RWANDA BIOMEDICAL CENTER

A Healthy People, A Wealthy Nation

Single Project Implementation Unit (SPIU)

For Health-Sector Projects Funded by the Government of Rwanda,

Multi/Bilateral Organizations, Private Sector and Foundations

UBUZIMA BURAMBYE PROGRAM

(LONG HEALTHY LIFE)

BTC RWANDA

RESULTS REPORT
JANUARY 2016 - JUNE 2017
RWA 13 092 11
UBUZIMA BURAMBYE

October 2017

CONTENT

Acronyms

ANC	Ante Natal Care/Clinic
BTC	Belgium Development Agency
CoK	City of Kigali
CREAM	Clear-Relevant-Economic-Adequate-Monitorable
DH	District Hospital
DHS	Demographic and Health Survey
DHSP	District Health Strategic Plan
DHU	District Hospital Unit
DPs	Development Partners
e-LMIS	electronic-Logistic Management Information System
EMR	Electronic Medical Record
GBV	Gender Based Violence
GoR	Government of Rwanda
HCs	Health Centres
HFs	Health Facilities
HCSAP	Health Care Services Access Policy
HIV/AIDS	Human Immunodeficiency Virus Infection and Acquired Immune Deficiency Syndrome
HMIS	Health Monitoring Information System
HNW	Hospital Net Work
HIS	Health Information System
HSSP	Health Sector Strategic Plan
HRIS	Human Resource Information System
HRTT	Health Resource Tracking Tool
IFMIS	Integrated Financial Management and Information System
IPPIS	Integrated Payroll and Personnel Information System
ISQUA	International Society for Quality Assurance in Health care
MH(D)	Mental Health (Division)
M&E	Monitoring and Evaluation
MINECOFIN	Ministry of Finance and Economic Planning
MoH	Ministry of Health
MSH	Management Sciences for Health
MTI	Medical Technology and Infrastructure
MTR	Mid-Term-Review
NDH	Nyarugenge District Hospital
NEX	National Execution
QA	Quality Assurance
RA	Result Area
RBC	Rwanda Biomedical Centre
RBM	Result Based Management
RDB	Rwanda Development Board

RHAO	Rwanda Health Accreditation Organization
RHMIS	Rwanda Health Management Information System
SPIU	Single Project Implementation Unit
SWAp	Sector Wide Approach
TBD	To be determined
TFF	Technical and Financial File
ToR	Terms of Reference
TWG	Technical Working Group
TWGEH	Technical Working Group in Environment Health
UB	Ubuzima Burambye

1 Intervention at a glance

1.1 Intervention form

Intervention Title	UBUZIMA BURAMBYE
Intervention Code	RWA 13 092 11
Location	Ministry of Health/RBC/Kigali/Rwanda
Budget	EUR 18,000,000
Partner Institution	Ministry of Health (MoH) / Rwanda Biomedical Centre (RBC) Nyarugenge and Gasabo Districts and City of Kigali
Start date Specific Agreement	30 June 2015: specific agreement signed
Date intervention start /Opening steering committee	4 December 2015: first steering committee
End date Specific Agreement	29 June 2020
Target groups	Health System Strengthening, vulnerable group and mental health patients
Impact	Strengthening the quality of primary health care and health services in Rwanda"
Long term Outcome (Specific Objective)	A people- centred, integrated and sustainable health care system with quality essential health care services as close to the community as possible has been reinforced"
Results	1. The quality assurance system is set up and integrated and functional at the level of all hospitals
	2. The mental health services are accessible at the community level up to the national level in a sustainable way
	3. The urban health service coverage is rationalized and extended in line with the three guiding principles of the National Health Sector Policy
	4. The leadership and governance is reinforced, specifically regarding district stewardship, the respective roles of the MoH and RBC and the public private partnership
	**5. Data are generated, analysed and used for evidence-based decision-making in a more correct, integrated, systematic, accessible and effective way*
	6.The asset management system is designed and operational in a cost-effective way
Year covered by the report	1st January 2016 – 30 June 2017

* This result area was later abandoned

1.2 Budget execution

	Budget/Euro	Expenditure/Euro		Balance	Disbursement rate at the end of FY16/17
		Previous years (FY 15/16)	Year covered by report (FY 16/17)		
Total	**18 000 000**	**841 589**	**1 968 948**	**15 189 463**	**16%**
Result 1	1 450 500	46 838	132 586	1 271 075	12%
Result 2	3 167 200	175 368	604 025	2 387 807	25%
Result 3	6 348 000	71 490	269 640	6 006 870	5%
Result 4	1 213 000	51 924	209 480	951 596	22%
Result 5	15 500	15 657	81	-238	102%
Result 6	3 097 000	130 368	276 135	2 690 497	13%
General Means	2 708 800	349 944	477 001	1 881 855	34%

Fiscal year 2016/17 was the first year of implementation using national systems for planning, budgeting, accounting and reporting (SMART Integrated Financial Management Information System – SMART IFMIS). This required a learning process and adjustments from the programme staff as well as from all users to ensure that all planned activities are well budgeted, implemented and the budget is used.

Budget execution for FY 2016/17 just fell short of 50% compared to the revised action plan and budget uploaded into the IFMIS after the budget revision of December 2016. This rather low execution is explained by a number of factors that will be further addressed in the following sections of the report (e.g. long decision-making processes requiring approvals at multiple senior levels; lack of pro-activeness and/or responsiveness with regards to the drafting of ToR or technical specifications from some user divisions, lengthy procurement processes; roll-out of a new e-procurement system by Government, resulting in low bidder responsiveness and the need to re-launch tenders; etc).

While the overall budget execution rate, which stood at 16% at the end of June 2017, may seem low after 1,5 years of programme implementation, it needs to be reminded that a large part of the budget is earmarked for constructions (Nyarugenge District Hospital (NDH), Gasabo Mental Health Day-care Centre, rehabilitation of maintenance workshops). Construction-related activities usually require a lot of preparation in terms of design and tendering processes, while the payments of related invoices naturally occur during the second half of implementation only. In that respect, it is worth noting that good progress has been made in the development of the NDH (design validated), as well as the procurement process for construction (bids evaluated during the month of June 2017).). In addition to that, a catch up plan will be developed during the budget revision of December 2017 and the upcoming MTR will help to set and review the programme priorities for upcoming two years.

1.1 Self-assessment performance[1]

The self-assessment was done during a participatory workshop that included all result areas actors and the programme. Each result area was requested to perform a self-assessment of its own performance using the provided BTC tool. The overall programme score was then calculated as an average of each result performance, using similar grading criteria.

1.1.1 Relevance

By definition, the **relevance of the intervention** is "the degree to which the intervention is in line with local and national policies and priorities as well as with the expectations of the beneficiaries". The programme assessed its reported performance of C as the average overall score of five Result Areas (RA) implementing UB Programme, obtained from the score attributed to the following questions related to the relevance of the intervention:

1.1. What is the present level of relevance of the intervention?
1.2. As presently designed, is the intervention logic still holding true?

	Performance
Programme overall Relevance	C

The table below is showing score by Result Areas. (see annex 4.1 quality criteria for details).

Table: Scores by Result Area

Questions	R1: Quality assurance	R2: Mental Health	R3: Urban Health	R4: Leadership and Governance	R6: Asset Management	UB Overall Score
1.1	A	A	A	A	A	A
1.2	B	A	B	B	C	C
AVERAGE 1	A	A	A	A	C	C

The Ubuzima Burambye's interventions and result areas are all **highly relevant** to the needs of target groups as it is embedded and in line with local and national policies as well as the Belgian Strategy. Intervention outputs have contributed much to the health performance indicators. However, due to unforeseen difficulties which interfered with the smooth implementation of activities, some Result Areas expressed a need of reviewing the intervention logic to suit realities (R3), others need improving the structure of the intervention by reviewing the hierarchy and priorities of actions as well as doing a close follow up of risks. It was particularly the case for Clinical Service (R1), Leadership and Governance/Planning (R4) and more importantly Asset management/MTI (R6). For R2, intervention logic does not seem requiring major revision as the intervention takes into account the context of the country

especially the level of development, low resources and post-genocide period. Thanks to its institutional anchorage, the UB Program supports different interventions under R2 at all levels of the health system; and in certain areas, the program has been able to develop innovative interventions.

1.1.2 Effectiveness

Effectiveness to date is "the degree to which the outcome (Specific Objective) is achieved as planned at the end of 2016-17". The programme assessed an overall average performance of **C**, representing the score attributed to the following questions related to the effectiveness of the intervention:

2.1. As presently implemented what is the likelihood of the outcome to be achieved?
2.2. Were activities and outputs adapted (when needed), in order to achieve the outcome?

	Performance
Effectiveness	C

The table below is showing scores by Result Areas and overall score (see annex 4.1 quality criteria for details).

Questions	R1: Quality assurance	R2: Mental Health	R3: Urban Health	R4: Leadership and Governance	R6: Asset Management	UB Overall Score
2.1	B	B	B	B	C	C
2.2	B	A	B	A	C	C
AVERAGE 2	B	A	B	A	C	C

This Fiscal Year, Ubuzima Burambye Programme implementation faced some challenges due to external factors and conditions like new rules in the administrative process (procurement and administrative requirements-initiation of e-procurement) which has affected the budget execution by delaying of tenders. For Quality Assurance (R1), the delay in setting up the accreditation agency and the lack of consultancy support by our partner MSH affected the implementation of some activities. For Mental Health (R2), changes and absence of the attribution of an appropriate plot for the construction of Gasabo- Mental Health Day Care Centre affected the budget execution and the whole construction process. Also, the lack of a clear legal framework to fund some proposed community-based activities affected that component. For Urban Health (R3) the budget for construction of Nyarugenge District Hospital was underestimated and this required mobilization of additional funds through budget reallocation. In governance and planning (R4), changes in the initially planned activities in order to to the national priorities meant significant changes compared to the initial plan, which delayed implementation. In asset management (R6), UB activities implementation was slow due to different challenges mainlyhigh work load volume and shortage of staff.

Ubuzima Burambye Programme faced some difficulties to commence implementation of its strategies on time especially the need for the UB Programme to comply to the NEX principle by using IFMIS. As contingency plan, each Result Area suggested measures to be taken to accelerate the implementation of activities. Therefore, the performance assessment estimated that the likelihood for the outcome to be achieved is high despite minor limitations, provided that current efforts are strengthened in the forthcoming years of implementation.

1.1.3 Efficiency

The efficiency of implementation is defined as "the degree to which the resources of the intervention (funds, expertise, time, etc.) have been converted into results in an economical way". The reported performance of D is the overall score of five Result Areas (RA) implementing UB Programme, representing the score attributed to the following questions related to the efficiency of the intervention:

3.1. How well were inputs (financial, HR, goods & equipment) managed?

3.2. How well was the implementation of activities managed?

3.3. How well were outputs achieved?

	Performance
Efficiency	D

The table below is showing the scores by Result Area and by sub-question the efficiency on the programme (see annex 4.1 quality criteria for details).

Questions	R1: Quality assurance	R2: Mental Health	R3: Urban Health	R4: Leadership and Governance	R6: Asset Management	UB Overall Score
3.1	B	B	C	B	C	C
3.2	C	B	C	C	D	D
3.3	C	B	C	B	C	C
AVERAGE 3	C	B	C	C	D	D

The final score related to efficiency aroused a lot of discussions and finally, UB overall score retained is **D "insufficient"** due mainly to serious delays and cancellation of a number of activities, certain outputs were not achieved according to time and plan. However, the scores expressed by each result area vary and most of inputs provided through the UB Programme fully contribute to reinforce the objectives set by MoH and were well used to achieve expected outputs of the intervention. However, due to. There is a serious need for improvement in terms of priority focus, improved planning and timeliness of implementation to ensure that the key outputs are delivered on time, especially under asset management result area. Details are in the description of progress made so far for each result respectively. Furthermore, efficiency will be discussed and reviewed with all stakeholders at length during the forthcoming Mid Term Review (MTR) to address the root causes of the low efficiency of the programme.

1.1.4 Potential sustainability

The potential sustainability is defined as "the degree of likelihood to maintain and reproduce the benefits of an intervention in the long run (beyond the implementation period of the intervention)". The programme assessed its overall performance as C as the average overall score of five Result Areas (RA) implementing UB Programme, obtained from the score attributed to the four following questions related to the relevance of the intervention:

4.1 Financial/economic viability?
4.2 What is the level of ownership of the intervention by target groups and will it continue after the end of external support?
4.3 What is the level of policy support provided and the degree of interaction between intervention and policy level?
4.4 How well is the intervention contributing to institutional and management capacity?

	Performance
Potential sustainability	C

The table below is showing the scores by Result Area and by sub-question on the potential sustainability as expressed by the team who participated in the programme implementation and performance assessment (see annex 4.1 quality criteria for details).

Questions	R1: Quality assurance	R2: Mental Health	R3: Urban Health	R4: Leadership and Governance	R6: Asset Management	UB Overall Score
4.1	B	B	C	B	C	C
4.2	A	A	C	A	B	C
4.3	B	A	C	A	C	C
4.4	A	A	A	B	B	A
AVERAGE 4	B	A	C	B	C	C

The ownership for the intervention at the level of policy and involvement of local structures is high. This shows that the economic/financial sustainability is likely to be good even beyond the implementation period of the intervention. The programme is implemented to reinforce the institutional targets and existing policies have been generally supportive. The steering committee and other relevant structures within MoH, RBC and local level are involved in all stages of implementation and decision making. Intervention management is well embedded in institutional structures and has somewhat contributed to capacity building.

What is needed is to deal with uncontrolled problems that may arise from changing external economic factors and ensure that mitigation measures will be sought to deal with these intervening factors. Concerns on financial viability and ownership for urban health (R3) and asset management (R6) will need to be addressed during the midterm review (MTR) planned in October 2017.

Finally, the anchorage of UB programme in the core of RBC/MoH as well as the close alignment to the HSSPIII/HSSPIV provide strong basis for maximum sustainability of the Intervention.

1.2 Conclusions

Ubuzima Burambye Programme implementation started after an inception period of about six months that was therefore not fully aligned to the GoR planning cycle of the first year. Alignment of IFMIS in the second year of implementation has required much attention to address the programme efficiency from the Y1 to Y2. Based on the above assessment, the programme is still very relevant but adjustments are needed to improve on efficiency and ensure expected outcomes are achieved. The programme sustainability has been found good thanks to the country ownership and commitment towards affordable promotive,

preventive, curative and rehabilitative health care services of the highest quality, thereby contributing to the reduction of poverty and enhancing the general well-being of the population.

National execution official	BTC execution official
	
Dr Gilbert BIRARO	Dr Vincent TIHON
SPIU Coordinator	**UB Coordinator**

2 Results Monitoring[2]

2.1 Evolution of the context

2.1.1 General context

During the Rwandan fiscal year 2016-17, there was no major new development. Sectors and programmes continued operating following EDPRS2 and HSSP III national strategies as the main references. MINECOFIN initiated in 2017 the reflections on the development of the new strategies of EDPRS 3 and HSSP IV and UB programme got fully involved in the process. MTR of HSSP III and DHSP 2012-2018 contributed to identify gaps and challenges which guided to set new health priorities and to adjust action plans. This impacts positively the implementation of UB interventions as it gave the opportunity to get involved in the set up and evaluation process and enabled joint reflections on future interventions for the coming years. Particularly for R4; the DHU is now operational in all districts; capacity to develop action plans and monitor performance is improving, but need further strengthening at DHU level.

Organizational changes done at the Ministry of Health and the City of Kigali (CoK) have not had any significant policy changes in implementation of UB programme but there was a need to familiarize with the programme and increase ownership of the programme activities by the new leadership.

In CoK, the monthly Car Free day policy initiative has positively influenced the achievements of result 3 for instance the mass campaign on NCDs and community sensitization on healthy living;

2.1.2 Institutional context

Institutional anchorage of the programme: UB programme management unit (including finance and procurement) is located in RBC/SPIU, in Remera, Gasabo District. Implementing partners include CoK, located in Nyarugenge District and MOH, located in Kicukiro District. This geographical distribution required some adjustments particularly for quality assurance (R1), urban health (R3), governance and planning (R4) whereby a specific office was provided at MOH to enable international and national UB technical assistants to have a base at MOH and interact better with the respective partners. While this office move had a very positive impact for MOH partner, this remain a challenge for CoK but the programme and staff ensure regular meetings and visits at CoK.

In terms of partner ownership, RBC monitors implementation by Mental Health (R2) and asset management (R6) and MOH monitors R1, R3, and R4.

For urban health (R3), despite the above challenges, the institutional anchorage of urban health in City of Kigali is still relevant. The programme acknowledges some strengths and weaknesses. The main strengths are existing policy, technical support, ownership, advocacy, Institutional support and complementarity of all interventions.

The move of Action Research budget from R5 to R4 had a negative impact on the overall budget execution for the reporting period since the action research agenda does not implicate R4 only but all other result areas. There is need for further improvement and clarification on action research topics as well as its implementation modalities.

The decentralization process, initiated before the support of UB programme, was reinforced through the review of District Strategic plans and identification of priorities in collaboration with all stakeholders. DHMT and DHU take the lead in the implementation of all health-related activities through the leadership of the Administrative District.

2.1.3 Management context: execution modalities

Ubuzima Burambye Programme is implemented according to the National Execution modalities, which implies the use of the Government of Rwanda systems for financial and procurement management.

UB programme encountered overall budget cuts that affected its scope and resources. The budget was reduced from 21M to 18M Euros. . This led to the first budget reallocation and reprogramming with deletion of one full result area (Result 5). Furthermore, the budget cuts in different RAs may lead to not achieving planned outputs particularly on quality improvement projects (R1), governance at central level (R4) and strategic projects (R6). This may, in turn, have a negative impact on the achievement of the programme outcomes.

A second budget reallocation had to take place in November 2016 when it was identified that the budget for the construction of Nyarugenge hospital was significantly underestimated. One million Euros had to be reallocated from R1 and R6 to R3 budget lines. The related budget modification is not yet reflected in the budget execution overview table (chapter 1.2), since it was implemented at the start of July 2017 in order to be aligned with the budget format in the national system which is the beginning of the new Fiscal Year.

The budget cut (in Euros) by Result Area

Result Area	Initial Budget	Budget cut (June 2016)	Revised Budget	hospital budget reallocation	Revised Budget (Nov 2016)
1	1,704,500	254,000	1,450,500	500,000	950,500
2	3,377,200	210,000	3,167,200	0	3,167,200
3	6,559,000	191,000	6,348,000	+1,000,000	7,348,000
4	1,556,000	343,000	1,213,000	0	1,213,000
5	1,090,000	1,074,500	15,500	0	15,500
6	3,820,500	723,5000	3,097,000	-500,000	2,597,000
Total (incl Gen means)	**21,000,000**	**3,000,000**	**18,000,000**	**0**	**18,000,000**

Note - R5 has been completely cancelled

Implications of budget cuts

- **R1 reduction** initially affected research funding and quality improvement project funding (254,000) and was further reduced to accommodate for the hospital budget requirement (450,000)
- **R2 reduction:** The part dedicated to MH intervention was reduced by 210,000 Euros which affected Drug Abuse Prevention and Treatment Output.
- **R3 reduction** affected investments for upgrade of HC (100,000 and hospital network activities). Only the hospital budget was increased to 4,500,000 for the construction
- **R4 reduction** affected the full support to the central level except funding for national conferences.
- **R5 cancellation** affected the whole programme as all result had to ensure that data quality, use and action research as well as documentation be included in all result areas. Furthermore, the action research budget (240,000) was transferred to R4 for accounting purposes while action research will be done by all results
- **R6 reduction** affected the support at central level, the cancellation of waste management policy and baseline as well as the strategic improvement project. Further cut affected the construction of district maintenance workshops (-250,000) and strategic improvement projects (-250,000)

NEX Implementation modalities: The use of National Execution modality (NEX) during FY2016/17 resulted in a better alignment with national systems and allowed for identifying challenging interventions that needed re-orientation of implementation modalities that were initially planned. In addition, it was the first year of integration of UB planned activities into different GoR-sanctioned systems such as the financial management system (IFMIS), e-procurement system (UMUCYO) and the personnel management system (IPPIS).

The UB Programme has capitalised on some strengths and challenges linked to this integration as well as excellent learning opportunities for smooth implementation of the next years.

2.1.4 Harmo context

Harmonization of the programme is part of the country policy. The Ministry of Health involves all Development Partners (DPs) in technical working groups for planning and the implementation of activities, ad-hoc core teams are set up for specific tasks. Alignment with partner strategies and systems is very high. All BTC ITA participate in the strategic planning, operational planning and follow up process of activities performed by the Directorate General or Division they are affiliated to. This significantly contributes to the implementation of activities and better coordination with UB Programme and BTC Representation. The close alignment of the programme to the HSSP III provide strong basis for maximum sustainability of the Intervention. However, during the reporting period, MSH did not fully honour its support to the Ministry of Health for the development of standards specific to mental and orthopaedic services and UB Programme couldn't spend the budget planned for organizing workshop for the validation of those standards. UB support will therefore have to be adjusted to include consultancy support on top of the planned logistic support.

During the 2016-17FY, City of Kigali, in collaboration with different partners active in NCD, organized a successful mass campaign for the second time. Those partners were: Rwanda Diabetes Association, Rwanda Heart Foundation, Kacyiru District Hospital, and Agarwal Eye Hospital. Next year, advocacy for more resources with specific partners will take place to be able to screen more people and have a bigger impact of the campaign.

