)	District Hospital (s)
DHMT	District Health Management Team
DHS	District Health Survey
DHUs	District Health Units
EDL	Essential Drugs List
EDPRS	Economic Development and Poverty Reduction Strategy
EmONC	Emergency Obstetric and Neonatal Care
ETAT+	Emergency Triage Assessment and Treatment
ETR	End of Term Review
EUR	Euro
FP	Family Planning
GIZ	German Technical Cooperation
HC(s)	Health Center(s)
HRH	Human Resources for Health
HSSP	Health Sector Strategic Plan
IFMIS	Integrated Financial Management Information System
HMIS	Health Management Information System
ITA	International Technical Assistant
JANS	
JADF	Joint Action Development Forum
JLCB	Joint Local Coordinating Body (Steering committee)
KFH	King Fayçal Hospital
LuxDev	Lux Development
M&E	Monitoring and Evaluation
MCH	Mother and Child health
MDGs	Millenium Development Goals
MEMMS	Medical Equipment Maintenance and Management System
MINECOFIN	Ministry of Finance and Economic Planning
MINISANTÉ	Ministry of Health
MINISANTÉ 4	Institutional Support Program to Ministry of Health – Phase 4

MMed	Master of Medicine
MoH	Ministry of Health
MSH	Management for Science Health
MTI (MMC)	Medical Technology and Infrastructure (former Medical Maintenance Center
MTR	Mid Term review
MWMP	Medical Waste Management Program
NCNM	National Council of Nurses and Midwives
PAPSDSK	Program d'Appui Institutionnel à la conception et la mise en œuvre du Plan Stratégique de Développement Sanitaire de la Ville de Kigali
PBF	Performance Based Financing
PECIME	Prise En Charge Intégrée des Maladies de l'Enfance - Integrated Management of Childhood Illnesses
RBC	Rwanda Biomedical Center
SONU	Soins Obstétricaux et Néonataux d'Urgence - Basic Emergency Obstetrical and Neonatal Care
SPH	School of Public Health
SPIU	Single Project Implementation Unit
TFF	Technical and Financial File
TWG	Technical Working Group
UB	Ubuzima Burambye (Long Healthy Life)

Intervention form

Intervention name	Institutional Support to Ministry of Health - Phase 4
Intervention Code	RWA 08 066 11
Location	Republic of Rwanda – Central level and local level (3 Districts; Bugesera District (Eastern Province), Gakenke and Rulindo Districts (Northern Province) From July 2013: Additional support to the city of Kigali three Urban Districts (Nyarugenge, Kicukiro, Gasabo)
Budget	**€ 12,601,756** (12,000,000 plus €306,279 reliquat APNSM II project plus € 295,477 reliquat PAPSDSK))
Partner Institution	Ministry of Health; Director of Intervention: Dr. Daniel NGAMIJE (Coordinator of MoH/Single Project Implementation Unit (MoH/SPIU)) Co-Manager (DELCO): Dr. Vincent Tihon
Date intervention start /Opening steering committee	15 August 2010 (start contract first ITA) 23rd of December 2010 (opening steering committee)
End date Specific Agreement	1st of August 2015
Target groups	Direct beneficiaries: The Ministry of health officials and employees, the regulatory framework, district of Bugesera, Gakenke, Rulindo, City of KigaliNyarugenge, Kicukiro and Gasabo and their health facilities Indirect beneficiaries: The population of the Republic of Rwanda using health care
Impact[1]	Rwanda has put in place a health system capable to respond in an appropriate way the needs of its population
Outcome 1 (Specific objective 1)	the local health system is strengthened through a better functionality of its institutions and their overall interactions
Outcome 2 (Specific objective 2)	The central level assures quality of the health sector through better planning, coordination, management and monitoring and evaluation, based on evidences generated by research

[1] Impact is a synonym for global objective, Outcome is a synonym for specific objective, output is a synonym for result

Outputs[2]	Note: Minisanté 4has the particular setting of double anchorage: this means that interventions at the district level (specific objective 1) do feed the policy development of the central level (specific objective 2). In turn, policies developed at central level (spec obj 2) can be tested or monitored closely at decentralized level (spec obj 1). This also explains why both specific objectives described below have the same outputs: **For Specific objective 1 decentralized level** 1. Capacity in planning, management and M&E has improved 2. The quality of health services in Rwanda is strengthened 3. Mental health of the Rwanda population is improved 4. The quality of health care technology management is increased 5. knowledge is systematically managed and developed at central level: action research is performed in the three districts and the evidences generated at local level do feed the development of policies **for Specific objective 2: central level** 6. Capacity in planning, management and M&E has improved 7. The quality of health services in Rwanda is strengthened 8. Mental health of the Rwanda population is improved 9. The quality of health care technology management is increased 10. knowledge is systematically managed and developed at central level: action research is performed in the three districts and the evidences generated at local level do feed the development of policies
Total budget of the intervention	12,601,756 + 300,000 (Rwandan Government contribution)
Period covered by the report	Final report -December 2010 - June 2015

[2] Outputs: note that the program initially had 13 outputs; following the MTR in 2012, this was later revised to 5 focus indicated in the table above

Global appreciation

Describe your global appreciation of the intervention (max 200 words):	Describe your global appreciation of the intervention (max 200 words):
Minisanté 4 has been an example of successful partnership at so many levels: With the community through initiatives around mutuelles as well as mental health support; through the construction of 10 maternities that have greatly improved access to health for pregnant mothers and allowed reduction of maternal mortality (as a contribution to MDGs goal) With District Hospitals and health staff in general, through the numerous training in quality and accreditation, supportive supervisions in mental health, and trainings in medical maintenance; through the provision of numerous medical equipment for maternities, health centers and hospitals to provide better quality of care With district authorities through the strengthening of decentralized level by the mentoring of DHMTs and DHUs as well as the support with district M&E Officers and the institutional support With the central level at MoH and RBC through the institutional, technical and financial support of the respective divisions and units With the partner BTC having been flexible and supportive to address the priority needs in the health sector in a successful partnership with SPIU and the Ministry of health	Minisanté 4 program was initially challenged due to its very broad scope and its inadequate anchorage with the Ministry of Health. The thorough analysis during the Midterm Review allowed to identify five focus areas to concentrated upon and facilitated an anchorage with SPIU. Particular attention enabled to address key priorities in the sector: planning, leadership and decentralization; quality of services and accreditation; support to adequate mental health services at all levels; strengthening of biomedical maintenance and infrastructure The program thereafter gained in relevance, through five critical area of support. It gained in effectiveness with the support of the SPIU expertise and procurement unit. Its efficiency improved through the coordination of all procurement of district constructions and procurement of equipment. As for sustainability, the nature of the realizations, the strong leadership at central level, the ownership at all levels are fair indicators to describe the program as having a good sustainability The partnership with districts, central level and particularly within SPIU was excellent and the spirit very good that made this program a stimulating, dynamic and very successful venture
Score your global appreciation of the intervention[3]:	**Score** your global appreciation of the intervention[4]:
Satisfactory	Satisfactory
National execution official[5]	BTC execution official[6]
Dr Daniel NGAMIJE	Dr Vincent TIHON

RWANDA BIOMEDICAL CENTER ★ P.O Box 7357 Kigali RBC/SPIU spiu@rbc.gov.rw ★ SINGLE PROJECT IMPLEMENTATION UNIT

APPUI INSTITUTIONNEL AU MINISTERE DE LA SANTE ★ PHASE IV B.P.84 KIGALI MINISANTE

[3] Very satisfactory - Satisfactory - Non satisfactory, in spite of some positive elements - Non satisfactory

[4] Very satisfactory - Satisfactory - Non satisfactory, in spite of some positive elements - Non satisfactory

[5] Name and Signature

[6] Name and Signature

PART 1: Results achieved and lessons learned

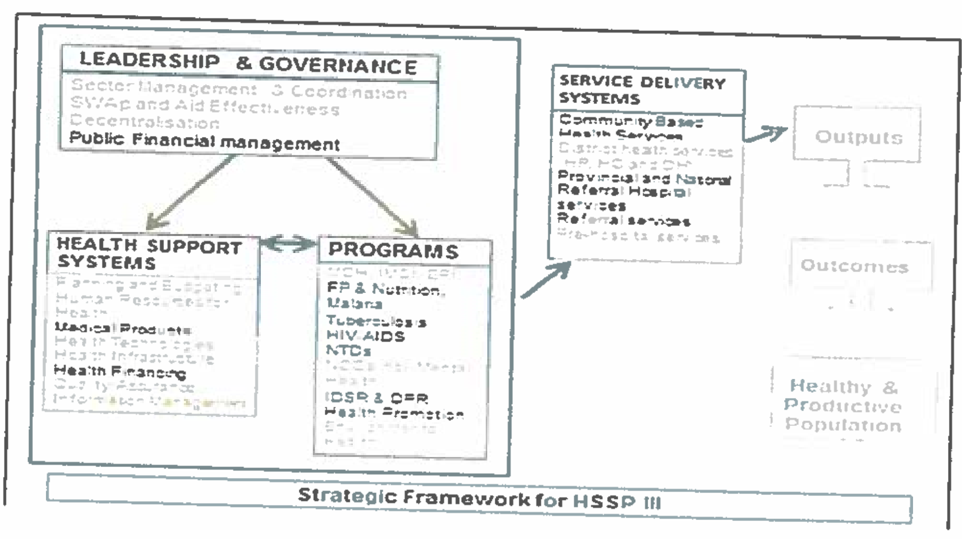
1 Assessing the intervention strategy

1.1 Context

1.1.1 General context

Minisanté 4 program was initially aligned to the HSSPII strategic plan 20009-2012 with its three strategic objectives and seven strategic interventions. The third Health Sector Strategic Plan (HSSP III) covering the period 2012-2018 was validated by the Ministry of Health in March 2012 following Cabinet approval of the second Economic Development and Poverty Reduction Strategy (EPDRS 2). It has become the reference for all MoH-supporting programs and is the key reference document for alignment to national strategies in the health sector. Minisanté 4 therefore aligned to HSSPIII upon its validation.

Conceptual framework of HSSP III:
HSSP III is guided by the same overall Vision and Goal as its predecessor, HSSP II:



Note: Yellow areas refer to areas supported by MINISANTÉ 4 program

Sector priorities and innovative directions of HSSP III:

The overall priority of HSSP III is to increasingly mainstream all MOH services to allow for quality and comprehensive care, requiring all programs and support systems to bring services into all levels of service delivery in a coordinated manner.

The following priorities were launched in 2012 and adopted for HSSP III implementation:

1. Achieve MDGs 1 (nutrition), 4 (child), 5 (MCH) and 6 (Disease control) by 2015;
2. Improve accessibility to health services (financial, geographical, community health)
3. Improve quality of health provision (QA, training, supervision)
4. Reinforce institutional strengthening (esp. towards district health services, DHU)
5. Improve quantity and quality of Human Resources for Health (planning, quality, management)

Strengthening the existing linkages between these components will ensure that the "*population receives promotive, preventive, curative and rehabilitative services of good quality, as close to the population as possible in an integrated manner*".

Two important programs were launched in 2012:

In September 2012, The Ministry launched the **accreditation program** whereby all district hospitals and later health centers will be benchmarked against agreed upon norms and standards. This is an ambitious program where other partners are also involved in particular Management Sciences for Health (MSH). This program has initiated its implementation in 2013 through norms and standards setting and initiation of District Hospital baselines. At this stage, most provincial hospitals have passed the first level of accreditation whereby district hospitals have initiated three components of accreditation namely: nosocomial infections, customer care and incident reporting. It is expected that 5 referral hospitals and 15 District Hospitals (DH) will be accredited by 2018

Another important new program is the **Human Resources for Health (HRH)**. This is an ambitious program and a unique national strategy that aims to strengthen health education in Rwanda for a healthy population and improved economic development. A key component of this strategy is the development of Rwandan faculty members to take the teaching responsibilities with the support of US universities. This program is expected to run over 7 years and initiatives are taken to ensure effective coordination with other capacity development initiatives such as Capacity Development Pool Fund (CDPF) funded by various partners including Belgium.

1.1.2 Institutional context

Minisanté 4 program was initially located within the Ministry of Health in link with the decentralization unit. Activities were directly linked with the respective units and departments.

In February 2011, Cabinet approved the creation of Single Project Implementation Unit (SPIU) in every Ministry (see description below 1.1.3)

In January 2011, a law established the Rwanda Biomedical Center (RBC) – Law No 54/2010 of 25 January 2011. The main missions of RBC are the following:

1. to coordinate and improve research activities in the field of disease prevention, education and provision of treatment to people at all levels;
2. to enable Rwanda to participate in the vital regional and global health activities, that it is beneficial to all people living in Rwanda;
3. to act as a biomedical center in the region;
4. to coordinate various biomedical and research activities with a view to generating income in health activities;
5. to provide Rwanda with a vision and coordinate joint activities of various organs in the fight against HIV/AIDS and other diseases;
6. to coordinate activities geared towards treatment, control and management of consequences of HIV and AIDS and other contagious and non-contagious diseases;
7. to put at the disposal of all people living in Rwanda drugs and medical equipment;
8. to provide highly classified medical expertise;
9. to establish relations and collaborate with other regional and international institutions having similar mission.

The RBC incorporated the following: National Commission against AIDS (CNLS); Center for Treatment and Research on AIDS, Malaria, Tuberculosis and other epidemics (TRAC PLUS); National Medical Referral Laboratory (LNR); Center for Blood Transfusion (CNTS); Kigali Health Institute (KHI); Procurement agency for medical equipment, drugs and supplies (CAMERWA); Pharmaceutical Laboratory of Rwanda (LABOPHAR); Central workshop and maintenance (ACM); Rwanda Health Communication Center (RHCC); Expanded Pro gram of Immunization (EPI); Psychosocial consultation services (SCPS). These were later restructured under the new RBC set up.

As a result, two focus areas for Minisanté 4 moved under the RBC structure (Mental Health and Medical technology and infrastructure) while two others remained under MOH (Planning & HIS and Clinical Services). Knowledge management remained across both RBC and MOH with external support from the School of Public Health (SPH).

During the year 2013, the establishment of the new position of Minister of State in charge of Public Health and Primary Health Care in the Ministry of Health strengthened its organizational and coordination structure. This enabled better functioning in terms of coordination and oversight of decentralized services. This included overseeing programs such as Minisanté 4. Two Director Generals were also appointed: Director General of Planning and Health Information System (DG/PHIS&M&E), and Director General of Clinical Services (DG/CS). This significantly strengthened the MoH as an institution.

1.1.3 Management context

Originally, Minisanté 4 program was not anchored in any unit or

department of the Ministry of health. It was operating with the respective units in line with the Technical and Financial Files (TFF) objectives and results. The Director of Intervention was initially the Director of Administration and Finance who was joined in 2011 by a medical coordinator in charge of Decentralization. This arrangement however did not prove to be optimal and a Mid-Term Evaluation (MTR) was called in after 19 months of implementation to address the issue.

The integration of Minisanté 4 into the MoH/SPIU was recommended by the MTR and took place in July 2012. Some recommendations included integrating the administrative management for the Minisanté 4 program into the SPIU by July 2012; reviewing the organization of the Minisanté 4 program to fill some key positions which were missing; limiting the number of national program directors to one (one Director of Intervention); clarifying the functions/Terms of Reference of Minisanté 4 Co-Managers and Senior Technical Advisors; and continuing to ensure the Ministry of Health's ownership and leadership of the program. The integration of Minisanté 4 implied that the program had to have a dedicated Project Officer within the SPIU and three District Project Officers to interact closely with the Minisanté 4 Director of Interventions and DELCO. The use of the functions of the SPIU such as organizing and conducting quarterly implementation progress review workshops and M&E field visits aimed at discussing the progress of planned activities with each of the sub-recipients had a positive impact on achieving targets.

This integration allowed continuous improved coordination and increasing ownership of interventions by the Ministry of Health and RBC. As the key role of SPIU is to ensure integrated and consistent management of projects in the health sector, its mandate includes: providing technical assistance to institutions, technical units and project beneficiaries MoH during the process of project planning and fundraising; ensure harmonization and complementarily of interventions and budgets across different projects including Minisanté 4. This integration of Minisanté 4 has been very suitable as it is an added value to the program, it has strengthened partner ownership and alignment especially in supporting the process of procurement

1.1.4 Management context: execution modalities

There has been a mix of modalities being used according to recipient institution status and program management:

- <u>Districts</u> operate through execution agreements. This provides the districts maximum autonomy (within comanagement context) and responsibility in the implementation of the actions plans approved by the steering committee
- <u>Central units of MoH and RBC Divisions</u> operate in a classic comanagement. Each unit or Division has one identified internal focal person and receives additional technical support from Minisanté 4 International Technical Assistants (ITA). Action plans are prepared before each fiscal year (July to June) to be approved

by the steering committee. Payment of approved activities is done by the Minisanté 4 financial staff (financial manager and accountant)

- School of Public Health: an execution agreement has been signed with the School of Public Health (SPH) and aims to strengthen and enable SPH to assist districts and central units to perform action research and capitalization of relevant experiences.

The integration of Minisanté 4 in SPIU (recommended during the midterm review) facilitated the improvement of the management of interventions including tender processes. The SPIU/Minisanté 4 organized trainings on procurement procedures, financial and hospital management, customer care, for Boards of Directors, district and hospital staff. However, due to slow tendering processes in the districts, the SPIU was given the mandate by the steering committee to implement some tenders for the districts in order to improve efficiency and accelerate the implementation of program activities. This in a way reduced the involvement of districts in managing their interventions but was identified by all parties as the best way forward to ensure effective implementation of the program. Nevertheless, districts were still in charge of assessing their needs and contributing to the technical specifications of Works and goods (medical equipment, etc) that were procured by MoH/SPIU with technical assistance from RBC/MTI.

Technical support at district level was initially provided by one ITA facing challenges to provide meaningful assistance to the three districts. Upon his departure in 2011, the steering committee approved that the position be replaced by three National Technical Assistants (ATN) in 2012, who were replaced by three Program Officers (POs) in June 2013. These were based in the three districts constituting the intervention area. A Procurement specialist was recruited in January 2013 to strengthen the procurement unit within SPIU (February 2013) and to contribute to Minisanté 4 program to make a significant step forward in the implementation of activities. In coordination with PAPSDSK program, the advisor for quality control in administration and finance pursued is part-time support to Minisanté 4. He later fully joined Minisanté 4 program to provide expertise in tenders and execution agreements management

At central level, an ITA psychiatrist joined the program in November 2011 and an ITA biomedical engineer was recruited in August 2013 to work with the Medical Technology and Infrastructure Division (MTI) in a strategic position to strengthen the MTI institution.

The reinforcement in human resources and integration within MoH/SPIU allowed Minisanté 4 Program to accelerate the implementation of activities and performed a cumulative budget execution of 62% by the end of 2013 comparing with 39% by end 2012.

1.1.5 Harmo context

In order to strengthen harmonization between development partners and the Ministry of Health, Minisanté 4 program participates in different Technical Working Groups (TWG) in particular:

- as co-chair of Health System Strengthening TWG thereafter co-chair of Quality and Standards TWG
- co-chair of Mental Health TWG
- co-chair of Health Technology Management TWG
- as member of Planning and M&E TWG
- member of Human resources TWG
- member of Sector Wide Approach (SWAp).

These TWG have been restructured in 2013 in order to reduce their number and increase their effectiveness.

The departure of German Technical Cooperation (GIZ) and Luxemburg Development (LuxDev) from the health sector, linked with adjustment to the donor labor distribution has left a gap in the policy dialogue between donors and MoH. 2013 has seen a general reduction in donor support in monetary terms related to global economic crisis and division of labor. As a result, major contributors in the health sector in 2015 are: the Global Fund, PEPFAR, USAID (incl MSH), CDC and Belgium Development Agency.

Furthermore, the establishment of SPIUs in each ministerial department by the Government of Rwanda allows for better coordination of interventions from different partners in the health sector. This includes among others: Center for Diseases Control, Rockefeller Foundation, Capacity Development Pooled Fund, Global Fund, Belgian Development Agency, World Bank, East African Community, and Global Action Vaccine Immunization (GAVI).
The results of this new structure gives room for alignment of procedures both at decentralized and center levels and increased ownership by the partner

1.2 Important changes in intervention strategy

In March 2012, after 19 months of program implementation, the Minisanté 4 program team requested a mid-term review. The rationale for an early MTR was that there had been a delay between formulation that called for 're-actualization' of some interventions as well as a change of context (creation of SPIU as well as RBC)

While the MTR highlighted that the program was highly relevant, findings included the fact that program implementation had been fraught with difficulties at managerial and technical levels. MTR review recommended two significant strategic changes among other recommendations:

1. The integration into SPIU/MOH (described above)
2. The focalization process

The focalization process:
Minisanté 4 initial framework included to work on 13 results (6 for the local system and 7 for the global system). These could not easily be implemented and led to dispersion of the program with high risk of low effectiveness and

efficiency. The logical framework was revised during the comprehensive midterm review that recommended to focus on a limited number of strategic areas (5) aligned to the health sector priorities. The strategic areas included:

- Planning, M&E and decentralization: to support capacity building of DHMTs in management, planning, M&E
- Clinical Services: The quality health services in Rwanda is strengthened
- Mental Health Division: Mental health of the Rwandan population is improved
- MMC Division: the quality of healthcare technology management is increased
- Research: knowledge is systematically managed and developed at central level: action research is performed in the three districts and the evidences generated at local level do feed the Development of policies

The focalization process was a very participatory process that involved all key stakeholders as well as MoH authorities. It did not actually represent a change of strategy but allowed for a concentration of the program on key priority areas for better efficiency and potential impact.

