REPUBLIC OF RWANDA

MINISTRY OF HEALTH

Enabel

RESULTS REPORT

2017 - 2018

UBUZIMA BURAMBYE PROGRAM

(LONG HEALTHY LIFE)

RWA1309211

Non Communicable Diseases mass Campaign – Kigali May 2018

July 2018

Belgian development agency

enabel.be

TABLE OF CONTENTS

ANC	Ante Natal Care/Clinic
BMETs	Biomedical Equipment Technicians
CDPF	Capacity Development Pooled Fund
CHAI	Clinton health Access Initiative
CoK	City of Kigali
DH	District Hospital
DHS	Demographic and Health Survey
DHSP	District Health Strategic Plan
DHU	District Health Unit
DPs	Development Partners
e-LMIS	electronic-Logistic Management Information System
EMR	Electronic Medical Record
Enabel	The Belgian development agency
GBV	Gender Based Violence
GoR	Government of Rwanda
HCs	Health Centers
HFs	Health Facilities
HMIS	Health Monitoring Information System
HNW	Hospital Net Work
HIS	Health Information System
HSSP	Health Sector Strategic Plan
HSWG	Health Sector Working Group
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
ITA	International technical Advisor
JHSR	Joint Health Sector review
JHSS	Joint Health Sector Support

MH(D)	Mental Health (Division)
M&E	Monitoring and Evaluation
MEMMS	Medical Equipment Maintenance Management System
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
NCD	Non Communicable Diseases
NDH	Nyarugenge District Hospital
NEX	National Execution
NTA	National Technical Assistant
QA	Quality Assurance
RA	Result Area
RBC	Rwanda Biomedical Center
RBM	Result Based Management
RDB	Rwanda Development Board
RHAO	Rwanda Health Accreditation Organization
SC	Steering Committee
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
UB	Ubuzima Burambye

1 INTERVENTION AT A GLANCE

1.1 INTERVENTION FORM

Intervention title	UBUZIMA BURAMBYE PROGRAM
Intervention code	RWA 1309211
Location	RWANDA
Total budget	€ 18 000 000
Partner Institution	MINISTRY OF HEALTH
Start date Specific Agreement	30 June 2015
Date intervention start /Opening steering committee	4 December 2015
Planned end date of execution period	3 December 2019
End date Specific Agreement	29 June 2020
Target groups	Rwandan population, health professionals
Impact*1*	Strengthening the quality of primary health care and health services in Rwanda
Outcome	A people-centered, integrated and sustainable health care system with quality essential health care services as close to the community as possible has been reinforced
Outputs	R1. The quality assurance system is set up and integrated and functional at the level of all hospitals
	R2. The mental health services are accessible at the community level up to the national level in a sustainable way
	R3. The urban health service coverage is rationalized and extended in line with the three guiding principles of the National Health Sector Policy
	R4. The leadership and governance is reinforced, specifically regarding district stewardship, the respective roles of the MoH and RBC and the public private partnership
	~~R5. Data are generated, analysed and used for evidence based decision-making in a more correct, integrated, systematic, accessible and effective way~~*
	R6. The asset management system is designed and operational in a cost-effective way
Year covered by the report	1 July 2017 – 30 June 2018

* This result area was later abandoned (R5) due to overall budget cut from 21Mi to 18 Mi

[1] Impact refers to global objective, Outcome refers to specific objective, output refers to expected result

1.2 CUMULATIVE BUDGET EXECUTION (EUROS) – INCLUDING REGIE

	Budget	Expenditure			Balance	Disbursement rate at the end of year 2017-18
		Previous years 2015-16	Previous years 2016-17	Year covered by this report (2017-18)		
Result 1	950,500	46,838	132,586	189,267	581,809	39%
Result 2	2,074,200	175,368	604,025	505,570	789,237	62%
Result 3	8,441,000	71,490	269,640	1,352,762	6,747,108	20%
Result 4	1,150,000	51,924	209,480	249,146	639,450	44%
Result 5	15,500	15,657	81	-	-238	102%
Result 6	2,660,000	130,368	276,135	475,924	1,777,573	33%
Admin& Support	2,708,800	349,944	477,001	223,107	1,658,748	39%
Total	**18,000,000**	**841,589**	**1,968,948**	**2,995,776**	**12,193,687**	**32%**