2.2

2.2. Performance outcome

2.2.1 Progress of indicators and Analysis of progress made (joint per each result outcome)

R1- Quality and safety of health services delivery improved

Outcome: Quality and safety of health services delivery improved					
Indicators	**Baseline value 2015-16**	**Value 2015-16**	**Value 2016-17**	**Target 2016-17**	**End Target 2019-20**
Degree of patient satisfaction	TBD	TBD	NA	TBD	TBD
% of post CS infection rate in a given period of time	1.13%	1,13%	1.26	1,08%	<0.8%
# of programmes integrated in the accreditation process	7/12	14/17	14/17	11/12	17/17

Note: as the baseline report has been approved in August 2016, the baseline value is the same as the value of Year 2015-16

Previous challenges related to administrative procedures, particular tenders, staff recruitment process, consultant availability, etc. are now addressed and this will contribute to achieve the planned outcomes under this result area.

R1. OUTCOME: Quality and safety of health services delivery improved

Three indicators were set to measure the quality of service delivery:

1. **The patient satisfaction rate.**
2.

The patient & health providers survey has not been done yet but TORs and concept note have been prepared waiting for approval and validation by MoH senior management. However, the review of surveys conducted in country has been done to guide the decision on the methodology which will be used for the current one. Report from patient satisfaction done in December 2011 by the School of Public Health indicated that 92% of respondents were satisfied with health services offered. Satisfaction was associated with being educated, having health insurance and attending private health facility. However, this was made from exit interviews (quantitative approach) with only 10 FGD (qualitative approach) and may not be representative of the whole country. Furthermore, the context has changed as the study was more focused on community-based health insurance and performance based financing. The planned study will assess whether recent quality improvement programmes have improved patient as well as staff satisfaction rates.

2. **Post caesarean infection rate**

Compared to the baseline (1,13%), post caesarean infection seems to increase (1,28%) while the target set for this FY was 1,08%. Reasons for increase in post caesarean infections is the inappropriate sterilisation process and equipment, inappropriate laundry process, poor surgical site cleaning and not following IPC polies and guidelines.

During the reporting period, numerous DHs submitted quality improvement projects which aim at reducing post caesarean infections. Some interventions on post caesarean infections in some health facilities were put in place late in April 2017 and will be closely monitored. A reduction of post caesarean infection is expected to be reported by next year.

3. **Programmes integrated in the accreditation process**

Most programmes have been integrated in the accreditation process (14/17). Compared to the baseline (7/12), the number of programmes increased (in terms of denominator) as well as numerator. The three remaining programmes which are adolescent sexual reproductive health and rights, sexual and gender based violence and disabilities will be integrated into PHC accreditation standards at the time of review in 2017.

- **The outputs to the above outcome are still leading to the change process envisaged.**

Quality improvement programmes include interventions to address post-surgical site infections among other interventions. A consultant is coming soon to complete the three remaining programmes together with development of standards specific to mental and orthopaedic services. The patient and health providers' satisfaction survey is still among MoH priorities. The quality improvement projects under implementation will certainly have a positive impact on the quality of care services delivered.

- **Issues that arose, influencing factors (positive or negative)?**

Some activities were expected to take place in collaboration with MSH: the support to the creation of the national accreditation agency, the development of standards for specialized hospitals and infrastructure could not be completed due to the absence of the MSH consultant. An alternative modality will be implemented next fiscal year (2017-18) to ensure successful implementation of the activity

- **Unexpected results?**

During a workshop organized for hospitals on quality improvement of health services and accreditation programme, sharing best practices, challenges and solutions, Kibungo presented achievements along their quality and accreditation journey, Bushenge presented achievements on reduction of post caesarean infection, Ruhengeri presented on patient flow analysis that reduced patient waiting time at OPD.

After the workshop, some hospitals conducted study tours as a collaborative approach to learn from each other. The main factor for the success of QI were found to be; strong hospital leadership, commitment and ownership of the programme, quality improvement committees being proactive, the commitment and involvement of district authorities in quality improvement activities

R2- Mental health care services are accessible and utilized at the community level up to the national level in a sustainable way

Outcome: Mental health care services are accessible, utilized at community level up to national level in sustainable way					
Indicators	**Baseline value**	**Value year 2015-2016**	**Value 2016-17**	**Target 2016-17**	**End Target 2019-20**
Mental health care services utilization rate at health facility level.	0.16%	0,16%	0.26%	0,2%	0.5%

Note: 1. as the baseline report has been approved in August 2016, the baseline value is the same as the value of Year 2015-16

Mental Health service utilization rate is the number of new consultations for mental health issues in **District Hospitals** reported to the total population. The table below shoes different mental health cases treated during the 2016-17.

Mental Health Consultation visits

Type of disease	July 2015-June 2016		July 2016-June 2017	
	New cases	Old Cases	New cases	Old Cases
Epilepsy	8649	101955	11980	111201
Other Psychological problems	9779	22049	8925	27278
Schizophrenia and other psychoses	2331	31934	2155	32322
Neurological problems	5189	2831	4437	3497
Depression	1347	5496	1350	5760
Psychosomatic problems	1540	3273	1105	2672
Post-traumatic stress disorder	536	1482	482	1270
Suicide attempted or successful	480	215	571	266
Behavior disorders not due to alcohol and drug abuse	196	570	218	408
Behavior disorders due to use of alcohol and drug abuse	178	406	147	403
Total visits	**30225**	**170211**	**31370**	**185077**

Source HMIS, July 2016-June 2017

Numerator: Number of new consultations in District Hospitals during the fiscal year July 2016-June 2017 = **31370 cases/12000000*100,000. As the baseline was calculated in percentage way, we kept the same caluclation .** For this evaluation, we consider the number of new consultations for mental health issues in District Hospitals to avoid double counting of patients sent to referral hospitals and patients received from HCs.

R2 - OUTCOME: Mental health care services are accessible and utilized at the community level up to the national level in a sustainable way

Under Ubuzima Burambye Programme monitoring and Evaluation, one indicator was set to measure the accessibility and utilization of mental health care services: **Mental health care services utilization rate at health facility level.**

Analysis of the progress made shows that, compared to the baseline (0.16%) of 2015-16, the reported result of 0,26% for 2016-17 is showing an increase in mental health utilization at health facility. Compared

to the target of 0,3%, this represents 86% of achievement. The performance reported has been achieved thanks to:

- Decentralisation of MH care to health centre level, near the communities. There is also better integration of MH services in districts hospitals and health centres via training general nurses and GPs, availing guidelines, mentorship and supervision.
- Utilisation of MH services (District hospitals and health centres) has been increased due to various community interventions: large outreach programme, capacity building of health professionals, support community-based psychological interventions during genocide commemoration including sensitisation on trauma and trauma cases follow up
- Tangible strides are made in the area of fighting Drug Abuse among high risk population especially youth
- Capacity and quality of specialised MH care is increasing where the MMed Psychiatry programme started to avail qualified psychiatrists and reinforce referral system via the clinical rotation of Residents among different hospitals.
- The quality of MH care continues to improve regarding the capacity building programme and mentorship and supervision

➢ **The outputs to the above outcome are still leading to the change process envisaged.**

Globally, the majority of activities are achieved as planned and baseline indicator is showing an increase in mental health utilization at health facilities, and accessibility of mental health care, we can consider that the outputs to the above outcome are still leading to the change process envisaged

➢ **Issues that arose, influencing factors (positive or negative)?**

Construction of the national mental health day care treatment centre: Despite all efforts, Gasabo district and CoK failed to identify a suitable plot for the construction of the centre. The preliminary design has been validated but the final design could not be completed as there is no approved final land allocated for construction. There is fear that this lack of plot may jeopardize this very innovative approach for mental health care in the country .

R3: urban Health

Indicators	Baseline value (2015)	Value 2015-16	Value 2016-17	Target 2016-17	End Target 2019-210
Outcome R3.1: Awareness on NCDs increased (people-centred)					
I3.1.1 Prevalence of NCD diabetes (raised fasting blood glucose)	7%	NA	NA	NA	TBD
I3.1.2 Prevalence of hypertension in adult population in CoK	14%	NA	NA	NA	TBD
I3.1.3 Prevalence of overweight BMI≥ 25 (& BMI≥ 30)	19% (10%°)	NA	NA	NA	TBD
Outcome R3.2: Environmental health management improved at different levels (integrated services and people-centred)					
I3.2.1 Prevalence acute diarrhoea <5	6%	NA	5%	5%	3%

I3.2.2 % of public places responding to at least 80% hygiene standard criteria	TBD	NA	70%	60%	80%
Outcome R3.3: Health facilities system in the CoK is rationalized by integrated equitable and sustainable services which are people-centred					
I3.3.1 % population living at < 1 hour walk/5 km from HC	77%	77%	NA	NA	100%
I3.3.2 Bed occupancy rate in different Kigali hospitals	36%	36%	34%	TBD	80%
I3.3.3 Patient and health care providers satisfaction rate	TBD	TBD	NA	NA	TBD
I3.3.4 4 ANC coverage in CoK HFs	44%	44%	25%	75%	100%
I3.3.5 Deliveries rate at HF level in CoK HFs	94%	94%	99%	95%	100%
I3.3.6 Ultrasound coverage for pregnant woman (at least one ex) in the catchment area of 4 HCs equipped with ultrasound	0%	0%	0%	5%	20%

Note: as the baseline report has been approved in August 2016, the baseline value is the same as the value of Year 2015-16

R3.1 OUTCOME1: Awareness on NCDs increased (people-centred)

Since the beginning of the project, two mass campaigns, of one-week duration each, took place and ended by a car free day with mass sports. The outcome indicators related to NCD are measures of prevalence (Diabetes, Hypertension and risk factor of overweight). This requires an extensive survey that is done every 4 or 5 years, depending on the resources available. A survey conducted by WHO-RBC in 2015 serves as the baseline. Another survey could be repeated using the same methodology before the end of the programme in 2019. The feasibility to repeat the survey (using Research budget) should be evaluated in collaboration with RBC-NCD division, WHO and the CoK.

However, the activities organized can only influence partially the results as many other factors can influence the above outcome indicators. The expectations are not to see a diminution, but rather an increase of the prevalence, especially because the main objective of the campaign is to have more people screened for early detection of the silent diseases like hypertension and diabetes. The direct results of those mass campaigns are presented in the "Output" section.

R3.2 OUTCOME2: Environmental health management improved at different levels

City of Kigali, through Environmental and Hygiene Technical Working Group, is conducting quarterly joint supervision on hygiene and sanitation in different public places (hotels and restaurants for the last supervisions). Those supervisions are followed by an evaluation meeting and a list of recommendations to improve the hygiene and the sanitation is prepared and transmitted to the different places visited. During the next visit the team assesses the implementation of the previous recommendations. The outcome indicator of the activity is the *'% of public places responding to at least 80% of hygiene standards criteria'* and the result for this year is higher than the planned target: 70%.

Another activity is to organize hygiene and sanitation campaign on good practices through mass media (spot TV & radio, newspapers). One campaign took place last year

One outcome indicator for general overview of hygiene and sanitation is the prevalence of acute diarrhoea from which the project can contribute probably modestly among numerous strategies taken by other stakeholders.

One activity, solid waste management plan, was removed because the estimated budget was too low compared to the winning bidder's proposal from competitive tender process.

R3.3 OUTCOME3: Health Facilities system in CoK is rationalized by integrated equitable and sustainable services which are people centred.

Several activities related to increasing the quality coverage of health services have started: medicalization of four health centres, revitalizing the hospital network with different components put in place, design of the new district hospital with ongoing tender process to recruit construction firm.

Regarding the measure of better coverage, six outcome indicators were retained. Among them, one, "Patient and health care providers' satisfaction rate" will require an initial survey to get a baseline value. A concept note and ToRs were proposed but they still need to be validated by senior MoH management.

A second indicator is specifically related to equipment that should be provided by the project to the 4 medicalized HCs: ultrasound coverage for pregnant women. Delay on delivering the machine took place and explain that this indicator did not progress as expected.
The other 4 outcome indicators measures are included in the national HIS and UB will contribute after implementation and operationalization of planned activities.
It should be noted that one activity was cancelled because of duplication with Result four regarding mapping and SARA study.

R4: Stewardship capacities at the level of the local health system (district) is strengthened

Outcome R4.1 : Stewardship capacities at the level of the local health system (district) is strengthened					
Indicators	**Baseline value**	**Value 2015-16**	**Value 2016-17**	**Target 2016-17**	**End Target June 2019 2020**
I4.1.1 % of Districts which have conducted Mid Term Review of their Strategic Plan (MTR) 2013/18 and developed a clear and sound implementation plan to address the gap identified	**0**	**100%**	**NA**	**NA**	**NA**
I4.1.2 % of Districts which have developed a comprehensive health strategic plan 2018- 2023*	**NA**	**NA**	**0**	**NA**	**100%**
I4.1.3 % of Districts functioning in a SWAp model (all related health activities and stakeholders are integrated/aligned under the leadership of District)**	**NA**	**NA**	**0**	**80%**	**100%**
Outcome R4.2: MoH and RBC are supporting decentralized levels according to their respective roles (policy, regulation, coordination, M&E, implementation)					
I4.2.1 Number of District Health Strategic Plan (DHSP) 2018-2023 with Quality assessment done by Central level	**0**	**NA**	**NA**	**NA**	**30**
I4.2.2 % of selected districts visited by Joint supervision team from central level at least once a year	**0**	**0**	**80%**	**100%**	**100%**

(*) The indicator should be evaluated in year N+1, but the activity is to be initiated in year N. (**) This will be implemented during the development of the DHSP 2018-2023 when??

R4.1 OUTCOME1. Stewardship capacities at the level of the local health system (district) is strengthened

All districts conducted already the MTR of their strategic plan during the FY 2015-2016. The next step was to speed up the implementation of the DHSP and in FY 17-18 for all districts to develop their second DHSP. The indicator related to the elaboration of the new DHSP will be measured in this FY 2017-2018 and will be closely related to the national HSSP IV , which is still in preparation. Two indicators with report due this reporting period were not achieved as planned. The first indicator is related to the development of DHSP2018 which will start after the finalization of the HSSP4.

During this reporting period, Districts gathered together to set priorities and develop the logical framework for the elaboration of the DHSPs. By November 2017, the HSSP4 will be finalized, disseminated and then after, District could start developing DHSP 2018-23.

Concerning the second indicator related to the districts functioning in a SWAp model, During the Mid-Term Review of HSSSPIII, the health stakeholders were formally represented and work often on an ad-hoc basis with the sector coordinating structures, including the CCM and this will be the case during the development of DHSP 2018-2023.

R4.2 OUTCOME2. MoH and RBC are supporting decentralized levels according to their respective roles (policy, regulation, coordination, M&E, implementation)

Two indicators were planned to measure the change. The first one related to the supervision which was achieved at 80%. The second indicator is linked to the development of DHSPs and related quality assessment. This will be achieved after new DHSPs development during FY 2017-2018. .

- **The outputs to the above outcome are still leading to the change process envisaged**. In fact, MoH started the process of developing HSSP4 during the last quarter of 2016-17FY. The planned indicators should be evaluated at the end of the year 2017-2018.

- **Issues that arose, influencing factors (positive or negative)?**

The most important issue is the programme implementation Action Research and mapping of Health facility

Almost activities related to the support of District have been done; co-ordination meeting, joint supervision and the recent workshop to identify district priorities will be helpful for the development of DHSP which will start by November 2017.

Regarding the MoH and RBC support to the decentralized levels, this has been done through joint supervision and other consultative meetings.

- **Unexpected results?**

One activity was cancelled because of duplication with Result 3 regarding mapping and SARA study.

R6 - Quality of health assets in health facilities is increased based on the implementation of standards

Outcome: Quality of health assets in health facilities is increased based on the implementation of standards					
Indicators	Baseline value	Value 2015-16	Value 2016-17	Target 2016-17	End Target 2019-20
An asset (equipment and infrastructure) management system is put in place and is operational	Weak	weak	Partially achieved. -Trainings on ultrasound anaesthesia and patient monitor machines, on the management of Health Assets, achieved. -Bachelors programme in Biomedical Engineering for three BMETs, started and ongoing. - Advanced level education in IPRC for 33 District hospitals and central Level BMETs is ongoing. -Guidelines for donations and disposal of medical equipment developed and approved for publication. ToRs for the consultant to develop Norms and standards for Health Infrastructure were developed.	Continuous Trainings Standards available	functional

R6. OUTCOME: Quality of health assets in health facilities is increased based on the implementation of standards

One indicator has been set to measure the change in health asset management area. The target set for this FY were continuous trainings of MTI engineers and technicians and availability of standards related to asset management.
So far, the outcome is partially achieved at some extent: guidelines for donations and disposal of medical equipment have been finalized and the training of users shall be done by MoH.

MTI is supporting the training of MTI engineers in the management of medical and Health Infrastructure(ongoing). MTI has initiated qualitative initiatives of protecting sensitive machines like ultrasound, provision of Oxygen pipeline systems to the neonatology service room of NYAMATA DH; and the Operating theatre of NEMBA DH). The construction and equipment of four provincial maintenance workshops is under implementation and will be completed next fiscal year.

Capacity development:

- In-house trainings are done continuously for BMETs of Health Facilities.
- The training of 3 BMETs for Bachelors programme in Biomedical Engineering in India is ongoing and studies will be completed by July 2019.
- MTI is providing technical support to IPRC where 27 BMETs working in different hospitals are pursuing in-house advanced diploma in Biomedical Technology.
- MTI is still facing challenges to send staff for specialization short courses abroad and for Master's Programme in Biomedical engineering.

Policy, Guideline and standards

- Guidelines for donation and disposal of medical equipment were developed and validated.

- Standards and norms for health infrastructure not yet developed but the preparation of ToRs for the consultant is ongoing.
- MTI has not developed Policy and Strategic Plan and also waiting for approval of reference documents like HACSAP

2.2.2 Potential Impact

The current progress implementation of UB Programme outcome as detailed above, gives a hope that they will contribute to the country impact indicators (2020 as revised during the HSSP4 Development) which are:

Indicators	Baseline (2014-15)	Target (2018)	Revised Target (HSSP4-2020)
Maternal mortality rate	210‰	200 ‰	168‰
U5s mortality rate	50‰	42 ‰	42.5‰
Neonatal mortality rate	20‰	10 ‰	16‰
Infant mortality rate	32‰	22 ‰	28‰
Total Fertility Rate	4 2	3 3	3,8
Utilization rate for modern contraceptive methods among women of 15-49	44	50%	-
HIV prevalence 15-49 years	3	3%	-

R1. Quality Assurance

In fact, all accreditation standards pay particular attention to the 7 impact indicators and the compliance to the standards will contribute to the improvement particularly from level 2 upwards. The reduction of post caesarean infection from 1,13% <0,8% by the end of the programme, will be possible as all inputs are almost ready (training done, QIP under execution, quality assurance plans developed, regular accreditation by internal facilitators done) and will contribute directly to the 3rd and 4th impact indicators. As of today, 82% of health programmes are integrated in the accreditation process (58% in the baseline) and this gives hope that target of 100% integration () by the end of UB program lifetime will be possible.

R2. Mental Health

The above mentioned factors reinforced the decentralization and integration of Mental Health care in PHC and played a key role in increasing the accessibility and quality of MH care which can impact positively the mental health of the Rwandan population and health in general. The mental health service utilization increased from 160/100,000 in 2015-16 to 260/100,000. The capacity building programme developed via the MH Intervention targeting various health care professionals, focus on psychological aspects centred on personal care in daily working and reinforcing quality of care as well as prevention of drug abuse among the youths will contribute to the impact in general.

R3-Urban Health

Ubuzima Burambye Programme doesn't have direct and measurable contribution to impact indicators, however, the activities like medicalization, increasing beds in the CoK, rationalization of health services through the HNW, mass campaigns and screening, etc. contribute to reduce the burden of disease and reduce morbidity and mortality in general in CoK/urban settings.

R4-Leadership and Governance

The capacity building at district level, through mentorship, supervision, coordination meetings, trainings on reporting and management, etc., empowered this level that was able to better set and implement priorities that were aligned to the HSSP4. In that way, the activities contributed partially to improve the national impact indicators.

R6-Asset Management

Having in place, a functional health assets management system (medical and infrastructure) contributes to a functional decentralisation of quality healthcare services. Standard-based health care assets management, ensures infection control. Building capacities of BMETs, provision of maintenance tools, construction and equipping maintenance workshops at decentralized levels ensures sustainability in the management of medical technologies and contribute to the reduction of infant, neonatal, under five and maternal mortality in the country.

2.3. Performance output 1

2.2.3 Progress of indicators

R1-Quality Assurance

Output R1.1.1: An independent accreditation body is established and functional					
Indicators	**Baseline value**	**Value year 15-16**	**Value year 16-17**	**Target year 16-17**	**End Target**
I1.1.1.1 Independent accreditation body in place and functioning	no	no	no	Yes	Yes
I1.1.1.2 # of NR, PH& District hospital assessed per year by the RHAO/MOH*	0/42	0/42	0/42*	42/42	42/42
Output R1.1.2: All HFs have functional QA committees					
I1.1.2.1 % of HCs with functional QA committees	90%	XXX	100%	100%	100%
I1.1.2.2 # of hospitals having submitted report on incident and its management systems	5	5	42	35	35
Output R1.1.3: District hospital achieving level 2 of accreditation					
I1.1.3.1 # of DHs achieving level 2 of accreditation	0	0	2	5	10

Output R1.1.4: Quality improvement initiatives are implemented and documented in HFs					
I1.1.4.1 # of HFs with quality improvement initiatives documented	0	0	0***	4	10
Output R1.1.5: Health care specialized centres are enrolled in accreditation programme					
I1.1.5.1 # of specialized health care centres enrolled in the programme	0	0	3	0	3

(*) As RHAO is not yet established all 42 hospitals were assessed by MOH

(**) QA in HCs has been established with TORs and working procedures and expected to be supervised by district hospital in the catchment area. To date MOH has no data to indicate whether they are functional or not.

(***) MOH selected 23 QI projects that are ongoing but not yet documented.