2 Results achieved

2.1 Monitoring matrix

The indicators used in the Technical and Financial File (TFF) of Minisanté 4 as well as the five focus areas identified after the 2012 mid-term review were streamlined with Health Sector Strategic Plan III priorities. The program initially did not have its own M&E plan and until 2013 focused on contributing to achieving the indicators set out in Health Sector Strategic Plans II and III.

A program M&E plan was developed in 2013 with a set of 2-3 indicators per focus to be monitored and reported on regularly. As there was no specific M&E plan in the beginning of the program, this report will refer to both: national indicators as well as the program indicators developed later on. The extent to which indicators (in particular national indicators) have been achieved cannot be attributed to Minisanté 4 only, since they are the results of numerous activities, programs as well as sources of funds. Since the program is a 'MoH-institutional support' program, it can also be proxy-evaluated based on the achievement of the health sector as a whole.

An important number of health indicators cannot be captured annually and hence require national surveys programs every five years such as Demographic and Health Survey (DHS). The next Rwanda DHS is programmed to start in August 2014.

Results / indicators	Baseline Value (2010)	End Target (2014)	End Value obtained (2014/15)	Comments
IMPACT/General Objective: Rwanda has put in place a health system capable to respond in an appropriate way the needs of its population.				
Reduce infant mortality rate	86‰	37‰	32‰	
Reduce Under 5 mortality rate	152‰	66‰	50‰	
Reduce maternal mortality rate (/100 000)	750	353	210	
Reduce fertility rate	6.1	4.5	4.2	
Reduce HIV prevalence among 15-49y	1.0%	0.5%	1%	
Reduce chronic malnutrition (stunting) amongst U5 children	51%	24.5%	38%	
OUTCOME 1/ Specific Objective 1: The local health system is strengthened through a better functionality of his decentralized institutions and their overall interactions.				
% of districts with 1 Health Center per sector	95% districts	100%	98%	7/ 416 (2%) sectors without HC
% of Health Facilities with the full package of	100%	100%	100%	Source: R-HMIS, 2015

activities (PMA, PCA)				
% of Health facilities covered by the whole package of PBF	93-100%	100%	100%	All public facilities except King Faisal Hospital are in PBF system. Currently, even some private facilities in Kigali like Carrefour and Le Plateau polyclinic have been added to the PBF system. Source: HFU/MoH, 2015
% of population living within less than one hour or 5 km walking distance of a Health Facility	N/A	N/A	57%	Compared to EICV3, the average time required to access the nearest health centre on foot has decreased by four minutes (from 61 to 57 minutes). Source: EICV 4, 2014-15
% of health facilities with electricity and water	85% HC and 100% DH	85% HC and 100% DH	HFs with Electricity: 85% HCs & 100% DHs HFs with Water: 89% HCs & 100% DHs	Total number of health facilities: 558 (include 8 RHs, 4 PHs, 35 DHs, 510 HCs) Source: R-HMIS 2015
% of health facilities with a maintenance tracking system	N/A	N/A	N/A	The maintenance tracking system (MEMMS) is still under development and has not been operationalized in all HFs
% of districts with operational SAMU	100%	100%	100%	Source: R-HMIS 2015
% of health facilities adhering to the EDL, Standard Treatment Guidelines and National Formulary	N/A	100%	100%	Updated list is available and is a requirement by MoH and health insurances for health facilities to adhere to EDL in order to be paid for medicines provided to patients. Source: PTF/MoH
% of health facilities with stock outs of essential drugs per quarter	N/A	Less than 5%	2%	98% of facilities did not report any stock out. Stock out is considered if there is a stock out of more than 5% of drugs on EDL
% of facilities offering the mental health package at all levels.	27/30 DH	100%	100%	Source: MoH
% of women aged 15 - 49 using modern contraceptives	45% (DHS 2010)		53%	Policy action focused on regular provision of FP commodities and reducing stock outs Source: R-DHS 2014-15
OUTCOME 2/ Specific Objective 2: The central level assures quality of the health sector through better planning, coordination, management and M&E, based on evidences generated by research.				
% of costed, implemented and monitored action plans	100%	100%	100%	Source: HSSP III – MTR report
% of DPs signed up to SWAp MoU	32%	100%	100%	DPs each have separate MoUs with SWAp/MoH. No collective SWAp MoU as yet to refer to. Awaiting orientation from MoH
% of Districts with operational SWAp		100% JADF	100% JADF	
Ratio of medical doctors to 10,000 inhabitants	1/16,000	1/13,748	1/10.055	Source: HSSP III MTR

				Report
Ratio of qualified nurse A1, A0, Masters	1/1,291	1/1,291	1/1,142	Source: HSSP III MTR Report
% of Health Facilities with a midwife present	156 midwives 1/66,749 Population	1/45,000	1/45,000	Source: HSSP III MTR Report
Public Health expenditure as % of GoR total expenditure (% of budget allocated to health out of total GoR budget)	11%	12%	17%	Public Health expenditure as % of GoR total expenditure cannot be known since we have no National Health Accounts (NHA)
% Population covered by health insurance	91%	91%	76.3%	Source: R-DHS 2014-15
% of eligible hospital bills reimbursed by District Pooling Risk	N/A	N/A	N/A	Districts are not paying bills anymore since no pooling risk and central level (RSSB) is paying bills.
% of Health facilities reporting according to existing HMIS norms	100%	100%	100%	Source: R-HMIS 2015
% of facilities involved in accreditation system	(5) labs	42 DHs /558 HFs		All DHs, referral and provincial hospitals are in accreditation process
% of national policies and guidelines referencing research results	100%	100%	100%	At least all policies of MoH refer to DHS findings

Result/Indicators	Baseline Value (2010)	End Target (2014)	End Value obtained (2014/15)	Comments
OUTPUT 1/Focus Area 1: Capacity in planning, management and M&E has improved				
DHMTs set up and functional based on ToRs (100% in 6 Districts supported by Minisanté IV)	N/A	100%	100%	Note that this is an ongoing process to be further strengthened
100% of Districts set up a functional and integrated M&E system	N/A	100%	100%	As above
100% of Districts have developed a five years Health Sector Strategic Plan to be implemented in alignment with HSSPIII & EDPRS II	N/A	100%	100%	Need MTR to take place in 2016
100% of Districts have developed operational and M&E plans for their Health Sector Strategic Plans	N/A	100%	100%	As above
OUTPUT 2/Focus Area 2: The quality of health services in Rwanda is strengthened				
05 DH with accreditation committees functional	N/A	100%	100%	Actually MOH moved faster to have committees in all hospitals
Registered Private HF respect norms and national standards	N/A	100%	100%	Norms for opening and operating clinics only Other norms tbc

Result/Indicators	Baseline Value (2010)	End Target (2014)	End Value obtained (2014/15)	Comments
OUTPUT 3/Focus Area 3: Mental health of the Rwandan population is improved				
100% DH have a decentralized & integrated mental health service and 100% of HC have at least one GN trained in MH	No trained staff in HC	100% of DHs provide integrated mental health service included 100% of HC have at least one GN trained in MH	100% of DHs provide integrated mental health service included 100% of HC have at least one GN trained in MH	MH focus started from November 2011
Referral structures strengthened by launching MMed Psychiatry in Rwanda: curriculum validated & 5/5 candidates following 1st academic year abroad in partner universities according to MOH HRH plan	No specialisation in psychiatry	Curriculum validated & 5/5 candidates following 1st academic year abroad in partner universities according to MOH HRH plan	Curriculum validated. 3 candidates admitted in 3d academic year and 2 candidates admitted in 2d academic year	Ongoing program will still require donor support (provided in future program)
Mental Health Division has drafted a Mental Health Law to regulate MH practice and preserve patients' rights	No MH law at that time	MHD has drafted a MH Law	MH Law has been drafted and in process of validation	Some delays at parliament for approval of the law
OUTPUT 4/Focus Area 4: Maintenance system and policy on management of biomedical equipment are strengthened				
Strategic plan of MTI Division developed and validated	N/A	100%	NA	Strategic plan not finalized ; waiting for recommendations from in depth assessment - 2016
Guidelines and norms of HCTM are developed and disseminated	N/A	100%	ongoing	Process initiated but need finalization during future program support
OUTPUT 5/Focus Area 5: Knowledge is systematically managed and developed, action research is performed and the evidences generated to feed the development of policies				
At least 3 action research projects developed in 3 districts on priority health problems to inform national policy and result in effective interventions in the districts	N/A	100%	100%	Done and disseminated
Strategic interventions are strengthened through evidence based action research supported by School of Public health	N/A	100%	100%	
Each Minisanté 4 focus and district	N/A	100%	100%	Booklet due to be

Result/Indicators	Baseline Value (2010)	End Target (2014)	End Value obtained (2014/15)	Comments
develop a capitalization action				published in 2016

2.2 Analysis of results

2.2.1 To what extent will the intervention contribute to the impact[7] (potential impact)?

Impact: Rwanda has put in place a health system capable to respond in an appropriate way the needs of its population

The activities supported by Minisanté 4 program both at central and district levels show a clear and tangible link between the Minisanté 4 program outcomes and impact in that the health sector (through the strengthening of both levels, MoH and RBC implementing institutions as well as the districts/DHMTs,), now has increased capacity to develop better strategic plans with corresponding operational and M&E plans; improved accessibility to and increased quality of MoH-priority core services (e.g. support to CBHI scheme and quality MCH services, Quality improvement schemes/Accreditation for District Hospitals, provision of key equipment and infrastructure especially for Maternal and Neonatal services). Collectively, these activities will enable the health sector to provide better quality services to the Rwandan population as the originally desired impact.

An important characteristic of the BTC's institutional strengthening approach is the 'double anchorage'. Institutional capacity is strengthened at two levels. At peripheral level, the district is strengthened to correctly manage and implement the national health programs, and at central level, national management and policy making is strengthened. Operating at these 2 levels provide the advantage that lessons learned from the field can be better translated into policies, and newly developed strategies can be piloted in the supported districts.

2.2.2 To what extent has the outcome been achieved? Explain

Outcome 1 (Specific Objective 1): The District health system is strengthened through a better functionality of its institutions and overall interaction including with the central level (Better planning, coordination, management and M&E)

The interventions supported by Minisanté 4 at district level were integrated in the annual action plans of each district and the Minisanté 4 budget was fully incorporated in the district budget and Integrated Financial and Management Information System (IFMIS). Furthermore, some funded activities were part of the district or MoH IMIHIGO performance program.

[7] Terminology : Impact = General Objective ; Outcome = Specific Objective; Outputs = Expected Result

Guidelines for districts to institute their DHMTs and District Health Units (DHUs) were disseminated and local technical assistance including the funding of district M&E officers in each district enabled districts to better use their data to identify their priorities, to plan realistically and monitor the implementation; M&E positions at district levels were later on taken over by the districts themselves. All districts have now development plans for health, annual action plans, monitoring dashboard and data quality tools. Collectively, the implemented activities have enabled the districts, especially DHMTs, to develop better strategic plans with accompanying operational and M&E plans, improve accessibility to and increase quality of MoH-prioritized health services (e.g. support to CBHI scheme and MCH, Accreditation initiated at District Hospitals, provision of medical equipment, provision key infrastructure for Maternal and Neonatal services). As a result, accessibility to assisted deliveries have increased from 69% to 91%

Imihigo is about outstanding performance: something worth of praise.

As part of efforts to reconstruct Rwanda and nurture a shared national identity, the Government of Rwanda drew on aspects of Rwandan culture and traditional practices to enrich and adapt its development programs to the country's needs and context. The result is a set of Home Grown Solutions - culturally owned practices translated into sustainable development programs. One of these Home Grown Solutions is Imihigo.

In 2000, a shift in the responsibilities of all levels of government as a result of a decentralisation program required a new approach to monitoring and evaluation. Local levels of government were now responsible for implementing development programs which meant that the central government and people of Rwanda needed a way to ensure accountability. In 2006, Imihigo (known also as performance contracts) was introduced to address this need in order to reinforce the local government

Imihigo is the plural Kinyarwanda word of Umuhigo, which means to vow to deliver. Imihigo also includes the concept of Guhiganwa, which means to compete among one another. Imihigo describes the pre-colonial cultural practice in Rwanda where an individual sets targets or goals to be achieved within a specific period of time. The person must complete these objectives by following guiding principles and be determined to overcome any possible challenges that arise.

In the modern day Rwanda, the Imihigo practice was adopted as a means of planning to accelerate the progress towards economic development and poverty reduction. Imihigo has a strong focus on results which makes it an invaluable tool in the planning, accountability and monitoring and evaluation processes.

Since its introduction, Imihigo has been credited with improving accountability and quickening the pace of citizen centred development activities and programs. The practice of Imihigo has now been extended to ministries, embassies and public service staff.

Outcome 2/ Specific Objective 2: The central level assures quality of the health sector through better planning, coordination, management and M&E, based on evidences generated by research.

The central level units supported by Minisanté 4 program include two MoH units (Directorate General of Planning, Health Information Systems and M&E plus Directorate General of Clinical and Public Health Services), two RBC Divisions (Medical Maintenance Division and Mental Health Division) as well as the University of Rwanda-School of Public Health (UR-SPH). Specific support included the evaluation of HSSPII and the development of

HSSPIII including its M&E plan, guidelines for implementation of decentralization of the health sector (DHMTs), support to district development planning process, SWAP, accreditation process development, mental health law and MMed Psychiatry initiation, review of medical maintenance standards, etc. A booklet including some of the evidence based work is under publication for dissemination

2.2.3 To what extent have outputs been achieved? Explain

FOCUS 1: Capacity-building of District Health Management Teams in management, planning and M&E:

The Minisanté 4 program has enormously contributed to strengthen the central level by increased human resources support, support for district planning and coordination, funding and trainings of 30 district M&E officers, data quality assurance and management, as well as use of data for decision-making; support central level for supervisions, mentorship and coaching of M&E Officers; further support to the Mutuelle Sector Units as well as facilities supported for infrastructure development and provision of equipment, etc. In addition, they facilitated the above-mentioned trainings, ensured supervision and mentorship to DHMTs so that they adhere to their TORs. While support at central level concentrated on policy development, guidelines, partner coordination around planning, decentralization and M&E guidelines, at local level, general support was provided through dissemination to all districts and specific support to the three districts specifically supported by Minisanté 4 financially as well as technically. Particular attention on M&E was in Rulindo district (see action research) while support to mutuelle and community based insurance was provided in Bugesera district.

FOCUS 2: Strengthening the quality of health services in Rwanda

Initial activities aiming at quality improvements concentrated on quality of care in particular clinical diagnosis. Clinical 'audits' were organized in the five district hospitals supported by the program as well as discussions with clinicians. In September 2012, the Ministry of Health embarked on a process of hospital accreditation whereby all district hospitals and later health centers, will be benchmarked against agreed norms and standards. A considerable amount of work has been done to update norms and standards of care with the support of Minisanté 4. District hospital accreditation committees have been put in place.

Other activities supported include

- training for health care providers on the accreditation policy and the expected roles at district level; training on emergency obstetric and neonatal care; and the rehabilitation and extension of key infrastructure such as maternity departments, operating theatres and neonatal units — all geared towards improving maternal and child health by improving access to quality care.
- Strengthening of district hospitals health quality committees and accreditation committees to plan, organize and mentor health providers according to the national guidelines related to Quality Assurance, accreditation and PBF;

- Training of health managers in accreditation and QA process and related activities in all supported district hospitals (following related supported policies and standards at central level by Minisanté 4;
- Technical and financial support of the process of linking accreditation with PBF in the 5 supported district hospitals;
- On-the-job training, coaching and mentorship, regular service SWOT analysis or internal assessment of QA, accreditation-PBF committee in partnership with Referral Hospitals (CHUK and KFH) to improve expected quality and accreditation.

In the urban setting of Kigali, four urban health centers had been built in 2013 through the support of another Rwandan-Belgian program supporting the City of Kigali. These centers are fairly large and it was suggested to appoint medical doctors to work there with the objective of increasing the accessibility to chronic disease management and maternal health (medicalization of health centers). Minisanté 4 embarked on supporting the coordination of all stakeholders to define this package of care in the new, modern health centers and assist both MOH and City of Kigali to implement it. However, by the end of the program, the health centers were still awaiting for the appointment of a Medical Doctor. This program will be followed up in the next health program (Ubuzima Burambye - UB).

Besides medicalization, the program continued assisting the establishment of an urban health concept including a functional interhospital network of Kigali hospitals. The objective of the networking being multifold: improve coordination of services, rationalize the access to specialist care, reduce waiting times for appointments at central hospitals, improve effectiveness of patients' referrals across the hospitals, improve cost benefits from joint procurement ventures, etc.

FOCUS 3: Mental Health

Mental health services are now effectively decentralized across the country. Each of the country's 40 district hospitals has its own mental health unit which delivers a comprehensive mental health care package according to the national standards. At least one general nurses per health center (over 480) and at least one CHW per village (15 000 CHW) were trained to ensure an integrated mental health care component in health centers and at community level. The decentralized health facilities are now capable of providing the appropriate care, and fewer referrals are made to specialized mental health care facilities at central level.

Rwanda lacks staff with an educational background in psychiatry. In 2013, with the support of the program, the University of Rwanda launched a third-cycle specialization in psychiatry to increase the pool of trained psychiatrists in the country. Specialists will ensure quality of care and expand health care provision.

The National Mental Health Policy (2011) highlighted the need for mental health legislation that upholds the rights of people with mental health problems and that establishes a legal framework in mental health care practice. Currently, a Mental Health Law has been drafted and is in process for validation after a large consultation process. In the future this law will

allow to regulate the mental health practice and protect rights of people living with mental illness.

Other major achievements by the Mental Health division include support to national policy development on drugs and substance abuse; sensitization of the community on mental health issues; strengthening referral systems from community to district to hospital and tertiary structures; management of psycho-social emergencies during the annual national Genocide Commemoration Week etc. There is now less need for central-level intervention at the district level during Genocide Commemoration Week, since the district-level facilities have now been trained and are capable of handling any emergency situation. A draft law to regulate the mental health practice and protect patients' rights has been developed and is currently being validated.

Reinforcing mental health care allowed the health system to better manage mental health disorders and deal with a major public health problem in the country.

Decentralizing mental health care allowed essential mental health care to be made available locally. Geographic accessibility was increased and the number of transfers to mental health referral structures reduced.

Integrating mental health care component in PHC and reinforcing capacity of health professionals allow patients to be treated as near as possible to their home.

By focusing on different levels of the health system and training non-specialist professionals, mental health interventions have been contributed to promote people-centered care.

FOCUS 4: Improving the quality of health care technology management and medical maintenance

Minisanté 4 provided equipment and capacity building to upgrade the DHs technicians in Medical Maintenance management and regular trainings supported by MOH. The program contributed to establish a Medical Equipment Maintenance and Management System "MEMMS" in all districts hospitals to facilitate the inventory of medical equipment, describe its condition (in use or not) and build an asset register in each hospital as well as nationally. It is a web based system that allow immediate transmission of information to the central level for the planning of maintenance as well as the priority setting for procurement and distribution of equipment.

Following one of the recommendation of the MTR, an International Technical Assistant/Biomedical Engineer was recruited in August 2013 to provide strategic support to the Medical Technology and Infrastructure division. Initial activities included situation analysis, on-site visits, development of policies on donations of medical equipment as well as on scrapping equipment, support to a web-based medical equipment inventory, and standardization of technical specifications and users' manuals.

Other achievements supported by Minisanté 4 include providing critical

medical equipment to five district hospitals, assistance in providing technical specifications for planned equipment, routine curative and preventive maintenance of equipment, and capacity-building initiatives for central and district-level maintenance staff.

Despite some good achievements, more work is required to strengthen the MMC Division that has been all along not clearly structured, understaffed, overworked and lacking financial support. Funding from the PAREC/study Funds co-managed by MINECOFIN and BTC has enabled a consultancy that is looking at asset inventory in all district hospitals and to provide strategic guidance to make medical equipment procurement and maintenance as well as infrastructures more effective and efficient (there are currently four procurement committees in the health sector). Consultancy report will assist both MOH and RBC to redefine clear objectives and system for effective medical maintenance and procurement systems in the country. This will be facilitated through the forthcoming health program 'Ubuzima Burambye' (UB) (long healthy life)

3 supported Districts:

The Minisanté 4 program supported 3 districts upon agreement with MoH. These were Bugesera, Gakenke and Rulindo Districts. The administrative district was the budget holder with activities in their execution agreements being implemented by the DHMTs and District Hospitals which received various forms of support channeled through the five focus areas.

All support felt under the first outcome (specific objective) namely: *the District health system is strengthened through a better functionality of its institutions and overall interaction including with the central level (Better planning, coordination, management and M&E)*

The tables below present the details on extent of achievements of outputs as reported in the final reports from the 3 districts.

Rulindo District

Results / indicators	Baseline Value	End Target	End Value obtained	Comments
RESULT 1: The DHMT is strengthened in management, coordination, planning and M&E				
DHMT Quarterly meeting	0	100%	100%	DHMT's quarterly meetings were organized and conducted as planned. It is functioning on a regular basis and coordination improved: A plan and calendar for meetings exists, reports available and recommendations are being put in action by field visits for implementation of resolutions taken.
Training of 42 leaders in leadership and good governance for all district health system leaders	N/A	100%	90%	The 90% District health System leaders(Elected committees members/Mayor, Vice- Mayors in charge of Social Affairs and Development & Economic Affairs, DHU and DHs) actively involved in health sector: 38 leaders from district to sectors were trained in leadership.