1.3 BUDGET EXECUTION 2017-18 (AS OF 30 JUNE 2018 IN FRW) – IFMIS REPORT

Result Area	**Planned Budget**	**Commitment**	**Budget Execution rate**
Quality Assurance/R1	261.384.137	189.267.465	72%
Mental Health/R2	528.970.195	376.671.507	71%
Urban Health/R3	2.115.289.962	1.238.658.178	59%
Urban Health/R3 without construction	*268.189.962*	*178.468.921*	*67%*
Leadership and Governance/R4	424.267.700	249.145.863	59%
Leadership and Governance/R4 without Action Research	*333.407.700*	*212.282.260*	*64%*
Asset Management/R6	1.174.834.281	359.378.101	31%
Administration and Support	117.868.900	102.160.740	87%
Grand Total	**4.622.615.175**	**2.515.281.854**	**54%**

Fiscal year 2017/18 was the second year of implementation using national systems for planning, budgeting, accounting and reporting (SMART Integrated Financial Management Information System – SMART IFMIS). This was marked by a remarkable improvement in terms of use of the system and communication between UB-Staff, Planning/RBC and implementers, with some flexibility for budget reallocation and carry over due to the delay of some tenders.

Budget execution for FY 2017/18 just fell short of 54% compared to the revised action plan and budget uploaded into the IFMIS after the budget revision of December 2017. 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; challenges with regards to the drafting of ToRs or technical specifications from some user divisions; lengthy procurement processes; etc.).

While the overall cumulative budget execution rate, which stood at 32%, may seem low after 2,5 years of Program implementation, it needs to be reminded that a large part of the budget is earmarked for constructions (Nyarugenge District Hospital - NDH) and MTI-Procurement of medical equipment's for quality improvement projects. The construction works contract was signed on 15 December 2017 with an execution period of 16 months and work on site has started the 15 January 2018 but the project is lagging behind the schedules. Indeed, per contract, duration of the project would be at 31% executed works by 15th June 2018 when it was 20% executed works; with the current productivity the project would complete after 28 months, meaning one-year delay. The supervising firm recommends over two times the current productivity to come back within contract timelines in 5 next months and to avoid further discrepancies towards project completion. The causes of the delay mainly related to non-compliance with terms of contracts have been discussed in a key meeting bringing together high level managers from both construction and supervision firms as well as from the RBC and City of Kigali. The meeting discussed and resolved on different issues concerning several topics such as lacking of required personnel (qualification and numbers), missing procurement of Plant and materials, missing procurement schedule & plan, no respect for site health and safety. A team has been set up to monitor and provide regular reports to all concerned parties for quick action and decision making.

1.4 SELF-ASSESSMENT PERFORMANCE

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

1.4.1 Relevance = A

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 Program assessed its reported performance of A** as the average overall score of five Result Areas (RA) implementing UB Program, obtained from the score attributed to the following questions related to the relevance of the intervention:

1. **What is the present level of relevance of the intervention?**
    - UB-overall score: **A** as the program is clearly still embedded in national policies and Belgian strategy, it responds to aid effectiveness commitments, it is highly relevant to needs of target group.
2. **As presently designed, is the intervention logic still holding true?**
    - UB-overall score: **B** as there is an adequate intervention logic although it might need some improvements regarding hierarchy of objectives, indicators, Risk and Assumptions.

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

Table: Scores of Relevance by Result Area

Questions	R1: Quality assurance	R2: Mental Health	R3: Urban Health	R4: Leadership and Governance	R6: Asset Management	UB Overall Score
1	A[2]	A	A	A	A	A
2	B[3]	A	B	B	B[4]	B
AVERAGE	A	A	A	A	A	A[5]

The Ubuzima Burambye's interventions 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, based on MTR report, some Result Areas reviewed the intervention logic to suit realities with more clarity in role and responsibilities of involved institution (R3) and this will be implemented starting this FY2018-19, others need improving the structure of the intervention by reviewing the hierarchy and

[2] Clearly still embedded in national policies and Belgian strategy, responds to aid effectiveness commitments, highly relevant to needs of target group.