R1-Quality Assurance -Progress of main activities [3]	Progress made					
	A	B	C	D	E	F
Progress towards the creation of an autonomous accreditation body						
Support strategic orientation meeting of core team of Accreditation organization to its roles and responsibilities.						
Provide Technical assistance to the development of a procedure manual for the Accreditation organization						
Update & disseminate standards and models (MOH)						
Support development of Rwandan Accreditation Standards for Specialized Centres/Hospitals (Neuropsychiatric Hospital and Orthopaedic Hospital including Gatagara, Rilima)						
Support the development of Quality Assurance plans for Health Centre level						
Support the workshop on sharing of Rwanda PHC standards with TWG and Accreditation steering committee (Quality Assurance indicators into PBF tool used at HC level						
Support the coordination of quality improvement in PPP (supervision, workshops,)						
Support the development of safe health design standards for infrastructure						
Facilitate and implement the accreditation process at all hospitals						
Training 120 internal facilitators from DHs for QI & Accreditation Certification course and support external facilitation for hospitals on QI & accreditation.						
Provide support to annual survey of Specialized and District hospital						
Finance people-cantered improvement projects						

A The activities are ahead of schedule
B The activities are on schedule
C The activities are delayed, corrective measures are required.
D The activities are seriously delayed (more than 6 months). Substantial corrective measures are required.
E The activities were postponned to 2017-18 Fiscal Year
F The activities were cancelled

R1-Quality Assurance -Progress of main activities [3]	Progress made					
	A	B	C	D	E	F
Support Strategic orientation workshop to develop people-centred QI strategies						
Support QI initiatives/projects in hospitals and Health Centres (shared with R6)						
National Long Term Technical Assistance in Accreditation and Quality improvement and Quality control						
Preparation for patient & staff satisfaction survey						
TOTAL	0	2	5	2	3	1

Out of 13 planned activities, none activity was achieved ahead of schedule, two (2) achieved on schedule, five (5) delayed, two (2) seriously delayed, three (3) postponed and one (10 activity was cancelled

R1- ANALYSIS OF PROGRESS MADE

Although some activities delayed, Clinical service performed almost planned activities.

1. **Progress towards the creation of an autonomous accreditation body**

The following activities were done:

- ✓ Establishment of technical advisory committee to speed up the establishment of RHAO
- ✓ Proposal for the establishment of accreditation body for public and private health facilities was developed
- ✓ Development of by laws for the establishment of RHAO

2. **Update & disseminate standards and models (MOH)**

The following activities were performed:

- ✓ Dissemination and communication of cross cutting standards to all specialized centres and Kacyiru DH,
- ✓ Training of staff and baseline assessment completed for Ndera Hospital.

The development of specialized standards is waiting for the availability of consultant who will be recruited by MSH. So far, concept has been prepared and the consultant expected by August 2017.

3. **Facilitate and implement the accreditation process at all hospitals**

Implementation of accreditation process was executed through

- ✓ Facilitation in 18 underperformed hospitals was conducted
- ✓ 30 Staff were trained as internal facilitators and baseline done for Ndera and Kacyiru Hospital.
- ✓ 538 staff from HCs were trained to develop QA plans
- ✓ 106 hospital staff were trained in fire safety as training of trainers

4. **Finance people-centred improvement projects implemented through QI**

The quality Improvement project was initiated by the end of December 2016. The progress made so far is

- ✓ 48 quality improvement projects developed by district hospitals and among them, 23 were selected as the best project recommended for funding.
- ✓ The procurement of IT and biomedical equipment for QI projects were included in the procurement plan of 2017/18 following the site visits for needs assessment.
- ✓ There is a delay in selecting standardized IT system for EMR as the country policy is to roll out

OpenMRS in use in some DHs instead of openClinic.

- ✓ All hospitals with the proposal on post-surgical infections and neonatal deaths were trained on IPC and neonatal care.

5. **Training 120 internal facilitators from DHs for QI & Accreditation Certification course and support external facilitation for hospitals on QI & accreditation.**

This activity has not been implemented as planned. Training of internal facilitators has been supported by MSH and UB Programme Budget was used to train 106 hospital staff in fire safety as training of trainers and for QA for Health Centres after consultation with UB Coordination and ITA.

6. **Provide support to annual survey of Specialized and District hospital**

During the reporting period, annual survey was not conducted due others due to Itorero- activities that were carried out by all health facilities from January to March 2017 but its preparation started in the first semester of the 2016-17FY.

7. **Support the development of safe health design standards for infrastructure**

The Process of developing safe health design standards for infrastructure delayed because of several issues; selection of qualified projects, development of TORs, coordination with MTI, site visits for verification of needs and submission of procurement needs (equipment's).

Despite delays, most activities will still lead to the intended results and an acceleration in implementation was significant in the last quarter.

The **main issue** is lack of funds to support the operations of the accreditation body and there is a need to incorporate safe health design in the standards of health infrastructures.

The following **factors influenced positively** UB Programme Performance:

- ✓ Commitment and ownership of MOH and its partners to support CQI,
- ✓ Availability of policies and strategies for CQI

The delayed in the availability of external consultant and funds from MSH had a **negative impact** on the UB Programme output related to the specialized standards as this activity was co-funded.

During the reporting period, after Itorero training sessions and the issue of ministerial instructions on the use of cell phones in the health facilities to minimize the disruption to patient services and care, positive feedback from client was noted.

Actions to be taken to mitigate the delays

Delay to establish RHAO was due to complex factors (cost and expertise), in regards to the health safe design and specialised standards, the delay was due to unavailability of the consultant from outside the country. Corrective measure is being looked at to avoid re-occurrence of delay in future. Decision has been taken regarding an accreditation agency and quality improved projects are ongoing.

R2-Mental Health

In general, the majority of planned activities were achieved. The RBC/MHD has initiated the process of reviewing the mental health strategic plan 2018-2022 in accordance with the on-going process of developing HSSP IV.

R2- Mental Heath - Output/Indicators	Baseline value	Value 2015-16	Value Year 2016-17	Target Year 2016-17	End Target 2019-20
Output : Strengthened community interventions on mental health care services					
Number of community mental health rehabilitation initiatives (Group psycho educative) funded.	0	16	0*	6	16
Number of awareness campaign conducted at community level.	1	4	2**	2	4
Output: Integrated Mental Health Care Services & a people-centred approach at all levels of health Facilities.					
% of HCs providing integrated MH care through trained health care providers.	84%	100%	84%	90%	100%
% of mental health provider (old and new appointed) trained in early detection & treatment of mental disorders as well as in people-centred related techniques	84%	100%	85%	90%	100%
Number of physicians specialized in psychiatry area	6	6	10	12	15
Level of completeness of Mental Health Treatment Day Centre construction: L0: Plot Identification; L1: Site assessment for feasible study L2: Tender process-evaluation and contract signature L3: Site assessment for equipment and construction L4: Equipment- reception and utilization	L0	L0	L0	L2	L4
Integrated Mental Health strategies and actions with regard to the fight against abuse of psychoactive substances, mental health issues related to HIV/AIDS and Gender Based Violence (GBV)					
Level of implementation of Mental Health Component National Strategy against drug abuse prevention & treatment of mental health conditions: Level 1: Development; Level 2: Validation Level 3: dissemination; Level 4: Utilization	L1	L1	L1	L2	L4

R2- Mental Heath - Output/Indicators	Baseline value	Value 2015-16	Value Year 2016-17	Target Year 2016-17	End Target 2019-20
Level of Huye Rehabilitation Centre equipment and functionality: Level 1: Procurement process Level 2: Equipment Distribution Level 3: Utilization and improved care services	L0	L1	L2	L2	L3

*Not yet implemented due to difficulties regarding the disbursement mechanisms to support chronic mentally ill rehabilitation initiatives.

The MHD/RBC Mental Health Division is composed of three units: development of psychiatric care unit; promotion of mental health and community interventions unit; prevention and treatment of substance use disorders unit. Its mandate is to implement the mental health policy through a strategic plan under the guidance of the health sector strategic plan which is running in its third phase. In this context, mental health coordinates initiatives and design programme to promote mental health and to develop of mental health care at the national level. Mental health division plays a key role in the integration of norms, standards and indicators for mental health in all on-going programmes of the Ministry of Health: human resources, health financing, planning, essential medicines, monitoring and evaluation, quality of care, community health, CBHI, performance based financing, etc. The recruitment of a National TA specialized in prevention and treatment of drug abuse related issues allowed increasing the capacity of the MHD to deal with these problems which are described as arising in the country. Her support largely contributed to the empowerment of the MHD to reach the pre-established targets.

Support UR in developing MMed Psychiatry programme, which will allow having psychiatrists trained in Rwanda, reached high level of progress as the programme is still running and the first cohort of three psychiatrists will be graduated.

The draft of mental health law developed last months is in the final process of validation as the institutional review was completed and the project sent to the parliament by the Cabinet. The law is expected to enable the regulation of MH practice and promoting human rights. The draft of design of Mental Health Treatment Day Centre was completed. However, up to now there is no attribution of appropriate plot for this project. The construction had a significant delay due to the change of plot.

Mental Health Intervention is aligned with the National Mental Health Policy and HSSP and plays a major role in the coordination of stakeholders regarding the design and the implementation of certain national and cross-cutting issues. Yearly, MHD organizes had-hoc TWGs to discuss and review the strategies on:

- Fighting against drug abuse,
- Psychological support for victims of genocide
- Community awareness on MH issues
- Rehabilitation of chronic mentally ill

This process was used while drafting a mental health law and will guide the process of reviewing the mental health strategic plan 2018-2022. The ITA/MH is fully integrated in the all process.

This role of coordination led by MHD is essential in term of harmonization initiatives to reinforce the process of decentralization and integration of mental health care at the local level and support the health system in general.

ITA/MH is fully integrated in the MHD team in terms of strategic planning, operational planning and follow up process of activities performed by the Division. This contributed to the implementation of activities and

better coordination with UB Programme. However there are concerns related to procurement process delays and difficulties to support community rehabilitation initiatives related to the rehabilitation of mentally ill as planned

R2- Mental Health - Progress of main activities [4]	Progress made					
	A	B	C	D	E	F
Strengthen community interventions on mental health						
Rehabilitation of mentally ill: Support community rehabilitation initiatives at District level						
Supporting awareness programme on mental health						
Support implementation mental health law						
Training CHWs/Palliative Care Promotor						
Support psychological interventions during genocide commemoration						
Consolidate Mental Health Care Services & a people-centred approach at the level of health Centres & hospitals and extend referral outpatient & inpatient Mental Health Care at the level of the provincial and national referral hospitals						
Support specialisation in psychiatry: 04 residents starting Y3 training in Switzerland (2016-2017)						
Support specialisation in psychiatry: Scholarship for 3 Residents starting Y1 abroad						
Support specialisation in psychiatry: Organise training site directors' meeting						
Support the coordination of in psychiatry						
Support specialisation in psychiatry: Organise international teaching missions						
Support Referral Hospitals: Purchase 4 EEG machine						
Support Referral Hospitals: Training & Internship for 3 GPs and 3 GNs						
Support District & provincial & new appointed referral Hospitals:						
Support organization of mentorship & formative supervision in DH						
Support DH: Conduct a bi-annual meeting of responsible of mental health services in district hospitals 45 participants						
Day Treatment Day Centre: Architect – design, Follow up construction						
Develop multidisciplinary strategies and actions with regard to the fight against abuse of psychoactive substances and with regard to mental health issues related to HIV/Aids and Gender Based Violence (GBV)						
Awareness on drug abuse: support International day of fighting against drug abuse 2016 celebration: Supporting awareness programme:						
Support rehabilitation centre in Huye: Equipment						
Long term technical assistance in mental health and people centred approaches						

R2- Mental Health - Progress of main activities [4]	Progress made					
	A	B	C	D	E	F
Prevention & treatment of substance abuse disorders specialist						
TOTAL	3	8	2	1	4	1

Out 19 activities planned for 2016-17, three (3) activities achieved ahead of schedule,eight (8) were achieved on schedule, two (2) delayed, one (1) seriously delayed, four (4) postponed and one activity was cancelled.

1. Strengthen community interventions on mental health

- ✓ Awareness activity carried out as planned. Two mass campaigns were organized. The first one related to the prevention of drugs abuse and illicit Trafficking reached more than 1,700,000 youth sensitized countrywide. The second one targeted the general population during the celebration of International Day against focused on Mental health issues in general
- ✓ Support psychological intervention during the genocide commemoration through:
  - Training of 37 metal health nurses,
  - 199 volunteers(AERG);244 volunteers(RRC);
  - 143 RNP; 60 GN from HC of CoK; 46 SAMU;
  - 55 Interveners from central levels
- ✓ Supportive supervision and coordination of interventions across the country during the three months (April-June)

2.Consolidate Mental Health Care Services & a people-centred approach at the level of health Centres & hospitals and extend referral outpatient & inpatient Mental Health Care at the level of the provincial and national referral hospitals.

- ✓ Planned specialization in MMed Psychiatry was implemented as planned
  - 10 students enrolled (3Y1,1Y3,3Y4)
  - First cohort of 3 new psychiatrists graduated
- ✓ Coordination of MMed Psychiatry done as planned
- ✓ Training of 564/590 GNs from HCs on integrated mental health care services
- ✓ Training of 86/90 GNs from DHs

3. Develop multidisciplinary strategies and actions with regard to the fight against abuse of psychoactive substances and with regard to mental health issues related to HIV/Aids and Gender Based Violence (GBV)

- ✓ Planned mass campaign against drug abuse and illicit trafficking has been done at 100% and reached more than 1.700,000 youth sensitized countrywide.
- ✓ Celebration of international Day against drug abuse and illicit trafficking

The following activities were not performed as planned

4. **Rehabilitation of mentally ill: Support community rehabilitation initiatives at District level:**

This activity not yet implemented due to difficulties regarding the disbursement mechanisms to support chronic mentally ill rehabilitation initiatives. The previous Steering Committee (SC of June 2017) recommended Mental Health Division to develop and present alternative strategies to the initial proposal by identifying other community rehabilitation initiatives.

5. **Training Community Health Workers (CHWs):** as the CHWs in place are overloaded by other programmes and delay from MoH to recruit new CHWs who will be in charge of NCDs & Mental Health. Then this activity has been cancelled waiting for other source of funds
6. **Purchase 4 EEG machine & support Huye Rehab Centre:**

There is delay on the procurement process which resulted to post pone the activity to the next FY. Even all

requirements were filled, tender process was delayed; and then offers did not meet the budget which led to re-launch all the process after reviewing the budget.

7. **Construction of Mental Health Treatment Day Centre:**

The construction of Mental Health Day Treatment Day Centre is facing a problem of plot and Gasabo District changed plot more than once.

In general, administrative procedures and requirements are complex and cause of delays. Sometimes changes are made without updating the implementers. **Corrective measures** are proposed to improve the execution:

- Better planning and close follow up of the planned activities
- Come up with alternative strategies in community rehabilitation of chronic mentally ill
- Improve the administrative procedures and requirements to avoid delays and update the implementers
- Continue discussions with Gasabo District and advocate for construction of Mental Health Day Treatment Day Centre

R3 Urban Health

R3-Urban Health- Output/Indicators	Baseline value	Value 2015-16	Value 2016-17	Target 2016-17	End Target 2019
R3.1.1 Health Promotional activities on NCDs are integrated in CoK Health plan					
I3.1.1.1 Number of NCD detected during the mass campaigns	0	500	489	1000	3000
R3.2.1 Hygiene and sanitation activities are routinely done					
I3.2.1.1 Situation analysis on Hygiene on sanitation in public places notified by TWG health environmental platform	NA	NA	Id	Identified	Identified areas of improvement by type of public place
I3.2.1.2 % of TWG health environmental platform recommendations implemented	NA	NA	60%	45%	80%
I3.2.1.3 10-years solid waste management plan	NA	NA	Cancelled	Cancelled	NA
R3.3.1 The Kigali Hospital Networking formalized (functional KHN)					
I3.3.1.1 Appointed members from different hospital and other stakeholders	NA	NA	Complete	NA	All stakeholders
I3.3.1.2 TOR and objectives approved	NA	NA	Yes	NA	yes
I3.3.1.3 Road map Operational plan	NA	NA	Partially (HIN)	NA	3-year plan
I3.3.1.4 Inventory of joint/ shared initiatives	NA	NA	3 identified but not yet implemented	4	8
R3.3.2 4 HCs are medicalized (beneficiate of MD visits on regular basis and are up graded accordingly with adequate drugs, supplies and equipment with insurance system adapted for medical consultations)					
I3.3.2.1 Monthly number of new cases seen by MD per HC	0	0	538	TBD	TBD
I3.3.2.2 Number of laboratory able to make FBP and biomedical analysis	3	3	2	4	4
I3.3.2.3 Number of HC equipped with ultrasound machine	0	0	0	4	4
I3.3.2.4 % of drugs for NCD and chronic diseases available at HC level	0	0	??	70%	100%
R3.3.3 A comprehensive and equitable urban Health Facilities coverage plan is developed and validated					
I3.3.3.1 Updated mapping of health facilities (public and private)	NA	NA	Not available	Mapping available	Mapping available
I3.3.3.2 Recommendations and operational plan proposal for improving coverage	NA	NA	Not available	Plan available	Plan available
I3.3.3.3 TWG on coverage plan in place with coordinator identified	NA	NA	NA	NA	In place
I3.3.3.4 Framework PPP available	NA	NA	Not available	PPP Fr. available	Approved PPP Fr
I3.3.3.5 Number of private investors engaged to finance new HC	NA	NA	0	2	3

R3-Urban Health- Output/Indicators	Baseline value	Value 2015-16	Value 2016-17	Target 2016-17	End Target 2019
I3.3.3.6 MOU insurance coverage public & private	NA	NA	Not available	MoU signed	MoU signed
I3.3.3.7 Number of HF up-graded	NA	NA	0	TBD/plan	TBD/plan
I3.3.3.8 Quality standard per HF category	NA (old one)	NA	Not available	NA	Quality standard per HF up-dated for each category
R3.3.4 District hospital is developed, built and equipped in an innovative way in Nyarugenge District which is articulated with the CoK HF coverage plan					
I3.3.4.1 Standard design for an innovating model District Hospital validated	NA	NA	Available	Available	NA
I3.3.4.2 120 bed-hospital equipped	NA	NA	NA	NA	Available
I3.3.4.3 Number of hospital beds for the CoK	2060	2060	??	TBD	TBD

R3- Urban Health - Progress of main activities	Progress[5]:					
	A	B	C	D	E	F
1.Develop promotional activities on social determinants of health in CoK						
1. Conduct study on solid waste management:						
2.a Organize hygiene and NCD mass campaign:						
2.b Organize hygiene mass campaign						
3. Establish a TWG for health environmental platform (10 people)						
4. Develop concept notes on the roles and responsibilities of TWG						
5. Organize quarterly joint supervision						
6. Organize quarterly TWG meeting of health environmental platform						
2.Develop and validate a sound concept and equitable coverage plan for HC						
1. To develop long term health coverage plan 1st and 2nd health care including private facilities.						
2. To organize a workshop with all stakeholders 5 days' workshop for result dissemination (health coverage plan)						
3. Medicalization of HCs: PBF for Medical doctor						

R3- Urban Health - Progress of main activities	Progress[5]:					
	A	B	C	D	E	F
Support the implementation of the coverage plan through various strategies: upgrades of the existing HF, or PPP initiatives in the most vulnerable sectors of CoK						
1. Upgrade existing HCs ultrasound						
2. Organize a workshop to attract investors in health field for the construction of health facilities in the vulnerable sectors of CoK						
Create a functional, autonomous and efficient hospital network						
1. Study tour for at least 5 persons to at least 2 different hospital networks						
2. Update concept note for functional network						
3. Finance secretariat (Laptop or computer, printer, retro projector)						
4. Finance secretariat (assistant)						
5. Preparation (selection topics) of training module for activity to be defined and budget						
6. Training of actors (KMH, KFH,CHUK,Muhima,Kibagabaga, Kacyiru, Poly Clinique la Médicale)						
7. Develop dashboard for shared monitoring (consultancy)						
8. Develop concept of telemedicine by the network coordinator (60 days consultancies on topics)						
9. Field facilitation to medical skills sharing (once a quarter or when needed)						
Design, build and equip a 120 beds Hospital in Nyarugenge District articulated with the CoK coverage plan						
1. Develop Master plan for phase 1 and 2, develop preliminary design phase1						
2. Develop final design						
TOTAL	**0**	**7**	**2**	**2**	**5**	**6**

Note: No activity achieved on ahead of schedule, 7 achieved on time, 2 activities delayed more than six months, 5 were postponed and 8 cancelled.

R3-ANALYSIS OF PROGRESS MADE

General comment

- From 22 activities, 7 were done on time, even if delays took time the year before for routine activities, this year they are done on regular basis (joint supervision, medicalization, etc.).
- 2 activities were completed with reasonable delay and concerned HNW development.
- 2 activities linked to Nyarugenge District Hospital were completed with very long delay due to difficulty with initial consultant recruited by BTC head office.
- 5 activities were postponed early to the next fiscal year and the reasons are:
    - Delay at procurement's office for getting US machine for the HC
    - Difficulties in findings modalities for use of funds regarding NEX execution (rigid modalities)
    - Delay in HNW development with impact on 3 activities
- 6 activities were cancelled

- 3 are linked to the cancellation of activity initially planned to develop and validate a sound concept and equitable coverage plan for HF long term health coverage plan: the cancellation was decided because a similar activity at national level, including the CoK, was planned under the Result 4: "Service availability through Rwanda Master Facility List – MFL (National Updated Health Facility Register) Phase 1 for Rwanda Service Availability and Readiness Assessment (SARA).
- 1 was cancelled because of insufficient planned budget (Solid waste management study)
- 1 was cancelled because of Belgian Budget cut Study tour HNW)
- 1 was cancelled because of unsolvable administrative problem that was to Recruit Finance secretariat assistant

Develop promotional activities on social determinants of health in CoK

✓ Non communicable Disease (NCD) mass campaign took place as planned (once a year) and analysis of data is ongoing. Less people were screened compared to previous year.