Results / indicators	Baseline Value	End Target	End Value obtained	Comments
Training in procurement for all members of district health system entities	N/A	100%	100%	34 Procurement Members of district health system entities trained in Procurement Procedures (DHU, Procurement Officers and DHs teams) with Minisanté 4 Program's officers.
Workshop organized for district health strategic and M&E plans	N/A	100%	100%	M& E plan and strategic plan set to guide overall district health system indicators and to operationalizing HSSPIII at district level. Availability of Data and analysis for accurate information for better decisions making by district authorities.
Training of all accountants of Health Facilities(HF) on Administrative & Financial Procedures Manual use and Reporting	N/A	100%	100%	Accounting system was improved within all Health facilities. Minisanté 4 budget support integrated in Information Financial Management System (IFMINISANTÉ) and monthly reported in overall financial reporting system.
Master's studies in Public health for 3 DHMT's members of districts health unit and DHs	N/A	100%	100%	At the beginning there were two candidates and then one additional due to the new hospital inaugurated, DHs and DHU supported for Master's in Public Health
Provide logistic to HFs and district (two vehicles for supervision and two motorcycles)	N/A	100%	100%	2 vehicles for supervision to the 2 DHs and 3 motos provided to 2HC and 1 for District M&E Officer
Integrated M&E system and Mentoring of data managers in charge of CHWs of HC in data analysis and management	N/A	90%	90%	Data Quality still needs many efforts
3 days' workshop to evaluation and annual planning for Kinihira and Rutongo DHs with their respective HC for FYs(12-13&13-14)	N/A	100%	100%	The planning process was successfully but M&E planning is still in its improvement.
CBHI Mobilization sessions conducted in 494 villages of Rulindo to develop small groups of CBHI in increasing CBHI coverage	N/A	100%	100%	The mobilization was done at the good rate but its outcome did not reach at the desired percentage.
Training of all CBHI sections ofRulindo in computer use, data analysis and reporting	N/A	100%	100%	Still need of support in this area

Results / indicators	Baseline Value	End Target	End Value obtained	Comments
RESULT 2: Quality Health Care Service delivered to population according to norms and standards				
Training in hygiene and clean environment for district, sectors and HC representatives	N/A	100%	100%	Supported 37 TOT (district, sectors and HC) for hygiene and clean environment: Existing 494 operational Clubs of hygiene
Formation des médecins en echographie et en chirurgie générale ou urgences	N/A	100%	100%	4 medical Doctors trained
Training in QA for Kinihira and Rutongo QA committees members for quality of health care	N/A	100%	100%	99 staff from Rutongo DH and 37 from Kinihira DH were trained
Training in ETAT for health providers of Kinihira district hospital	N/A	100%	100%	7 health providers trained in ETAT
Training in EONMC for health providers of Kinihira district hospital	N/A	100%	100%	48 health providers trained in EONMC
Training in IMNCI for health providers of Kinihira district hospital	N/A	100%	100%	48 health providers trained in IMNCI
Training in Data use and dissemination for health providers of Kinihira&Rutongo districts hospitals	N/A	100%	100%	17 health providers trained in Data use and dissemination
Training in Drugs Management for health providers of Kinihira&Rutongo districts hospitals	N/A	100%	100%	23 health providers trained in Drugs Management
Training in Accreditation Program for health providers of Kinihira&Rutongo districts hospitals	N/A	100%	100%	All staff in Kinihira and Rutongo DH were trained in 3 key areas: customer care, surgical infection control and conflict management(internal situation analysis, elaboration of policies and procedures ongoing after assessments done by MOH/ central level)
Provide funds for fuel and other running costs for ambulances and moto for evaluation and supervision of HC and for references and counter reference	N/A	100%	100%	The expected budgeted was provided in the normal period (End October 2011-2012) but finally it was pulled out in running costs

Results / Indicators	Baseline Value	End Target	End Value obtained	Comments
RESULT 3: Maintenance system and policy on management of biomedical equipment are strengthened				
Purchase equipment for MCH, Radiology, theater, dentistry and orthopedic, etc. following the DHs capacity needs for Kinihira and Rutongo DHs	N/A	100%	100%	All planned equipment was bought except for some reallocations done. There is still a need in this area (More equipment are needed)
Support trainings for BMT in software for medical maintenance equipment, inventories and updates on needs of spare parts and tools	N/A	100%	60%	BME of 2 DH trained in MME management, but there is still lack of knowledge in service departments.
Provide water tanks (10 000 litres) Tare, Rulindo, Kisaro, Masoro, Tumba (2 water tanks / HC) HCs	1HC	100%	100%	All planned water tanks were bought. Quality of care still requires sufficient water.
Extension of Nyabuko et Marembo health posts to become health centers, rehabilitation of 5 maternity halls(MUSHONGI, BUYOGA, MURAMBI, TUMBA & KAJEVUBA), Rehabilitation of retaining wall of TARE HC and Purchase medical equipment for BUBANGU, BUREGA, MAREMBO, NYABUKO ET MUSHONGI health posts become new HC	N/A	100%	100%	Geographical access improved but still to be increased
Rehabilitation of latrines of Rutongo DH	N/A	100%	100%	Improved hygiene in health facilities but still remains a big challenge at HC level.
Extension of DHU office	N/A	100%	100%	It was extended but still small
Rehabilitate the services of Maternity and theater of Rutongo DH	N/A	100%	100%	Improved quality of health care services but due to low budget, the rehabilitation required still remain
RESULT 4: Mental health is developed according to strategic plan and integrated model of health care				
Support monthly supervision in MH for all HC of Kinihira & Rutongo (1 supervision/HC/M)	0	100%	100%	Mental health package integrated in MPA&CPA in all Public HF of Rulindo District. 30% indicates that the activity is done in one time one year/3yrs
Training for 46 health providers in MH for	0	100%	100%	44 health providers of DH and health centers trained in MH

Results / indicators	Baseline Value	End Target	End Value obtained	Comments
Kinihira et Rutongo DHs				management, supervision and community mental health management
Technical support during national mourning period activities in Kinihira & Rutongo catchment areas	0	100%	100%	Continuum of care in MH ensured at all levels
MH sensitization sessions in Kinihira et Rutongo catchment's areas	0	100%	100%	Continuum of care in MH ensured at all levels
Supporting groups of Kinihira & Rutongo DHs oriented in MH care	0	100%	100%	Continuum of care in MH ensured at all levels
Support MH coordination of planned activities.	0	100%	100%	Each HC and DH has a Mental Health Focal Point and the whole MH package is integrated in MPA and CPA
RESULT 5: Knowledge is systematically managed and developed, action research is performed and the evidences generated to feed the development of policies				
3 key persons of DHU and DHs trained in research and development of action research with support of SPH	0	100%	100%	ANC4 lower utilization determinants report done but not yet published
Develop a topic for capitalization	0	100%	100%	Overall capitalization data quality results should be used by all operational levels.

Gakenke District:

Results / indicators	Baseline Value	End Target	End Value obtained	Comments
RESULT 1: The District Health Management Team is strengthened in leadership, planning, monitoring and evaluation				
Coordination meetings on health activities are regular; concrete decisions are taken and well followed up	NA	NA	NA	This result was achieved through quarterly meetings for DHMT, monthly meetings for COGE and COSA

Results / indicators	Baseline Value	End Target	End Value obtained	Comments
Health data are of quality and orient decision making by authorities	0	12	9	Quarterly meetings with data managers and HFs' leaders are used to improve the quality and the use of data (data analysis and data quality audit)
The joint planning process is conducted on time and the follow up of its implementation is effective	0	6	4	Before MINISANTÉ4 there was no culture of joint planning. Hence the baseline is 0.= the figures represent the number of joint planning session and joint annual evaluation
Capacity building of health managers is strengthened trough training in area of financial management, procurement, HR management (78 members of health management team COSA, COGE, CA)	0	78	78	This activity has help DH facilities management committee to ensure HR, financial and material management system is well done in their respective HFs
RESULT 2: Health services are accessible and of quality according to norms and standards				
Health providers' skills are strengthened in areas of pediatrics, gynego-obstetrics, traumato and cardio.				Various trainings in SONU, PCIME, ETAT, traumatology were organised in favor of health providers (nurses and doctors) in order to improve the quality of services
Knowledge and awareness of bucco-dental hygiene are increased among the population of Gakenke				With IEC materials purchased and distributed by Ruli DH, its respective HCs organized IEC session on bucco-dental hygiene to rdeduce the related diseases among the population
Demand in capacity and quality of services is satisfied through extension and renovation of some departments in health facilities				New maternities in Bushoka and Cyabingo HCs, Neonatology department in Ruli DH and Operating theatre in Nemba DH renovated and extended, etc.
Hygiene is improved in health facilities and public areas through the better functionality of hygiene committees at different levels: district level, health facility level and sector committees of hygiene.				A need assessment on hygiene was conducted and all hygiene committees were trained and made functional

Results / indicators	Baseline Value	End Target	End Value obtained	Comments
Annual contribution to CBHI membership by the population is increased during last 2 years	70%	100%	84%	Training of local leaders, sensitization with a new approach:IBIMINA (groups of 50 households at village level)
Management of CBHI funds is improved: the number of CBHI section with mismanagement and/or loss was reduced to zero	3	0	0	Trainings of CBHI section managers and some management tools were provided
The drug management system is improved: the district pharmacy with enough working space and the store, the drug distribution to HFs is easily done, the cold chain is permanently ensured with availability of a generator.	NA	NA	NA	This was achieved through the renovation and extension of the District Pharmacy, support the drug distribution to HFs and by availing an electricity generator to strengthen the cold chain at the District Pharmacy
RESULT 3: Mental health is developed according to strategic plan and integrated model of health care				
Mental health services are offered in all Health Facilities and in the community as well	2	22	22	At community level: involvement of CHWs and traditional healers for referral and home based care of people with mental probleMinisanté
Care and treatment of mental health patients is decentralized at DH and HC levels, which has reduced the number of referal cases at Ndera Hospital				The number of cases referred to Ndera Hospital has reduced thanks to capacity building of mental health staff at DH level
The number of mental health patients received/followed at HC has increased				Training of 1 nurse at each HC, training of CHWs and traditional healers
RESULT 4: Maintenance system and policy on management of biomedical equipment strengthened				
Equipment maintenance plans were developed for Nemba and Ruli DHs	0	2	2	The process to put in place maintenance workshops has started with the support from *Minisanté 4* intervention
A new Health Center named Kamubuga was fully equipped with medical equipment and is now offering a full package of services (MPA)	0%	100%	100%	The target of availing all needed medical equipment was achieved 100% for this new HC
The maintenance of solar energy is regularly made to ensure the cold chain at HFs without electricity	0	6	6	At the beginning of *Minisanté 4* intervention 6 health centers without electricity had difficult to perform some activities requiring electricity but now it is feasible

Results / indicators	Baseline Value	End Target	End Value obtained	Comments
Hygiene equipment and infrastructures are improved in health facilities	NA	8	8	7 HCs received rain water collection equipment (water tanks) and 1 HC benefited the renovation of a water supply adduction (AEP Janja)
Hygiene and waste management infrastructures are improved in health facilities	NA	8	8	New latrines were constructed in 5 HCs while new burners and waste pits were constructed in 3 HCs
New modern equipment were procured for 2DHs and some HCs to improve the quality of care and services offered to the population	0	4	4	2 dental chairs, physiotherapy and neonatology departments were equipped for Nemba and Ruli DHs, whereas new maternities of Cyabingo and Bushoka received also new equipment
Health infrastructure are improved to meet the standards of quality of care and services in health facilities	0	5	5	2 DHs, 3 HCs and 1 district pharmacy were renovated: neonatology department, intensive care, operating theatre, maternities and pharmacy, etc.
RESULT 5: Knowledge is systematically managed and developed, action research is performed				
Research findings are used to set up new strategies against neonatal mortality in Gakenke District	0	1	1	A study was conducted in July 2012 to June 2013 to search the causes and determinants of neonatal mortality in Gakenke District Health facilities

Bugesera District:

Results / indicators	Baseline Value	End Target	End Value obtained	Comments
Result 1: The DHMT is strengthened in management, coordination, planning and M&E				
Number of DHMT quarterly meetings organized	NA	9	5	The president of DHMT was absent for 3 quarters and there was a delay in implementation of DHMT
Number of Health managers trained on leadership, good governance and principles of management	NA	16	21	15 health center Managers and 6 health supervisors from District Hospital
Organize retreat for 30 persons on leadership, good governance and management principles	NA	30	48	Two sessions organized. We focused on financial audit results
Number of person trained in management and Hospital risk management	NA	14	14	Participants were responsible of services in Nyamata Hospital

Results / indicators	Baseline Value	End Target	End Value obtained	Comments
Number of persons trained on CBHI management principles	NA	62	62	Executive secretaries from sectors, CBHI managers, accountants and CBHI counter verifications
Number of CBHI management tools Provided	NA	400 000	400 000	CBHI cards for membership were provided
Community Mobilization on CBHI and supervision of CBHI sections are regularly done in 15 sectors	NA	15	15	All people in 15 sectors were reached (through mobilization: 5 times. 1time=7days) and 9 supervisions visits were supported from District to sectors
Training in procurement and resources management	NA	26	26	Tender committee members and Health services managers were trained
Number of Financial audit Conducted in health facility and CBHI sections	NA	31	31	Done once for one District Hospital, 15 Health centers and 15 CBHI sections
Support for Monitoring and Evaluation of Health activities in District	NA	1	1	Salary of 3 years for 1 M&E Officer recruited for District Health unit and 1 motocycle provided for M&E activities
Strategic plan elaborated	NA	1	1	For District Health unit and Health facilities
Annual action plan elaborated and implemented for Health sector and *Minisanté 4*	NA	3	3	Done for MINISANTÉ4, District health unit, Health Facilities and all action plan were implemented District Hospital
Quarterly monitoring and evaluation workshops organized for implementation of *Minisanté 4* action plan	NA	7	5	Delay due to Some activities not included in District budget lines
Monthly health coordination meeting organized	NA	36	36	Active participation in preparation and attendance of meeting
Number of CBHI Study tours organized	NA	1	1	20 persons from District involved in CBHI management
Result 2. Quality of Health care Services delivered to population according to norms and standards and accessibility of services				
Number of health providers trained on clinical Integrated Management of Child Illnesses (IMCI)	NA	20	20	15 Health Providers from HCs and 5 from DH were trained in one session of 5 days
Number of CHW trained on community IMCI	NA	250	251	249 New CHWs recruited have been trained with 3 new monitors at 6 HCs (Nyamata, Juru, Gashora, Ngeruka, Nyarugenge &Mareba) during 3 days
Number of people Trained on death audit and verbal autopsy for maternal and <5 years infant death	NA	1238	1782 (47 health Providers	Done in 2 steps. One session for providers trained in 4 days and another for CHWs trained at HCs

Results / indicators	Baseline Value	End Target	End Value obtained	Comments
			and 1741 CHWs)	
Training on SONU (EMoC)	NA	50	50	Trained in two sessions of 15 days for each. Theory and practices in 3 hospitals
Training on Hospital accreditation process	NA	NA	6 trainers	5 providers trained from Nyamata Hospital and all staff were trained on customer care, infection prevention and incident reporting during staff meeting *Technical and financial support from *Minisanté 4* /MoH
Mentorship visits on ANC and maternity services delivery by Hospital staff;	NA	72	41 field visits in 15 HCs	43% of visits missed due to some budget line not included District plan and FMIS system and shortage of staff at hospital
Audit and verbal autopsy conducted at HF and Community level	NA	NA		Done at Health Facilities and community level for167 under 5 years infants death and for 98 still birth and 3 mother's death
Support Availability of specialist for hospital in internal medicine, gynecology, surgery and pediatric	NA	4	3	Done for specialist in surgery, gynecology and internal medicine. Any case for pediatrician specialist
Number of persons trained in customer care	NA	40	137	14 from HCs, 1 from District office and others from Nyamata Hospital
Number of persons trained in self-financing of Health facilities	NA	32	47	Participants were health Facility managers and accountants (2 days)
Social assistance of poor patient assured	NA	NA		Done for all patients in need
Result3: Maintenance system and Politic of biomedical equipment are strengthened				
Equipment and furniture provided	NA			*Medical Equipment for maternity unit, Theater, radiology, dentistry and neonatology, *1000 Bed sheets and 700 bed covers provided for Nyamata Hospital and 13 HCs *oxygen producer for Nyamata DH *Provision of fridge for District Pharmacy and Rilima HC * 1 ambulance boat provided for Mazane Health post * 1 photocopier provided to Nyamata District hospital
Number of institutions where quality of infrastructures are improved	NA	6	6	* Construction of Maternity bloc at 3 HCs (Gakurazo, Mareba and Kamabuye).

Results / indicators	Baseline Value	End Target	End Value obtained	Comments
				* Construction of Neonatology bloc, Rehabilitation of mental health bloc and renovation of other services at Nyamata Hospital * construction of Customer office and hangar at Nyamata DH *Internet connection at Nyamata Hospital *Provision of Solar energy at Mazane Health Post * Provision of1 Generator for District Pharmacy
Number of Health facilities where Hygiene and sanitation are improved:	NA	10	10	* 2 septic tank constructed at Nyamata DH *11 water tanks provided to 1 Health post and 9 HCs and *7 incinerators constructed in 7 HFs including Nyamata DH * a public toilet constructed at Gakurazo HC and *1 washing machine provided to Nyamata DH
Maintenance of hospital and HCs cycles assured				This was done in the first 2 years of the *Minisanté 4* program for 5 ambulance and 14 motorcycles
Result4: Mental health is developed according to strategic plan and integrated model of health care				
Number of health facilities providing integrated Mental Health services	NA	17	17	At Hospital, at 15HCs and prison health center
Number of persons trained in mental Health	NA	1234	1264	104 Health providers from Hospital &HCs and 1160 CHWs trained in mental health cases management at HFs and community level. CHWs were trained in 29 groups
Number of people supported for internship in mental Health	NA	6	6	internship of 4 nurses and 2 Physicians at Ndera hospital and CHUK (specialized hospitals)
Number of provision of psychotropic Drugs	NA	4	4	Psychotropic drugs were delivered to Nyamata DH at least 4 times for mental health service
Number of times logistic support provided during national mourning period (including preparation meetings with mental health partners)	NA	3	3	Done each year for genocide memory period since 2012.
Number of HCs where supervision were conducted in mental health			16	This activity was done by psychiatric nurses from hospital to HCs
Result5. Knowledge is systematically managed and developed, action research is performed				
Number of people Trained on health data	NA	NA	52	Participants were health institution managers, data

Results / indicators	Baseline Value	End Target	End Value obtained	Comments
management and use and leadership of DHMT				managers and supervisors from Hospital, District pharmacy, CBHI direction and HCs
Operational research on Determinants of postnatal care services utilization in Bugesera District	NA	2	1	1 research accomplished by Nyamata Hospital in collaboration with DHU/DHMT team and School of Public Health; 2nd research dropped due to budget constraints.
Number of persons who benefited scholarship for Master in Public Health	NA	1	1	Study on going from 2013
Number of people trained in health planning	NA	NA	48	Training combined with the strategic plan elaboration
Capitalization theme on CBHI situation analysis for management and adherence	NA	NA	1	Data collection done and final document elaboration in process.

Note: Urban Health

The program only included a component of urban health upon the closure of the PAPSDSK program in 2013. Main activities aimed at consolidating the gains from PAPSDKS until the onset of the new health program, closing the gap between MOH and City of Kigali in terms of health coordination and vision and taking some initiatives to the next step. This included:
Support to the Joint Supervision with District Health Management Teams, Inter Hospital Networking in City of Kigali concept further development, Production of a brief note on Medicalization of Urban Health centers, Strengthening capacity in Private Health sector, HIV Campaign/ condoms mobilization and usage in City of Kigali, Hygiene campaign and evaluations, Roads cleanness daily assessment, Medicalization of Urban Health Centers strategic note present

Private Health Care Services
Ministerial instructions, norms and standards governing private health facilities drafted
Data managers in private health facilities trained in HMIS
All health facilities within the City Districts were jointly visited and supervised by the DHMT and the City of Kigali Health and Environment Unit. 134 pharmacies,3 District hospitals, 1 Police hospital,41 health posts, 36 health centers,15 private clinics,8 polyclinics,2 private hospitals.

2.2.4 To what extent did outputs contribute to the achievement of the outcome

The program organized quarterly monitoring and evaluation for the progress of planned activities by each of the 3 supported districts and this had an impact in mindset progress change. District plans' reviews were initially seen with fear and defensiveness. They are now perceived as a positive fact of mindset change and self-evaluation with constructive analysis. Capacity buildings in leadership, procurements management and data use have been crucial elements to consolidate both decentralization and improvements in district health system.

There has been significant strengthening of health M&E activities at district level as proven by the assessment done by SPH in June 2013 which demonstrated the contribution of district health M&E Officers to strengthening of the district health system which is a pillar of the national health system.

The central level increased its planning capacities and developed strategies which allow it to play a key role in the monitoring and coordination of planned activities. These are essential components in the process of decentralization at the local level and support to the health system in general.