[3] Adequate intervention logic although it might need some improvements regarding hierarchy of objectives, indicators, Risk and Assumptions.

[4] Problems with intervention logic may affect performance of intervention and capacity to monitor and evaluate progress; improvements necessary.

[5] *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*

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 Asset management (R6). For R2, intervention logic does not seem requiring major revision as the intervention considers the context of the country especially the level of development, low resources and post-genocide period. Thanks to its institutional anchorage, the intervention supports all levels of the health system; and in certain areas, the intervention has been able to develop innovative interventions.

1.4.2 Effectiveness = C

Effectiveness to date is "the degree to which the outcome (Specific Objective) is achieved as planned at the end of 2017-18". The Program assessed an overall average performance of C, representing the score attributed to the following questions related to the effectiveness of the intervention:

1. **As presently implemented what is the likelihood of the outcome to be achieved**
    - Overall score: 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.
2. **Were activities and outputs adapted (when needed), in order to achieve the outcome?**
    - Overall score: C as 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.

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

Table: Scores of Effectiveness by Result Area

Questions	R1: Quality assurance	R2: Mental Health	R3: Urban Health	R4: Leadership and Governance	R6: Asset Management	UB Overall Score
1	B	A	C	B	C[6]	C
2	B[7]	A[8]	B	B	C[9]	C
AVERAGE	B	A	C	B	C	C

Compared to the last FY, there is no improvement in term of program effectiveness. The same challenges related to external factors and conditions like rules in the administrative process (procurement and administrative requirements) has affected the implementation through delaying of some tenders.

[6] 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.
[7] The intervention is relatively successful in adapting its strategies to changing external conditions in order to achieve its outcome. Risks management is rather passive.
[8] 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.
[9] 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

For Quality Assurance, (R1), the delay in setting the accreditation agency and the lack of consultancy support affected the implementation of some activities.

For Mental Health (R2), the effective attribution of an appropriate plot for the construction of Gasabo- Mental Health Day Care Center and design is not yet finalized. The lack of clear legal framework to fund some community activities affected also that component.

For urban health (R3), the diversity and number of implementation actors (MOH, CoK, RBC) slowed the implementation of activities, particularly those related to the hospital network and medicalization. For the construction of Nyarugenge District Hospital, we are facing a very slow progress because the construction company does not respect the terms of the contract such as staffing and adequate materials. Strong commitment will be necessary to catch-up the delays.

In Governance and planning (R4), changes in the hierarchy of priorities aligned to the national priorities delayed some implementation. In addition, during this FY, the team has worked hard to support the development of 30 new district health strategic plans.This very huge and important task took a big part of MoH human resources and energy that reduce the availability to implement other activities. Another important activity on mapping consultancy (establishing a Master Facility List at national level) was delayed due to changes on ToRs and deliverable leading to delay for collecting data.

In asset management (R6), UB activities implementation was slow due to other competing priorities and limited staff for implementation. Another reason is related to long processes required for procurement.

Ubuzima Burambye Program's intervention seems facing difficulties to implement its strategies in time. The Program has not been actively reactive in risk management. As contingency plan, each Result Area suggested measures to be taken to improve the implementation of activities. Therefore, the group who worked on the performance assessment estimated that the likelihood for the outcome to be achieved will be good despite minor limitations, provided that last quarter efforts continue in the forthcoming year of implementation. Effort will be put on the implementation of corrective measures related to the construction of Nyarugenge District Hospital, close follow up of the implementation of procurement plan, development of sustainability plan for medicalization of health centers, the use of provincial maintenance workshops and improvement of communication between involved institutions.