The following recommendations were made:

- Organize the follow up of patients detected with abnormal values (Hypertension and hyperglycemia) by phone call, home visit, etc.
- Can be used as Action Research (benefit of the campaign with stakeholders and patients)
- Review communication to increase participants number
- Improved partnership and sponsorship to mobilize people and funds (RBC, WHO, Private sectors, etc.)

✓ Hygiene and sanitation activities with TWG are routinely done (quarterly supervision of public places and quarterly meeting) and TWG health environmental platform is functional. The Hygiene mass did not take place for unknown reason, however all required modalities were ready (request and budget approved and secure).

✓ Study on solid waste management did not take place. In fact, the tender was launched but only one proposal reached the required technical specification. Unfortunately, the financial proposal was higher than the amount available; so, the activity has been cancelled.

✓ A meeting on how to reallocate the budget is planned for the first quarter of FY2017-18.

Support the implementation of the coverage plan through various strategies

✓ The tender for the procurement of 4 Ultrasound machines for the 4 medicalized health centres was launched with delay. By now the contract is signed and HC are waiting for delivery and training.

✓ Medicalization of 4 HCs is functioning

- Regular visits by MD but failure of regular supervision and poor attendance in some HC
- Still waiting for legal framework from MoH. During the follow up of the implementation, the following recommendations were formulated:
  - Closer follow-up and evaluation of activities by the CoK and MoH
  - Make an evaluation with all stakeholders and revise the frequency of visit by doctors for two HC
  - Finalize the legal standard package for this level
  - Establish a list of needed equipment by HC
  - Make a sustainability plan

✓ The Kigali Hospital Network is progressing well

- Structure with SC members and focal point are formalized
- ToR and objectives are defined
- 3 joint/ shared initiatives are defined (IT information sharing, exchanges of medical skills and quality assurance programme)

- Operational plan HIN in place with 5 Work Package Groups

Design, build and equip a 120 beds Hospital in Nyarugenge District articulated with the CoK coverage plan

✓ The design for an innovating model District Hospital is validated and tender process has been completed.

Proposed design Nyarugenge District Hospital – aerial view

15

✓ 10 bids were received and evaluation report sent to BTC Brussels for No objection.
✓ Recruitment of ITA and NTA infrastructure done
✓ The construction is subject to additional funds (1.2 Million Euros) which are under mobilization
✓ The works execution is expected to take 16-18 months.

R4-Leadership and Governance

R4-Leadership and Governance - Output/Indicators	Baseline value	Value 2015-16	Value 2016-17	Target 2016-17	End Target 2019-20
Output 1: All DHMT/DHU are fully functional					
% DHU operational with at least 3 DHMT meeting held per year under the secretary of DHU	NA		83%	70%-	100%
% of districts submitting to MoH the quarterly reports on selected key indicators		100%	100%	100%	100%
% district with integrated health plan					
Number of action researches Studies/Short courses initiated, completed and documented by district unit	0	0	0	10	10
Output 2: MoH and RBC have provided support and capacity building regarding the gaps and needs identified in terms of planning, M&E, finance, management and					
Quarterly coordination meeting with DHU on data analysis and use, and on management with identification of gaps and needs	0	1	3	3	3
Output 3: MoH and RBC have provided support and capacity buildings regarding the gaps and needs identified					
% of DHU with two staff per District trained on planning, M&E, Finance and management	0		100%	100%	100%
Medical internship programme at district hospitals (DH) is evaluated and weaknesses addressed	NA	NA	0	1	3
Number of action researches Studies/Short courses initiated, completed and documented by district unit (DHU)	0	0	0	3	3

R4-Leadership and Governance -Progress of main activities [6]	Progress made					
	A	B	C	D	E	F
Strengthen stewardship capacities at the level of the local health system (districts)						
Organize a workshop for District Hospital Board of Directors to provide orientation and overview on health system and on performance follow up						
Support districts to train Health Centres management committees in Planning and Leadership at district level						
Elaborate and validate tools for district health strategic plan (DHSP) self-assessment (mid-term review) and organize a workshop for DHU for training on tools for self-assessment of the current DHSP for 30 districts						
Organize a workshop with district teams to finalize self-assessment of their current DHSP (2012-2018) for 30 districts						
Identify potential and needed action-researches/studies/short courses at district level						
Support the 30 districts to elaborate the next DHSP 2018-2023 including all stakeholders active in health sector in each district (SWAp model)						
Conduct Quarterly coordination meeting with DHU						
Support training and coaching of DHUs and DHMT in line with roles and responsibilities						
Provide support to MoH and RBC with regard to their respective roles (separation of regulatory/coordination/ M&E, and implementing role)						
Organize mentorship supervision to the internship programme						
Organize joint supervision at district level at least once a year						
Mapping of health facilities survey						
Identify potential action-researches/studies/short courses to be conducted by central level						
National Technical Assistant in support of governance						
Total	**0**	**3**	**2**	**0**	**5**	**3**

Out of thirteen actities, none was achieved on ahead of schedule, two activities (.2) activities were achieved on time, five (5) activities delayed more than six months and postponed to next FY and three (3)cancelled.

The mid-term review of the HSSPIII and the DHSP 2012-2018 was successfully followed by the development of the HSSP 4 and soon after the elaboration of DHSP 2018-2023. A knowledge capacity transfer has been done to empower District level to set doable and relevant priorities to be aligned with the HSSP4 with ownership and a strong commitment to achieve them. However, the delay in implementation of mapping of health facility had a negative impact on the availability of data before finalization of HSSP4

The MoH and RBC played their role in terms of capacity building to Districts level through mentorship supervision which was conducted to assess and a better reporting system of health activities, coordination meeting with DHU, which happened 3 times during the financial management using the HRTT tool.
All these initiatives enable DHUs to better implement and monitor health activities on both institutional and policy context.
The last self-assessment (mid-term review) of the DHSPs 2012-2018 was a success and a proof of stewardship and decentralization of planning and monitoring of health-related activities as well the implementation.

The following activities were not implemented as planned:

1. Mapping to support the 30 districts to elaborate the next DHSP 2018-2023 including all stakeholders active in health sector in each district

The activity will take place this FY 2017-2018. During this reporting period, districts gathered together to set priorities and develop the logical framework for the elaboration of the DHSPs. By November 2017, the HSSP4 will be finalized, disseminated and then after, district could start developing DHSP2018-23.

2. Organize mentorship supervision to the internship programme

Was postponed to next FY because other more urgent priorities.

3. Action researches

None has started. This activity concerns all other results that should present a plan of action with roadmap early next FY.

4. Mapping of HC

This activity was decided late, during budget revision and the modalities of recruitment are longer than expected; the activity will take place in 2017-2018.

5.0rganize a workshop for District Hospital Board of Directors to provide orientation and overview on health system and on performance follow up

This activity has been planned for both 2015-16 and 2016-17 and implemented only for 2015-16 and the workshop of this FY cancelled due to other priorities.

6. Support districts to train Health Centres management committees in Planning and Leadership at district level

Initially planned in FY 2015-16 and cancelled during the second year of programme implementation. The SC August 2016 recommended that Planning and Financial Department reviewing all results planned activities and then after, a list of activities has been identified and implemented.

7. National Technical Assistance in support of governance

The national post has been cancelled as Programme Activities were integrated.

R6-Asset Management

Indicators:	Baseline value	Value 15-16	Value 16-17	Target 16-17	End Target 2019-20
Output 1: The policy, (standards and/or guidelines regarding Health assets management) is updated, approved, and disseminated.					
Availability of a national policy regarding Health asset management system.	NA	National policy (2009/2013) draft	Not achieved. -Guidelines for - donation of medical equipment -guidelines for disposal of medical equipment.	National policy draft (reviewed version)	National policy available.
Output 2: Technical support towards Harmonized, standardized effective acquisition, distribution, and disposal of Medical equipment at the level of all Health Facilities.					
Database of technical specifications of medical equipment and inventory of medical equipment in health facilities	NA	Database development ongoing.	Achieved. Bank of technical specifications available -Inventory for district hospitals is done. - Inventory for Health Centres is Ongoing.	Database development.	database and inventory available
Output 3: Health Facilities are designed according to standards and guidelines.					
Norms and standards for Health infrastructure developed and approved.	existing service packages	draft of norms and standards	Not yet achieved. Development of terms of reference for the consultant to develop Norms and standards for Health Infrastructure.	validation	approved norms and standards
Output 4: Improved capacity of Biomedical and Health Infrastructure Engineers and Biomedical technicians at central and district levels.					
% of medical equipment curatively maintained upon HF requests.	NA	0%	63%	50%	70%
Number of Staff trained and Upgraded the education levels in Biomedical engineering and Health infrastructure.	A1: 50 MSc: 3	NA	33 are looking for A1. 3 BMETs for District hospitals are	NA	A1: 80 A0: 2 MSc: 5

Indicators:	Baseline value	Value 15-16	Value 16-17	Target 16-17	End Target 2019-20
			pursuing A0 in BE.		
Output 5: Better utilisation of assets in health facilities					
Health facilities benefiting improvement initiatives	0	0%	51.25%*	70%	95%

* The formula used is: Number of Hospital that was completed, over the total number of the projects. The indicator needs to be redefined.

R6- Asset Management Progress of main activities [7]	Progress:					
	A	B	C	D	E	F
Develop, validate and disseminate policies, technical standards for HF in infrastructure and equipment, acquisition standards including donation, procurement & replacement standards, collaboration with private sector…						
Develop guidelines for donation of medical equipment						
Develop guidelines for scrapping of medical equipment						
Workshop on MTI Policy planning and strategic plan review, first session						
Implementation of the recommendation from depth assessment						
Develop a functional procurement and maintenance system at operational level.						
Construct maintenance workshop in remote district hospitals including workbenches						
Procure flat screen, Photocopier with UPS to be used in MTI conference room						
Purchase electromechanical tool boxes for district hospitals						
Procure Laptops, flat screen with UPS and photocopier to be used in MTI						
Renovate/upgrade of MTI central workshop and workbenches.						
Purchase biomedical engineering books for MTI staff.						
Setting call centre at MTI Office and recruitment of call centre staff and purchase software						
Develop a waste management policy, strategy and baseline						
Assessment on liquid and solid waste management system in 20 DHs.						
Finance strategic improvement projects with impact on the asset management						
Implementation of Measures taken for radiation safety suggested the consultant seven hospitals in short term (Identification of all needs, technical specification developments, etc.)						
To procure Provision of power protection of ultrasound machines in 41DHs						
Pre -installation of Autoclaves						
Provide oxygen lines for neonatology services in Nyamata DH and Operating theatre of NEMBA DH.						
Develop Domestic Human capacity with regard to asset management						
Master degree in Biomedical Engineering						

R6- Asset Management Progress of main activities [7]	Progress:					
	A	B	C	D	E	F
Bachelor degree in Biomedical Engineering (three candidates)						
Short Training for 42 technicians from central level and districts level						
Short course for two MTI Staff in health infrastructure design						
Long term technical assistance						
National Technical assistant for Asset management						
Total	0	5	7	5	9	2

Out of twenty eight 28) planned activities, none activity achieved ahead schedule, five (5)achieved on schedule, seven (7) delayed, nine (9) postponed and two activities (2) activities were cancelled,

The following activities **were achieved on schedule:**

- ✓ Procurement of flat screen, photocopier with UPS to be used in MTI conference room
- ✓ Procurement and distribution of 41 UPS for ultrasound in District Hospitals
- ✓ Procurement and distribution of 15 electromechanical tool boxes for district hospitals
- ✓ Procurement of 10 Laptops, one flat screen with UPS and one photocopier for MTI
- ✓ Short Training for 42 technicians from central level and districts level

The following activities **were done with a reasonable delay due to the administrative and procedures delays**

- ✓ Develop guidelines for donation of medical equipment
- ✓ Develop guidelines for scrapping of medical equipment
- ✓ Construct maintenance workshop in 15 remote district hospitals including workbenches: due to the MoH policy change and priorities, the construction of maintenance workshops changed from 15 District Hospitals to 4 provincial maintenance workshops. However, the sustainability plan is being developed by MTI in collaboration with PMEBS Division.

The following activities **were not implemented** during the reporting period

- ✓ Policy and strategic planning: MTI is a division in BIOS department of RBC. Bios policy is still pending for final approval by Honourable Minister.
- ✓ Implementation of the recommendation from in-depth assessment on the status of medical equipment and infrastructure management: the study has been initiated in 2014-15, the draft report issued in 2016. From there, many consultation meetings between MTI and the AMPC health consultancy took place to review the report and formulate strong recommendations to be used for the development of MTI strategic plan and other related guidelines. Recently, final analysis has been done by the committee and the validation of the report is awaited.
- ✓ **Setting call centre at MTI Office:** this activity has been planned since 2015-16 and seriously delayed due to the proper justification by MTI. In fact, the programme Technical and Financial File (TFF) suggested to strengthen MTI division and, among other ways, the setup of a call center that

will manage technical and administrative requests was proposed. The SC of Dec, 4 15 approved the principle of establishing a call center and recommended to develop a full concept note with budget. The rationale and concept were presented and discussed during the second SC which questioned the root causes of the existing situation at MTI and recommended again to review it and finally approved. Current, the technical specifications have been submitted by MTI and tender is in process.

The following activities were cancelled due to the lack of funds (budget cut) and change of priorities

- ✓ Renovate/upgrade of MTI central workshop and workbenches (done using ordinary budget as not initially in the TFF)
- ✓ Assessment on liquid and solid waste management system in 20 DHs. Due to the fact that the planned budget was not sufficient to do that and proposed to the budget cut.

As at 30 June 2017, below activities were implemented as follows:

1. **The policy, (standards and/or guidelines regarding Health assets management) is updated, approved, and disseminated.**

- ✓ Development of guidelines on donations and disposal of equipment was done.
- ✓ As a gap, we still fail to update the national policy regarding Health assets management.

2. **Technical support towards Harmonized, standardized effective acquisition, distribution, and disposal of Medical equipment at the level of all Health Facilities**

- ✓ A bank of technical specifications is in place.
- ✓ Disposal of medical equipment procedures are set in the guidelines at all health facilities.

3. **Health Facilities are designed according to standards and guidelines.**

Terms of reference for the consultancy service to develop the norms and standards for Health Infrastructure were developed. The activity has budget line in 2017-2018 Fiscal Year.

4. **Improved capacity of Biomedical and Health Infrastructure Engineers and Biomedical technicians at central and district levels**

- ✓ 27 BMETs are in pursuit of advanced diploma in Biomedical engineering.
- ✓ 2 BMETs were sent for Bachelors Programme in Biomedical engineering.
- ✓ Trainings on ultrasound, anaesthesia and patient monitor machines were conducted.

5. **Better utilization of assets in health facilities**

- ✓ Provision of UPSs to protect ultrasound and other sensitive machines in 41 District Hospitals.

From the analysis of the progress made, it appears the all activities are still leading to the intended result. Some issues like Health Care Services Access Policy (HCSAP)- validation in depth persists and corrective measure are required.

Due to the budget cut, the following activities were not implemented

- ✓ Renovate/upgrade of MTI central workshop and workbenches.
- ✓ Assessment on liquid and solid waste management system in 20 DHs.

2.3 Transversal Themes

2.3.1 Gender

R1-Quality Assurance

- ✓ They appear to be no gender gap within the result. Patient satisfaction survey will identify any gender gap that will be taken into account
- ✓ UB programme doesn't have a specific gender component but t QI projects have a strong attention to women health with a specific output of reducing post caesarean infection
- ✓ Satisfaction survey should collect data and desegregate them by sex.
- ✓ MOH/MCCH department look at the reduction of maternal mortality and family planning
- ✓ The programme beneficiaries are not specifically sensitized about gender discrimination
- ✓ The intervention doesn't have a specific gender budget scan nor other method to mainstream gender
- ✓ The result area is not considered as 'gender blind'
- ✓ The result didn't organize specific awareness for the staff except technical training for health centre and DHs staffs
- ✓ The result is not collaborating directly with a gender –friendly actor in Rwanda like MIGEPROF, Gender Monitoring office, National Women Council, UN Women, Women for Women, others…
- ✓ The challenge to take gender into consideration is that there is no specific budget on gender issue

R2-Mental Health

As UB programme doesn't have a specific gender component, The Mental Health Intervention did not have a specific intervention or specific budget dedicated to gender. However:

- ✓ Women are part of the target population of the Mental Health intervention
- ✓ Data reporting (HMIS) are disaggregated considering gender
- ✓ During the training of health professionals, gender aspects are very considered in psychiatric pathology in term of diagnosis and treatment plan.
- ✓ During community awareness, women are part of the target population
- ✓ Associations targeting genocide survivor widows are part of the stakeholders of the TWGs in charge of Support psychological interventions during genocide commemoration
- ✓ The result has not gender budget scan nor other method to mainstream gender
- ✓ As it not part of the UB programme action plan and not foreseen by TFF, the result didn't organize awareness activity for the staff
- ✓ The programme is collaborating with the Associations targeting genocide survivor widows AVEGA as one of the stakeholders programmed

R3- Urban Health

The main gender gaps are

- ✓ Insufficient 4 ANC visits for ANC coverage in the CoK (25%)
- ✓ No access to ultra sound exams in the HC for pregnant woman
- ✓ Higher prevalence of overweight and obesity among women in the CoK

How does the result take gender into account?

- ✓ There are no specific gender interventions that have been identified in the course of the year but:
- ✓ It is expected that improved access of services and urban health developments will benefit the entire population with attention on maternal (Ultrasound for pregnant woman at HC level) and child care
- ✓ Nyarugenge District Hospital design considers gender difference issues
- ✓ Some indicators will be disaggregated by sex (screening of NCD and Risk factors, patient satisfaction rate, medical consultations at HC level
- ✓ Mass sport campaign is targeting also women

Has your result been through a gender budget scan or through any other method to main stream gender?

- ✓ No specific budget on gender issue.
- ✓ Did your result organised any awareness activity for the staff, implementing partner
- ✓ No

Do you collaborate, are you in contact with a gender-friendly actor in Rwanda?

- ✓ The result is not yet collaborating with gender-friendly actor in Rwanda

What are your challenges to take gender into consideration in your result area?

- ✓ No specific challenges to take into account gender

R4- Leadership and Governance

- ✓ The HSSP4 has been designed to eliminate or minimize all forms of violence, gender based violence (especially against women and girls). This will include enhancing access to RMNCAH (Reproductive Maternal Neonatal Child and Adolescent Health) services without gender barriers.
- ✓ Interventions under UB Programme were not threatened by any form of gender violence. However, the programme contributed a lot in setting health sector priorities and moreover in the development of the Health Sector Strategic Plan 4 which takes into consideration gender equality.
- ✓ The Ministry of Health is collaborating with MIGEPROF, Gender Monitoring office, National Women Council, UN Women, Women for Women, other NGO like AVEGA
- ✓ The MoH is fighting against GVB and started implementing this intervention in District Hospital
- ✓ No specific challenges to take into account gender

R6-Asset Management

- ✓ **There is no gender gap**

How does the result take gender into account?

- ✓ Most of our activities involve Procurement and all bidders are invited to apply for the supply, regardless of their sex.
- ✓ Anyone who succeeds after technical, financial, and administrative evaluations is awarded the tender.

Has your result been through a gender budget scan or through any other method to main stream gender?

- ✓ No specific budget on gender issue.

Did your result organised any awareness activity for the staff, implementing partner

- ✓ No

Do you collaborate, are you in contact with a gender-friendly actor in Rwanda

- ✓ Not collaborating with gender-friendly actor in Rwanda

What are your challenges to take gender into consideration in your result area

- ✓ No specific challenges to take into account gender
- ✓ The result doesn't collect sex-disaggregated
- ✓ The country takes into consideration gender policy at all levels.
- ✓ The result has not gender budget scan nor other method to mainstream gender
- ✓ The result didn't organize awareness activity for the staff, implementing partner

2.3.2 Environment

How does your result take environment into account?

RA	Statements
1	Among the risk 5 areas containing accreditation standards, risk area 3 is focused on safe environment for staff and patients. Examples; Ensure regular inspection for safe environment, fire safety programme and waste management
2	As it not part of the UB programme action plan and not foreseen by TFF, The MH Intervention did not have a specific intervention or specific budget dedicated to Environment.
3	Yes. Environmental aspect taken into consideration during the design of Nyarugenge District Hospital. A technical working group for hygiene and environmental has been put in place and I conducting regular supervision and making strong recommendations
4	NA
6	Environment aspects are considered by doing before and during the designing and construction of new Health facilities by conducting, feasibility studies, validation sessions of the designs, regular supervisions of constructions

What is the potential effect that your result can bring to the environment

RA	Statements
1	Safe health environment, coordination of Infection control and prevention,
2	Aspects related to Environment will be considered while drafting design of the Mental Health Treatment Day Center
3	CoK is focusing on green and clean city . This is implemented through awareness activities and inspection done by EHTWG
4	NA
6	Safe health environment (radiation protection strategies, safe disposal of obsolete equipment's,...)

What are your proposals to include environment in your result area

RA	Statements
1	Continue to improve what is under implementation
2	The MH Intervention did not have specific budget dedicated to Environment.
3	Continue to improve what is ongoing
4	NA
6	To improve safe health environment (radiation protection strategies, safe disposal of obsolete equipment's,...)