2.2.5 Assess the most important influencing factors. What were major issues encountered? How were they addressed by the intervention?[8]

Decentralization:
District authorities have been involved in the program planning and implementation and were also supported where required (i.e. training in procurement). The involvement of district organizational structures has been good and more could still be done in future programs in the field of use of district financial unit and system (Integrated Financial Management Information System - IFMIS)

Strong MOH leadership and ownership at all levels and alignment to national policies

Performance contracts
The Performance Contract approach (IMIHIGO) by District authorities also influenced positively the functionality of the DHMTs since they have to make a day-to day follow up of heath activities planned in IMIHIGO. Similarly, activities included in the district or central level imihigo plan had much better chance of timely completion

BTC flexibility while keeping a focus on priorities, flexibility in implementation modality has been much appreciated

Major issues
Complexity of the program: the ambitious TFF accompanied by a delay in inception (compared to the end of formulation), a weak administrative anchorage stopped the program from starting effectively. Internal meetings, backstopping and intervention from the representation did not make any improvement. At the end the solution came with asking for an early MTR whereby consultants really provided genuine and appropriate recommendations in terms of technical focalization and administrative reorganization.

[8] Only mention elements that aren't included 1.1 (Context), if any.

Early stage of decentralization: districts were not always in a strong position in terms of procurement and following the implementation procedures (ie non objection). Delays in those led the program to request that procurement of constructions and equipment be made by SPIU centrally with the involvement of districts at key steps (specifications, evaluation, monitoring, until reception)

Procurement systems in districts: decentralization has empowered district to manage their own funds and address their specific priorities. The signing of the execution agreement has made additional funding available at district level to implement their activities including procurement of medical equipment and infrastructure. However, districts could not always follow procedures of no-objections and had challenges in developing solid tenders for medical equipment due to lack of expertise. This could have led to delay in procuring the desired equipment or even cancellation of tenders. The steering committee approved that procurement be made at central level for the sake of economies of scale (joining the request of the three districts) and efficiency with the experience of SPIU in tender management. This has led to successful procurement of valuable medical equipment, construction of 10 maternities, and other buildings within the time frame of the project

2.2.6 Assess the unexpected results, both negative and positive ones

Support to mutuelles in Bugesera and Rulindo districts: an initial request from Bugesera district to fund the gap left by mutuelle debts in 2011 was made with the support of MOH. However, there was no request to analyze the root causes and address them. A delicate dialogue took place with MOH to share the concern that funding the gap might not be enough to ensure efficient and accessible health care in the district. A partial funding was agreed upon accompanied with support initiatives that led to an audit of mutuelles in the district. Upon completion, it was identified that community sensitization to adhere to mutuelle was not the only solution and that mutuelle system had to be strengthen in its accountability as well as health cost could be reduced through more rational use of laboratory tests and prescriptions. In Rulindo, a seed fund to assist mutuelle sectors with honey production has enabled the mutuelle to fund gaps related in sectors with higher proportion of people living in poverty or extreme poverty

Support to M&E in the 30 districts: an unusual request to support salaries for M&E officers in all 30 districts was approved and implemented for two successive years upon an evaluation after the first year. While this could have appeared as a substitution to MOH role, it actually assisted the district to appreciate the need for quality monitoring of activities and the relevance of a position that became essential to provide information for decision making at district level. Even if ultimately the position was not fully integrated in the district structure for M&E officer for health sector, a general M&E position was created and some districts decided to give contracts to their health M&E officers in order to keep them.
M&E officers
Mutuelles

knowledge management: the program used a number of approaches for knowledge management: from scientific support to action research and capitalization. It culminated in a dissemination workshop for MOH and partners at the end of the program. Interestingly, the approach was then taken by one partner MSH and introduced in their new program as a methodology to implement on a wider scale.

Urban health: this component was included in MS4 with the view of maintaining the gains of PAPSDSK program, bridging to the next health program to come (Ubuzima Burambye) and bringing on board MOH in the specific issues related to urban health. A concept of medicalization of health centers was developed with the idea of improving accessibility as well as quality of health care services in Kigali. The concept is to be implemented in the future program.

2.2.7 Assess the Integration of Transversal Themes in the intervention strategy

Environment, gender, social economy, children rights and HIV were identified in the TFF as transversal themes. There was no specific activity addressing them on their own but all were indirectly addressed as follows:

Environment: interventions addressing waste management through MMC and following a study in Gakenke district; Hygiene campaigns in City of Kigali; policy guideline on scrapping of obsolete and out of use equipment

Social economy: this was done through local system strengthening, use of local companies at district level to implement infrastructure works, including construction of latrines and procurement of office furniture

Gender and children rights: construction of 10 maternities improved geographical access to maternal health and two neonatology units addressed quality of care for the newborns. Interventions were seen as gender equitable during the final evaluation and it is anticipated that the institutional support program contributed to Rwanda's exceptional achievements of the MDGs in health

2.2.8 To what extent have M&E, backstopping activities and/or audits contributed to the attainment of results? How were recommendations dealt with?

Mid-term review: as mentioned above, the initial year of the program faced administrative and conceptual challenges that led to an early midterm evaluation. The evaluation did a thorough assessment of the program at all levels and provided well thought through recommendations for all parties. The program took all the recommendations that were under its control (except the ones for BTC HQ and DGD). This enabled the program to focus on four key areas plus knowledge management as a transversal intervention. It allowed for a much necessary restructuration of its management including the integration into SPIU of the Ministry. Figures are there to demonstrate that interventions took off and financial execution was sped up until reaching 100% in comanagement and 99% overall

M&E contributed to analyze the progress of activities towards program goals, providing guidance and advices. MORE results approach was not developed at the onset of the program and therefore the initial M&E components were mainly linked to national indicators and systems. The proposed outcome mapping approach described in the TFF was not implemented due to lack of expertise in the team and no training support. Following MTR and a workshop on MORE results, indicators were identified for each focal area. Besides, quarterly meetings were used to monitor the progress of implementation and address identified gaps and needs (see annex 9)

Backstopping: twice yearly missions took place. Initially they contributed to build a program perspective to bring all the existing programs under a coherent and coordinated perspective, enabling the various anchorages and funding modalities

to work in a coherent and consistent manner. Later on, they assisted the program in operationalizing the MTR recommendations. Practical activities were defined with tasks and responsibilities defined for each focal area including knowledge management. We refer the reader to the systematic backstopping missions for better understanding

Scientific support: Scientific support was provided simultaneously to both programs, PAPSDSK and MS4 by the ULB School of Public Health, led by Prof Dujardin. While it assisted to provide a coherent vision across all BTC funded programs in the health sector, it failed to practically assist in the development of reflective documents or action research reports. The expected support from School of Public Health in Rwanda only materialize at the end of the program and the support from ULB appeared very strong in theory and systems but maybe too remote for practical initiatives. Ultimately, the concept of scientific support was not well integrated by the partner at MOH and SPH levels, leading to reduced ownership

Capitalization: External support from KIT Netherlands assisted the team in the writing of action research projects done with the support of School of Public Health of University of Rwanda. It led to the production of a booklet but fell short of the publication of papers in the literature. The process was seen as good for the writing exercise but lacked support in terms of content and publication.

Final review: 46 recommendations were developed, of which 34 concern the future health program

3 Sustainability

Overall sustainability was rated reasonably good during the external evaluation though the program estimates that sustainability is very good. Indeed, as there has been continuous leadership and ownership by the partner, clearly committed to the success of implementation of MTR recommendations and of approved activities. Furthermore, the program showed a very clear alignment to the sector priorities and strategic plan, confirmed by the final review. As a result, there are numerous factors that contribute to sustainability. Focus group discussion with the respective districts and staff at central level indicated the following perceptions on sustainability:

Sustainability at district level – view of the actors

FOCUS	ECONOMIC VIABILITY	OWNERSHIP	POLICY INTERACTION	INSTITUTIONAL CAPACITY
PLANNING M&E DHMT	MEDIUM	GOOD	GOOD	GOOD
QUALITY OF CARE ACCREDITATION	MEDIUM	GOOD	GOOD	GOOD
MENTAL HEALTH	MEDIUM	GOOD	GOOD	GOOD
MEDICAL MAINTENANCE	MEDIUM / LOW	MEDIUM	[premature]*	MEDIUM*

Sustainability at central level – view of the actors

FOCUS	ECONOMIC	OWNERSHIP	POLICY INTERACTION	INSTITUTIONAL CAPACITY
PLANNING M&E	GOOD / MEDIUM	GOOD	GOOD	GOOD
QUALITY OF CARE	MEDIUM / LOW	GOOD	GOOD	GOOD
MENTAL HEALTH	MEDIUM	GOOD	GOOD	GOOD
MEDICAL MAINTENANCE	LOW	MEDIUM	MEDIUM	MEDIUM*
URBAN HEALTH	MEDIUM	MEDIUM	MEDIUM	MEDIUM
SPH	MEDIUM / LOW	MEDIUM	MEDIUM	MEDIUM / GOOD

3.1.1 What is the economic and financial viability of the results of the intervention? What are potential risks? What measures were taken?

Most of the interventions avoided creating external systems or structures that would be difficult to pursue at the end of the program. Except the funding of district M&E officers that was not fully included in the district structure, and MTI support that still needs clear vision and strategic document to refer to, most of the activites and achievements will not create significant economic dependency. And, in the area where it is required, the future program will continue its institutional support to accompany the sustainability plan: in particular for mental health, accreditation and

medical maintenance. For medical maintenance in particular, the program has laid foundations for improvements but numerous contextual, administrative and technical challenges have been identified. An in-depth assessment has been initiated that will assist both the partner and the program in developing a clear strategy and priorities for support in a sustainable way.

Constructions that were realized have all been handed over to the respective institutions that commit to ensure adequate use and provide resources for using them.

Urban health support, in particular medicalization and hospital networking are not fully instituted at this stage but the concept has now been fully shared and appropriated by MOH as well as CoK. They have been identified as key priorities in the future program

Potential risks at district level:

- M&E improvements may not last if M&E position is not institutionalized
- No funding for planning exercise may lead to lack of integrated and comprehensive planning process
- Accreditation gaps hard to address without adequate funding
- Medical maintenance still not given priority level by health facility managements

Potential risks at central level:

- M&E improvements may not last if M&E position is not institutionalized
- Accreditation gaps may not be fully addressed without adequate mentoring and support
- Medical maintenance norms and standards not fully established
- MMC Division HR constraints
- Mental Health Division mentoring and formative supervision incomplete without adequate supportive staff and logistics. MMed program be at risk of temporary interruption if the next program does not start on time
- Networking Kigali delayed

Proposed measures include the following:

- Continue institutionalized efforts towards integration of District M&E officers (while addressing funding gap to bridge until full integration)
- Accreditation steering committee to look at ways to reinforce mentorship as well as funding mechanisms (incl link PBF and accreditation) and other donors to be encouraged for funding (USAID)
- MSIV to approach RBC and SPIU to ensure adequate integration of MH Division and its staffing component
- Strengthen Medical maintenance TWG as support group to MMC
- Anchorage Urban health at MOH
- MMC support to 5 DH maintenance staff and workshops
- Ensure that the future program starts immediately at the end of MS4 to avoid any gaps and include a continuity in the support to the above identified risk areas

3.1.2 What is the level of ownership of the intervention by target groups and will it continue after the end of external support? What are potential risks? What measures were taken?

Ownership has been good throughout both at district level and at central level. Particularly around the annual planning exercises, the MTR and its focalization process and the implementation in particular in planning, quality of services and mental health, a little less in medical maintenance due to institutional context.

The anchorage of Minisanté 4 program in the core of MoH and SPIU as well as the close alignment to the HSSPIII provide strong basis for maximum ownership of the program intervention. The steering committee has been strongly involved in all steps of planning and monitoring of the progress in a proactive manner. Clear directions have been provided in regards to implementing the agreed upon focus areas in particular around M&E and knowledge management. Therefore there are no major potential risks identified

3.1.3 What was the level of policy support provided and the degree of interaction between intervention and policy level? What are potential risks? What measures were taken?

Policy support has been high in all focal areas in particular:

- Planning: assistance in guidelines for DHMT and DHU, in JANS review of HSSPII and HSSPII MTR, in the development of HSSPIII, etc.
- Quality: support in guidelines for private practices, concept of medicalization and hospital networking, accreditation norms, standards, policies, etc.
- Mental health: development of Mental health strategic plan, mental health law, etc.
- Medical maintenance: development of policy guidelines for scrapping, donations, norms and standards, etc.

Potential risks are higher in medical maintenance as there is no strategic plan approved so far. Measures included the in-depth assessment study that aims to provide strategic guidance for MOH and RBC to guide policy and strategic directions. It is also anticipated that an exit strategy might be considered for some focal area during the next program.

3.1.4 How well has the intervention contributed to institutional and management capacity? What are potential risks? What measures were taken?

At district level, the program provided significant support to the set up and strengthening t-of the District Health Management Teams, the District Health Units and the various Boards (Board of Hospital, board of mutuelles, board of Pharmacy). It also provided training in procurement for the district and hospital teams to increase their capacity in public procurement.

At central level, institutional support contributed to the strengthening in all focal areas:

- Planning: active contributions in the planning, decentralization and M&E working groups; support to HSSPII MTR and its analysis, support to development of HSSPIII; trainings of M&E officers at district level
- Quality Besides the support in writing guidelines and concept papers, training in accreditation was facilitated at institution and central level, clinical trainings (EmONC, ETAT+, etc.).

- Mental health: institutional development of the Division, creation of MMed Psychiatry at University of Rwanda, training of 15000 Community Health Workers, formative supervision of health providers, etc.
- Medical maintenance: training of biomedical technicians at hospital levels, guidance in the structure development of the Division, .

While all Divisions and Directorate have been strengthened in a significant manner, some Divisions have not yet reached their full institutional capacity. Fo example MTI still requires to have its structure fully functional (staff recruitment) and its strategy validated. Technical support for strategic development will still be required during the implementation of the next program (UB)

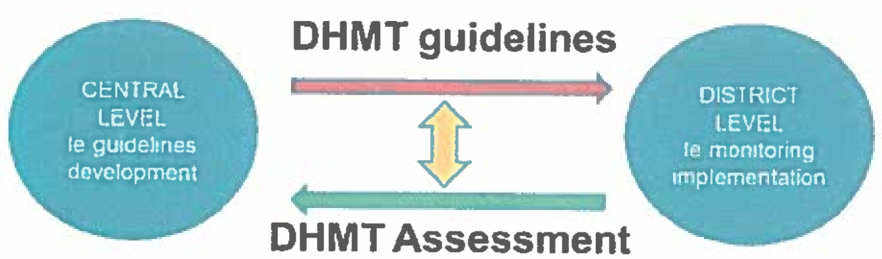
4 Learning

4.1 Lessons Learned

General lessons

- **Focalization** has allowed the program to concentrate on priority areas of HSSPIII
- Integration into SPIU: this integration has facilitated a more efficient management of the program and ensured high level interactions for ownership of the program. It has allowed smooth implementation with technical support to implementing parties at district and central level
- **Institutional support**: the initial approach required to be adjusted to ensure a more focused support with clearer deliverables. While funding assist as an entry point in the system, and is therefore necessary, it might divert the attention to implementation activities that may divert from a specific institutional support program.
- **Early MTR** is a useful tool when a program has a slow start or requires technical support and contextual adjustments. However, it requires clear terms of reference and qualified consultants to perform the MTR
- **Double anchorage** has facilitated a dialogue and interconnection between the central and decentralized level. It provided room for dialogue between policy makers and implementers to ensure more realistic policies and guidelines adapted to the need are developed and effective support is provided to the districts and health facilities

Double anchorage by working at both ends:



Expected result: better adapted system tools are in place

Lessons per focus

1. Planning, M&E and decentralization;
    - Decentralization is a large program that will require time, close mentoring, capacity development tools, support and monitoring tools and system strengthening support. It requires clear guidance and adequate support

from the Central level. This also calls for a mindset change at central level to develop mentoring skills and support

- While the funding of district M&E officers critically assisted and strengthened the district in its new role and responsibilities, careful attention is required to ensure that it is be done in view of sustainability
- Functional DHMT has increased ownership of health matters at district level

2. Clinical Services and quality of services;

    - Focalization exercise allowed for a clearer support to the Division priorities than a piece meal approach
    - Accreditation is an ambitious program. We noted that external facilitators were trained but do not have much time to assist institutions. Therefore, emphasis should be on internal facilitators with initiatives such as peer reviews and support
    - Urban health requires specific attention as health problems are not fully similar to rural health. CoK appeared to be a very committed partner and actor in addressing those specific needs and appropriate coordination mechanisms with MOH and RBC need to be strengthened.

3. Mental Health Division;

    - Third cycle in Psychiatry: Provided the vision is clear, the program is structured, the partners are identified and committed, it is possible to develop and implement a new university level education program in Rwanda
    - Decentralization of mental health services is possible provided that it is done in a system approach, each level assisting and supporting the other. It requires support at all levels, from community to provincial and referral services.

4. MTI Division;

    - Minimum relevant human resources for infrastructure and medical maintenance is required at central, provincial and district hospital level
    - Strategic framework and standard norms for infrastructure and equipment can assist in priority settings and improve efficiency in design, procurement and maintenance

5. Knowledge management;

    - Action research is a useful tool for decision making at all levels
    - Action research can provide evidence based information for action and reflection upon the effectiveness of the action

4.2 Recommendations

Recommendations below include some of the recommendations from the final review and the reader should consult the final review report for full understanding and view of the recommendations

Reference	Recommendation	Source	Target audience
MTR	Specify the concrete results the program aims to achieve by 2014 both at central and district level	MTR	MS-IV
	Develop a more results oriented approach in line with the dynamics of the sector but fostering reflective action.	MTR	MS-IV
	Contract the 3 national experts	MTR	MS-IV
	Clarify, together with the MoH, MS-IV, KV/PAPSDSK, ESP/UNMR, ESP/ULB and BTC the purpose of the scientific support (SS) and ensure consensus.	MTR	MS-IV
	Foster the change of mind-set from a project type of approach to a sector support approach	MTR	MS-IV
	Review the MS IV program organization a. Limit the BTC program director to 1 (one Delco); b. Review the new organizational structure and propose to the JLCB for validation.	MTR	BTC CO
	Formalize the appointment of the overall program coordinator for both MS-IV and KV, with a view to progressively merging both into a single support program.	MTR	BTC CO
	Ensure that above reorganization is implemented (see 6a, 6b; and section 4.1.3)	MTR	JLCB
	Integrate the program administrative management in the SPIU	MTR	JLCB
	Validate the central operational plan 2012-2013 (including the period up to June 2012). Accept later revision of the central plan (July 2012 to June 2013), based on the (to be decided) new focus of the program.	MTR	JLCB
	Ensure that MS-IV comes up with a focused strategic plan for the post MTR period up to 2014	MTR	JLCB
	Ensure that the contracting of the 3 national TAs is finalized.	MTR	JLCB
	In order to bring MinaLoc more on board of MS-IV, consider reviewing the status of MinaLoc in the JLCB	MTR	JLCB
	Consider organizing the backstopping and scientific support missions at the same time (or at least partly overlapping) in order to reduce time investment by project and counterpart staff and optimize efficiency of both support modalities. If kept separate, ensure that mandates (and de facto implementation) are clear and mutually reinforcing.	MTR	BTC HQ
General	Maintain the good alignment with government policies and other DP support.	ETR	DGD, BTC

	Implement as much as possible the 'fully run by GoR' program management approach, reducing parallel financial management and procurement to a minimum. Reporting time Belgium Rwanda	ETR	DGD, BTC
	In case of delay between formulation and execution, or interruption between support programs in a sector, it is recommended to have an actualization of the TFF at the onset of the program	MS4	BTC
	Continue to develop the double anchorage approach with proper feedback systems	ETR	Future program
Focus Planning M&E	Improve the quality of the quarterly M&E exercises at district level, with a stronger focus on 'reflective action' rather than on monitoring national quantitative impact and outcome indicators.	ETR	RBC Planning M&E, future program
	Supervision of health facilities should be owned totally by the District level	Joint Supervision with DHMT	District Authority
	Continue strengthening of Decentralization through mentoring and development of tools as well as the strengthening of planning at district level	ETR	MOH, RBC
	Reassess the system for regular district level M&E and knowledge management and promote leadership of Action-research dynamic through M&E at central and district level	ETR	MOH, RBC
Focus quality	Definition of a unique national accreditation framework: - governance arrangements, - clear procedures and guidelines adapted to the local context - integration of existing parallel systems (PBF, supervisions) - Improve the coordination and division of tasks with the different institutions/partners involved in the Rwandan accreditation	ETR	MOH
	Ensure a focused and coherent approach in identifying what activities will be supported to improve quality of care	ETR	Future program
	Ensure adequate human resource in health facilities at all levels	Medicalization of Urban Health Centers/ Hospital Networking	MoH District Authority
	Support a comprehensive coordinated approach integrating the various components of urban health system and all relevant actors to implement effective Medicalization of health centers and document the process	MS4	Future program
	Private health facilities should be strengthened and called to support public health facilities in an organized /coordinated way	Hospital Networking	MOH Local Administrative Authority
	Promote better coordination across the different stakeholders involved, in particular CoK and MOH for mutual ownership and validation in	ETR	MOH, CoK, future program

	urban health		
Focus Mental health	Consolidate and develop the achievements of MS4 in particular the decentralization process	ETR	Future program
	Prepare progressive takeover of the mental health program in the long term and address the remaining sustainability requirements - sustainability preparation plan should be elaborated at the starting-up of the next phase.	ETR	RBC MH Division, Future program
	Address newly identified needs: day care, children and teenagers' services, prevention and care for addictions, target specific environments such as schools, prisons, youth groups	ETR	RBC MH Division, Future program
	Develop and promote capitalization activities	ETR	Future program
Focus biomedical maintenance	Support a clear vision and maintenance strategy including organizational arrangements (central, provincial and district levels), role of private sector, required critical human resources expertise, costing and financing issues.	ETR	MOH, RBC, future program
	Develop MTI package of services for each level	MS4	MOH, RBC, future program
	Address MTI capacity development needs at all levels	ETR	MOH, RBC, future program
	Joint planning of biomedical equipment and health infrastructures to ensure coherent development of both and coordinated procurement	ETR	MOH, RBC, future program
Focus knowledge management	Research should be embedded in daily management of work through a reflective action process (asking questions about daily decisions, construct pathways of improvement, and evaluate progress in the perspective of continuous quality improvement) Institutionalization of action-research dynamic at all levels Research findings should result in clear operational recommendations for decision-makers	ETR	MoH DG/PHIS RBC
	Models for knowledge management including scientific support need to be better developed and owned by the partner for a successful implementation	ETR	MOH, RBC, BTC, future program
	Strengthen the platform at central level for better coordination and planning of research	ETR	MOH, RBC, future program