1.4.3 Efficiency = C

The reported performance in terms of the use of resources to convert them into results in an economical way is **C** (mainly because of R6) as detailed in the followings paragraph:

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

   - UB-Overall score: C, most inputs are available in reasonable time (R1, 2, 3 and 4) and do not require substantial budget adjustments. However, there is room for improvement especially for R6.

2. **How well was the implementation of activities managed?**

   - UB-Overall score: C, the intervention uses mainly ad-hoc arrangements, the steering committee, and other relevant local structures to ensure implementation; except for R4 and 6 for which continued results are not

guaranteed and corrective measures are needed.

3. **How well were outputs achieved?**

- UB-Overall score: C because of R6 as some outputs will be not delivered on time or with good quality and adjustments are necessary.

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

Table: Scores of Efficiency by Result Area

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

Compared the last FY score (D)-'insufficient', the current reporting period has been marked by an improvement in terms of the use of program resources especially under R6 which moved from D to C (last year, there were serious delays and cancellation of a number of activities, certain outputs were not achieved according to time and plan). However, delays are persisting and R6 has still the lowest score. However, all RA found that there is a need for improvement in terms of priority focus, improved planning and timeliness of implementation to ensure that the key outputs are delivered on time.

1.4.4 Potential sustainability = B

The degree of likelihood to maintain and reproduce the benefits of UB-Program in the long run ("beyond the implementation period of the intervention") has an overall performance of **B** resulting from the following criteria assessment:

1. **Financial/economic viability?**

- UB-Overall score: B as outcome will be achieved with minor limitations; negative effects (if any) have not caused much harm.

2. **What is the level of ownership of the intervention by target groups and will it continue after the end of external support?**

- UB-Overall score: A as 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.

3. **What is the level of policy support provided and the degree of interaction between intervention and policy level?**

- UB-Overall score: B as general 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.

4. **How well is the intervention contributing to institutional and management capacity?**

- UB-Overall score: 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).

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

Table: Scores of Sustainability by Result Area

Questions	R1: Quality assurance	R2: Mental Health	R3: Urban Health	R4: Leadership and Governance	R6: Asset Management	UB Overall Score
1	B[10]	B	C[11]	B	C	B
2	A[12]	A	B[13]	A	B[14]	A
3	B[15]	A[16]	C[17]	A	B	B
4	A[18]	A	A	A[19]	B	A
AVERAGE	B	A	B	A	B	B

The ownership for the intervention at the level of policy and involvement of local structures is high except for R3 and R6 for which intervention uses mainly ad-hoc arrangements and the steering committee and other relevant local structures to ensure sustainability. Continued results are not guaranteed and corrective measures are needed. Capacity of absorption by staff of Directorates and Divisions is sometimes challenges by conflicting priorities requiring all attention from RBC/SPIU to ensure that adequate support is provided.

The economic/financial sustainability is likely to be good even beyond the implementation period of the intervention. The Program is implemented to reinforce the institution target and existing policy have been generally supportive. The steering committee and other structures from 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. Concerns on financial viability and ownership for urban health (R3) and asset management (R6) will need to be addressed by the high-level leadership; for instance, it will require a legal framework with standard package for medicalized health centers.

---

[10] Financial/economic sustainability is likely to be good, but problems might arise namely from changing external economic factors.
[11] Problems need to be addressed regarding financial sustainability either in terms of institutional or target groups costs or changing economic context.
[12] 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.
[13] 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.
[14] 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.
[15] 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.
[16] Policy and institutions have been highly supportive of intervention and will continue to be so.
[17] Intervention sustainability is limited due to lack of policy support. Corrective measures are needed.
[18] Intervention is embedded in institutional structures and has contributed to improve the institutional and management capacity (even if this is not an explicit goal).
[19] 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.

Finally, the anchorage of UB Program 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.

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.

1.5 CONCLUSIONS

Based on the above assessment, the Program is still very relevant but adjustments are needed to improve on efficiency and effectiveness and to ensure expected outcomes are achieved. The program Mid-Term-Review identified some weaknesses and formulated strong recommendations which will certainly contribute to the improvement of program performance for the next FY. The Program 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. However, some areas of the program such as medicalization of four health centers, construction of Nyarugenge District Hospital and MTI- maintenance workshops will need specific and clear business plan in order to contribute to the general sustainability of the health sector.