2.4 Risk management

2.7.1. R1 QUALITY ASSURANCE

Risk Identification		Risk analysis				Risk Treatment			Follow-up of risk	
Description of Risk	Period of identification	Risk category	Probability	Potential Impact	Total	Action(s)	Resp.	Deadline	Progress	Status
Delay of establishment of accreditation body by MOH	RBM Baseline	Effectiveness	Medium	High	High Risk	Joint Meeting MOH/USAID and MSH to review progress in the funding and setup of the agency	*MOH*	*Aug-17*	Joint meeting planned in 2nd week of August 2017	On track
						Assist MSH in the recruitment of International consultant to support establishment of RHAO (depending of USAID funding)	*ITA*	*Sep-17*	Waiting for the resolution of the joint meeting	
Failure to get competent local organization to become RHAO	RBM Baseline	Effectiveness	High	High	Very High Risk	Alternatively: Assist MOH to recruit an international organization to develop capacity of local organization to become RHAO	*MOH*	*Dec-17*	-A local NGO has presented itself to MOH for collaboration -MOH signed a letter of collaboration with the NGO in June 2017	On track
Insufficient funding to respond to accreditation recommendations / needs (implementation risk)	RBM Baseline	Sustainability	Medium	High	High Risk	Prioritize resource on basis of high impact investment for infrastructure and equipment that will make a	*Dir Q&S MOH*	*Dec-17*	Quality improvement initiatives have been identified and selected	On Track

Risk Identification		Risk analysis				Risk Treatment			Follow-up of risk	
Description of Risk	Period of identification	Risk category	Probability	Potential Impact	Total	Action(s)	Resp.	Deadline	Progress	Status
						difference for public health improvement				
						Advocacy to mobilize funding (DPs, insurance schemes, cost sharing etc…): meeting DPs, present to HSWG, prior to budget preparation period	*Dir Q&S MOH*	*Sep-17*	MOH to present an overview of accreditation programme to the UB steering committee and other DPs for financial support	
						Ensure the initiative is included in HSSPIV	*ITA*	*Jul-17*	Initiatives were included in the HSSP IV	
Inadequate leadership ownership and commitment for accreditation programme at facility level	RBM Baseline	Effectiveness	Low	High	Medium Risk	Support the leadership through external facilitators and training of internal facilitators and orientation	*Dir Q&S MOH*	*Dec-17*	*Workshop on QI in Feb 2017 for all 30 Vice mayors in charge of social affairs in the districts, all hospital BODs, directors of hospitals, director of nurses , all hospital customer care officer*	*On Track*
						Organise training on QI and accreditation for Vice mayors in charge of social affairs in the districts, all hospital BODs, new directors of hospitals,	*Dir Q&S MOH*	*Dec-17*	*Under preparation*	*On track*

Risk Identification		Risk analysis				Risk Treatment			Follow-up of risk	
Description of Risk	Period of identification	Risk category	Probability	Potential Impact	Total	Action(s)	Resp.	Deadline	Progress	Status
						hospital DAF and directors of DHUs, as recommendation from Feb 2017 workshop				
						Create more awareness on importance of accreditation programme and its benefits	*Dir Q&S MOH*	*Dec-17*	*ongoing*	*On Track*
						Collaborative approach model	*Dir Q&S MOH*	*Dec-19*	*Ongoing, will be presented to TWG Collaborative approach model QI Conference takes place every year*	*On Track*
						Change the Hospital leadership	*Dir Q&S MOH*	*Dec-17*	*where appropriate - see reports Under process*	*On track*
QA committees are not active and do not address incidents timely and effectively	RBM Baseline	Effectiveness	Low	High	Medium Risk	Empower the QAC and support internal and external facilitation	*Dir Q&S MOH*	*Dec-19*	*training mentoring done*	*On Track*
						Monitoring and reporting of QAC at both central level and district	*Dir Q&S MOH*	*june-17*	*To develop a comprehensive reporting format*	*On Track*
						Write Health facility performance management	*Dir Q&S MOH*	*Aug-17*	*Ongoing*	*On track*

Risk Identification		Risk analysis				Risk Treatment			Follow-up of risk	
Description of Risk	Period of identification	Risk category	Probability	Potential Impact	Total	Action(s)	Resp.	Deadline	Progress	Status
						letter compliance with standards				

2.7.2 R2 MEMTAL HEALTH

Risk/ Issue Event	Likelihood	Impact	Magnitude	Action(s)	Resp.	Deadline	Progress as of July 2017	Status
Psychiatrists trained overseas do not return in their country	Low	Medium	Low Risk	Attentive selection criteria, monitoring and support/coordination with residents while abroad	*UR: Faculty of Medecine and Pharmacy - Coordinationof MMed Psychiatry*	*déc-19*	*5 Residents were selected on April 2017*	On Track
				Retention Contract signed and "A qui de droit" granted before departure	*MoH & Mifotra*	*déc-19*	*Documents were signed and provided before departure abroad*	On Track
				Offer attractive contract upon training completion by the Ministry of Health	*HR MOH*	*déc-19*		On Track
Delay in Construction process (site assessment, tender process, construction ,,) of Mental Health Day Care centre and risk of losing money	Medium	High	**High Risk**	Tracking mechanisms for tender process.	*UB PC DI*	*déc-16*	The tender process was abandoned as the activity has been transferred to the Gasabo District	———
				Implement recommendation from the Organization assessment, document all challenges identified during the implementation of construction by BTC.District/RBC	*UB PC DI*	*déc-17*	There is delay in implementation due to administrative process	Delay
				Accelerate the construction and procurement of equipment by SPIU/RBC	*ITA Engr*	*déc-17*	Postponed and will be done using ordinary budget as the planned budget has been allocated to Nyarugenge District Hospital	Pending

Risk Identification			Risk analysis			Risk Treatment			Follow-up of risk	
Description of Risk	Period of identification	Risk category	Probability	Potential Impact	Total	Action(s)	Resp.	Deadline	Progress	Status
financing for next survey to measure prevalence on NCD	RBM Baseline	Effectiveness	Medium	Medium	Medium risk	To ask RBC-NCD Division and WHO if another survey is planned before the end of the programme If not, discuss the feasibility CoK to initiate such survey in collaboration with RBC-NCD division and WHO (Research budget)	ITA PH CoK Dir PH&EU	Dec 2016	RBC-NCD has no secured funding; need to contact WHO or another donor	Late
Financial constraint to repeat NCD mass campaigns (screening and awareness)	RBM Baseline	Sustainability	Medium	High	High risk	Advocacy with leadership at CoK to include these activities in the next health strategic plan and to involve other DPs	CoK Dir PH&EU	Dec 2016	CoK has not yet started the planning activity for health plan	Late
Sustainability of medicalized health centres	RBM Baseline	Sustainability	Medium	High	High risk	Plan progressive payment of medical doctors by the HC	CoK Dir PH&EU	July 2017	Not yet started	Late
						MoH Central support to appoint officially MD at HC level	CoK Dir PH&EU	Dec 2017	Not yet started	Not yet due
Insufficient resources to up-grade and/or to build necessary health facilities (implementation risk)	RBM Baseline	Effectiveness	High	High	Very high risk	Support resource mobilization efforts by MoH, CoK and private sector to ensure funding	ITA PH	Dec 2017	Not yet started because plan cancelled	Not yet due
Hospitals continue as independent entities and conflict of interest , especially for private health facilities not willing to work as a network (management and effectiveness risk)	RBM Baseline	Effectiveness	Medium	Medium	Medium risk	Advocacy with leadership at MoH and hospital direction towards network development	Hospital network coordinator	31 Dec 2017	Done, no more a risk,	No longer existing risk: Private hospitals are motivated and active in the HNW
						Put a formalization of the network with a secretariat as a condition for the construction of the Nyarugenge District Hospital	UB coordination	31 Dec 2017	Done	
Delay of BTC non-objection on awarding (and/or contract	Results Delivery	Effectiveness	Medium	High	High Risk	Meeting at high level (SC) to identify complementary budget	RBC-SPIU-UB Coordination	31 July 2017	Budget identified through budget reallocation	No longer existing risk:

signature) due to absence of confirmation of GoR contribution for the co-financing of the NDH (given the shift of responsibilities to RHA)									approved by SC of 11th Sept 2017	
						Letter to PS requesting confirmation of availability of funds	RBC-SPIU-UB Coordination	31 July 2017	Letter sent, answer received from GoR	

R3-Urban Health

2.7.4.R4 LEADERSHIP AND GOVERNANCE

Risk Identification			Risk analysis			Risk Treatment			Follow-up of risk	
Description of Risk	Period of identification	Risk category	Probability	Potential Impact	Total	Action(s)	Resp.	Deadline	Progress	Sta
Risk 1: Delay of implementation and/or no implementation of planned activities	Result delivery	Results Delivery	Effectiveness	Very High Risk	Very high	R4 Focal Person Planning to present roadmap for implementation of activities including next District Health Strategic Plan support activities for fiscal year 2017-18	*DG PI*	*juil-17*	*The roadmap has* been prepared and will submitted by the first week of August	C tra
Risk 2: Low implementation of action research	Result delivery	Results Delivery	Effectiveness	High risk		Assist DG Planning to validate action research implementation plan linked to Quality Improvement initiatives	*ITA PH, PC, DI*	*août-17*	Done	di
						Identify support mechanism (SPH, consultants) according to result areas	*ITA*	*août-17*	done	dor
						Use challenge fund initiative to increase motivation of MOH staff and also allow for relevance of action research agenda	*ITA*	*sept-17*	On track	ont

Risk3: Competing activities (ie development of HSSP IV) delay the development of district plans				High risk		Have a planning meeting with R4 staff to review calendar of implementation	*ITA*	*août-17*	Done	
						Anticipate any incidents and propose mitigating measure with R4 team	ITA	*déc-17*	*As of today no incidents arise*	

2.7.6 R6 ASSET MANAGEMENT

Risk Identification			Risk analysis			Risk Treatment			Follow-up of risk	
Description of Risk	Period of identification	Risk category	Probability	Potential Impact	Total	Action(s)	Resp.	Deadline	Progress	Status
High cost of maintenance of diverse non standardized medical equipments (management)	RBM Baseline	Efficiency	Medium	High	High Risk	Develop and enforce policy for equipment standardization	*MTI Div Mgr*	*Dec-17*	*In depth assessment completed*	*Not yet due On Track Late*
						Technical assistance to the Medical Technology and Infrastructure department for policy development	*ITA Biomed*	*Dec-17*	*Ongoing*	
						implement in depth study recommendation on standardization	*MTI Div Mgr*	*Dec-17*		
	RBM Baseline	Effectiveness	High	High		Establishment of strong pre-service and in-service training	*MTI Div Mgr*	*Dec-17*		*Not yet due*

Risk Identification			Risk analysis			Risk Treatment			Follow-up of risk	
Description of Risk	Period of identification	Risk category	Probability	Potential Impact	Total	Action(s)	Resp.	Deadline	Progress	Status
suboptimal care due to non functional medical equipment and inadequately maintained infrastructures					Very High Risk	for MTI and decentralized maintenance staff				
						decentralization of maintenance services: construction/renovation of 4 provincial maintenance workshops	*MTI Div Mgr*	*Jun-18*		
Insufficient coverage of DH maintenance workshops	RBM Baseline	Effectiveness	Medium	High	High Risk	Support MoH efforts for resource mobilization for this strategic investment area: ensure inclusion in HSSPIV	*ITA Biomed*	*Sep-17*		*On Track*
						construction of 4 provincial maintenance workshops	*MTI Div Mgr*	*Jun-18*		*On Track*
DH cannot get accredited if infrastructure and medical equipment standards are not included in the accreditation process and	RBM Baseline	Effectiveness	Medium	High	High Risk	Joint process with MOH Clin Serv and MTI to develop safe health design	*MTI Div Mgr*	*Mar-18*		*Not yet due*
						ensure adequate inclusion of infrastructure standards in the accreditation system	*MTI Div Mgr*	*Dec-17*		*Not yet due*
						development of norms and standards for infrastructure	*MTI Div Mgr*	*Mar-18*		Not yet due
high workload at MTI may delay implementation of plans	Start-up	Effectiveness	High	High	Very High Risk	assist MTI in completing all staffing recruitment (incl the one identifioed for UB funding)	*ITA Biomed Engr*	*Dec-17*		*Late*
						assist MTI Director Planning to ensure tasks and activities are propoerly delegated and implemented	*ITA Biomed Engr*	*Jun-18*		*On Track*

Risk Identification			Risk analysis			Risk Treatment			Follow-up of risk	
Description of Risk	Period of identification	Risk category	Probability	Potential Impact	Total	Action(s)	Resp.	Deadline	Progress	Status
						Assist in the development of MTI strategic plan that includes adequate institutional component (HR, procurement, finance, etc)	*ITA Biomed Engr*	*Jun-18*		*On Track*
						assist MTI in the final report approval for the in depth assessment to enable payment of due balances and closing of the contract	*ITA Biomed Engr*	*01/0!/2017*		*Late*
						assist in developing plan and implementating the relevant in depth assessment recommendations	*ITA Biomed Engr*	*Dec-17*		*Late*

3 Steering and Learning

3.1 Strategic re-orientations

RA	Strategic Orientation
R1 Quality Assurance	Accreditation agency will need some funding for it to operate in early stage, as an NGO. There is a need to mobilize funds and getting more competitive NGO
	Quality improvement project need more funds
R2 Mental Health	There is no strategic re-orientation related to the Mental Health Intervention. Decentralisation and integration of MH care in PHC made large strides and on-going strategies are contributing to strengthening the health system. Regarding the execution rate of certain activities, there is a need for corrective measures: • Better planning and close follow up of the planned activities by increasing coordination with Partners and stakeholders Submit practical measures to develop community rehabilitation programmes of chronic mentally ill which respect the financial procedures of UB and RBC There is a need to think about the support of community intervention
R3- Urban Health	Two major studies were planned: solid waste management and coverage plan HF for the CoK. For different reasons (ref to performance annual report) those output have been cancelled. To reach objectives and outcomes partially depending of those output (improved environmental health management and rationalized health facilities system in the CoK by integrated equitable and Sustainable services which are people centred) new strategies will be developed and implemented: • For environmental health, the CoK management will propose alternative activities in relation with waste management improvement and greening improvement of the city • For HF coverage, the CoK will: o Collaborate closely with Result 4 and will facilitate the collection of data o Develop the next health strategic plan including HF coverage plan by using the data collected
R4- Leadership and governance	Reference HSSP4, MoH needs to strengthen capacity building of decentralized level
R6 Asset Management	Division will if there is a need to do things differently, to change strategy in place?

3.2 Recommendations

Recommendations	Actor	Deadline
R1		
QI initiatives still need financial support to make them sustainable as they are still growing	UB SC	Q2
There is a need for high collaboration between DPs and other stakeholders supporting QI to ensure sustainability of the programme and hence patient centred	QSTWG	*Q1, Q2, Q3 and Q4*
Identify UB funding during budget revision for the accreditation agency to operate	UB SC	Q2
To improve on collaboration and communication on shared activities; approval process for the payments, and logistics for workshops and management of tenders	UB programme unit, MOH directorates, RBC divisions	Q2
R2		
- Simplify the administrative procedures and requirements - Update the implementers on the new procedures	*Finance Unite: RBC/SPIU+UB*	*Q1*
Reinforce the advocacy to Gasabo District for construction of Mental Health Treatment Day Centre	MoH; RBC; MHD; BTC	*Q1*
Improve the communication and follow up of tender proceeding	SPIU/procurement Unit + UB	*Q1*
R3		
CoK to propose operational plan on new activities related to environmental health	Director PH&Env Unit CoK	September 2017
CoK to submit detailed budget for developing the next health strategic plan	Director PH&Env Unit CoK	October 2017
Approval of operational plan for environmental health by CoK	CoK Executive committee	September 2017
Approval of detailed budget for developing the next health strategic plan by CoK	CoK Executive committee	October 2017
Approval of operational plan for environmental health by Programme coordination	SC	Q2 2017-2018
Approval of detailed budget for developing the next health strategic plan by Programme coordination	SC	Q2 2017-2018
R4		
Development of realistic operational plans (see SC decision)		
To select which councils to support (among the list at MoH)		
R6		
II MTI related activities requiring procurement/ consultancy, to have technical specifications/ToRs in quarter 1.	Director HTIP.	15th August, 2017.

Recommendations	Actor	Deadline
For any required technical support, the procurement team should request it 7 days before. This will allow the team to plan and act smoothly.	SPIU Procurement team.	NA.
MTI to submit the plan for each quarter, of the implementation of workshops-related activities to UB Coordination.	MTI Division manager.	15th august, 2017.
Clear policy and procedures for short courses conducted abroad for MTI, should be put in place.	MTI Division manager	Quarter 1.
A regular monitoring approach should be put in action.	UB Programme coordinator and Head BIOS.	Monthly

3.3 Lessons Learned

Lessons learned	Target audience
When an activity is cofounded by two or more partners, to put in place mechanism that allows to monitor the commitments of each to avoid delays or not achieving planned by both parties	UB IMPMENTORS
The use of IFMIS require a very careful planning to ensure effective implementation	
Avoid planning many activities in the last quarter of the FY as implementation becomes difficult due to the deadline of payment imposed by MINECOFIN	
Shared activities with other divisions are difficult to implement and require additional effort for successful implementation	
Mastering and be familiar with OB and UB procedures and FMIS tool facilitated to perform activities on time despite the long process and time consuming	Other components of the UB programme
Better planning, clear operational plan and weekly management meetings to follow up implementation of activities allowed better coordination and reaching high rate of execution this year	MHD + Other components of the UB programme
External factors could lead to unexpected delays and sometimes there is a need to ask for high level decision making. It is the case with Mental Health Treatment Day Centre	MoH, BTC, RBC, MHD

Lessons learned	Target audience
Organising regularly ad-hoc thematic TWGs involving stakeholders allowed to share information, prioritise actions, coordinate implementation of activities on time	MHD + Other components of the UB programme
R3-Urban Health	
During the planning process (TFF development) several events were not anticipated: The consequences of the change of modality (National Execution, e-procurement) that have led to reduced flexibility with many difficulties in terms of implementation and financing (delay, cancellation, loss of motivation, loss of time, etc.) The complexity of the intervention support for the R3 (many actors, several separate institutions, e.g. MOH, RBC, CoK, districts, etc.,) leading to lack of leadership and ownership The Baseline report with BTC format bringing ambiguity, mixing in terms of definition, output, outcome, etc. The true cost for several essential activities (hospital, medical equipment, medicalisation, digitalisation, study on waste management, on HF coverage) leading to high risk of cancellation, delay and/or poor quality of output	BTC HQ and representation
During the development of the CoK HNW, the exchanges between private and public health facilities are fruitful and both sectors showed high degree of motivation and interest (more than expected). This enthusiasm should push the MoH/Unit of policy and regulation to develop national policy and guideline for network	MoH-
R4- Leadership and Governance	
The budget revision process doesn't improve the budget execution when it about tenders as the PSM Plan is updated later alone (March)	Intervention-partner department
The implementation of activities during the last quarter of the FY is most of time jeopardized because of finances restrictions	Partner department
R6 – Asset Management	**Target audience**
On the side of activities involving procurement, some of them were not achieved due to delays in the process and steps. Specifications submitted late, Tenders cancelled in the last days due to non-compliance by the bidder, Evaluations delayed due non availability of technical staff and delay in communication, … Budget execution and activity should be closely monitored and improved.	MTI, Procurement team.
Low execution budget due to some over-budgeting during the planning session. Strong market survey and liaising with financial experts before and during the Planning process are required.	MTI/HTIP

Lessons learned	Target audience
Expect Delays in programme activities due to possibility of changing procurement methods (E-procurement) budget cuts, exchange rate.	UB programme management.
Focusing much on unplanned priorities led MTI to not work on their operational plan. The priority has to be given to annual operational and IMIHIGOs plans.	MTI Division manager, and Directors.
Delaying in initiating activities (Especially delays in providing technical specs) led to postponements and low budget execution rate. Postponement increases the likelihood for the activity to be not done or to be totally cancelled. Avoiding postponement as possible as we can, will be helpful towards the achievement of activities.	MTI Division manager.
Delays in starting the implementation of MTI work-improvement-related activities, due to difficulties in conceptualizing them.	Focus much on the operational plan and regular updates sharing on UB activities progress in each MTI management meeting.
Crosscutting lessons learnt	
On the side of activities involving procurement, some of them were not achieved due to delays in the process and steps. Specifications submitted late, Tenders cancelled in the last days due to non-compliance by the bidder, Evaluations delayed due non availability of technical staff and delay in communication,	All RA Initiating all procurement-related activities in the First quarter will be a good step towards the achievement.
Actions requiring consultations with stakeholders. Ex: Workshops, dissemination of technical information. Lack of action in first quarters led to not completing all the planned workshops and disseminations of the information from the achieved ones.	All RA Scheduling and monitoring of these activities, in the First three quarters will lead us to complete them all, and have approvals on time.
Capacity building initiatives. Some of the in-house and external trainings could not happen, because of late communication with Equipment manufacturers who had to provide trainings and procedural obstacles. Team work: Bank of specifications, call centre,...	

4 Annexes

4.1 Quality criteria

R1-Quality Assurance

1. RELEVANCE: The degree to which the intervention is in line with local and national policies and priorities as well as with the expectations of the beneficiaries		
In order to calculate the total score for this quality criterion, proceed as follows: 'At least one 'A', no 'C' or 'D' = A; Two times 'B' = B; At least one 'C', no 'D'= C; at least one 'D' = D		
Assessment RELEVANCE: total score	**A**	X
	B	
	C	
	D	
1.1 What is the present level of relevance of the intervention?		
X	A	Clearly still embedded in national policies and Belgian strategy, responds to aid effectiveness commitments, highly relevant to needs of target group.
...	B	Still fits well in national policies and Belgian strategy (without always being explicit), reasonably compatible with aid effectiveness commitments, relevant to target group's needs.
...	C	Some issues regarding consistency with national policies and Belgian strategy, aid effectiveness or relevance.
...	D	Contradictions with national policies and Belgian strategy, aid efficiency commitments; relevance to needs is questionable. Major adaptations needed.
1.2 As presently designed, is the intervention logic still holding true?		
	A	Clear and well-structured intervention logic, feasible and consistent vertical logic of objectives; adequate indicators; Risks and Assumptions clearly identified and managed; exit strategy in place (if applicable).
X	B	Adequate intervention logic although it might need some improvements regarding hierarchy of objectives, indicators, Risk and Assumptions.
	C	Problems with intervention logic may affect performance of intervention and capacity to monitor and evaluate progress; improvements necessary.
	D	Intervention logic is faulty and requires major revision for the intervention to have a chance of success.