PART 2: Synthesis of (operational) monitoring

1 Follow-up of decisions by the JLCB

Decision	Date	Status
Integration of mental health support activities into MINISANTÉ 4program	*SC 19 Jul 2011*	
Replacement of ATI by 3 ATN for each district	*SC 13 Dec 2011*	
Early call for Mid Term review	*SC 13 Dec 2011*	
District M&E officers funding	*SC 18 April 2012*	*Annual evaluation proved the intervention relevant and MOH identified budget to ensure continuity. However the positon for M&E health was changed in general M&E in district HR structure*
Integration into SPIU	*1st July 2012*	
Approval of focalization	*SC 16 July 2012*	
MOH ordinary budget will fund activities already approved in MINISANTÉ4 action plans for 2013-14 for an amount up to Rwf 112,192,577 in order to free some MS4 budget for district M&E officers	*Sept 2013*	
Structure the medicalisation of urban health centers keeping complementary and integrated levels	*Backstopping Dec 2013*	
Approval of 2013-2014 operational plans City Kigali transition plan *- The transition plan, covering a period of one year, costing 132,000 Euros was approved - MOH will provide salaries for Medical Doctors in the new four urban heaalth centres from ordinary budget - Salaries for data managers will be provided by MS4 considering that running expenses of transition plan will be limited to the essential needs so that the overall budget figure of 132,000 Euros will be respected. The trainings for pediatrics to be funded by the budget line "Resssource Humaines" under "Regie"*	*25/06/2013*	*completed*
Focus of Planning M&E and Decentralisation : *- The steering committee approves the payment of salaires by the program for the district M&E officers for one extra month (July) until the evaluation report is available.*	*25/06/2013*	*completed*

- MOH and School of Public Health committed to provide an evaluation report with one month (31st July 2013) with the support from BTC & SPIU/MS4. A clear agreement between the parties is needed on the methodology of the evaluation process, before it is conducted. - The committee delegated the Permanent Secretary (Chair) and the BTC Resident Representative (co chair) to decide upon the request for payment of salaries for a new period on the elements that will be provided by the evaluation report. - In case their decision will be to continue to support the salary of M&E officers, this will be officialised through a circulating letter.		
Decision of Ditrict tenders management : The streering committee approves the 2013/14 procurement plan and approves that similar tenders be regrouped for harmonisation and efficiency under SPIU procurement management while involving districts in the selection processs and providing appropriate procurement trainings to the districts	25/06/2013	completed
Proposal to extend the duration of the operational period of Minisante IV - The steering committee approved the extension of the operational period until 31 st December 2014 and noted the need to icluse BTC commitment payment deadlines of 31 st August 2014 in the infrastructure's and equipments contracts	25/06/2013	completed
Miscellaneous - It was decided that MS4 program presents a topic on sustainability at the next steering committee meeting	25/06/2013	ongoing
M&E district strengthening system - The committee approves the M&E assessment report "Health system strengthening at district level : Assessment of the contribution of health monitoring and evaluation officers towards strengthening the district health system First assessment of a 12 months experience"	03/09/2013	completed
The committee approves the roadmap mechanism as well as the list of progress indicators presented and asks for a regular reporting to the steering Committee on the implementation of these indicators' progress	03/09/2013	completed
The committee approves the funding by Minisante IV programme of the position of 26 M&E officers and the recruitment of 3 additional officers until 30 June 2014 (Frw 277,770,618)	03/09/2013	completed
MOH ordinary budget will fund activities already approved in MS4 action plans for 2013-14 for an amount up to Rwf 112,192,577 to cover M&E salaries gap	03/09/2013	completed
Planning M&E: MoH will ensure M&E services continuity after 30 June 2014 in collaboration with MINALOC and MIFOTRA: lead- PS MoH	18-Feb-14	completed
Planning M&E: To carry out analysis of performance of DHMTs and Boards of Directors as part of capitalization, by 15 June 2014, and to be presented to next Steering Committee: lead - DG/Planning & HIS	18-Feb-14	completed

Quality and Accreditation:		
To set Urban health Task Team with 3 tasks:	18-Feb-14	
- to develop proposal for medicalization of some HCs in CoK		completed
- to develop Gatenga HC upgrade proposal (including package of care and services)		completed
- updating the CoK action plan implementation, including inter-hospital network (limited to 2014 MS4)		completed
MoH to validate both by 31 March 2014; lead- DG Clinical Services		late
MTI		
- Adjusted ToRs of ITA biomedical engineer approved	18-Feb-14	completed
Roadmap with results to be reached by ITA to be ready by 28 Feb 2014: lead- MS4 Program and DDG/RBC Biomedical Services		
MTI Set up a sub-group TWG on Health Technology Management (to assist in technical expertise, norms, procedures and guidelines approval for biomedical maintenance), by 28 Feb 2014: lead - MMC Division	18-Feb-14	late
MTI Given the strategic importance of MMC in management of biomedical equipment and a need for more clarity in the governance, in practice, of the biomedical equipment maintenance center: - To perform an in depth study on the biomedical equipment and maintenance system in the public sector in Rwanda by 31 August 2014. - The analysis should provide clear recommendations for an effective and efficient biomedical equipment procurement and maintenance system adapted to the local context and findings. - The report will be shared to all stakeholders. Tender document should be ready by 15 April 2014. Lead: DDG/RBC Biomedical Services - Clarify the vision and governance on biomedical maintenance in Rwanda regarding the next 10 years, by 15 March 2014. Lead: DDG/RBC Biomedical Services	18-Feb-14	late
To continue advocacy for the integration of M&E Officers in District structure-Lead DG Planning & HIS - by end of September 2014	20-Jun-14	completed
To present the final report of assessment of DHMTs and BoDs during the next SC meeting lead -DG Planniing & His (follow up from previous SC meeting decision n0 2)	20-Jun-14	completed
Medicalized HC Concept (justification, site identification, budget, etc) to be validated by SMM eithin 2 months : Lead DG CS		ongoing
Need to engage with RBC in regards with staffing requirements for the Division in view of sustainability issues beyond 31/12/2014; lead Head of Division MH	20-Jun-14	completed

To accelerate TWG proceedings to assist in norms, standards, guidelines validation - lead MMC head of Division - TWG on Health Technology Management to present donations, scrapping guidelines and ambulances standards to SMM within two months - lead -DDG Biomedical Services	20-Jun-14	late
Cok and MOH need to institute hospital networking in Kigali within 6 months - Lead Director Environmental Health Unit Cok (in coordination with DG CS) - deadline December 2014	20-Jun-14	late
To approve very last 'no extension ' of 3 months only (until 30th September 2014) - lead SPH Director in link with DG Planning HIS	20-Jun-14	completed
Approval in principle of ToR for in depth study of health assets management - Lead DDG Biomedical Services - TOR to be confirmed after consultations and quality check by external expertise - To ensure implementation of the assessment through consultancy-Lead DDG Biomedical Services	20-Jun-14	late
The SC approves the updated action plan of CoK that was presented. Upon review of MASS contract by PS office, the decision to select MASS Group or to select the best offer from the ongoing tender will be taken by the chair and co-chair	30 oct. 2014	completed
The SC approves extension of MS4 operational period to 31 March 2015 (include the admin.fin team contracts as well as the extension for the MTI data analyst, CoK Director EHT, and admin staff of MH until 31 March 2015 and takes note of the adm. fin support requirement beyond 31 March 2015. SC requested SPIU to present in the next SC meeting of December 2014 the last commitments of contracts with deadlines for each tender and /or contract. SC approves the transfer of the three MS4 vehicles to the future program upon completion of MS4 activities	30 oct. 2014	completed
The SC approves the budget modification corresponding to transfer of belance from PAPSDSK project	30 oct. 2014	done
The SC approves the capitalization plan and its budget including the involvement of external support by Tropical iInstitute Amsterdam (KIT) through framework contract with BTC and funding of 35000 euros available under regie budget line audit.	30 oct. 2014	ongoing
Despite the transfer of SPIU under RBC planned for end December 2014, members of SC agreed that the chairperson of the SC remains the permanent Secretary, MOH since MS4 program covers activites both under RBC and MOH structures.	30 oct. 2014	done

***Updated Decision (30)**: To perform an in-depth study on the Biomedical equipment's and maintenance system in the public sector in Rwanda by 31st August 2014 Status: The tender process was delayed due to the complexity of the study and the deadline to submit the RFP is 8th April 2015. Updated decision: The steering committee requested the SPIU and BTC to do a close follow up to have this tender committed at 30/05/2015 Technical monitoring will be provided by ITA Biomedical engineer with MTI Head of Division. SC decides that the presence of ITA Biomedical engineer Sankaran in the field during the assessment is critical for the good execution of the study. Therefore, the In depth assessment contract will not be signed if there is no clear solution for his presence in the field during the 3 months of the implementation of the study. The contract of ITA might require to be bridged through study fund (PAREC) for three months or until the ITA contract in the future program is signed. MS4 will prepare a request for ITA contract funding, including TOR and budget estimate for the extension, to be sent by PS MINISANTE to PS MINECOFIN, with copy to BTC*	*1 avril 2015*	*ongoing*
***Closing Plan** The steering committee takes note of the progress of the closing plan and requests the project management to do a close follow up*	*1 avril 2015*	*ongoing*

2 Expenses

Budget vs Actuals (Year to Date, Last 5 years) of RWA0806611

Project Title	**Appui Institutionnel au Ministère de la Santé - phase 4**
Budget Version :	**J1**
Currency :	EUR
YtD :	**Report includes all valid transactions, registered up to today**

	Status	Fin Mode	Amount	Start to 2012	2013	2014	2015	Expenses 2016	Total	Balance	% Exec
A Objectif spécifique 1			4 888 934,00	1.283 844,65	1'340 554,50	1 481 148,20	765 228,95	44 009,13	4 914 583,45	-87 649,48	101%
01 L'Equipe intégrée de gestion du district est			174 790,00	72 284,23	102 505,42	0,00	0,00	0,00	174 789,66	0,34	100%
01 améliorer dynamique de travail en équipe		COGES	51 270,00	20 979,40	30 230,28	0,00	0,00	0,00	51 209,68	0,32	100%
02 renforcer cohésion interne		COGES	28 484,00	7 544,58	20 939,98	0,00	0,00	0,00	28 483,56	0,44	100%
03 stimuler coordination et régulation		COGES	95 036,00	43 760,25	51 270,17	0,00	0,00	0,00	95 030,42	-0,42	100%
02 La disponibilité des ressources humaines			342 422,00	110 702,56	231 806,59	-10,86	0,00	0,00	342 497,28	-75,28	100%
01 stimuler disponibilité		COGES	70 458,00	30 046,53	40 411,06	0,00	0,00	0,00	70 457,59	0,41	100%
02 formation adaptée		COGES	252 608,00	60 362,30	192 235,39	0,00	0,00	0,00	252 597,69	0,31	100%
03 renforcer motivation		COGES	19 356,00	20 293,72	-840,86	-10,86	0,00	0,00	19 442,00	-76,00	100%
03 L'accessibilité équitable aux services de			2 398 124,00	843 299,73	631 369,87	823 701,34	323 142,44	44 009,13	2 595 572,50	-197 448,50	108%
01 cartes sanitaires		COGES	3 000,00		-243,00	0,00	0,00	0,00	-243,00	3 243,00	-8%
02 renforcer PMA PCA PTA		COGES	1 850 301,00	439 919,81	420 227,14	823 701,34	323 142,44	44 009,13	2 059 059,86	-202 758,86	111%
03 intégrer santé mentale		COGES	82 440,00	32 528,72	49 910,78	0,00	0,00	0,00	82 439,50	0,50	100%
04 assurer complémentarité santé		COGES	61 673,00	15 042,59	46 030,89	0,00	0,00	0,00	61 073,48	-0,48	100%
05 développer stratégie contre la malnutrition		COGES	10 533,00	8 407,03	0,00	0,00	0,00	0,00	8 407,03	2 035,97	80%
06 mise en oeuvre plan environnemental		COGES	177 376,00	141 541,56	35 834,05	0,00	0,00	0,00	177 375,60	0,40	100%
07 renforcer accessibilité financière		COGES	206 801,00	203 803,23	0,00	0,00	0,00	0,00	203 800,23	0,77	100%
04 La gestion des ressources est plus			1 344 930,00	217 040,37	372 801,41	322 287,30	368 434,72	0,00	1 280 569,81	64 360,19	95%
01 améliorer la gestion des ressources		COGES	93 748,00	51 390,79	42 365,49	0,00	0,00	0,00	91 748,29	-0,29	100%
02 améliorer la gestion des ressources		COGES	1 233 844,00	149 930,43	311 831,13	322 287,30	368 434,72	0,00	1 169 483,58	64 360,42	95%
03 renforcer la gestion de l'information		COGES	17 340,00	18 725,15	-1 385,21	0,00	0,00	0,00	17 339,94	0,06	100%
05 La qualité des soins est améliorée d'une			63 934,00	35 872,19	28 032,23	0,00	0,00	0,00	63 934,42	-0,42	100%
	REGIE		2 811 560,00	1 242 988,28	521 708,93	596 338,30	353 831,64	0,00	2 714 917,11	96 638,89	97%
	COGEST		9 790 201,00	3 108 039,81	2 711 974,35	2 650 911,05	1 201 705,89	44 038,87	9 775 258,99	14 942,01	100%
	TOTAL		12 601 757,00	4 401 027,09	3 233 683,25	3 247 249,35	1 556 537,54	44 038,87	12 490 170,10	111 593,90	99%

Budget vs Actuals (Year to Date, Last 5 years) of RWA0808611

Project Title :	**Appui Institutionnel au Ministère de la Santé - phase 4**
Budget Version :	**J1**
Currency :	EUR
YtD :	**Report includes all valid transactions, registered up to today**

	Status	Fin Mode	Amount	Expenses 2012	2013	2014	2015	2016	Total	Balance	% Exec
01 développer vision		COGES	63 934,00	35 872,19	28 032,23	0,00	0,03	0,00	63 934,42	-0,42	100%
06 les connaissances sont développées de			532 734,00	4 439,58	44 019,99	335 108,43	73 051,79	0,00	457 219,78	**75 514,22**	**86%**
01 organiser la RA		COGES	36 000,00	4 439,58	1 029,72	40 019,11	0,00	0,00	52 108,41	-10 169,41	145%
02 organiser l'appui scientifique		COGES	0,00		2 578,60	293,87	0,00	0,00	2 872,47	-2 872,47	?%
03 assurer le lien entre le district et le niveau		COGES	14 000,00		2 519,21	1 786,53	0,00	0,00	4 305,75	9 694,25	31%
04 Appui aux districts urbains		COGES	371 679,00		5 564,44	225 297,22	53 056,17	0,00	283 817,83	84 801,17	77%
05 Salaires PO districts		COGES	111 065,00		32 338,00	61 121,89	17 595,62	0,00	111 065,32	-0,32	100%
B Objectif spécifique 2			**5 062 012,00**	**1 805 175,22**	**1 406 608,12**	**1 284 743,11**	**[illegible]**	**0,00**	**4 959 435,40**	**[illegible]**	**98%**
01 Les plans du secteur de la santé sont			214 345,00	214 345,24	95,05	0,00	0,00	0,00	214 440,29	**-95,29**	100%
01 Appui à la planification - organisation ateliers		COGES	214 345,00	214 345,24	95,05	0,00	0,00	0,00	214 440,29	-95,29	100%
02 La coordination et la gestion du secteur			1 148 805,00	228 813,42	594 991,88	276 029,26	16 609,21	0,00	1 116 433,77	32 371,23	97%
01 Consolidation de la coordination et la		COGES	1 013 365,00	177 267,90	518 935,83	266 729,70	16 609,21	0,00	979 572,70	33 792,30	97%
02 Appui au cadre régulateur		COGES	135 440,00	51 545,40	76 016,05	9 269,56	0,00	0,00	136 861,07	-1 421,07	101%
03 Renforcement de la gestion		COGES	0,00		0,00	0,00	0,00	0,00	0,00	0,00	?%
03 Les ressources humaines sont renforcées			1 455 017,00	703 612,65	145 611,22	265 971,17	297 558,05	0,00	1 412 653,09	42 363,91	97%
01 Appui au développement et réalisation du		COGES	500 000,00	500 103,53	-48,74	0,00	0,00	0,00	500 054,78	-54,78	100%
02 Renforcement du RBMC et de ses instituts		COGES	638 725,00	72 418,00	118 431,83	168 419,00	242 841,10	0,00	602 137,72	36 587,28	94%
03 Maintien de la dynamique instaurée dans le		COGES	131 093,00	131 093,13	0,00	0,00	0,00	0,00	131 093,13	-0,13	100%
04 Développement des compétences en HR		REGIE	185 199,00		27 093,34	97 562,17	54 716,95	0,00	179 367,46	5 831,54	97%
04 La gestion financière est assurée de façon			85 515,00	85 515,06	0,00	0,00	0,00	0,00	85 515,06	-0,06	100%
01 Appui à l'amélioration de la gestion financière		COGES	0,00		0,00	0,00	0,00	0,00	0,00	0,00	?%
02 Appui à la dynamique instaurée dans le		COGES	85 515,00	85 515,06	0,00	0,00	0,00	0,00	85 515,06	-0,06	100%
		REGIE	2 811 556,00	1 242 038,28	521 708,90	590 398,30	351 831,64	0,00	2 714 917,11	96 638,89	97%
		COGEST	9 790 201,00	3 166 038,81	2 711 974,35	2 656 901,05	1 201 705,89	44 038,87	9 775 258,93	14 942,01	100%
		TOTAL	12 601 757,00	4 408 027,09	3 233 683,25	3 247 299,35	1 553 537,54	44 038,87	12 490 176,10	111 580,90	99%

Budget vs Actuals (Year to Date, Last 5 years) of RWA0806811

Project Title	Appui institutionnel au Ministère de la Santé - phase 4
Budget Version	J1
Currency	EUR
YtD :	Report includes all valid transactions, registered up to today

	Status	Fin Mode	Amount	Start to 2012	2013	2014	2015	2016	Total	Balance	% Exec
05 Un système intégré et performant de suivi et			42 563,00	42 562,89	0,00	0,00	0,00	0,00	42 562,89	0,11	100 %
01 Developpement d'un système de monitoring		COGES	42 563,00	42 562,89	0,00	0,00	0,00	0,00	42 562,89	0,11	100%
06 Les services et les soins délivrés sont de			2 010 777,00	630 335,98	636 019,95	631 270,86	109 741,70	0,00	1 993 318,48	14 408,52	99 %
01 Développement d'un système de qualité		COGES	45 115,00	45 583,91	0,00	135,19	0,00	0,00	45 719,10	-604,10	101%
02 Appui à la mise en œuvre des PMA et PCA		COGES	420 324,00	41 735,60	214 625,02	175 686,52	7 429,67	0,00	439 476,81	-13 152,81	103%
03 Développement de la Santé Mentale suivant		COGES	1 038 537,00	323 255,11	309 910,97	308 933,67	94 747,01	0,00	1 036 886,77	1 650,23	100%
04 Boursiers santé mentale		REGIE	37 301,00	36 501,39	0,00	1 534,27	0,00	0,00	38 085,66	-784,66	102%
05 Assistant technique santé mentale		REGIE	448 000,00	83 249,95	141 450,21	135 358,40	60 166,33	0,00	423 224,89	19 776,11	95%
06 Communication et visibilité du Programme		COGES	17 500,00		33,76	9 542,02	399,08	0,00	9 975,25	7 524,75	57%
07 La recherche action est développée et			95 000,00		0,00	91 471,82	0,00	0,00	91 471,82	3 528,18	96%
01 Developpement de la Recherche action		COGES	0,00		0,00	108,50	0,00	0,00	108,50	-108,50	?%
02 Réalisation de publications nationales et		COGES	95 000,00		0,00	91 363,32	0,00	0,00	91 363,32	3 636,68	96%
X Réserve budgétaire			8 055,00	0,00	0,00	0,00	0,00	0,00	0,00	8 055,00	0 %
01 Réserve budgétaire			8 055,00	0,00	0,00	0,00	0,00	0,00	0,00	8 055,00	0 %
01 Réserve budgétaire COGESTION		COGES	8 055,00	0,00	0,00	0,00	0,00	0,00	0,00	8 055,00	0%
02 Réserve budgétaire REGIE		REGIE	0,00		0,00	0,00	0,00	0,00	0,00	0,00	?%
Z Moyens généraux			2 684 766,00	1 120 807,22	436 520,83	501 294,23	308 633,99	29,74	2 617 285,81	67 470,19	97 %
01 Frais de personnel			2 150 165,00	1 078 483,77	391 471,93	411 711,17	223 672,32	0,00	2 105 219,24	44 945,76	98 %
01 Assistant technique		REGIE	1 581 402,00	843 027,13	222 730,73	288 910,47	148 594,54	0,00	1 509 882,87	71 519,13	95%
02 Directeur national		COGES	0,00		0,00	0,00	0,00	0,00	0,00	0,00	?%
03 Equipe finance et administration		COGES	353 202,00	113 818,18	103 203,81	95 858,38	60 560,27	0,00	303 436,64	-10 234,64	105%
04 Responsable administratif et financier du		REGIE	72 560,00	21 547,02	23 503,95	23 792,69	17 400,97	0,00	83 253,63	-13 703,63	119%
	REGIE		2 811 560,00	1 242 938,28	521 708,90	596 338,30	353 831,04	0,00	2 714 917,11	96 638,89	97%
	COGEST		9 790 201,00	3 160 038,41	2 711 974,35	2 050 931,05	1 201 705,89	44 038,87	9 775 258,99	14 942,01	100%
	TOTAL		12 601 767,00	4 403 027,69	3 233 683,25	3 247 231,35	1 556 537,54	44 038,87	12 490 176,10	111 590,90	91%