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

UBUZIMA BURAMBYE PROGRAM
RBC / SPIU
B.P. 6089
KIGALI
LONG HEALTHY LIFE

2 RESULTS MONITORING

2.1 EVOLUTION OF THE CONTEXT

2.1.1 General context

Context in Rwanda

There has been no major change nor event in the course of 2017-18 year that had any significant impact on the program. Presidential elections were held on 4th August 2017 and saw president Paul Kagame succeed with 98.8% of the vote. He will serve a seven-year mandate until 2024.

At Ministry of health level, the major contextual influence is related to the validation of the Health Sector Strategic Plan IV (HSSP IV 2018-2024). UB program did provide significant input in the development of this strategic document. It will also be the reference for further alignment of the program to the sector strategy. This is relevant for all program result areas with some novelties with regards to the inclusion of medicalized health center level as well as a focus on Non-Communicable Diseases (NCD). Both novelties being highly relevant to UB program.

Organizational changes took place at the City of Kigali (CoK) with new Mayor, Executive Secretary and Director General Corporate Services but these did not have any significant impact UB Program as the program is well embedded within national policies and strategies.

In CoK, the now bimonthly 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 (see newsletter and abstract annex 4.11) . Every month in Kigali, on two Sunday mornings, cars are not allowed on the boulevard between City Center and Remera with all citizens invited to march, run and roll on the boulevard towards Rwanda Revenue Authority parking where fitness exercises are done under trainer guidance. At times, screening for NCDs is also organized during those events with the support of UB Program.

Context in Belgium

BTC becomes Enabel, the Belgian development agency. Its task is to implement and coordinate the Belgian development policy. The change of name fits into the reform of the Belgian development policy, which is aimed at a better alignment with the 2030 Agenda for Sustainable Development and the Sustainable Development Goals (SDGs).

Enabel's legal status does not change. Like BTC, Enabel is a public-law company with social purposes. All contracts, agreements and commitments signed or made by BTC remain valid.

Enabel is entrusted with more autonomy, more competences and a broader mandate than before. This way, the agency is better equipped to achieve its vision, to contribute to a sustainable world where women and men live under the rule of law and are free to pursue their aspirations.

In 2016, UB Program 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). This result deletion definitely affected the implementation of action research in all other result areas. UB SC therefore recommended in 2018 that specific support from RBC/Medical research Council (MRC) be provided to all result areas for implementation of action research. A second budget reallocation had taken 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. A third reallocation took place in September 2017 when the budget for the construction of the mental health treatment center was allocated to the construction of NDH with the commitment of MINECOFIN to fund the construction of the mental health treatment center with ordinary budget. This commitment is still to be seen as it is not included in the budget for 2018-19.

2.1.2 Institutional context

UB Program management unit (including finance and procurement) is still located in RBC/SPIU, in Remera, Gasabo District as RBC is the central operational institution in the health sector and SPIU is the organ that is coordinating and managing major donor funded Programs. End June 2017, the SPIU coordinator, Dr Daniel Ngamije, who is de facto the Director of Intervention of UB Program left the office. He has been replaced by Dr Gilbert Biraro who used to be the head of SPIU Planning and M&E unit and is therefore very familiar and experienced in SPIU. While a change in leadership is always testing the system and may be a threat to the successful implementation of the program, we expect that this change will not affect the program as Dr Gilbert Biraro comes from within SPIU and knows the health sector very well.

UB program implementing partners include MOH, located in Kicukiro District and CoK, located in Nyarugenge District. In terms of partner ownership and leadership, RBC hosts the SPIU offices that manage the Program and RBC monitors the implementation done by Mental Health (R2) and asset management (R6) that is located in city center near the National reference hospital; MOH monitors R1, R3, and R4. This geographical distribution sometimes represents a challenge particularly for quality assurance (R1), urban health (R3), governance and planning (R4) whereby technical staff (ITAs and NTAs) do not share the same office building as the administrative, procurement and finance staff of the Program. While the specific office provided at MOH facilitates international and national UB technical assistants to have a base at MOH and interact better with the respective partners, they sometimes lack the daily interaction with the management unit that is based at RBC/SPIU.