2. EFFICIENCY OF IMPLEMENTATION TO DATE: Degree to which the resources of the intervention (funds, expertise, time, etc.) have been converted into results in an economical way		
In order to calculate the total score for this quality criterion, proceed as follows: 'At least two 'A', no 'C' or 'D' = A; Two times 'B', no 'C' or 'D' = B; at least one 'C', no 'D'= C; at least one 'D' = D		
Assessment EFFICIENCY : total score	**A**	
	B	
	C	X
	D	
2.1 How well were inputs (financial, HR, goods & equipment) managed?		
	A	All inputs were available on time and within budget.
X	B	Most inputs were available in reasonable time and do not require substantial budget adjustments. However, there is room for improvement.
	C	Availability and usage of inputs face problems, which need to be addressed; otherwise results may be at risk.

	D	Availability and management of inputs have serious deficiencies, which threaten the achievement of results. Substantial change is needed.
2.2 How well was the implementation of activities managed?		
	A	Activities implemented on schedule
	B	Most activities were on schedule. Delays exist, but do not harm the delivery of outputs
X	C	Activities were delayed. Corrections are necessary to deliver without too much delay.
	D	Serious delay. Outputs will not be delivered unless major changes in planning.
2.3 How well were outputs achieved?		
	A	All outputs have been and most likely will be delivered as scheduled with good quality contributing to outcomes as planned
	B	Output delivery is and will most likely be according to plan, but there is room for improvement in terms of quality, coverage and timing.
X	C	Some output were/will be not delivered on time or with good quality. Adjustments are necessary.
	D	Quality and delivery of outputs has and most likely will have serious deficiencies. Major adjustments are needed to ensure that at least the key outputs are delivered on time.

3. EFFECTIVENESS TO DATE: Degree to which the outcome (Specific Objective) is achieved as planned at the end of year N				
In order to calculate the total score for this quality criterion, proceed as follows: 'At least one 'A', no 'C' or 'D' = A; Two times 'B' = B; At least one 'C', no 'D'= C; at least one 'D' = D				
Assessment EFFECTIVENESS : total score	A	B	C	D
		X		
3.1 As presently implemented what is the likelihood of the outcome to be achieved?				
	A	Full achievement of the outcome is likely in terms of quality and coverage. Negative effects (if any) have been mitigated.		
X	B	Outcome will be achieved with minor limitations; negative effects (if any) have not caused much harm.		
	C	Outcome will be achieved only partially among others because of negative effects to which management was not able to fully adapt. Corrective measures have to be taken to improve ability to achieve outcome.		
	D	The intervention will not achieve its outcome unless major, fundamental measures are taken.		
3.2 Were activities and outputs adapted (when needed), in order to achieve the outcome?				
	A	The intervention is successful in adapting its strategies / activities and outputs to changing external conditions in order to achieve the outcome. Risks and assumptions are managed in a proactive manner.		
X	B	The intervention is relatively successful in adapting its strategies to changing external conditions in order to achieve its outcome. Risks management is rather passive.		
	C	The intervention has not entirely succeeded in adapting its strategies to changing external conditions in a timely or adequate manner. Risk management has been rather static. An important change in strategies is necessary in order to ensure the intervention can achieve its outcome.		
	D	The intervention has failed to respond to changing external conditions, risks were insufficiently managed. Major changes are needed to attain the outcome.		

4. POTENTIAL SUSTAINABILITY: The degree of likelihood to maintain and reproduce the benefits of an intervention in the long run (beyond the implementation period of the intervention).		
In order to calculate the total score for this quality criterion, proceed as follows: At least 3 'A's, no 'C' or 'D' = A ; Maximum two 'C's, no 'D' = B; At least three 'C's, no 'D' = C ; At least one 'D' = D		
Assessment POTENTIAL SUSTAINABILITY : total score		A / B / C / D: X
4.1 Financial/economic viability?		
	A	Financial/economic sustainability is potentially very good: costs for services and maintenance are covered or affordable; external factors will not change that.
X	B	Financial/economic sustainability is likely to be good, but problems might arise namely from changing external economic factors.
	C	Problems need to be addressed regarding financial sustainability either in terms of institutional or target groups costs or changing economic context.
	D	Financial/economic sustainability is very questionable unless major changes are made.
4.2 What is the level of ownership of the intervention by target groups and will it continue after the end of external support?		
X	A	The steering committee and other relevant local structures are strongly involved in all stages of implementation and are committed to continue producing and using results.
	B	Implementation is based in a good part on the steering committee and other relevant local structures, which are also somewhat involved in decision-making. Likeliness of sustainability is good, but there is room for improvement.
	C	The intervention uses mainly ad-hoc arrangements and the steering committee and other relevant local structures to ensure sustainability. Continued results are not guaranteed. Corrective measures are needed.
	D	The intervention depends completely on ad-hoc structures with no prospect of sustainability. Fundamental changes are needed to enable sustainability.
4.3 What is the level of policy support provided and the degree of interaction between intervention and policy level?		
	A	Policy and institutions have been highly supportive of intervention and will continue to be so.
X	B	Policy and policy enforcing institutions have been generally supportive, or at least have not hindered the intervention, and are likely to continue to be so.
	C	Intervention sustainability is limited due to lack of policy support. Corrective measures are needed.
	D	Policies have been and likely will be in contradiction with the intervention. Fundamental changes needed to make intervention sustainable.
4.4 How well is the intervention contributing to institutional and management capacity?		
X	A	Intervention is embedded in institutional structures and has contributed to improve the institutional and management capacity (even if this is not an explicit goal).
	B	Intervention management is well embedded in institutional structures and has somewhat contributed to capacity building. Additional expertise might be required. Improvements in order to guarantee sustainability are possible.
	C	Intervention relies too much on ad-hoc structures instead of institutions; capacity building has not been sufficient to fully ensure sustainability. Corrective measures are needed.
	D	Intervention is relying on ad hoc and capacity transfer to existing institutions, which could guarantee sustainability, is unlikely unless fundamental changes are undertaken.

R2-Mental Heath

1. RELEVANCE: The degree to which the intervention is in line with local and national policies and priorities as well as with the expectations of the beneficiaries					
In order to calculate the total score for this quality criterion, proceed as follows: 'At least one 'A', no 'C' or 'D' = A; Two times 'B' = B; At least one 'C', no 'D'= C; at least one 'D' = D					
Assessment RELEVANCE: total score		**A**	**B**	**C**	**D**
		X			
1.1 What is the present level of relevance of the intervention?					
X	A	Clearly still embedded in national policies and Belgian strategy, responds to aid effectiveness commitments, highly relevant to needs of target group.			
...	B	Still fits well in national policies and Belgian strategy (without always being explicit), reasonably compatible with aid effectiveness commitments, relevant to target group's needs.			
...	C	Some issues regarding consistency with national policies and Belgian strategy, aid effectiveness or relevance.			
...	D	Contradictions with national policies and Belgian strategy, aid efficiency commitments; relevance to needs is questionable. Major adaptations needed.			
1.2 As presently designed, is the intervention logic still holding true?					
X	A	Clear and well-structured intervention logic; feasible and consistent vertical logic of objectives; adequate indicators; Risks and Assumptions clearly identified and managed; exit strategy in place (if applicable).			
	B	Adequate intervention logic although it might need some improvements regarding hierarchy of objectives, indicators, Risk and Assumptions.			
	C	Problems with intervention logic may affect performance of intervention and capacity to monitor and evaluate progress; improvements necessary.			
	D	Intervention logic is faulty and requires major revision for the intervention to have a chance of success.			

Total score: A

The intervention is still relevant.

- Rwanda faces an exceptionally large burden of mental disorders and mental health problems that are the leading cause of disability in the country.
- Mental health is considered within the overall health sector policy as a priority area for intervention
- The intervention is performed within the institutional support framework and allows the Ministry of Health to implement the National Mental Health Policy across the country. The intervention particularly contributes to HSSPIII priorities through interventions such decentralization of mental health services through training, formative supervision and inclusion of mental health services in the package of care. (cfr HSSPIII priority No1 and 4)
- The intervention supports the process of decentralisation and integration mental health care at PHC aiming at providing comprehensive mental health care, the closest possible to the community.

Clear and well-structured intervention logic:

- The Intervention supports (is present at) all levels of the health system; the upper level of the system supervises the next level and each level of intervention is designed to support of the others.
- The intervention takes into account the context of the country especially the level of development, poverty and post-genocide period. The intervention has consequently been able to develop innovative interventions taking into account the context of low resources, for example by promoting the task-shifting in the decentralization of care and community approaches in dealing with the consequences of trauma, etc.
- The intervention adopts population-centered care approaches as recommended by HSSPIII and the reviewed National Health Policy

2. EFFICIENCY OF IMPLEMENTATION TO DATE: Degree to which the resources of the intervention (funds, expertise, time, etc.) have been converted into results in an economical way					
In order to calculate the total score for this quality criterion, proceed as follows: 'At least two 'A', no 'C' or 'D' = A; Two times 'B', no 'C' or 'D' = B; at least one 'C', no 'D'= C; at least one 'D' = D					
Assessment EFFICIENCY : total score		A	B	C	D
			X		
2.1 How well were inputs (financial, HR, goods & equipment) managed?					
	A	All inputs were available on time and within budget.			
X	B	Most inputs were available in reasonable time and do not require substantial budget adjustments. However there is room for improvement. Much discussions/debate on it where group oriented to B or C due to unachieved activities (delay of treatment day centre, EEG delivering and MH rehabilitation for mentally ill people)			
	C	Availability and usage of inputs face problems, which need to be addressed; otherwise results may be at risk.			
	D	Availability and management of inputs have serious deficiencies, which threaten the achievement of results. Substantial change is needed.			
2.2 How well was the implementation of activities managed?					
	A	Activities implemented on schedule			
X	B	Most activities were on schedule. Delays exist, but do not harm the delivery of outputs			
	C	Activities were delayed. Corrections are necessary to deliver without too much delay.			
	D	Serious delay. Outputs will not be delivered unless major changes in planning.			
2.3 How well were outputs achieved?					
	A	All outputs have been and most likely will be delivered as scheduled with good quality contributing to outcomes as planned.			
X	B	Output delivery is and will most likely be according to plan, but there is room for improvement in terms of quality, coverage and timing.			
	C	Some output were/will be not delivered on time or with good quality. Adjustments are necessary.			
	D	Quality and delivery of outputs has and most likely will have serious deficiencies. Major adjustments are needed to ensure that at least the key outputs are delivered on time.			

Total score: B

Resources provided through the UB Programme fully reinforce the objectives set by MoH to develop mental health in the country. The targets set were largely met :

- Training of General Nurses and their deployment in the Health Centers has reinforced the integration of mental health in PHC and increased accessibility for mental health care countrywide.
- Mental health Division/RBC managed to train and mentor staff at District level who in turn supervises health centers that provide services at lower levels and encourage Community Health Workers to provide community sensitization and early detection of symptoms and orientation patients for referral.
- Specialisation in Psychiatry was successfully launched by UR in Rwanda and up to now 10 students are enrolled in this programme among them three are expected to

be graduated in August 2017. A new cohort of 5 students was selected in April for the next academic year.

- There is joint planning process integrated at general planning of RBC

Because there is a delay in construction of Mental Health Day Treatment Center and difficulties to implement certain activities related to the psychosocial rehabilitation of chronic mentally ill, the criterion is graded "B"

3. EFFECTIVENESS TO DATE: Degree to which the outcome (Specific Objective) is achieved as planned at the end of year N				
In order to calculate the total score for this quality criterion, proceed as follows: 'At least one 'A', no 'C' or 'D' = A; Two times 'B' = B; At least one 'C', no 'D'= C; at least one 'D' = D				
Assessment EFFECTIVENESS : total score	A	B	C	D
	X			

3.1 As presently implemented what is the likelihood of the outcome to be achieved?		
	A	Full achievement of the outcome is likely in terms of quality and coverage. Negative effects (if any) have been mitigated.
X	B	Outcome will be achieved with minor limitations; negative effects (if any) have not caused much harm.
	C	Outcome will be achieved only partially among others because of negative effects to which management was not able to fully adapt. Corrective measures have to be taken to improve ability to achieve outcome.
	D	The intervention will not achieve its outcome unless major, fundamental measures are taken.
3.2 Were activities and outputs adapted (when needed), in order to achieve the outcome?		
X	A	The intervention is successful in adapting its strategies / activities and outputs to changing external conditions in order to achieve the outcome. Risks and assumptions are managed in a proactive manner.
	B	The intervention is relatively successful in adapting its strategies to changing external conditions in order to achieve its outcome. Risks management is rather passive.
	C	The intervention has not entirely succeeded in adapting its strategies to changing external conditions in a timely or adequate manner. Risk management has been rather static. An important change in strategies is necessary in order to ensure the intervention can achieve its outcome.
	D	The intervention has failed to respond to changing external conditions, risks were insufficiently managed. Major changes are needed to attain the outcome.

Total score: A

The planned activities are implemented to a large extent. The intervention does not face major difficulties. There is delay in construction of Mental Health Day Treatment Center and difficulties to implement certain activities related to the rehabilitation of chronic mentally ill, but Risks and assumptions are managed in a proactive manner. The criterion is graded A.

4. POTENTIAL SUSTAINABILITY: The degree of likelihood to maintain and reproduce the benefits of an intervention in the long run (beyond the implementation period of the intervention).		
In order to calculate the total score for this quality criterion, proceed as follows: At least 3 'A's, no 'C' or 'D' = A ; Maximum two 'C's, no 'D' = B; At least three 'C's, no 'D' = C ; At least one 'D' = D		
Assessment POTENTIAL SUSTAINABILITY : total score	A: X	B / C / D:
4.1 Financial/economic viability?		
	A	Financial/economic sustainability is potentially very good: costs for services and maintenance are covered or affordable; external factors will not change that.
X	B	Financial/economic sustainability is likely to be good, but problems might arise namely from changing external economic factors.
	C	Problems need to be addressed regarding financial sustainability either in terms of institutional or target groups costs or changing economic context.
	D	Financial/economic sustainability is very questionable unless major changes are made.
4.2 What is the level of ownership of the intervention by target groups and will it continue after the end of external support?		
X	A	The steering committee and other relevant local structures are strongly involved in all stages of implementation and are committed to continue producing and using results.
	B	Implementation is based in a good part on the steering committee and other relevant local structures, which are also somewhat involved in decision-making. Likeliness of sustainability is good, but there is room for improvement.
	C	The intervention uses mainly ad-hoc arrangements and the steering committee and other relevant local structures to ensure sustainability. Continued results are not guaranteed. Corrective measures are needed.
	D	The intervention depends completely on ad-hoc structures with no prospect of sustainability. Fundamental changes are needed to enable sustainability.
4.3 What is the level of policy support provided and the degree of interaction between intervention and policy level?		
X	A	Policy and institutions have been highly supportive of intervention and will continue to be so.
	B	Policy and policy enforcing institutions have been generally supportive, or at least have not hindered the intervention, and are likely to continue to be so.
	C	Intervention sustainability is limited due to lack of policy support. Corrective measures are needed
	D	Policies have been and likely will be in contradiction with the intervention. Fundamental changes needed to make intervention sustainable.
4.4 How well is the intervention contributing to institutional and management capacity?		
X	A	Intervention is embedded in institutional structures and has contributed to improve the institutional and management capacity (even if this is not an explicit goal).
	B	Intervention management is well embedded in institutional structures and has somewhat contributed to capacity building. Additional expertise might be required. Improvements in order to guarantee sustainability are possible.
	C	Intervention relies too much on ad-hoc structures instead of institutions; capacity building has not been sufficient to fully ensure sustainability. Corrective measures are needed.
	D	Intervention is relying on ad hoc and capacity transfer to existing institutions, which could guarantee sustainability, is unlikely unless fundamental changes are undertaken.

Total score: A

- In terms of its objectives, Mental Health Intervention is aligned with the National Mental health Policy and HSSP III
- Interventions provided within the previous phases of the MH Intervention are still on-going and services are still delivered for the population. Funding of decentralized mental health units is fully integrated in the budget of district hospitals (salaries of staff, purchase of psychotropic medicines, general means), and NOW provided by the Government. In addition, rehabilitated buildings are still used for mental health care and regularly maintained.
- All activities are fully implemented by RBC.
- The Mental Health Division, which the main mission is to implement the mental health policy, is now recognized and fully integrated in the organization chart of RBC. The Division has now more staff and has started receiving more significant budget from RBC to implement activities in the field.
- Finally, the anchorage of UB programme in the core of RBC/MoH as well as the close alignment to the HSSPIII provide strong basis for maximum sustainability of the Intervention.

R3-Urban Health

1. RELEVANCE: The degree to which the intervention is in line with local and national policies and priorities as well as with the expectations of the beneficiaries		
In order to calculate the total score for this quality criterion, proceed as follows: 'At least one 'A', no 'C' or 'D' = A; Two times 'B' = B; At least one 'C', no 'D'= C; at least one 'D' = D		
Assessment RELEVANCE: total score	A: X	B / C / D:
1.1 What is the present level of relevance of the intervention?		
X	A	Clearly still embedded in national policies and Belgian strategy, responds to aid effectiveness commitments, highly relevant to needs of target group.
...	B	Still fits well in national policies and Belgian strategy (without always being explicit), reasonably compatible with aid effectiveness commitments, relevant to target group's needs.
...	C	Some issues regarding consistency with national policies and Belgian strategy, aid effectiveness or relevance.
...	D	Contradictions with national policies and Belgian strategy, aid efficiency commitments; relevance to needs is questionable. Major adaptations needed.
1.2 As presently designed, is the intervention logic still holding true?		
	A	Clear and well-structured intervention logic; feasible and consistent vertical logic of objectives; adequate indicators; Risks and Assumptions clearly identified and managed; exit strategy in place (if applicable).
X	B	Adequate intervention logic although it might need some improvements regarding hierarchy of objectives, indicators, Risk and Assumptions.
	C	Problems with intervention logic may affect performance of intervention and capacity to monitor and evaluate progress; improvements necessary.
	D	Intervention logic is faulty and requires major revision for the intervention to have a chance of success.

2. EFFICIENCY OF IMPLEMENTATION TO DATE: Degree to which the resources of the intervention (funds, expertise, time, etc.) have been converted into results in an economical way		
In order to calculate the total score for this quality criterion, proceed as follows: 'At least two 'A', no 'C' or 'D' = A; Two times 'B', no 'C' or 'D' = B; at least one 'C', no 'D'= C; at least one 'D' = D		
Assessment EFFICIENCY : total score	A / B / C: X	D:
2.1 How well were inputs (financial, HR, goods & equipment) managed?		
	A	All inputs were available on time and within budget.
	B	Most inputs were available in reasonable time and do not require substantial budget adjustments. However there is room for improvement.
X	C	Availability and usage of inputs face problems, which need to be addressed; otherwise results may be at risk.
	D	Availability and management of inputs have serious deficiencies, which threaten the achievement of results. Substantial change is needed.
2.2 How well was the implementation of activities managed?		
	A	Activities implemented on schedule

	B	Most activities were on schedule. Delays exist, but do not harm the delivery of outputs
X	C	Activities were delayed. Corrections are necessary to deliver without too much delay.
	D	Serious delay. Outputs will not be delivered unless major changes in planning.
2.3 How well were outputs achieved?		
	A	All outputs have been and most likely will be delivered as scheduled with good quality contributing to outcomes as planned.
	B	Output delivery is and will most likely be according to plan, but there is room for improvement in terms of quality, coverage and timing.
X	C	Some output were/will be not delivered on time or with good quality. Adjustments are necessary.
	D	Quality and delivery of outputs has and most likely will have serious deficiencies. Major adjustments are needed to ensure that at least the key outputs are delivered on time.

3. EFFECTIVENESS TO DATE: Degree to which the outcome (Specific Objective) is achieved as planned at the end of year N				
In order to calculate the total score for this quality criterion, proceed as follows: 'At least one 'A', no 'C' or 'D' = A; Two times 'B' = B; At least one 'C', no 'D'= C; at least one 'D' = D				
Assessment EFFECTIVENESS : total score	A	B	C	D
		X		
3.1 As presently implemented what is the likelihood of the outcome to be achieved?				
	A	Full achievement of the outcome is likely in terms of quality and coverage. Negative effects (if any) have been mitigated.		
X	B	Outcome will be achieved with minor limitations; negative effects (if any) have not caused much harm.		
	C	Outcome will be achieved only partially among others because of negative effects to which management was not able to fully adapt. Corrective measures have to be taken to improve ability to achieve outcome.		
	D	The intervention will not achieve its outcome unless major, fundamental measures are taken.		
3.2 Were activities and outputs adapted (when needed), in order to achieve the outcome?				
	A	The intervention is successful in adapting its strategies / activities and outputs to changing external conditions in order to achieve the outcome. Risks and assumptions are managed in a proactive manner.		
X	B	The intervention is relatively successful in adapting its strategies to changing external conditions in order to achieve its outcome. Risks management is rather passive.		
	C	The intervention has not entirely succeeded in adapting its strategies to changing external conditions in a timely or adequate manner. Risk management has been rather static. An important change in strategies is necessary in order to ensure the intervention can achieve its outcome.		
	D	The intervention has failed to respond to changing external conditions, risks were insufficiently managed. Major changes are needed to attain the outcome.		