Budget vs Actuals (Year to Date, Last 5 years) of RWA0806811

Project Title :	Appui institutionnel au Ministère de la Santé - phase 4
Budget Version :	J1
Currency :	EUR
YtD :	Report includes all valid transactions, registered up to today

	Status	Fin Mode	Amount	Start to 2012	2013	2014	2015	Expenses 2016	Total	Balance	% Exec
05 Autres frais de personnel		COGES	20 255,00	8 380,93	3 840,02	3 129,63	1 774,76	0,00	17 131,33	9 123,67	65%
06 Assistants techniques nationaux		REGIE	116 750,00	85 040,61	38 184,47	0,00	-708,21	0,00	122 514,77	-5 759,77	105%
02 Investissements			156 998,00	102 937,05	50 310,09	17 847,43	-1.284,45	0,00	175 930,12	-19.932,12	113 %
01 Véhicules		REGIE	115 998,00	80 440,93	40 045,47	5 790,85	-1.751,03	0,00	131 128,22	-15 128,22	113%
02 Equipement bureau		REGIE	26 000,00	12 029,36	6 315,96	10 135,55	493,57	0,00	29 937,44	-3 937,44	115%
03 Equipement IT		REGIE	15 000,00	10 498,70	3 349,66	1 951,04	0,00	0,00	15 800,40	-800,40	105%
03 Frais de fonctionnement			162 243,00	75 371,18	26 310,44	40 518,56	16,120,25	29,74	158 350,18	3.892,82	98 %
01 Services et frais de maintenance		COGES	57 000,00	17 739,28	6 937,23	17 518,63	5 421,88	0,00	43 647,03	10 352,97	82%
02 Frais de fonctionnement des véhicules		COGES	50 000,00	25 750,73	12 769,03	9 025,51	7 527,41	0,00	55 071,69	-5 071,69	110%
03 Télécommunications		COGES	28 867,00	12 075,89	7 284,91	8 806,77	14 018,08	0,00	42 285,65	-13 418,65	146%
04 Fournitures de bureau		COGES	22 776,00	10 025,27	4 401,39	1 407,47	169,88	0,00	16 003,51	6 772,49	70%
05 Frais financiers		COGES	3 000,00	307,25	-264,18	-4 036,48	147,51	29,74	-3.955,16	7 565,16	-110%
06 Frais TVA		COGES	0,00	9 472,75	-3 787,45	7 755,67	-11 163,62	0,00	2 297,46	-2 297,46	?%
04 Audit et Suivi et Evaluation			218 360,00	64 005,23	12 429,10	31 398,67	67 737,15	0,00	175 569,16	40 790,85	81%
01 Frais de suivi et évaluation		REGIE	109 252,00	58 935,78	8 284,09	3 941,65	38 291,47	0,00	109 472,98	-220,98	100%
02 Audit		REGIE	25 000,00		0,00	16 900,00	2 385,00	0,00	19 285,00	5 715,00	77%
03 Backstopping		REGIE	15 000,00	4 420,81	2 975,61	6 527,84	0,00	0,00	13 924,16	1.075,84	93%
04 Etudes convention d'exécution		REGIE	2 038,00		0,00	2 037,53	0,00	0,00	2 037,53	0,47	100%
05 Frais TVA		REGIE	0,00	678,64	1 109,10	1 567,99	-3 300,63	0,00	54,09	-54,09	?%
06 Frais financiers		REGIE	0,00		60,42	-78,32	-222,38	0,00	-240,28	240,28	?%
07 Capitalisation		REGIE	65 000,00		0,00	331,97	30 583,70	0,00	30 965,67	34 034,33	48%
99 Conversion rate adjustment			0,00	0,00	0,00	-105,80	1 234,36	0,00	1 128,56	-1.128,56	?%
		REGIE	2 811 560,00	1.242 938,28	521 708,90	596 349,30	353 831,04	0,00	2 714 917,11	96 633,89	97%
		COGEST	9 790 201,00	3 106 039,81	2 711 974,35	2 650 911,05	1 201 705,89	44,038,87	9 775 258,99	14 942,01	100%
		TOTAL	12.001 757,00	4 409 027,09	3 233 683,25	3 247 259,15	1 556 537,54	44,038,87	12 490 176,10	111 591,90	91%

Budget vs Actuals (Year to Date, Last 5 years) of RWA0808611

Project Title :	**Appui institutionnel au Ministère de la Santé - phase 4**
Budget Version :	**J1**
Currency :	EUR
YTD :	**Report includes all valid transactions, registered up to today**

	Status	Fin Mode	Amount	2012	2013	2014	2015	2016	Total	Balance	% Exec
99 Conversion rate adjustment			0,00	0,00	0,00	-105,80	1 234,36	0,00	1 128,56	-1 128,56	?%
98 Conversion rate adjustment		REGIE	0,00	0,00	0,00	-105,80	1 234,36	0,00	1 128,56	-1 128,56	?%
99 Conversion rate adjustment		COGES	0,00		0,00	0,00	0,00	0,00	0,00	0,00	?%

	Amount	2012	2013	2014	2015	2016	Total	Balance	% Exec
REGIE	2 811 550,00	1 242 938,28	521 708,90	596 338,30	353 831,04	0,00	2 714 917,11	96 633,89	97%
COGEST	9 790 201,00	3 163 638,81	2 711 974,35	2 650 901,05	1 201 705,89	44 038,87	9 775 258,99	14 942,01	100%
TOTAL	12 601 757,00	4 406 627,09	3 233 683,25	3 247 239,35	1 555 537,54	44 038,87	12 490 176,10	111 580,90	99%

3 Disbursement rate of the intervention

Source of financing	Cumulated budget	Real cumulated expenses	Cumulated disbursement rate	Comments and remarks
Direct Belgian Contribution	**TOTAL 12 610 757.00**	**TOTAL 12 490 176,10**	**99%**	
	A = 4 856 934.00	A = 4 914 583.45	>100%	
	B = 5 052 012.00	B = 4 959 435.40	98.2%	
	Z = 2 684 756.00	Z = 2 617 285.81	97.5%	Pending payment of capitalization booklet
Contribution of the Partner Country				
Other source	300 000	300 000		This was an estimate including the office space and maintenance, water and electricity charges, salary for DI, etc

4 Personnel of the intervention

Employee Identification								
Surname	Name	Gender	Nationality	Title	Employer	Funder	Start of the contract	End of the contract
Vincent	Tihon	male	Belgian	Délégué à la cogestion	BTC	BTC	28-Aug-2010	31-Jul-2015
Achour	Ait Mohand	male	Algerian	Assistant technique International	BTC	BTC	17-Nov-2011	30/Juin 2015
Sankaran	Narayanan	male	Indian	Assistant technique International	BTC	BTC	1-08-2013	30Juin/2015
Kamali	Rumiya	male	Rwandan	CSQ	BTC	BTC	01 september 2012	Indeterminé
Jean Marie	Sinari	male	Rwandan	Program Officer district de Rulindo	Partner	BTC&Partner	15-06-13	31/3/2015
Edith	Musabyimana	female	Rwandan	Program Officer district de Bugesera	Partner	BTC&Partner	15-06-13	31/3/2015
Felicien	Rusagara	male	Rwandan	Program Officer district de Gakenke	Partner	BTC&Partner	15-06-13	31/3/2015
Gilbert	Biraro	male	Rwandan	Chargé de Projet /SPIU /Minisanté 4		Partner	11-Nov-2013	30 Avril 2014

Fidèle	T. Nsengimana	male	Rwandan	Gestionnaire Comptable SPIU/ Minisanté 4	Partner	BTC&Partner	15-Feb-2011	30 juin 2015
Donata	Nyirandinda	femelle	Rwandan	Assistante Administrative SPIU / Minisanté 4	Partner	BTC&Partner	15-Feb-2011	30 juin 2015
Gentille	Uwamahoro	femelle	Rwandan	Assistante Comptable SPIU/ Minisanté 4	Partner	BTC&Partner	10 september 2011	30 juin 2015
Chris	Mahirwe	male	Rwandan	Procument Officer	Partner	BTC&Partner	25-01-2013	30 juin 2015
Vital	Marara	male	Rwandan	Chauffeur au SPIU/ Minisanté 4	Partner	BTC&Partner	1-Mar-2011	30 juin 2015
Mathieu	Uwimana	male	Rwandan	Chauffeur au SPIU/ Minisanté 4	Partner	BTC&Partner	1-Mar-2011	30 juin 2015
Phocas	Mundeke	male	Rwandan	Chauffeur au SPIU/ Minisanté 4	Partner	BTC&Partner	6-Sep-2012	30 juin 2015
Ernest	Habimana	male	Rwandan	Chauffeur /Santé Mentale	Partner	BTC&Partner	23-Aug-2012	31 mars 2015
Flora	Barakagwira	female	Rwandan	Assistante Administrative	Partner	BTC&Partner	31-Jul-2012	31 mars 2015
James	Byagatonda	male	Rwandan	Chauffeur Santé Mentale	Partner	BTC&Partner	31-Jul-2012	31 Mars 2014
Lazaro	Ndazaro	male	Rwandan	Agent de SWAP	Partner	BTC&Partner	1-Jan-2012	31 Oct 2014
Guillaume	Rugira	male	Rwandan	Agent Unité Secteur Privé	Partner	BTC&Partner	7/06/2012	31 mars 2015

Innocent	Turate	male	Rwandan	Assistant technique : Services Cliniques	Partner	BTC&Partner	08-07-13	28 février 2015
Regis	Kazindu	male	Rwandan	Technical Data Analyst	Partner	BTC&Partner	18nov.2013	20 Juin 2015
Alsen	Ndaruhutse	male	Rwandan	Project Manager	Partner	BTC&Partner	01-03-14	Aug.2014 (resigned)
Consolatrice	Niyibizi Rahab	Female	Rwandan	Psychologue	Partner	BTC&Partner	01/Oct.2014	31/Mars 2015
Vladescu Erick	Ayirwanda Vladescu Eric	male	Rwandan	Urban health program Officer	Partner	BTC&Partner	01/Oct. 2014	30 juin 2015
Beattrice	Uwayezu	Female	Rwandan	National Technical Assistant	BTC	BTC		
Jean damascene	Makuza	Male	Rwandan	National Technical Assistant	BTC	BTC		
Félicien	Rusagara	Male	Rwandan	National Technical Assistant	BTC	BTC		
Klaus	Grütjen	Male	German	DELCO	BTC	BTC	1 January 2011	May 2012
Ian	Van Engelgem	Male	Belgian	International Technical Assistant	BTC	BTC	Sept 2010	August 2011

Personnel (title and name)	Gender (M/F)	Duration availability ~~of recruitment~~ (start and end dates) – PART TIME

National personnel put at disposal by the Partner Country:		
Dr Daniel Ngamije - Director of Intervention	M	1st July 2012 - 30 June 2015
Dr Gilbert Biraro - Program Officer	M	2014 - 30 June 2015
Dr Théophile Dushime – Program Officer	M	1st July 2012 - 2013
Dr Ida Kankindi – DI Technical	F	October 2010 – June 2013
Innocent Duka – DI Finance	M	October 2010 – June 2013
Gervais Baziga - DI	M	August 2010 -
Jean d'Amour Manirafasha director of Health Rulindo	M	From August 2010
François Karambizi – director of Health Bugesera	M	From August 2010
Janvière Uwamahoro – director of Health Gakenke	F	From August 2010

5 Public procurement

Insert public procurement table.

Nr Tender in partner Institution Register	Nr Tender in BTC Register	Tender type	Tender title	Budget line(s) activity	Tendering Method	Status	Publication date	Contract signing date	Amount in RWF	Amount in EUR	Successful Bidder	Contract Execution Start Date	Planned Contract Closure Date	Contract Duration (days)
011/S/2013-2014/ REoI/BTC-MINISANTE IV-RWA 722/SPIU-MoH	RWA/722	Individual Consultants	Radiological safety status and quality assurance audit of medical X-ray installations in Rwanda	B0302	REOI	Closed	09/10/2013	21/10/2013	61.746.400	68.607	Dr Juvenal HATEGE KIMANA	17/12/2013	30/04/2014	
011/S/2013-2014/ REoI/BTC-MINISANTE IV-RWA 722/SPIU-MoH	RWA/722	Individual Consultants	Radiological safety status and quality assurance audit of medical X-ray installations in Rwanda	B0302	REOI	Closed	29/08/2013	21/10/2013	61.746.401	68.607	Dr Juvenal HATEGE KIMANA	28/11/2013	22/02/2014	
049/S/2012-AONO/SPIU-SS HIV	RWA/697	Services	SURVEILLANCE DE 7 INFRASTRUCTURES FINANCEES PAR LA CTB	A0302	NCB	Closed		13/10/2013	25.830.000	28.700	HICO Ltd			
049/S/2012-AONO/SPIU-SS HIV	RWA/697	Services	SURVEILLANCE DE 7 INFRASTRUCTURES FINANCEES PAR LA CTB	A0302	NCB	Closed		13/10/2013	25.830.000	28.700	HICO Ltd	28/10/2013	31/5/2014	

070/S/2012-2013/AONO-CTB MINISANTE	N/A	Services	SERVICES DE SURVEILLANCE DES CONSTRUCTIONS DE BLOC DE NEONATOLOGIE DE KANGURU (HOPITAL DE RULI) ET BUGESERA (HOPITAL DE NYAMATA)	A0302	NCB	Closed	20/03/2013	04/01/2014	14.749.995	16.389	Atlas Engineering Consultant Ltd	04/01/2014	20/06/2014	
070/S/2012-2013/AONO-CTB MINISANTE	N/A	Services	SERVICES DE SURVEILLANCE DES CONSTRUCTIONS DE BLOC DE NEONATOLOGIE DE KANGURU (HOPITAL DE RULI) ET BUGESERA (HOPITAL DE NYAMATA)	A0302	NCB	Closed	20/03/2013	04/01/2014	14.749.995	16.389	Atlas Engineering Consultant Ltd	05/01/2014	20/6/2014	
013/S/2013-2014/AONO/SPIU-MOH	NA	Services	Surpervision of constructions of works of 3 maternities and 1 pharmacy & Supervision of 4 construction works at Kamabuye, Bouanderie, Consultation block at Nemba and Mental health at Nyamata	A0302	NCB	Closed	09/09/2013	25/3/2014	9.360.000	10.400	HICO Ltd	25/3/2014	30/11/2014	
013/S/2013-2014/AONO/SPIU-MOH	NA	Services	Surpervision of constructions of works of 3 maternities and 1 pharmacy & Supervision of 4 construction works at Kamabuye, Bouanderie, Consultation block at Nemba and Mental health at Nyamata	A0302	NCB	Closed	09/09/2013	25/3/2014	9.360.000	10.400	HICO Ltd	25/3/2014	30/11/2014	

058/S/2013-2014/ REoI/BTC-MINISANTE IV/SPIU-MoH	N/A	Services	Consultancy service for the CHUB Strategic Plan	B0201	NCB	Closed	04/02/2014							
058/S/2013-2014/ REoI/BTC-MINISANTE IV/SPIU-MoH	N/A	Services	Consultancy service for the CHUB Strategic Plan	B0201	NCB	Closed	04/03/2014	17/11/ 2014	9.150.000	11,524	Alexis Dukudane	17/12/2014	20/01/2015	33 days
	N/A	Services	IN DEPTH STUDY OF ASSET MANAGEMENT IN HEALTH SECTOR	B0302	ICB	Closed	15/11/2014	31/01/ 2014						
				B0302	ICB	Closed	04/11/2014							
				B0302	ICB	Closed	9/03/2015 launch RFP	06/01/ 2015						
070/S/2013-2014/REOI/CTB/KICUKIRO	N/A	Services	DESIGN OF NEW HOSPITAL FOR KICUKIRO HOSPITAL	A0604	ICB	Closed	01/10/2014	30/12/ 2014						

				A0604	ICB	Closed	10/10/2014	04/09/ 2015						
090/G/2012-2013/NCB/BTC-MINISANTE IV/SPIU-MoH	RWA/695	Goods	SUPPLY OF QUALITY CONTROL DEVICES FOR RBC	B0302	NCB	Closed	20/05/2013	13/1/2 014	75.957.626	84.397	RIEX Ltd and ECOME M	13/1/2014	13/4/2014	60
090/G/2012-2013/NCB/BTC-MINISANTE IV/SPIU-MoH	RWA/695	Goods	SUPPLY OF QUALITY CONTROL DEVICES FOR RBC	B0302	NCB	Closed	20/05/2013	13/1/2 014	75.957.626	84.397	RIEX Ltd and ECOME M	13/1/2014	13/04/2014	60
N° 031/G/2013-2014/NCB/BTC RWA-731/SPIU-MoH	RWA/731	Goods	Procure medical, electromechanical and electrical equipments spare parts	B0302	NCB	Closed	12/10/2013	29/8/2 014	137.523.000	152.80 3	HUBR UD POWER SOLUTI ON			
N° 031/G/2013-2014/NCB/BTC RWA-731/SPIU-MoH	RWA/731	Goods	Procure medical, electromechanical and electrical equipments spare parts	B0302	NCB	Closed	25/11/2013	29/8/2 014	137.523.000	152.80 3	HUBR UD POWER SOLUTI ON	15/09/2014	14/11/2014	60
N° 023/G/2013-2014/NCB/BTC RWA-729/SPIU-MoH	RWA/729	Goods	Procurement of 20 Aspirators, 17 Electronic Tools and 10 Electronic Measuring Instruments for Biomedical Engineer's for RBC-MMCD	B0302	NCB	Closed	18/10/2013	09/04/ 2014	33.256.933	36.952	NEUT RON Co Ltd	09/04/2014	09/06/2014	60

N° 023/G/2013-2014/NCB/BTC RWA-729/SPIU-MoH	RWA/729	Goods	Procurement of 20 Aspirators, 17 Electronic Tools and 10 Electronic Measuring Instruments for Biomedical Engineer's for RBC-MMCD	B0302	NCB	Closed	18/10/2013	09/04/ 2014	33.256.933	36.952	NEUT RON Co Ltd	09/04/2014	09/06/2014	60
N°016/G/2012-2013/NCB/BTC–MINISANTE IV-RWA-699/SPIU-MoH	RWA/669	Goods	Procure software (AutoCAD Architecture, ARC GIS, AUTOCAD CIVIL-3D Metric, ARCHICAD, Autodesk structure and Training for 3 staff)	B0302	NCB	Closed	25/09/2013	23/04/ 2014	14.884.440	16.538	AFTE C LTD			
N°016/G/2012-2013/NCB/BTC–MINISANTE IV-RWA-699/SPIU-MoH	RWA/669	Goods	Procure software (AutoCAD Architecture, ARC GIS, AUTOCAD CIVIL-3D Metric, ARCHICAD, Autodesk structure and Training for 3 staff)	B0302	NCB	Closed	25/9/2013	02/05/ 2014	14.884.440	16.538	AFTE C LTD	02/05/2014	03/07/2014	
N° 022/G/2013-2014/NCB/BTC RWA-728/SPIU-MoH	RWA/728	Goods	Medical equipment (developeuse-Rutongo et equipments dans l'urgence)	B0402	NCB	Closed	18/10/2013	06/03/ 2014	14.833.810	16.482	Crown Healthcare	06/03/2014	05/05/2014	
N° 022/G/2013-2014/NCB/BTC RWA-728/SPIU-MoH	RWA/729	Goods	Medical equipment (developeuse-Rutongo et equipments dans l'urgence)	B0402	NCB	closed	18/10/2013	07/03/ 2014	14.833.810	16.482	Crown Healthcare	06/03/2014	05/05/2014	