Quality assurance (R1) is mandated to establish and integrate quality assurance mechanisms and ensure they are functional at all levels of hospitals. Besides the above described challenges, performance has been improving year after year in terms of budget execution and efficiency. The remaining challenge lies in the establishment of an autonomous accreditation agency in Rwanda. The process to select the agency is not yet clearly identified as it may not be appropriate for MOH to select an agency that is expected to assess the sector performance. Further consultations will be needed with Rwanda Development Board (RDB) and other agencies in coordination with Management for Science Health (MSH) that is jointly supporting this initiative with UB program.

A Mental Health Division located at RBC HQ implements the National Mental Health Policy. The Division is provided with 2 units namely Community Mental Health Unit, Development of Psychiatric Care Unit and an office in Charge of

Prevention and Treatment of Substance Use Disorders. The Division has grown over the years and, with support from the Belgian development agency, is now fully established within RBC. It has an excellent network with all stakeholders, whether public (i.e. the Interministerial Committee for the Fight Against Drug Abuse and Illicit Trafficking), civil society (i.e. during Genocide commemoration period and also at community level) and private (i.e. Rwanda mental health survey with support of Johnson & Johnson among others). A 5-year National Mental Health Strategic plan is in a development process with support from Enabel and will provide guidance and reference for the Division to further implement its mission. The Mental Health Division also developed a sustainability plan in the perspective of the end of contract of the International Technical Advisor (ITA) planned by 30 June 2018 as per TFF arrangement. The ITA has worked towards ensuring smooth takeover of his valuable and valued support to the Division through capitalization documentation, handover of documents and responsibilities. It is to be noted that the ITA had all along worked in a support position hence the colleagues in the Division were equipped to fulfill their responsibilities including the steering of UB funded activities.

In the course of the year, the SC was informed that budget for the construction of Nyarugenge District Hospital was underestimated: surface area as well as some critical services had been inadequately covered. This led to a budget readjustment within the whole program and particularly R1, R6 and R2. For mental health, the decision was that UB funding for the construction of the national mental health center be shifted for the hospital construction and ordinary budget (from MINECOFIN) be committed for the construction of the center. UB support is to continue providing technical assistance for the construction of the mental health center.

For urban health (R3), beside the above challenges, the institutional anchorage of urban health with the City of Kigali has been challenging: while activities take place within the city, most of them are still at policy and strategic levels (i.e. the package of medicalized health centers, the hospital network approach, etc.) which is the prerogative of the Ministry of Health. This context has sometimes led to lengthy administrative processes that have delayed the implementation of activities. This institutional arrangement was also questioned by the Mid Term Review (MTR) team that recommended drastic changes to address efficiency of the Program. It was therefore agreed that all activities related to policy and strategic issues were to be under MOH leadership while operational activities such as NCD mass campaigns were to be under the leadership of CoK. The above being done in mutual communication for effective implementation.

In term of decentralization (R4) UB Program assisted MOH in the development of new District health strategic plans, in alignment with HSSP IV. UB also assisted RBC Medical Technology and Infrastructure (MTI) Division to decentralize some of its operations through the renovation or construction of four provincial maintenance workshops. Further technical assistance will be provided to make those workshops fully functional.

For R6: In the area of asset management, there has been institutional support towards the development of a National Strategic Plan that is much needed to provide guidance and priority orientations, including on the capacity development. The workload is still too high if left to the Division at central level.

2.1.3 Management context: execution modalities

Most activities of Ubuzima Burambye Program are implemented according to the National Execution modalities (NEX), which implies the use of the Government of Rwanda systems for financial and procurement management. Only the construction of Nyarugenge District Hospital (NDH) is managed in co-management with Nyarugenge District.