4. POTENTIAL SUSTAINABILITY: The degree of likelihood to maintain and reproduce the benefits of an intervention in the long run (beyond the implementation period of the intervention).
In order to calculate the total score for this quality criterion, proceed as follows: At least 3 'A's, no 'C' or 'D' = A ; Maximum two 'C's, no 'D' = B; At least three 'C's, no 'D' = C ; At least one 'D' = D

Assessment POTENTIAL SUSTAINABILITY : total score	A	B	C	D
			X	

4.1 Financial/economic viability?		
	A	Financial/economic sustainability is potentially very good: costs for services and maintenance are covered or affordable, external factors will not change that.
	B	Financial/economic sustainability is likely to be good, but problems might arise namely from changing external economic factors.
X	C	Problems need to be addressed regarding financial sustainability either in terms of institutional or target groups costs or changing economic context.
	D	Financial/economic sustainability is very questionable unless major changes are made.
4.2 What is the level of ownership of the intervention by target groups and will it continue after the end of external support?		
	A	The steering committee and other relevant local structures are strongly involved in all stages of implementation and are committed to continue producing and using results.
	B	Implementation is based in a good part on the steering committee and other relevant local structures, which are also somewhat involved in decision-making. Likeliness of sustainability is good, but there is room for improvement.
X	C	The intervention uses mainly ad-hoc arrangements and the steering committee and other relevant local structures to ensure sustainability. Continued results are not guaranteed. Corrective measures are needed.
	D	The intervention depends completely on ad-hoc structures with no prospect of sustainability. Fundamental changes are needed to enable sustainability.
4.3 What is the level of policy support provided and the degree of interaction between intervention and policy level?		
	A	Policy and institutions have been highly supportive of intervention and will continue to be so.
	B	Policy and policy enforcing institutions have been generally supportive, or at least have not hindered the intervention, and are likely to continue to be so.
X	C	Intervention sustainability is limited due to lack of policy support. Corrective measures are needed.
	D	Policies have been and likely will be in contradiction with the intervention. Fundamental changes needed to make intervention sustainable.
4.4 How well is the intervention contributing to institutional and management capacity?		
X	A	Intervention is embedded in institutional structures and has contributed to improve the institutional and management capacity (even if this is not an explicit goal).
	B	Intervention management is well embedded in institutional structures and has somewhat contributed to capacity building. Additional expertise might be required. Improvements in order to guarantee sustainability are possible.
	C	Intervention relies too much on ad-hoc structures instead of institutions; capacity building has not been sufficient to fully ensure sustainability. Corrective measures are needed.
	D	Intervention is relying on ad hoc and capacity transfer to existing institutions, which could guarantee sustainability, is unlikely unless fundamental changes are undertaken.

R4-Leadership and Governance

1. RELEVANCE: The degree to which the intervention is in line with local and national policies and priorities as well as with the expectations of the beneficiaries		
In order to calculate the total score for this quality criterion, proceed as follows: 'At least one 'A', no 'C' or 'D' = A; Two times 'B' = B; At least one 'C', no 'D'= C; at least one 'D' = D		
Assessment RELEVANCE: total score	A: X	B / C / D:
1.1 What is the present level of relevance of the intervention?		
X	A	Clearly still embedded in national policies and Belgian strategy, responds to aid effectiveness commitments, highly relevant to needs of target group.
...	B	Still fits well in national policies and Belgian strategy (without always being explicit), reasonably compatible with aid effectiveness commitments, relevant to target group's needs.
...	C	Some issues regarding consistency with national policies and Belgian strategy, aid effectiveness or relevance.
...	D	Contradictions with national policies and Belgian strategy, aid efficiency commitments; relevance to needs is questionable. Major adaptations needed.
1.2 As presently designed, is the intervention logic still holding true?		
	A	Clear and well-structured intervention logic; feasible and consistent vertical logic of objectives; adequate indicators; Risks and Assumptions clearly identified and managed; exit strategy in place (if applicable).
X	B	Adequate intervention logic although it might need some improvements regarding hierarchy of objectives, indicators, Risk and Assumptions.
	C	Problems with intervention logic may affect performance of intervention and capacity to monitor and evaluate progress; improvements necessary.
	D	Intervention logic is faulty and requires major revision for the intervention to have a chance of success.

2. EFFICIENCY OF IMPLEMENTATION TO DATE: Degree to which the resources of the intervention (funds, expertise, time, etc.) have been converted into results in an economical way		
In order to calculate the total score for this quality criterion, proceed as follows: 'At least two 'A', no 'C' or 'D' = A; Two times 'B', no 'C' or 'D' = B; at least one 'C', no 'D'= C; at least one 'D' = D		
Assessment EFFICIENCY : total score	A / B / C: X	D:
2.1 How well were inputs (financial, HR, goods & equipment) managed?		
	A	All inputs were available on time and within budget.
X	B	Most inputs were available in reasonable time and do not require substantial budget adjustments. However there is room for improvement.
	C	Availability and usage of inputs face problems, which need to be addressed, otherwise results may be at risk.
	D	Availability and management of inputs have serious deficiencies, which threaten the achievement of results. Substantial change is needed.
2.2 How well was the implementation of activities managed?		
	A	Activities implemented on schedule

	B	Most activities were on schedule. Delays exist, but do not harm the delivery of outputs
X	C	Activities were delayed. Corrections are necessary to deliver without too much delay.
	D	Serious delay. Outputs will not be delivered unless major changes in planning.
2.3 How well were outputs achieved?		
	A	All outputs have been and most likely will be delivered as scheduled with good quality contributing to outcomes as planned.
X	B	Output delivery is and will most likely be according to plan, but there is room for improvement in terms of quality, coverage and timing.
	C	Some output were/will be not delivered on time or with good quality. Adjustments are necessary.
	D	Quality and delivery of outputs has and most likely will have serious deficiencies. Major adjustments are needed to ensure that at least the key outputs are delivered on time.

3. EFFECTIVENESS TO DATE: Degree to which the outcome (Specific Objective) is achieved as planned at the end of year N				
In order to calculate the total score for this quality criterion, proceed as follows: 'At least one 'A', no 'C' or 'D' = A; Two times 'B' = B; At least one 'C', no 'D'= C; at least one 'D' = D				
Assessment EFFECTIVENESS : total score	A	B	C	D
	X			
3.1 As presently implemented what is the likelihood of the outcome to be achieved?				
	A	Full achievement of the outcome is likely in terms of quality and coverage. Negative effects (if any) have been mitigated.		
X	B	Outcome will be achieved with minor limitations; negative effects (if any) have not caused much harm.		
	C	Outcome will be achieved only partially among others because of negative effects to which management was not able to fully adapt. Corrective measures have to be taken to improve ability to achieve outcome.		
	D	The intervention will not achieve its outcome unless major, fundamental measures are taken.		
3.2 Were activities and outputs adapted (when needed), in order to achieve the outcome?				
X	A	The intervention is successful in adapting its strategies / activities and outputs to changing external conditions in order to achieve the outcome. Risks and assumptions are managed in a proactive manner.		
	B	The intervention is relatively successful in adapting its strategies to changing external conditions in order to achieve its outcome. Risks management is rather passive.		
	C	The intervention has not entirely succeeded in adapting its strategies to changing external conditions in a timely or adequate manner. Risk management has been rather static. An important change in strategies is necessary in order to ensure the intervention can achieve its outcome.		
	D	The intervention has failed to respond to changing external conditions, risks were insufficiently managed. Major changes are needed to attain the outcome.		

4. POTENTIAL SUSTAINABILITY: The degree of likelihood to maintain and reproduce the benefits of an intervention in the long run (beyond the implementation period of the intervention).
In order to calculate the total score for this quality criterion, proceed as follows: At least 3 'A's, no 'C' or 'D' = A ; Maximum two 'C's, no 'D' = B; At least three 'C's, no 'D' = C ; At least one 'D' = D

Assessment POTENTIAL SUSTAINABILITY : total score		A	B	C	D
			X		
4.1 Financial/economic viability?					
	A	Financial/economic sustainability is potentially very good: costs for services and maintenance are covered or affordable; external factors will not change that.			
X	B	Financial/economic sustainability is likely to be good, but problems might arise namely from changing external economic factors.			
	C	Problems need to be addressed regarding financial sustainability either in terms of institutional or target groups costs or changing economic context.			
	D	Financial/economic sustainability is very questionable unless major changes are made.			
4.2 What is the level of ownership of the intervention by target groups and will it continue after the end of external support?					
X	A	The steering committee and other relevant local structures are strongly involved in all stages of implementation and are committed to continue producing and using results.			
	B	Implementation is based in a good part on the steering committee and other relevant local structures, which are also somewhat involved in decision-making. Likeliness of sustainability is good, but there is room for improvement.			
	C	The intervention uses mainly ad-hoc arrangements and the steering committee and other relevant local structures to ensure sustainability. Continued results are not guaranteed. Corrective measures are needed.			
	D	The intervention depends completely on ad-hoc structures with no prospect of sustainability. Fundamental changes are needed to enable sustainability.			
4.3 What is the level of policy support provided and the degree of interaction between intervention and policy level?					
X	A	Policy and institutions have been highly supportive of intervention and will continue to be so.			
	B	Policy and policy enforcing institutions have been generally supportive, or at least have not hindered the intervention, and are likely to continue to be so.			
	C	Intervention sustainability is limited due to lack of policy support. Corrective measures are needed.			
	D	Policies have been and likely will be in contradiction with the intervention. Fundamental changes needed to make intervention sustainable.			
4.4 How well is the intervention contributing to institutional and management capacity?					
	A	Intervention is embedded in institutional structures and has contributed to improve the institutional and management capacity (even if this is not an explicit goal).			
X	B	Intervention management is well embedded in institutional structures and has somewhat contributed to capacity building. Additional expertise might be required. Improvements in order to guarantee sustainability are possible.			
	C	Intervention relies too much on ad-hoc structures instead of institutions; capacity building has not been sufficient to fully ensure sustainability. Corrective measures are needed.			
	D	Intervention is relying on ad hoc and capacity transfer to existing institutions, which could guarantee sustainability, is unlikely unless fundamental changes are undertaken.			

R6-Asset Management

1. RELEVANCE: The degree to which the intervention is in line with local and national policies and priorities as well as with the expectations of the beneficiaries		
In order to calculate the total score for this quality criterion, proceed as follows: 'At least one 'A', no 'C' or 'D' = A; Two times 'B' = B; At least one 'C', no 'D'= C; at least one 'D' = D		
Assessment RELEVANCE: total score		A / B / **X** C / D
1.1 What is the present level of relevance of the intervention?		
X	A	Clearly still embedded in national policies and Belgian strategy, responds to aid effectiveness commitments, highly relevant to needs of target group.
...	B	Still fits well in national policies and Belgian strategy (without always being explicit), reasonably compatible with aid effectiveness commitments, relevant to target group's needs.
...	C	Some issues regarding consistency with national policies and Belgian strategy, aid effectiveness or relevance.
...	D	Contradictions with national policies and Belgian strategy, aid efficiency commitments; relevance to needs is questionable. Major adaptations needed.
1.2 As presently designed, is the intervention logic still holding true?		
	A	Clear and well-structured intervention logic; feasible and consistent vertical logic of objectives; adequate indicators; Risks and Assumptions clearly identified and managed; exit strategy in place (if applicable).
	B	Adequate intervention logic although it might need some improvements regarding hierarchy of objectives, indicators, Risk and Assumptions.
X	C	Problems with intervention logic may affect performance of intervention and capacity to monitor and evaluate progress; improvements necessary.
	D	Intervention logic is faulty and requires major revision for the intervention to have a chance of success.

2. EFFICIENCY OF IMPLEMENTATION TO DATE: Degree to which the resources of the intervention (funds, expertise, time, etc.) have been converted into results in an economical way		
In order to calculate the total score for this quality criterion, proceed as follows: 'At least two 'A', no 'C' or 'D' = A; Two times 'B', no 'C' or 'D' = B; at least one 'C', no 'D'= C; at least one 'D' = D		
Assessment EFFICIENCY : total score		A / B / C / **X** D
2.1 How well were inputs (financial, HR, goods & equipment) managed?		
	A	All inputs were available on time and within budget.
	B	Most inputs were available in reasonable time and do not require substantial budget adjustments. However there is room for improvement.
X	C	Availability and usage of inputs face problems, which need to be addressed; otherwise results may be at risk.
	D	Availability and management of inputs have serious deficiencies, which threaten the achievement of results. Substantial change is needed.
2.2 How well was the implementation of activities managed?		
	A	Activities implemented on schedule

	B	Most activities were on schedule. Delays exist, but do not harm the delivery of outputs
	C	Activities were delayed. Corrections are necessary to deliver without too much delay.
X	D	Serious delay. Outputs will not be delivered unless major changes in planning.
2.3 How well were outputs achieved?		
	A	All outputs have been and most likely will be delivered as scheduled with good quality contributing to outcomes as planned.
	B	Output delivery is and will most likely be according to plan, but there is room for improvement in terms of quality, coverage and timing.
X	C	Some output were/will be not delivered on time or with good quality. Adjustments are necessary.
	D	Quality and delivery of outputs has and most likely will have serious deficiencies. Major adjustments are needed to ensure that at least the key outputs are delivered on time.

3. EFFECTIVENESS TO DATE: Degree to which the outcome (Specific Objective) is achieved as planned at the end of year N				
In order to calculate the total score for this quality criterion, proceed as follows: 'At least one 'A', no 'C' or 'D' = A; Two times 'B' = B; At least one 'C', no 'D'= C; at least one 'D' = D				
Assessment EFFECTIVENESS : total score	A	B	C	D
			X	
3.1 As presently implemented what is the likelihood of the outcome to be achieved?				
	A	Full achievement of the outcome is likely in terms of quality and coverage. Negative effects (if any) have been mitigated.		
	B	Outcome will be achieved with minor limitations; negative effects (if any) have not caused much harm.		
X	C	Outcome will be achieved only partially among others because of negative effects to which management was not able to fully adapt. Corrective measures have to be taken to improve ability to achieve outcome.		
	D	The intervention will not achieve its outcome unless major, fundamental measures are taken.		
3.2 Were activities and outputs adapted (when needed), in order to achieve the outcome?				
	A	The intervention is successful in adapting its strategies / activities and outputs to changing external conditions in order to achieve the outcome. Risks and assumptions are managed in a proactive manner.		
	B	The intervention is relatively successful in adapting its strategies to changing external conditions in order to achieve its outcome. Risks management is rather passive.		
X	C	The intervention has not entirely succeeded in adapting its strategies to changing external conditions in a timely or adequate manner. Risk management has been rather static. An important change in strategies is necessary in order to ensure the intervention can achieve its outcome.		
	D	The intervention has failed to respond to changing external conditions, risks were insufficiently managed. Major changes are needed to attain the outcome.		

4. POTENTIAL SUSTAINABILITY: The degree of likelihood to maintain and reproduce the benefits of an intervention in the long run (beyond the implementation period of the intervention).
In order to calculate the total score for this quality criterion, proceed as follows: At least 3 'A's, no 'C' or 'D' = A ; Maximum two 'C's, no 'D' = B; At least three 'C's, no 'D' = C ; At least one 'D' = D

Assessment POTENTIAL SUSTAINABILITY : total score		A	B	C	D
				X	
4.1 Financial/economic viability?					
	A	Financial/economic sustainability is potentially very good: costs for services and maintenance are covered or affordable; external factors will not change that.			
	B	Financial/economic sustainability is likely to be good, but problems might arise namely from changing external economic factors.			
X	C	Problems need to be addressed regarding financial sustainability either in terms of institutional or target groups costs or changing economic context.			
	D	Financial/economic sustainability is very questionable unless major changes are made.			
4.2 What is the level of ownership of the intervention by target groups and will it continue after the end of external support?					
	A	The steering committee and other relevant local structures are strongly involved in all stages of implementation and are committed to continue producing and using results.			
X	B	Implementation is based in a good part on the steering committee and other relevant local structures, which are also somewhat involved in decision-making. Likeliness of sustainability is good, but there is room for improvement.			
	C	The intervention uses mainly ad-hoc arrangements and the steering committee and other relevant local structures to ensure sustainability. Continued results are not guaranteed. Corrective measures are needed.			
	D	The intervention depends completely on ad-hoc structures with no prospect of sustainability. Fundamental changes are needed to enable sustainability.			
4.3 What is the level of policy support provided and the degree of interaction between intervention and policy level?					
	A	Policy and institutions have been highly supportive of intervention and will continue to be so.			
	B	Policy and policy enforcing institutions have been generally supportive, or at least have not hindered the intervention, and are likely to continue to be so.			
X	C	Intervention sustainability is limited due to lack of policy support. Corrective measures are needed.			
	D	Policies have been and likely will be in contradiction with the intervention. Fundamental changes needed to make intervention sustainable.			
4.4 How well is the intervention contributing to institutional and management capacity?					
	A	Intervention is embedded in institutional structures and has contributed to improve the institutional and management capacity (even if this is not an explicit goal).			
X	B	Intervention management is well embedded in institutional structures and has somewhat contributed to capacity building. Additional expertise might be required. Improvements in order to guarantee sustainability are possible.			
	C	Intervention relies too much on ad-hoc structures instead of institutions; capacity building has not been sufficient to fully ensure sustainability. Corrective measures are needed.			
	D	Intervention is relying on ad hoc and capacity transfer to existing institutions, which could guarantee sustainability, is unlikely unless fundamental changes are undertaken.			

4.2 Decisions taken by the steering committee and follow-up

Decision			Follow-up of decision		Actions needed to implement the decision (if any)				Follow-up of actions	
Decision	Date	Responsible	Progress	Status	Action	Organization in charge	Resp.	Deadline	Progress	Status
Presentation of the knowledge management strategy at the next steering committee	4-déc.-15	PGM COORD	SC informed of delay	Late	reflection meeting in communication with health coordination	PMU	PC	29/02/2016	ongoing review	Completed
			discussions ITA in view of BS workshop dec 2016		need support for from Karel BS to define options	PMU	PC	next BS	done in dec 2016	Completed
			discussion with Karel re options re scientific support		prepare concept to SC	PMU	PC	next SC	to be reviewed with DG planning	On Track
R6 MOH to validate the report of the "in-depth assessment on medical equipment, procurement and maintenance system and health infrastructure in the public sector in Rwanda" by 30/9/2016	26-août-16	R6 DM	document reviewed by ITA with summary findings	Late	validation workshop planned 18-19 Oct including devpt of implementation action plan	R6	SN	18_19 Oct	Report review done through 3 workshops and feedback requested to AMPC consultant	Still waiting for validated report
			no validation by MTI in due time		close follow up of contract management	R6	SN	Oct 2016	AMPC revised report was received on 27 March: validation by SMT + SMM due by end April 2017	Still waiting for validated report
R6 Adoption of action plan for the implementation of the recommendations of the "in-depth	26-août-16	R6 DM	Not yet.	Late	follow up workshop outputs to be brought to SMT and SMM	R6	SN OR	Oct 2016	A new set of comments were sent to AMPC on 22 May and response received on 14 June	Still waiting for validated report

Decision			Follow-up of decision		Actions needed to implement the decision (if any)				Follow-up of actions	
Decision	Date	Responsible	Progress	Status	Action	Organization in chargo	Resp.	Deadline	Progress	Status
assessment on medical equipment, procurement and maintenance system and health infrastructure in the public sector in Rwanda" by 30/11/2016									Waiting for final review by MTI	
R6 RBC/MTI to develop an interim national strategic plan for MTI (until 2018) by 31/03/2017 as recommended by in depth study; strategic plan to consider a proposal for decentralization of medical maintenance operations to provincial level (provincial workshop sites to be identified with clear description of tasks)	26-août-16	R6 DM	Not yet re 29/3 SC decision to update the existing document internally Waiting first validation of HACSAP MTI to provide roadmap by end July	Late	develop step/roadmap for strategic plan during validation workshop	R6	SN OR	Oct 2016	MTI not yet ready with TOR for external consultant, therefore SC decides that the update of the existing document will be done internally through a MTI workshop by mid-May for approval by SMT by end June	Strategic plan not yet developed during the reporting period
R6: Approval to use technical consultant to assist in the development of standards for health care infrastructure (Health centre, District	26 Aout 2016	R6 DM	Not yet draft available by R6 and R1 Activity to be joined with R1 and postponed to Q1 2017-18	Late	escalate issue to head of biomedical services and confirm relevance of activity as well	PMU	PC/DI	14/10/2016	Final draft done by 24 March, to be presented to SMT RBC for validation 1st week of April Still no progress by 30 June	ToRs drafted but not yet submitted to SPIU

Decision			Follow-up of decision		Actions needed to implement the decision (if any)				Follow-up of actions	
Decision	Date	Responsible	Progress	Status	Action	Organization in charge	Resp.	Deadline	Progress	Status
Hospital, Provincial Hospital, Referral Hospital). ToR to be approved by 30/09/2016					as inclusion in imihigo					
R6: Principle approval to establish a call centre for MTI (a full concept note with budget to be developed by end of October for validation).	26 Aout 2016	R6 DM	Ongoing discussion will be further discussed at validation workshop	Late	escalate issue to head of biomedical services and confirm relevance of activity as well as inclusion in imihigo	PMU	PC/DI	14/10/2016	TOR for call centre officer and technical specification finally transmitted to procurement on 20 June. MTI expecting to have call centre functioning July-Sept 2017.	ongoing
An analysis is made of the inclusion of the key programme activities in the institutional imihigos of the respective entities for the next steering committee	26 Aout 2016	DGPFHIS	to be further discussed with focal person	Late	Dr Turate cvommitted feedback on behalf of DG RBC by end June 2017	RBC	DDG IHDPC	30/06/2017	There is an ongoing discussion at RBC and MOH to develop performance based evaluation per Division/Directorates. Constructions are included in district imihigo (signature of construction contracts by 30/6/2017)	ongoing
Updated Decision 2/16: Each Division Manager/DG to select 2 to 3 indicators per results to be shared to SC for e-decision by end of May	29/03/2017	RBC DG		Late	Dr Turate committed feedback on behalf of DG RBC by end June 2018					