N° 024/G/2013-2014/NCB/BTC RWA-272/SPIU-MoH	RWA/727	Goods	Electromechanical Equipment for Nyamata, Ruli, Nemba and Rutongo District Hospitals	B0402	NCB	Closed	18/10/2013	09/04/2014	77.101.518	85.668	Merite Equipment Ltd et Tech Grand lac	09/04/2014	08/06/2014	
	RWA/728	Goods	Electromechanical Equipment for Nyamata, Ruli, Nemba and Rutongo District Hospitals	B0402	NCB	Closed	18/10/2013	09/04/2014	77.101.518	85.668	Merite Equipment Ltd et Tech Grand lac	09/04/2014	08/06/2014	
054/S/2012/NCB/MINISANTE IV/SPIU - MOH	RWA/697	Goods	Acquisition de 2 motos	B0402	SS	Closed	NA		4.214.000	4.682	Rwandamotor			
	RWA/697	Goods	Acquisition de 2 motos	B0402	SS	Closed	NA		4.214.000	4.682	Rwandamotor			
N° 026/G/2013-2014/NCB/BTC RWA-735/SPIU-MoH	RWA/735	Goods	Physiotherapy Equipment	B0402	NCB	Closed	28/1/2014	29/8/2014	44.931.068	49.923	KIPHARMA+DUCRAY+JO ACHELIS	29/08/2014	28/10/2014	60
N° 026/G/2013-2014/NCB/BTC RWA-735/SPIU-MoH	RWA/735	Goods	Physiotherapy Equipment	B0402	NCB	Closed	28/1/2014	28/08/2014	44.931.068	49.923	KIPHARMA	09/12/2014	11/11/2014	60
				B0402	NCB	Closed	28/1/2014	28/08/2014	44.931.068	49.923	DUCRAY	09/12/2014	11/11/2014	60
				B0402	NCB	Closed	28/1/2014	28/08/2014	44.931.068	49.923	JO ACHELIS			60
Contrat cadre CTB	Contrat cadre CTB	Goods	Acquisition de 3 vehicules	A0302 & B0402	FC	Closed	NA		68.245.200	75.828	BTC Framework Contract			

Contrat cadre CTB	Contrat cadre CTB	Goods	Acquisition de 3 vehicules	A0302 & B0402	FC	Closed	NA		68.245.200	75.828	BTC Framework Contract			
056/G/2013-2014/NCB/BTC-RWA 739/SPIU-MoH	RWA/739	Goods	Acquisition des monitors et machine d'anesthesie (Rutongo et Bugesera)	A0302	NCB	Closed	04/12/2014	29/8/2014	84.054.175	93.394	GBB Engineering Ltd	01/09/2014	30/11/2014	
056/G/2013-2014/NCB/BTC-RWA 739/SPIU-MoH	RWA/739	Goods	Acquisition des monitors et machine d'anesthesie (Rutongo et Bugesera)	A0302	NCB	Closed	14/4/2014	29/08/2014	84.054.175	93.394	GBB Engineering Ltd	09/12/2014	12/11/2014	90
062/G/2013-2014/ICB/BTC-RWA 741/SPIU-MoH	RWA/741	Goods	Supply and Installation of Medical Equipemets for 10 Maternites, 2 Neonat and 1 Operation block	A0302	ICB	Closed	04/12/2014	15/08/2014	321.241.100	356.935	Michiels/GBB Engineering/ Africhem Rwanda	15/08/2014	30/10/2014	75
062/G/2013-2014/ICB/BTC-RWA 741/SPIU-MoH	RWA/741	Goods	Supply and Installation of Medical Equipemets for 10 Maternites, 2 Neonat and 1 Operation block	A0302	ICB	Closed	14/4/2014	29/82014	321.241.100	356.935	Michiels LOT 1 2	10/08/2014	01/07/2015	90
				A0302		Closed					LOT 4 GBB	09/12/2014	12/11/2014	
				A0302		Closed					LOT 3 GBB Engineering Ltd	14/11/2014	13/02/2015	90
				A0302		Closed					LOT 5 6 AFRICHEM RWANDA	24/11/2014	23/02/2015	90

063/G/2013-2014/ICB/BTC-RWA 740/SPIU-MoH	RWA 740	Goods	Sypply and Installation of Orthopedic Equipment for Rutongo and Kinihira Hospitals	A0302	ICB	Closed	12/04/2014	30/07/2014	72.402.805	80.448	KIPHA RMA+C ROWN	30/06/2014	30/09/2014	90
063/G/2013-2014/ICB/BTC-RWA 740/SPIU-MoH	RWA 740	Goods	Sypply and Installation of Orthopedic Equipment for Rutongo and Kinihira Hospitals	A0302	ICB	Closed	14/4/2014	29/8/2014	72.402.805	81.148	KIPHA RMA	29/08/2014	28/11/2014	90
				A0302		Closed				4.657	CROWN	29/08/2014	28/11/2014	90
061/G/2013-2014/NCB/BTC/MS4/SPIU-MoH	N/A	Goods	Supply of 23 Laptop for Mutielle de Sante/ Rulindo and other IT equitment for MOH Planning and MHD-RBC	A0302	NCB	Closed	30/04/2014	30/07/2014	17.330.000	19.256	Robotics	30/07/2014	30/08/2014	30
061/G/2013-2014/NCB/BTC/MS4/SPIU-MoH	N/A	Goods	Supply of 23 Laptop for Mutielle de Sante/ Rulindo and other IT equitment for MOH Planning and MHD-RBC	A0302	NCB	Closed	14/04/2014	01/09/2014	17.330.000	19.256	Robotics	01/09/2014	16/09/2014	15
002/G/2014-2015/nCB/SPU-CTB MINISANTE IV	RWA 748	Goods	EQUIPEMENT FOR CENTRE PSYCO-THERAPEUTIQUE/ POLICE HUYE	B0302	NCB	cancelled	29/09/2014	05/01/2015						
				B0302	NCB	cancelled	29/09/2014	17/04/2015	95.811.016	131.218	The Golden Supply Ltd			80

008/G/2014-2015/SS/CTB-MINISANTE IV/SPIU-MOH	N/A	Goods	ECRI - HPCS (health care product comparison system)	B0302	SS	Closed	09/09/2014	22/10/ 2014						
				B0302		Closed	09/09/2014	BC 20/11/20 14	3.106.800	3.452	ECRI	upon payment transfer	31/12/2014	
	N/A	Goods		A0604	RFQ	Closed	06/10/2014	30/10/ 2014						
				A0604	RFQ	Closed	06/10/2014	BC 20/11/20 14	1.538.864	1.710	KIPHA RMA	20/11/2014	12/05/2014	14
046/T/2012-13/N/CTB	RWA/696	Works	Construction of 7 maternities in 3 districts (Gakenke, Rulindo and Bugesera)+ Avenant main d'oeuvre CS Cyabingo	A0302	ICB	Closed	12/03/2013	27/08/ 2013	420.176.134	466.86 2	BURE COM	16/09/2013	15/3/2014	180
046/T/2012-13/N/CTB	RWA/696	Works	Construction of 7 maternities in 3 districts (Gakenke, Rulindo and Bugesera)	A0302	ICB	Closed	12/03/2013	27/08/ 2013	420.176.134	466.86 2	BURE COM	16/09/2013	15/3/2014	180
004/T/2013-2014/ SPIU –MINISANTE-CTB-RWA /719	RWA/719	Works	Construction d'un block operatoire a l'hopital de Nemba	A0302	NCB	Closed	30/07/2013	03/01/ 2014	112.687.237	125.20 8	BETA Construc tion	18/01/2014	17/7/2014	180
004/T/2013-2014/ SPIU –MINISANTE-CTB-RWA /719	RWA/719	Works	Construction d'un block operatoire a l'hopital de Nemba	A0302	NCB	Closed	30/07/2013	03/01/ 2014	112.687.237	125 20 8	BETA Construc tion	18/01/2014	17/7/2014	180

001/T/2013-2014/ SPIU –MINISANTE-CTB-RWA /714	RWA/714	Works	Construction de deux blocs de neonatologie pour les hopitaux: Ruli et Nyamata	A0302	NCB	Closed	12/07/2013	03/01/ 2014	132.686.271	147.42 9	GECO INTER	18/01/2014	17/7/2014	180
001/T/2013-2014/ SPIU –MINISANTE-CTB-RWA /714	RWA/714	Works	Construction de deux blocs de neonatologie pour les hopitaux: Ruli et Nyamata	A0302	NCB	Closed	12/07/2013	03/01/ 2014	132.686.271	147.42 9	GECO INTER	18/01/2014	17/7/2014	180
009/T/2013-14/N/MS 4/CTB-RWA/720/SSF-HIV	RWA/720	Works	Execution works of construction of 3 maternities and 1 pharmacy funded by BCT/MS4	A0302	NCB	Closed	22/08/2013	03/03/20 14	219.086.167	243.42 9	GLISC O			
009/T/2013-14/N/MS 4/CTB-RWA/720/SSF-HIV	RWA/720	Works	Execution works of construction of 3 maternities and 1 pharmacy funded by BCT/MS4	A0302	NCB	Closed	22/08/2013	20/4/201 4	219.086.167	243.42 9	GLISC O	20/04/2014	20/10/2014	
025/T/2013-2014/SPIU-MINISANTE -CTB-RWA/734	RWA/734	Works	Other works: Execution works of 4 constructions funded by BCT/MS4	A0302	NCB	Closed	20/11/2013	02/05/20 14	139.442.140	154.93 6	EFOG EC	02/05/2014	01/11/2014	180
		Works	Paving 3 new HC(Mageragere, Kanyinya and Remera)	A0604	NCB	Cancelled	13/10/2014	20/01/20 15						
					NCB	Cancelled	04/11/2014	31/02/20 15	40.665.610	51216,133 5				60

6 Public agreements

Number of the Agreement	Name of partner institution	Statut Institution	Object of the Agreement	Type	Payment modality	Entering into force (date)	End date	Total amount (€)	Total amount (FRW)	Total Transfer Amount (€)	Percentage Transferred	Audit Date	Final Financial and narrative report date	Formal Closure of EA FA Date	Comments
RWA 08 066 11/001-GAKENKE	Nemba Hospital	Autonomous Public Institution	Strenghen the Management of Health facilities and improve the quality of instrastructure and equipment	AE	Variable instalment	30-03-11	30-09-11	€ 159,039	Rwf 127231200	159,039.00	100%	31/12/2011	30/11/2011	30/11/2011	
Amendment 1				AE		13-07-11	30-11-11								
RWA 08 066 11/002-GAKENKE	Rul Hospital			AE		26-03-11	30-09-11			81,868.00	100%	31/12/2011	30/11/2011	30/11/2011	
Amendment no 1				AE		13-07-11	30-11-11	€ 81,868	Rwf 65494400						
RWA 08 066 11/003-BUGESERA	Nyamata Hospital	Autonomous Public Institution	Strenghen the Management of Health facilities and improve the quality of instrastructure and equipment	AE	Variable instalment	28-03-11	30-09-11	€ 150,667	Rwf 120533600	346,719.00	100%	31/12/2011	31/03/2012	30/11/2011	
Amendment no 1				AE		13-07-11	30-11-11	€ 196,052	Rwf 156841600						
Amendment no 2				AE		30-11-11	31-03-12								
RWA 08 066 11/004-RULINDO	Rutongo Hospital	Autonomous Public Institution	Strenghen the Management of Health facilities and improve the quality of instrastructure and equipment at decentralised level	AE	Variable instalment	28-03-11	30-09-11				100%	31/12/2011	31/12/2014	27/05/2014	The balance of 11 183 Euros is not yet refunded After numerous correspondance with the hospital and the district, the management of MS M has written to the Governor on 11th April 2015 in order to make a pressure both to Rulindo District and Rutongo hospital
Amendment no 1				AE		13-07-11	30-11-11	€ 108,181	Rwf 84944800	€ 108,183					
RWA 08 066 11/005-BUGESERA	Bugesera distict	Autonomous Public Institution	Strenghen the Management of Health facilities and improve the quality of instrastructure and equipment at decentralised level	AE	Variable instalment	12-12-11	31-01-14	€ 556,571	Rwf 445256800		69%	05-12-14	15/12/2014	31/10/2014	a last balance is to be paid in April 2015 (less than 1 Mil FRW)
Amendment no 1				AE											
Amendment 2				AE		01-05-13	30-04-14								
Amendment 3				AE		11-03-14	30-06-14	€ 300,000	Rwf 240000000	€ 384,793					

RWA 08 056 11/008-GAKENKE	Gakenke district	Autonomous Public Institution	Strengthen the Management of Health facilities and improve the quality of infrastructure and equipment at decentralised level	AE	Variable instalment	12-12-11	31-01-14	€ 1,280,022	Rwf 1008017600	€ 607,198	42%	27/05/2014	15/12/2014	31/10/2014	
Amendment 1				AE		01-05-13	30-04-14	€ 100,000	Rwf 80000000						
Amendment 2				AE											
Amendment 3				AE		11-03-13	30-08-14	€ 92,500	RWF 83,250,000						
RWA 08 056 11/007-RULINDO	Rulindo district	Autonomous Public Institution	Strengthen the Management of Health facilities and improve the quality of infrastructure and equipment at decentralised level	AE	Variable instalment	12-12-11	31-01-14	€ 990,017	Rwf 792013600	€ 364,730	31%	05-12-14	15/12/2014	31/10/2014	
Amendment nr 1				AE											
Amendment 2						01-05-13	30-04-14								
Amendment 3						11-03-13	30-08-14	€ 200,000	Rwf 160000000						
AE RWA 100	School of Public Health	Central Ministry	Strengthen the Health System and improve continuous research of the Belgian - Rwanda cooperation	AE	Variable instalment	23-01-12	31-10-13	€ 125,143	RWF 152,554,400	€ 208,891	99%		30/08/2014	30/09/2014	A successful external audit has been done and submitted on 30th March 2015 by ERNST & YOUNG
Amendment 1						25-02-14	30-08-14	€ 83,318	RWF 68,654,400						
Amendment 2 (in process)				AE		30-08-14	30-09-14								

7 Equipment

The list equipment acquired during the intervention is too long for being meaningful in this report. Therefore, a summary list is included below with the total budget involved and a list with the most important items follows below

Summary table

BENEFICIARY	AMOUNT (FRW)	AMOUNT (EUROS)	OBSERVATION
GAKENKE DISTRICTS	957,873,010	1,224,902	Transferred already
RULINDO DISTRICTS	780,507,226	998,091	Transferred already
BUGESERA DISTRICTS	628,885,414	804,201	Transferred already
SUB-TOTAL DISTRICTS	**2,367,265,650**	**3,027,194**	
MTI/RBC	371,791,129	475,436	Transferred already
MH/RBC	92,067,886	117,734	Transferred already
DG PLANNING/MOH	65,550,000	83,824	Transferred already
SUB-TOTAL CENTRAL UNIT	**529,409,015**	**676,994**	
GENERAL MEANS MS4	**141,153,079**	**180,503**	
Grand Total	3,037,827,744	3,884,690	

INFRASTRUCTURE	Cost	delivery date	Remarks

GAKENKE DISTRICT	RWF 615 MI (787 000 E)	2011 - 2015	
Ruli hospital: neonatology unit, laundry room			
Nemba Hospital pharmacy, operating theatre, renovation of Xray, neonat			
District: latrines, district pharmacy			
Health centers: two maternities			
RULINDO DISTRICT	RWF 347 MI (443.000 E)	2011 - 2015	
5 Maternities			
2 blocs health centres			
latrines			
BUGESERA DISTRICT	RWF 285 Mi (364 000 E)	2011 - 2015	
Nyamata hospital: neonatology, mental health, customer care			
Latrines			
Health centers: 3 maternities			

Equipment type	Cost	delivery date	Remarks
GAKENKE DISTRICT			
Two supervision vehicles	RWF 55Mi	2011-12	
Non medical equipment (computers, printers, office furniture for health centres, etc)	RWF 58.6 Mi	2011-15	
Medical equipment (dental chair, health centre delivery beds, etc)	RWF 229.2 Mi	2014-15	
RULINDO DISTRICT			
Transport: 1 ambulance, 2 vehicles, 4 Motos	RWF 151.6 Mi		
Non medical equipment (computers, printers, office furniture for health centres, water tanks, etc)	RWF 45.7 Mi		
Medical equipment (maternity equipments, health centre delivery beds, etc)	RWF 269.3 Mi		
BUGESERA DISTRICT			
Non medical equipment (computers, printers, office furniture for health centres, etc)	RWF 52.5 Mi		
Medical equipment (maternity equipments, health centre delivery beds, etc)	RWF 229.2 Mi		
DG PLANNING HEALTH FINANCING HIS			
4 laptops	RWF 2.3 Mi		
30 motorbikes for District M&E officers in all districts	RWF 63.2 Mi		

MENTAL HEALTH DIVISION			
Two vehicles	RWF 85 Mi		
Office furniture	RWF 12.5 Mi		
MTI DIVISION			
Quality Control devices	RWF 41 Mi		
17 toolboxes	RWF 33.2 Mi		
Desktop for all hospital maintenance workshops (46)	RWF 31.5 Mi		
Spare parts for oxygen concentrators, fridges, etc	RWF 124 Mi		
Architecture software for infrastructure design	RWF 22.2 Mi		
REGIE			
Three vehicles	RWF 123 Mi		
Office furniture	RWF 18.2 Mi		

8 Original Logical Framework from TFF :

Titre du program: **APPUI INSTITUTIONNEL AU MINISANTE PHASE 4**				
	Objectifs	**Indicateurs**	**Moyens de vérification**	**Risques et hypothèses**
Objectif Général	**Le Rwanda a mis en place un système de santé capable de répondre de manière appropriée aux besoins de sa population**			
Objectif Spécifique	**Objectif Spécifique 1.** **Le système de santé de district est renforcé à travers une meilleure fonctionnalité de ses organes décentralisés et de leurs interfaces d'interaction (liés aux résultats 1-6)** **Objectif Spécifique 2.** **Le niveau central assure la qualité du secteur de la santé à travers un renforcement de la planification, coordination, gestion et M&E, et en se fondant sur les résultats générées par la recherche (liés aux résultats 7-13)**	° Indicateurs du HSSP II ° Incidence visée: par rapport à la formulation des politiques de santé sont-elles équitables (pro-pauvres) ? sont-elles efficaces (adaptés aux besoins réels) ? sont-elles efficientes ? renforcent-elles l'autonomie des personnes et des communautés locales? sont-elles développées suivant une démarche participative ? prennent-elles en compte des thèmes transversaux comme le genre et l'environnement ? ° Incidence visée: le secteur fait preuve d'une flexibilité pour s'adapter au contexte changeant à l'extérieur et à l'intérieur du secteur ('contextual responsiveness') (pour détails cf. 3.5.2.2)	Rapports HSSP II, DHS Politiques de santé Rapports d'ateliers, PV foruMinisanté de discussion, PV comité mixte de concertation local	

	Résultats	Indicateurs	Moyens de vérification	Risques et hypothèses
Résultat 1	L'Equipe intégrée de gestion du district est renforcée	° Alignement aux indicateurs nationaux relatifs à ce résultat ° Incidence visée: la gestion interne des équipes (en premier lieu USFPDE et HD) au niveau du district assure un environnement stimulant de travail (pour détails cf. 3.5.2.2) ° Incidence visée: le district s'approprie les objectifs de santé et clarifie les relations, la division des rôles et des tâches entre les entités du district administratif et les structures responsables pour les services de santé (USFPDE, HD, CS) (pour détails cf. 3.5.2.2)	Rapports SIS Rapports annuels districts et Minisanté Organigrammes, description tâches, interviews personnel, entretiens de fonctionnement., plans de formation, PV réunions, PV groupes de travail, évaluations Ordre du jour et PV réunions avec Minaloc, Directives Minaloc, plan de développement des districts ciblés, organigramme du district, rapport annuel du district, PV comité du pilotage santé dans le district, PV réunions district 'management team'	H: les équipes sont sur place H: le district dans son organisation actuelle est maintenu H: l'USFPDE a un staff suffisant H: les rôles et responsabilités sont clarifiés R: le staff est insuffisant

Résultat 2	**La disponibilité au niveau local des ressources humaines compétentes et motivées est améliorée**	° Alignement aux indicateurs du HSSP II: *Ratio of medical doctor* *Ratio of qualified nurse A1, A0, Masters* *% of Health Facilities with a midwife present* *% of Health Staff outside of Kigali (in selected districts)* ° Incidence visée: les ateliers de formation organisés par le Ministère, les districts (ciblés) ou les Partenaires Techniques et Financiers sont orientés vers les besoins du terrain (pour détails cf. 3.5.2.2)		H: les professionnels vont travailler dans les districts H: le cycle de formation de sage-femmes est organisé H: le PBF est maintenu dans les HD, CS et les agents communautaires H: les gens formés restent R: la concentration des professionnels de la santé dans les zones urbaines. R: les gens formes ne restent pas dans leur poste d'affectation
Résultat 3	**L'accessibilité équitable aux services de santé adaptés aux normes et aux besoins est augmentée (couverture sanitaire)**	° Alignement aux indicateurs du HSSP II: *% of districts with 1 Health Center per sector* *% of Health Facilities with the full package of activities (PMA, PCA)* *% of population living within less than one hour or 5 km walking distance of a Health facility* *% of districts with operational SAMU* *% of facilities offering the mental health package at all levels* *% of women 15-49 using modern contraceptives* *% of districts implementing MWMP (added)* *% of CBHW involved in CBEHP (added)*		H: les moyens sont disponibles pour construire H: les paquets sont disponibles H: les contraceptifs sont disponibles H: le MWMP est réaliste H: la population se rend dans les structures de santé