NEX modality is now well understood by the management unit and has been implemented in a smoother way than in the previous year. This has allowed better ownership and alignment to the partner system and better score in efficiency compared to last year (from D to C). It is a transparent accounting system that allows for monitoring and comparison of performance within and with other Programs. However, its multilayer control process may sometimes be slow and there is still lack of flexibility that results in more rigid use in the system and reduced problem-solving approach. In area of high unpredictability such as research action, the Integrated Financial Management Information System (IFMIS) used by the public sector in Rwanda has showed some limitation in terms of flexibility. The Steering Committee (SC) therefore agreed to use the regie modality in this particular area. Besides, UB program still needs to improve its effectiveness and efficiency in the next year and ensure that planned activities are implemented. Some Divisions have been affected by staff dismissal and may therefore be too cautious and slow in decision making. This has particularly affected UB program support in human resources training Program.

About overall sector procurement, a decision was taken to relocate the infrastructure and equipment procurement services from MOH to RBC in order to strengthen the coordination in the health sector. E-procurement pilot phase has been successfully implemented and is now spread to all public sectors.

Procurement within UB program and RBC/SPIU has not been efficiently managed in the past year. Respective roles and responsibilities between users, procurement, management unit need streamlining to improve decision making and management of procurement. A specific section will develop this further (section 2.9).

An external mid-term review of UB was commissioned by Enabel in October 2017 to provide an in- depth analysis of strategies and activities and to assess the level of performance of the Program. It was implemented by HERA with a team of three consultants, a health systems and management expert, a public health expert and a biomedical engineer. In addition to the performance- related evaluation questions provided by Enabel, the terms of reference included specific questions in five areas: (i) Program modalities and approaches; (ii) accreditation; (iii) mental health; (iv) urban health; and (v) asset management. Ubuzima Burambye represents a new step in the health sector cooperation between Belgium and Rwanda in that it adopted the internationally agreed principles of effective development cooperation. In terms of advantages and opportunities, the approach is reflected in the high level of performance of UB in terms of Program relevance and sustainability. The risks, which in the remaining Program period can still be mitigated, are reflected in low efficiency of implementation which has also contributed to a lower than expected Program effectiveness. Issues that affected efficiencies are:

- The adoption of the national execution modality required the integration of UB management with Rwandan planning, budgeting, procurement and financial management systems.
- National execution, as defined by Enabel, is only partial as perceived by the Rwandan partners who point to inefficiencies due to parallel processes in financial management and procurement.
- Changes in the institutional mandate of the implementing partner, the RBC SPIU resulted in the loss of direct authority by the SPIU and has weakened Program leadership.

- The partnership structure of UB divides ownership, technical leadership, management authority and financial accountability among five Rwandan government partner institutions, each with its own level of decentralized authority.

The MTR formulated 17 recommendations to different stakeholders in the Program. However, the consultant had not managed to follow the realistic evaluation process and a subsequent backstopping mission was necessary in January 2018 to review and finalize the recommendations that were validated by SC meeting of April 2018

2.1.4 Harmonization context

The Program is fully aligned to the country policy. The Ministry of Health involves all Development Partners (DPs) in Technical Working Groups (TWG) for planning and the implementation of activities, ad-hoc core teams are set up for specific tasks. These TWGs report to the health Sector Working Group (HSWG) chaired by MOH Permanent Secretary (PS) and co-chaired by Development partner (DP), currently USAID. HSWG meets quarterly. There are also two annual review processes for all sectors, the Joint Sector reviews (JSR) under the leadership coordination of Minecofin. These, among other platforms of dialogue, allow UB Program for full alignment and harmonization with partner strategies and system. UB team regularly attends the JSR and HSWG as well as some specific TWG such as Quality and Standards (co-chair), Planning Health Financing HIS, Medical Technology (little active) and mental health

While the above fora's have facilitated donor harmonization, there have been opportunities for further harmonization with partners such as management for Science health (MSH), funded by USAID, in the area of quality assurance and accreditation (R1), governance (R4). However, during the reporting period, MSH did not fully honor its financial support to the Ministry of Health for the development of standards specific to mental and orthopedic services and for the setup of the accreditation agency. UB Program could not spend the budget planned for organizing workshop for the validation of those standards and has been requested by MOH to identify funding for the accreditation agency (see output R1). UB support will therefore have to be adjusted to address these issues, provided the agency is being developed in alignment to policies and sustainability principles. Similarly, UB support to MTI and medical asset management has been done in collaboration with the Clinton Health Access Initiative (CHAI) in the area of strategic development plan and Medical Equipment Maintenance Management System (MEMMS).