Decision			Follow-up of decision		Actions needed to implement the decision (if any)				Follow-up of actions	
Decision	Date	Responsible	Progress	Status	Action	Organization in charge	Resp.	Deadline	Progress	Status
The co-chair reminded that evidence of availability of ordinary budget for the completion of the works and procurement of goods is a condition for BTC no-objection for awarding the tenders. The Chair and the members took note of the remark.	1st November 2016	PMU	PMU to draft letter for PS to sign	On Track	Reminder letter sent to PS	PMU	PC	30/06/2017	RBC VAT budget in 2017-18 increased from 5 to 7 Bi RWF Letter sent waiting feedback	ongoing
R2 RBC/MHD to work on legal and budget status of the centre with all stakeholders including MIFOTRA and MINECOFIN to secure Ordinary Budget for 2018-19 and present proposal and address sustainability conditions in next SC meeting	29/03/2017	R2 DM	Ongoing - As the Day Treatment Centre is considered a National Referral MH structure, it will be functioning according to the national standards for national referral health facilities in terms of HR and running budget. As MoH/Clinical Services is the one in charge of	On Track	need follow up meeting MOH Clin Serv and RBC/MHD	R2	ITA	31/07/2017	The planned budget for MH DAY CARE Center has been allocated to Nyarugenge District Hospital. Discussion on its construction by the Government using ordinary budget is ongoing	Under discussion

Decision			Follow-up of decision		Actions needed to implement the decision (if any)				Follow-up of actions	
Decision	Date	Responsible	Progress	Status	Action	Organization in charge	Resp.	Deadline	Progress	Status
			health facilities, discussion with them is scheduled to determine the structure of the centre							
R2 Recommendation: National Mental Health Treatment Centre construction contract must be signed by 15th October 2017	29/03/2017	ES	• New plot identified and communicated to MOH while some technical clarifications are expected from Gasabo District and CoK One Stop Centre • The construction has a significant delay due to repeated change of plot	Late	follow up new plot allocation and response from District Concerns on the suitability of new plot!	PMU	PC	31/07/2017	The planned budget for MH DAY CARE Center has been allocated to Nyarugenge District Hospital. Discussion on its construction by the Government using ordinary budget is ongoing	Under discussion
Need to speed up finalization of design, procurement process of construction, purchase of equipment and recruitment of staff	29/03/2017		on hold due to recurrent change of plot location							

Decision			Follow-up of decision		Actions needed to implement the decision (if any)				Follow-up of actions	
Decision	Date	Responsible	Progress	Status	Action	Organization in charge	Resp.	Deadline	Progress	Status
R4 Focal Person Planning to present roadmap for implementation of activities including next District Health Strategic Plan support activities for fiscal year 2017-18 by beginning of June 2017	29/03/2017	R4 FP	in process	On Track	follow up meeting with Gervais on 18/7/17	PMU	PO	18/07/2017	Not possible to nominate focal point. All staff are involved in the program implementation	
R4 DG Planning to develop action research implementation plan linked to Quality Improvement initiatives by end of April and to present the progress to next SC	29/03/2017	R4 DG	Revised plan is under finalization due end of June	On Track	follow up meeting with DG Parfait	PMU	PC	31/07/2017	Still under discussion. All result AREA received template to identified and submit their needs in order to continue their prpo	Still under discussion
R6 MTI focal person to present roadmap to implement all activities including strategic improvement projects for 2017-18 by end of April 2017 during UB monthly meeting	29/03/2017	R6 FP	In process – to be presented in July UB coordination meeting	On Track					Not yet submitted due to other duties	Not done
R6 MTI with support from RBC/PMEBS and RBC/SPIU/UB to develop business plans for provincial workshops to be	29/03/2017	R6 DM	meeting planned in June Business plan to be presented to RBC/SMT by 30 July	On Track	Need follow up meeting in July	R6	DM	31/07/2017	Some discussions MTI and RBC/PMEB started budt didn't conclude to something tangible.	Ongoing

Decision			Follow-up of decision		Actions needed to implement the decision (if any)				Follow-up of actions	
Decision	Date	Responsible	Progress	Status	Action	Organization in charge	Resp.	Deadline	Progress	Status
functional and self-sustained and present to the next SC										
R6 selection and admissions of Master's degree students to be finalized by 15 May by RBC– report to be presented during UB monthly meeting	29/03/2017	R6 DM	Selected names transmitted Waiting for final selection by RBC education committee	On Track	Need follow up with DG RBC	R6	DM	18/07/2017	Candidates were selected and are waiting for official authorit	
R6 Approval to increase number of Master degree students from 1 to 3 in order to increase critical mass of expertise within MTI Need to assess option of doing a Master programme in sandwich vs full time training to present to DG RBC for validation for SC e-decision	POSTPONED	R6 DM	No sandwich programme available Waiting for final selection by RBC education committee: HOD BIOS and HOD IHDPC to engage education committee members for final completion of this process before 15 July	On Track	Need follow up with DG RBC	R7	DM	18/07/2017		
Programme Management: UB Programme will present the matrix and updates in indicators of the programme at the	29/03/2017	UB	annual report will include those and will be presented to next fiscal year SC	On Track					Done	Done

Decision			Follow-up of decision		Actions needed to implement the decision (if any)				Follow-up of actions	
Decision	Date	Responsible	Progress	Status	Action	Organization in charge	Resp.	Deadline	Progress	Status
end of fiscal year to the first SC of next fiscal year										
R1 - Quality improvement initiatives: MoH to provide approved ToRs for the request of 5 District Hospitals to develop a software for medical records, aligned with MOH policy, by June 30, 2017	20/06/2017	R1 DG	EXPECTED NEXT QUARTER		meeting DG Clin services for follow up	R1	PC	15 July 2017	A list of needed equipment's has been availed for an amount of 200,000,000 Discussions are underway inorder to reduce the quantity or start with with few hospital	Under discussion
R1/R3 - Concept note on 'national patient satisfaction survey': A technical team (RBC, MoH-Clinical Services, UB) to meet by June 30, 2017 to finalize the Concept Note for presentation to MOH senior management to obtain guidance and a decision by July 15, 2017 at the latest.	20/06/2017	R1 DG	draft concept with DG for discussion with senior management		meeting DG Clin services for follow up	R²	PC	15 July 2017	Discussions are in process with Clinical Service to see which methodology could be used.	ongoing
R1 - Comprehensive accreditation strategy and related action plan: Clinical	20/06/2017	R1 DG	EXPECTED NEXT QUARTER		Contact Edward to prepare the document	R1	PC	15 July 2017		

Decision			Follow-up of decision		Actions needed to implement the decision (if any)				Follow-up of actions	
Decision	Date	Responsible	Progress	Status	Action	Organization in charge	Resp.	Deadline	Progress	Status
services to present it at the next steering committee meeting.										
R2 - Alternative strategy for MH community-based initiatives: MHD will present an alternative to the initial proposal (the one aiming to fund one NGO in Musanze) by identifying other community rehabilitation initiatives (MHD feedback to UB programme management by June 30, 2017)	20/06/2017	R2 DM			Assist MHD to prepare document	R2	ITA	30 June 2017	Mental Health Divison is planning to transfer money to District Hospitals instead of NGOs or associaltions but needs to be present to the SCs	Under preparation
R2 - Future Mental Health Day Centre: DG MoH/CS to lead the discussion around the establishment of the structure, the embedding in the global Health system and the functioning of the centre	20/06/2017	MOH CLIN SERV			meeting MHD and Clin services to ensure the process is engaged	R2	ITA		Not yet done	Not yet done
R3 - Hospital networking: RBC/SPIU and UB to	20/06/2017	RBC/SPIU			RBC/SPIU Coordinator to seek	RBC/SPIU Coord	RBC/SPIU Coord	15 July	Not yet done	Not yet done

Decision			Follow-up of decision		Actions needed to implement the decision (if any)				Follow-up of actions	
Decision	Date	Responsible	Progress	Status	Action	Organization In charge	Resp.	Deadline	Progress	Status
revise the concept note to seek confirmation from PS-MoH by July 15, 2017 on the option to bring international consultants to mentor the development of hospital networking in Rwanda					appointmnet with PS					
R3 - Urban health: to present by October 2017 (during budget revision exercise) all activities that will need budget reallocation	20/06/2017	R3 DG			UB to meet with Clin serv and CoK	R3	ITA	October 2017	Ongoing. The budget revision is expected in October 2017	Ongoing
R6 - Study 'In-depth assessment funded' by PAREC: MTI to ensure final validation of the report by 15 July 2017 latest as the contract is expired, the process has been much delayed and PAREC fund is in its closure phase.	20/06/2017	R6 DM			Final review meeting planned end June	R6	ITA	15July 2017	Meeting postponed twice	
All results: to Present 'Physical progress' of UB Programme in next Steering Committee	20/06/2017	PMU			All divisions to prepare information during annual report	PMU	PC			

4.3 Updated Logical framework

No significant changes

4.4 MoRe Results at a glance

Logical framework's results or indicators modified in last 12 months?	NA
Baseline Report registered on PIT?	yes
Planning MTR (registration of report)	October 2017
Planning ETR (registration of report)	November 2019
Backstopping missions since 01/01/2016	July 2016

4.5 "Budget versus current (y – m)" Report

Included (point 1.2)

4.6 Communication resources

NA – planned for next year

Budget vs Actuals (Year to Date) of RWA1309211

Project Title : **Improving the quality of health care and services**
Ubuzima Burambye

Budget Version: **E01**
Currency : EUR
YtD : **Report includes all valid transactions, registered up to today**

	Status	Fin Mode	Amount	Start - 2016	Expenses 2017	Total	Balance	% Exec
A PEOPLE-CENTERED, INTEGRATED AND SUSTAINABLE HEALTH			15.291.290,00	1.020.359,40	963.233,06	1.983.592,45	13.307.687,55	13%
01 The quality assurance system is set up and integrated and			1.450.500,00	80.638,21	98.786,44	179.424,65	1.271.075,35	12%
01 Progress towards the creation of an autonomous accreditation		COGES	0,00	0,00	0,00	0,00	0,00	?%
02 Update & disseminate norms, standards and models (MOH)		COGES	95.000,00	29.177,69	14.449,59	43.627,28	51.372,72	46%
03 Facilitate and implement the accreditation process at all		COGES	283.500,00	47.004,38	52.512,87	99.517,25	183.982,75	35%
04 Finance people-centered improvement projects		COGES	1.000.000,00	0,00	17.497,89	17.497,89	982.502,11	2%
05 Medium term technical assistance in accreditation, quality		REGIE	0,00	0,00	0,00	0,00	0,00	?%
06 National long term technical assistance in accreditation, quality		COGES	72.000,00	4.456,14	14.326,09	18.782,23	53.217,77	26%
02 The mental health services are accessible from the			3.167.200,00	355.030,06	424.363,27	779.393,33	2.387.806,67	25%
01 Strengthen community interventions on mental health		COGES	250.000,00	19.315,45	53.628,76	72.944,21	177.055,79	29%
02 Consolidate Mental Health Care Services & a people-centred		COGES	1.865.200,00	48.992,21	158.622,34	207.614,55	1.657.585,45	11%
03 Develop multidisciplinary strategies and actions with regard to		COGES	390.000,00	53.833,99	95.416,91	149.250,90	240.749,10	38%
04 Long term technical assistance in mental health and people		REGIE	440.000,00	209.729,66	75.558,98	285.288,64	154.711,36	65%
05 National long term technical assistance in mental health and		COGES	72.000,00	4.882,29	10.357,47	15.239,76	56.760,24	21%
06 Scholarship for training in psychiatry in Belgium		REGIE	150.000,00	18.276,46	30.778,81	49.055,27	100.944,73	33%
03 The urban health service coverage is rationalized and			6.348.000,00	162.194,22	178.935,79	341.130,01	6.006.869,99	5%
01 Develop promotional activities on social determinants of health		COGES	110.000,00	7.709,56	11.554,50	19.264,06	90.735,94	18%
02 Develop and validate a sound concept and equitable coverage		COGES	82.000,00	5.604,66	20.552,48	26.157,14	55.842,86	32%
03 Support the implementation of the coverage plan through		COGES	300.000,00	0,00	0,00	0,00	300.000,00	0%
04 Create a functional, autonomous and efficient hospital network		COGES	318.200,00	0,00	11.346,05	11.346,05	306.853,95	4%
05 Design, build and equip a 300 beds Hospital in Kicukiro District		COGES	4.777.800,00	13.947,77	56.909,28	70.857,05	4.706.942,95	1%
06 Long term technical assistance in public health, hospital		REGIE	688.000,00	127.955,65	68.216,01	196.171,66	491.828,34	29%
		REGIE	4.091.000,00	1.010.443,25	442.081,04	1.452.524,29	2.638.475,71	36%
		COGEST	13.909.000,00	601.547,79	756.465,37	1.358.013,16	12.550.986,84	10%
		TOTAL	18.000.000,00	1.611.991,04	1.198.546,41	2.810.537,45	15.189.462,55	16%

Budget vs Actuals (Year to Date) of RWA1309211

Project Title : **Improving the quality of health care and services**
Ubuzima Burambye

Budget Version: **E01**
Currency : EUR
YtD : **Report includes all valid transactions, registered up to today**

	Status	Fin Mode	Amount	Start - 2016	Expenses 2017	Total	Balance	% Exec
07 National long term technical assistant in public health, hospital		COGES	72.000,00	6.976,58	**10.357,47**	17.334,05	54.665,95	24%
04 The leadership and governance is reinforced, specifically			1.213.000,00	183.675,45	**77.728,09**	261.403,54	951.596,46	22%
01 Strengthen stewardship capacities at the level of the local		COGES	1.060.000,00	164.428,76	**54.875,34**	219.304,10	840.695,90	21%
02 Provide support to MoH and RBC with regard to their respective		COGES	90.000,00	19.246,69	**22.852,75**	42.099,44	47.900,56	47%
03 Long term technical assistance in (district) capacity building		REGIE	0,00	0,00	**0,00**	0,00	0,00	?%
04 National long term technical assistance in (district) capacity		COGES	63.000,00	0,00	**0,00**	0,00	63.000,00	0%
05 Data are generated, analysed and used for evidence-based			15.500,00	15.737,79	**0,00**	15.737,79	-237,79	102%
01 Assure the integration of different systems of information and		COGES	3.500,00	3.473,70	**0,00**	3.473,70	26,30	99%
02 Assure the production of quality data		COGES	0,00	0,00	**0,00**	0,00	0,00	?%
03 Develop strategies for effective utilization of data for monitoring,		COGES	0,00	0,00	**0,00**	0,00	0,00	?%
04 Long term technical assistance in HMIS development and M&E		REGIE	12.000,00	12.264,09	**0,00**	12.264,09	-264,09	102%
06 An asset management system is designed and operational in			3.097.000,00	223.083,87	**183.419,46**	406.503,13	2.690.496,87	13%
01 Develop, validate and disseminate policies, technical standards		COGES	66.000,00	4.876,09	**6.071,25**	10.947,34	55.052,66	17%
02 Develop a functional procurement & maintenance system at		COGES	578.000,00	4.945,89	**33.971,21**	38.917,10	539.082,90	7%
03 Develop a waste management policy, strategy and baseline		COGES	0,00	0,00	**0,00**	0,00	0,00	?%
04 Finance strategic improvement projects with impact on the		COGES	1.100.000,00	147,01	**34.387,18**	34.534,19	1.065.465,81	3%
05 Develop domestic human capacity with regard to asset		COGES	465.000,00	21.108,42	**38.987,10**	60.095,52	404.904,48	13%
06 Long term technical assistance in maintenance of biomedical		REGIE	816.000,00	192.006,26	**66.786,54**	258.792,80	557.207,20	32%
07 National long term technical assistance in maintenance of		COGES	72.000,00	0,00	**3.216,18**	3.216,18	68.783,82	4%
X CONTINGENCY			300.000,00	0,00	**0,00**	0,00	300.000,00	0%
01 Contingency			300.000,00	0,00	**0,00**	0,00	300.000,00	0%
01 contingency CO-MANAGEMENT		COGES	250.000,00	0,00	**0,00**	0,00	250.000,00	0%
		REGIE	4.091.000,00	1.010.443,25	**442.081,04**	1.452.524,29	2.638.475,71	36%
		COGEST	13.909.000,00	601.547,79	**756.465,37**	1.358.013,16	12.550.986,84	10%
		TOTAL	18.000.000,00	1.611.991,04	**1.198.546,41**	2.810.537,45	15.189.462,55	16%

Budget vs Actuals (Year to Date) of RWA1309211

Project Title : **Improving the quality of health care and services**
Ubuzima Burambye

Budget Version: **E01**
Currency : EUR
YtD : **Report includes all valid transactions, registered up to today**

	Status	Fin Mode	Amount	Start - 2016	Expenses 2017	Total	Balance	% Exec
02 Contingency BTC-management		REGIE	50.000,00	0,00	**0,00**	0,00	50.000,00	0%
2 GENERAL MEANS			2.408.800,00	591.631,84	**235.310,36**	826.945,00	1.581.855,00	34%
01 Personnel costs			1.416.800,00	406.559,98	**181.345,72**	587.905,70	828.894,30	41%
01 ITA Public Health – Program Coordinator (co-manager)		REGIE	720.000,00	243.370,14	**79.479,42**	322.849,56	397.150,44	45%
02 Program manager		COGES	72.000,00	0,00	**0,00**	0,00	72.000,00	0%
03 Finance and admin team		COGES	334.800,00	107.330,70	**46.611,81**	153.942,51	180.857,49	46%
04 Technical team		COGES	0,00	0,00	**0,00**	0,00	0,00	?%
05 RAFi / PFM expert		REGIE	270.000,00	54.446,78	**51.290,29**	105.737,07	164.262,93	39%
06 BTC Driver		REGIE	20.000,00	1.412,36	**3.964,20**	5.376,56	14.623,44	27%
02 Investments			55.000,00	15.713,49	**17.298,19**	33.011,68	21.988,32	60%
01 cars		REGIE	0,00	0,00	**0,00**	0,00	0,00	?%
02 Office equipment		REGIE	25.000,00	1.800,00	**1.484,05**	3.284,05	21.715,95	13%
03 IT equipment		REGIE	30.000,00	13.913,49	**15.814,14**	29.727,63	272,37	99%
04 Office refurnising		REGIE	0,00	0,00	**0,00**	0,00	0,00	?%
03 Functional costs			347.000,00	106.145,19	**21.948,81**	128.094,00	218.906,00	37%
01 Functioning costs cars		REGIE	60.000,00	22.342,20	**14.589,70**	36.931,90	23.068,10	62%
02 Tele communication		REGIE	40.000,00	10.138,08	**7.238,05**	17.376,13	22.623,87	43%
03 Office material		REGIE	10.000,00	584,70	**706,36**	1.291,06	8.708,94	13%
04 Missions		REGIE	30.000,00	6.142,74	**6.173,93**	12.316,67	17.683,33	41%
05 Representation costs and external communication		REGIE	40.000,00	0,00	**0,00**	0,00	40.000,00	0%
06 Training (including on HIV workplace policy)		REGIE	40.000,00	7.663,37	**113,06**	7.776,43	32.223,57	19%
07 Consultancy costs - PFM support		REGIE	48.000,00	21.188,46	**0,00**	21.188,46	26.811,54	44%
		REGIE	4.091.000,00	1.010.443,25	**442.081,04**	1.452.524,29	2.638.475,71	36%
		COGEST	13.909.000,00	601.547,79	**756.465,37**	1.358.013,16	12.550.986,84	10%
		TOTAL	18.000.000,00	1.611.991,04	**1.198.546,41**	2.810.537,45	15.189.462,55	16%

Budget vs Actuals (Year to Date) of RWA1309211

Project Title : **Improving the quality of health care and services**
Ubuzima Burambye

Budget Version: **E01**
Currency : EUR
YtD : **Report includes all valid transactions, registered up to today**

	Status	Fin Mode	Amount	Start - 2016	Expenses 2017	Total	Balance	% Exec
08 Financial transaction costs		REGIE	2.000,00	87,91	**37,40**	125,31	1.874,69	6%
09 Costs VAT		REGIE	0,00	2.308,95	**3.216,88**	5.525,83	-5.525,83	?%
10 Other functioning costs		REGIE	10.000,00	1.598,97	**1.912,58**	3.511,55	6.488,45	35%
11 Cost VAT		COGES	0,00	22.186,19	**-16.646,21**	5.539,98	-5.539,98	?%
12 Financial transaction costs		COGES	3.000,00	147,78	**76,80**	224,58	2.775,42	7%
13 Workshops and meeting		COGES	24.000,00	1.583,48	**2.413,82**	3.997,30	20.002,70	17%
14 Offie materials & services		COGES	40.000,00	10.172,36	**2.116,44**	12.288,80	27.711,20	31%
04 Audit, monitoring and evaluation			590.000,00	63.212,98	**14.720,64**	77.939,62	512.066,38	13%
01 M&E costs (baseline, 1 EMP + 1 EF)		REGIE	130.000,00	3.940,00	**0,00**	3.940,00	126.060,00	3%
02 Audit		REGIE	50.000,00	0,00	**0,00**	0,00	50.000,00	0%
03 Capitalisation		REGIE	40.000,00	0,00	**0,00**	0,00	40.000,00	0%
04 Backstopping expert department BTC		REGIE	25.000,00	22.270,69	**0,00**	22.270,69	2.729,31	89%
05 Scientific support		REGIE	200.000,00	0,00	**9.129,09**	9.129,09	190.870,91	5%
06 QA procurement medicines (membership Quamed platform)		REGIE	45.000,00	0,00	**0,00**	0,00	45.000,00	0%
07 Technical & Procurement support for constructions		REGIE	100.000,00	37.002,29	**5.591,55**	42.593,84	57.406,16	43%
99 Conversion rate adjustment								0%
		REGIE	4.091.000,00	1.010.443,25	**442.081,04**	1.452.524,29	2.638.475,71	36%
		COGEST	13.909.000,00	601.547,79	**756.465,37**	1.358.013,16	12.550.986,84	10%
		TOTAL	18.000.000,00	1.611.991,04	**1.198.546,41**	2.810.537,45	15.189.462,55	16%