				R: les moyens pour réaliser les paquets ne sont pas disponibles
Résultat 4	**La gestion des ressources en vue d'une rationalisation progressive du fonctionnement interne des formations sanitaires est améliorée**	° Alignement aux indicateurs du HSSP II: *% of health facilities with electricity and water* *% of health facilities with a maintenance tracking system* *% of facilities submitting pharmacovigilance reports* *% of health facilities with stock outs of essential drugs per quarter.*		H: l'ACM répond aux besoins H: le plateau technique existe pour eau et électricité H: la CAMERWA répond aux besoins H: les systèmes de gestion sont à la portée R: la CAMERWA et l'ACM ne fonctionnent pas de façon optimale
Résultat 5	**La qualité des soins est améliorée d'une façon continue**	° Alignement aux indicateurs du HSSP II: *% of Health facilities covered by the whole package of PBF* *% of health facilities adhering to the EDL, Standard Treatment Guidelines and National Formulary* °Incidence visée: le système de supervision (niveau central -> niveau de district ; niveau de district -> niveau de secteur) permet un bon accompagnement et une bonne communication entre les différents niveaux du secteur de santé publique (pour détails cf. 3.5.2.2)		H: le système d'accréditation est mis en œuvre H: le financement pour le PBF décentral est garanti R: les bailleurs ne financent plus le PBF

Résultat 6	**Les connaissances sont développées d'une façon systématique**	° nombre de dossiers de Recherche-action élaborés et validés techniquement		H: l'ESP a les ressources H: un partenaire international pour l'appui scientifique est recruté
Résultat 7	**Les plans du secteur de la santé sont développés**	Rapportage HSSP II TDR et rapport d' atelier, enquête de satisfaction systématique. après l'atelier, PV réunions/visites de restitution, rapports de supervision, plans stratégiques et opérationnels		H: le HSSP II est validé
Résultat 8	**La coordination et la gestion du secteur sont faites de façon globale et intégrée.**	Rapportage HSSP II	Rapportage HSSP II Organigrammes, description tâches, interviews personnel, entretiens de fonctionnement., plans de formation, plan opérationnel du	H: le Rwanda continue à développer l'approche SWAp H: les bailleurs s'inscrivent dans la démarche d'un appui au secteur H: la stabilité dans le pays est maintenue

			Minisanté, PV réunions et groupes de travail, rapports ateliers M&E, évaluations Ordre du jour et PV des réunions, plan stratégique, convention entre Minisanté et acteurs non-étatiques, rapports annuels, comptes nationaux inventaire interventions des PTF, déclarations PTF lors du JHSR, publications données financières, plan stratégique., rapport point focal	
Résultat 9	**Les ressources humaines sont renforcées suivant plan**	Rapportage HSSP II	Rapportage HSSP II	H: le PSRH est réaliste H: le pooled fund est opérationnel H: les procédures pour l'utilisation du CDPF existent

				R: le démarrage du RBMC est retardé R: les partenaires internationaux ne s'intéressent pas au RBMC
Résultat 10	**La gestion financière est assurée de façon efficace suivant les normes et standards nationaux et internationaux**	Rapportage HSSP II Calendrier et rapports de supervision, enquêtes de satisfaction des 'supervisées', PV réunions entre superviseurs, politique de supervision	Rapportage HSSP II Ordre du jour et PV des réunions, rapports financiers du gouvernement et du district, document politique financière santé, marché public médicaments	H: les bailleurs s'alignent H: les budgets sont on plan et on budget R: les effectifs manquent pour assurer la bonne gestion financière
Résultat 11	**Un système intégré et performant de suivi et évaluation est mis en place et opérationnel**	Dossier RA, PV réunions TWG	Rapportage HSSP II Ordre du jour JHSR, documents préparatoires, PV réunions, enquête de	H: les données à monitorer sont intégrables H: le Rwanda accepte un suivi par M&E R: la technicité pour développer un système intégré et le maintenir n'est pas disponible

			satisfaction à la fin du JHSR, rapport JHSR et liste de sa distribution, intégration des conclusions dans les documents politiques/ plans et directives du ministère de santé Politique M&E, bases de données, formulaires SIS, rapports QA données, indic HSSP, dossiers RA, publications, PV réunions d'analyse	
Résultat 12	**Les services et les soins délivrés sont de qualité suivant les normes et standards**	Rapportage HSSP II Plan stratégique Plans opérationnels Rapports nationaux Plan stratégique, plans opérationnels, liste participants	Rapportage HSSP II	H: le système d'accréditation est développé et intégré H: le PNSM est réaliste R: le système d'accréditation n'est pas opérationnel
Résultat 13	**La recherche action développée au niveau opérationnel alimente les politiques**	° Alignement aux indicateurs du HSSP II: *% of national policies and guidelines referencing research results*	Rapportage HSSP II	R: les ressources pour la recherche et la publication ne sont pas disponibles.

		° Incidence visée: les groupes de travail thématiques (TWG) au sein du secteur de santé produisent, d'une façon concertée, des propositions d'amélioration des politiques sectorielles (pour détails cf. 3.5.2.2)	Ordre du jour et PV réunions TWG, Documents techniques, dossiers de RA, PV foruMinisanté de discussions et de décision	

Dans le cadre de l'harmonisation et de l'alignement les indicateurs du HSSP II, de l'EDPRS sont privilégiés dans le cadre de cet appui institutionnel. Toutefois, afin de mieux apprécier les interactions entre les différents acteurs du système, 11 incidences visées sont ajoutées à titre expérimental (explication cf.

9 Complete Monitoring Matrix

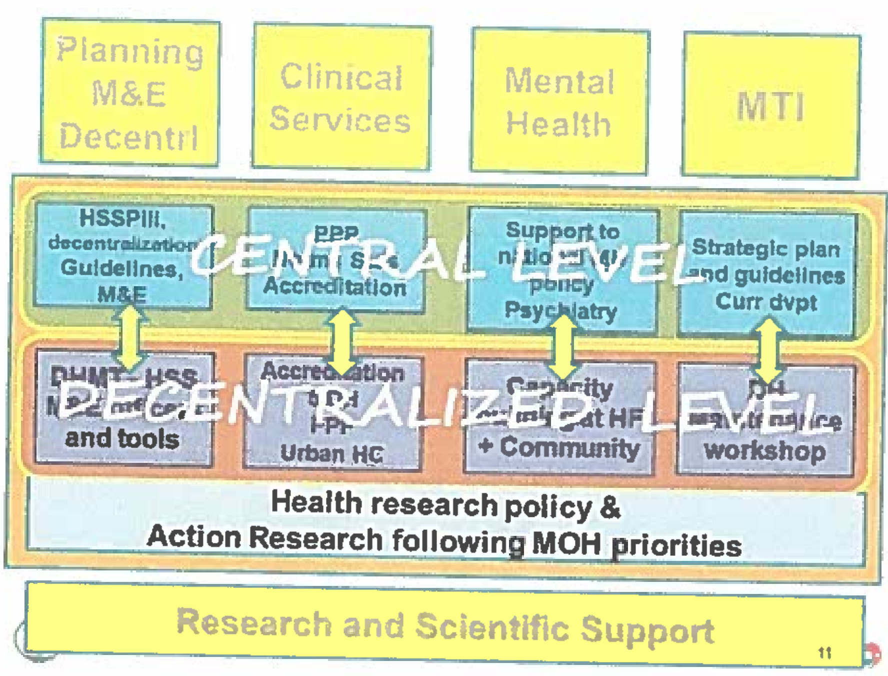
Include the last (full) version of the monitoring matrix

Results chain R/O	Indicators	HSSP3 Log Frame Target	Base value (2013)	Target value / Milestone / Log frame	Year 2014	Source of verification	Frequency of collection	Responsible	Analysis Responsible	COMMENTAIRES / POINTS D'ATTENTION
Focus I: Planning, M&E and Decentralisation										
Capacity in planning, management and M&E has improved	DHMTs set up and functional based on ToR: 90% at national level; 100% in 3 Districts supported by MS4/SPIU	[illegible] *** 90 % of Districts hold at least two effective DHMT meetings with stakeholders (comprehensive district annual planning, budgeting, reporting timely) by 2015. District Health Services (HP, HC and DH) and Management (DHU)		Central level: 80% DHMTs Functional. District level (3 districts): 100% DHMTs Functional	90 % of Districts hold at least two effective DHMT meetings with stakeholders	Quarterly reports DG P&HS; Quarterly reports Districts TA; Weekly report	Quarterly; Weekly	MoH/DG P&HS; MS4/SPIU; MS4/SPIU	MS4/SPIU; MS4/SPIU; MS4/SPIU	DHMTs are now functional in all [illegible] districts countrywide, meet on defined regular basis, documentation of implementation, follow up of decisions, reports [illegible], etc. This has been possible due to enhanced mentorship and supervision by central level staff. A legal framework of DHMTs is being elaborated to allow them to source district funds for their activities and give them more authority over "supervisees" and other health issues in district
	100% of Districts set up a functional and integrated M&E system	HSSP III monitoring and implementation arrangements: Routine Data – 80% Annual targets met from HSSP III by 2018		100% of Districts set up a functional and integrated M&E system	3 Districts supported by MS4/SPIU have achieved a functional and integrated M&E system	Quarterly reports DG P&HS; Quarterly reports Districts TA; Weekly report	Quarterly; Weekly	MoH/DG P&HS; MS4/SPIU; MS4/SPIU	MS4/SPIU; MS4/SPIU; MS4/SPIU	A study on [illegible] use at sector level in Rwanda district emphasized the need for better data collection and analysis so as to provide more reliable data for better decision-making and planning. The 3 MS4-supported districts currently have an active M&E system that strongly supports the DHMT decisions and this has been especially through central level facilitation and implementation of 'functionality' criteria such as availability of a clear M&E framework and reporting structure, availability of tools (data collection, analysis, reporting, feedback, etc.), financial means for supervision, equipments, communication. The role and contribution of District M&E officers have contributed largely to this effect though quality of reporting can still be improved to ensure local data use
	100% of Districts have developed a five years Health Sector Plan to be implemented in alignment with HSSPIII & EDPRS II	Planning, budgeting, and monitoring: planning process in terms of priorities, indicators, and the overall planning process, HSSP III is fully aligned with EDPRS II		100% of Districts have developed a five years Health Sector Plan to be implemented in alignment with HSSPIII & EDPRS II	3 Districts supported by MS4/SPIU have developed and validated annual plans	Action plan	Annually	3 Districts & MS4/SPIU	MS4/SPIU	The 3 MS4 supported districts currently have [illegible] district annual plans with integrated M&E plan. A new planning process that integrates all DPs and MOH has been initiated in Jan 2015
Focus II: Clinical services										
The quality of health services in Rwanda is strengthened	38 DH with accreditation committees functional	See narrative document		38 DH with accreditation committees functional	38 DH eligible and on track for accreditation process	Quarterly reports DG clinical services; Quarterly reports Districts TA; Weekly report	Quarterly; Weekly	MoH/DG clinical services; MS4/SPIU; MS4/SPIU	MS4/SPIU; MS4/SPIU; MS4/SPIU	Accreditation and other related committees are currently functional with clear TORs of each committee elaborated. Clear action plans with responsible for each activity and timelines. As part of accreditation national safety program, MoH Clinical Services staff facilitated an training for healthcare professionals on quality improvement and infection control in October 2014 targeting all the [illegible] district hospitals. [illegible] Provincial hospitals attained level one in October 2014
	Registered Private HF respect norms and national standards	Health Information Management: *** 80% of registered private clinics and dispensaries reporting routinely to HMIS by 2014. *** The Rwandan regulatory framework has to ensure that the private sector respects the same [illegible]		*** 80% of registered private clinics and dispensaries reporting routinely to HMIS by 2014	100% registered private clinics and dispensaries in CoK districts reporting routinely to HMIS	Quarterly reports DG clinical services; Quarterly reports Districts TA; Weekly report	Quarterly; Weekly	MoH/DG clinical services; MS4/SPIU; MS4/SPIU		Trainings on the new DHIS 2 platform of the R-HMIS were completed countrywide and consequently, 87% of registered private health facilities report via the R-HMIS
Focus III: Medical Maintenance Division										
The quality of health care technology management is increased	Strategic plan of MTI Division developed and validated	Improved infrastructure and maintenance: *** 14 DH with effective maintenance workshops by 2014. Develop a maintenance system: *** Prepare and implement a physical infrastructure development and maintenance plan, as well as establish a procurement and maintenance plan for medical and energy equipment. In this regard, ten maintenance workshops (two in each province) will be constructed and provided with appropriate tools and equipment. *** A national quality control system for the main equipment office will be established, and all managers will be sensitized on maintenance. *** A maintenance fund will be created in the budget for the health sector. Develop the technical capacity of HR[illegible]: at least 70 percent of all [illegible]		Strategic plan of MTI Division developed and validated	Strategic plan of MTI Division developed and validated	Strategic plan	Status reports	MTI & MoH	MoH	The International Technical Assistant Biomedical Engineering for MTI is working with RBC authorities for alignment of MTI with RBC strategic plans. Strategic plan development will be in function of the planned hospital assessment survey results as well as review by RBC of its current role and responsibilities
	Guidelines and norms of HCTM are developed and disseminated			Guidelines and norms of HCTM are developed and disseminated: equipment, procurement, maintenance, donation, distribution	Guidelines and norms developed and disseminated	Documents	Status reports	MTI & MoH	MTI & MoH	Draft guidelines for equipment donations and scrapping of equipment which are out of service as well as norms and standards for quality control of medical equipment for health facilities and ambulances are awaiting to be reviewed by a sub-TWG set up specifically for that purpose. Normative draft guidelines have been shared to experts in the field while waiting for TWG to meet in Q1 2015
	38 DH have an functional medical maintenance workshop			38 DH have an functional medical maintenance workshop	38 DH have an functional medical maintenance workshop	Quarterly reports MTI Division; Quarterly reports Districts TA; Weekly report	Quarterly; Weekly	RBC/MTI Division; MS4/SPIU; MS4/SPIU	MS4/SPIU; MS4/SPIU; MS4/SPIU	The concept of a model biomedical equipment maintenance workshop is currently being developed as part of capitalisation activities of MTI Division. Maintenance package of DH will be presented during the capitalisation process. The 5 DH supported by MS4 have developed their workshop plans and at least 1 tool box per DH and other equipment will be delivered. An analysis of available equipment at all hospitals was done, equipment [illegible] has been updated but supportive visits are still required. Meanwhile a hands on workshop was organised for all 43 hospitals maintenance staff and will be repeated in Feb 2015

Focus IV: Mental Health										
Mental health of the Rwanda population is improved	100% DH have a decentralized & integrated mental health service and 100% of HC have at least one GH trained in MH	Mental health integrated in all HC/DH 100% of health centers providing integrated mental health care by 2018 50% CHWs trained and providing community-based care in mental health by 2018		100% DH have a decentralized & integrated mental health service and 100% of HC have at least one GH trained in MH	100% of HC have at least one GH trained in MH	Quarterly reports MHD	Quarterly	RBC/MH Division	MS4/SPIU	Indicators have been achieved, mental health has been successfully decentralized and integrated even up to community level At least 1 nurse at 480 HCs in Rwanda has been trained on mental health. CHWs are planned to be trained in collaboration with the Community Health Desk of MoH
	Referral structures strengthened by launching MMed Psychiatry in Rwanda curriculum validated & 5/6 candidates following 1st academic year abroad in partner universities according to MOH HRH plan	MH Division will concentrate on the following priority strategies and interventions: Strengthen the integrated mental health care model within the health system Initiate referral mental health services in provincial hospitals Perform mentorship in mental health services in DHs, provincial hospitals, and specialized institutions. Develop protocols and guidelines for treatment of MH problems and [illegible]		Launching MMed Psychiatry in Rwanda curriculum validated & 5/6 candidates following 1st academic year abroad in partner universities according to MOH HRH plan	5/6 candidates following 1st academic year abroad in partner universities according to MOH HRH plan	Quarterly reports MHD	Quarterly	RBC/MH Division	MS4/SPIU	Three candidates enrolled for first academic year in Belgium have returned to Rwanda in October 2014 for their second year. Two Candidates registered in Switzerland Three more candidates have been selected as a second intake and went to Belgium in September 2014
	MHD has drafted a MH Law to regulate MH practice and preserve patients rights			MH Law in place to regulate MH practice and preserve patients rights	MH Law in place to regulate MH practice and preserve patients rights	Quarterly reports MHD	Quarterly	RBC/MH Division	MS4/SPIU	Draft Law has been developed by consultant. It is in its last stage of translation prior to being tabled in Parliament
Focus V: HEALTH SECTOR RESEARCH										
Knowledge is systematically managed and developed at central level: action research is performed in the three districts and the evidences generated at local level do feed the development of policies	At least 3 action research projects developed in 3 districts on priority health problems to inform national policy and result in effective interventions in the districts SPH is responsible to support the action research process	Health management and research strategies and interventions Against this promising (but limited) background, HSSP III will focus on the following strategies. 1. Build human resource capacity: The MOH will hire more staff for data management and dissemination, and for operational research, and will strengthen research staff capacity (capacity-building, PhD) 2. Strengthen coordination among research institutions: The MOH will strengthen research coordination mechanisms and develop an agreed-upon and prioritized research agenda. The agenda will help both domestic and international investigators to guide design of new research proposals in a way that is aligned with the real research needs of the country. The MOH will also support efforts for publication of research results in international peer-reviewed journals. 3. Initiate new research activities: The MOH, in coordination with the staff of the various research institutions, will stimulate the development of national research proposals (Rwandans being the first authors) that will be submitted for funding to the relevant technical and ethical committees. 4. Provide financial resources: To the extent possible, the MOH will increase funding for relevant research initiatives that contribute to evidence-based policy development		At least 3 action research projects developed in 3 districts	At least 3 action research projects developed in 3 districts	Quarterly reports Districts TA Weekly report	Quarterly Weekly	MS4/SPIU MS4/SPIU	MS4/SPIU MS4/SPIU	The final reports for the three action research themes have validated and have been disseminated during capitalization showcase week BUGESERA: "Determinants of Post Natal Care (PNC) utilization in BUGESERA District" RULINDO: "Factors associated with timely prenatal care in Rulindo District" GAKENKE: "A retrospective analysis of neonatal deaths in health facilities of Gakenke District from 2011-2013"
	Strategic interventions are strengthened through evidence based action research supported by School of Public health Proposed thematic: - 3 NCDs sub studies from STEPWISE Study - DHMT set up and functionality - Assessment of District [illegible]			Research supported by School of Public health Proposed thematic - 3 NCDs substudies from STEPWISE Study - DHMT set up and functionality - Assessment of District M&E strengthening	Research supported by School of Public health Proposed thematic: - 3 NCDs substudies from STEPWISE Study - DHMT set up and functionality - Assessment of District M&E strengthening	Reports	Quarterly	SPH	MS4/SPIU	Assessment of District M&E strengthening was completed with a detailed report showing contribution of M&E Officers towards better health outcomes at district level An assessment of DHMT [illegible] was done between May and August 2014 (report issued in October 2014) and one of the outcomes was development of a supervision guide for DHMTs to better supervise HCs in their catchment area
	Each MSIV focus and district develop a capitalization action			Each MSIV focus and district develop a capitalization action	Each MSIV focus and district achieved a capitalization action	Reports	Quarterly	MS4/SPIU	MS4/SPIU	Regular meetings were held with each central focus and districts to share [illegible] regarding selected capitalization themes. This was before the Capitalization Writing week held in Musanze from 9-12th December 2014 facilitated by expert researchers from the Netherlands Royal Tropical Institute (KIT). The themes are: Gakenke: medical waste management Rulindo: M&E at sector level Bugesera: Mutuelles schemes [illegible]: urban health and medicalised HC [illegible]: assessment of DHMT and [illegible] MH: Integration of MH services MTI: District hospital workshop guide The draft articles from each focus and district which are at different levels of advancement (some more than others) have been shared with the KIT staff for feedback and further writing advice. The different themes were part of Capitalization Showcase week planned in March 2015 A booklet including 11 case studies is under editing and three policy briefs were developed Four research papers are under preparation
Focus VI: 03 Districts Bugesera, Rulindo & Gakenke										
The District health system is strengthened through a better functionality of its institutions and overall interaction including with the central level (Better [illegible]	At least 90% of District implementation agreement executed in each of 3 Districts with support and coordination of MoH/SPIU/ MS4/SPIU team	Planning, budgeting, and monitoring: planning process in terms of priorities, indicators, and the overall planning process, HSSP III is fully aligned with EDPRS II. All districts develop their [illegible]		At least 90% of District implementation agreement executed in each of 3 Districts with support and coordination of MoH/SPIU/MS4/SPIU team	At least 90% of District implementation agreement executed in each of 3 Districts with support and coordination of MoH/SPIU/ MS4/SPIU team	Quarterly reports Districts TA Weekly report	Quarterly Weekly	MS4/SPIU MS4/SPIU	MS4/SPIU MS4/SPIU	Execution Agreements of the 3 districts were all executed at above 90% (overall execution rate of [illegible]) They ended in December 2014

10 Tools and products

See capitalization booklet



1. **MCH improved: 2 new maternities, trainings in SONU, ETAT+, PCIME,...**

Transport for 30 M&E Officers

MULTISECTORAL APPROACH