All UB 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 Program and Enabel Representation health portfolio that includes Joint Health Sector Support (JHSS) and Capacity Development Pooled Fund (CDPF). The close alignment of the Program to the HSSP IV provides strong basis for maximum sustainability of the Intervention. The use of IFMIS and the alignment to the Government of Rwanda fiscal year further strengthen UB alignment to the partner systems.

2.2 PERFORMANCE OUTCOME

2.2.1 Progress of indicators

R1- Quality Assurance

Outcome: Quality and safety of health services delivery improved					
Indicators	Baseline value 2015-16	Value year 2016-17	Value year 2017-18	Target year 2017-18	End Target 2019-20
Degree of patient satisfaction	TBD	NA	NA	70.5%	TBD
% of post CS infection rate in a given period of time	1.13%	1.26	1.91%	1.05%	<0.8%
# of Programs integrated in the accreditation process	7/12	14/17	18/18	17/17	17/17

R1 OUTCOME: Analysis of progress made

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

1. **The patient satisfaction rate**

The patient satisfaction survey that was initially planned for baseline and outcome monitoring is not going to be funded anymore by the Program as decided by the MOH management. It will be conducted by MOH itself and results will be communicated. However, a report from patient satisfaction done by RGB (Citizens report card) in October 2017 indicated that 70.5% of respondents were satisfied with health services offered. Satisfaction was associated with access to services of "Mutuelle de santé", Pharmacy services and services offered by Community Health Workers (CHW).

2. **Post caesarean infection rate**

Compared to the baseline (1.13%), post-caesarean infection seems to increase (1.91%) while the target set for this FY was 1,05%. Reasons for increase in post caesarean infections is the inappropriate sterilization process and equipment, inappropriate laundry process, poor surgical site cleaning and not following Infection Prevention and Control (IPC) policies and guidelines.

During the reporting period, the program facilitated some DHs with quality improvement projects aiming at reducing post caesarean infections and these are being monitored (see section 2.3.3). Some interventions on post caesarean infections in some health facilities were put in place late in April 2017 and close monitoring will continue to take place. With high impact interventions that are being put in place, a reduction of post caesarean infection is expected at the end of the next financial year.

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

All Programs have been integrated in the accreditation process (18/18) as planned. Compared to the baseline (7/12), the number of Programs increased (in terms of denominator) as well as numerator and continue to increase depending on the review and development of new standards. Selected Programs are listed below:

1. Management of Non-Communicable Disease
2. Complete Reproductive and Maternal Health care
3. Adolescent sexual reproductive health and right
4. Complete New Born and Child health care
5. Comprehensive HIV prevention and care
6. Comprehensive TB prevention and care
7. Comprehensive Malaria prevention diagnosis and treatment
8. Mental Health care
9. Gender Based Violence
10. Disabilities
11. Integrated disease surveillance and response
12. Nutrition Program
13. Essential emergency equipment and supply
14. Safe Medication use
15. Monitoring and reporting on communicable disease
16. Clean and sanitary Environment
17. Stable safe water sources
18. Health Promotion and disease prevention

The outputs of the above outcomes are still leading to the change process envisaged.

Quality improvement Programs include interventions such as training of health providers, renovation of neonatology rooms and medical equipment for different health services to address post-surgical site infections among other interventions. The development of standards for specialized health facilities (orthopedic, psychiatric) was to be done in partnership with MSH that was to provide the accreditation consultant. As MSH failed to bring the consultant, UB decided to fund baseline and generic accreditation assessment of those facilities to include them in the accreditation process while specific standards might be developed in the future. 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. This will be reflected in the data that will be collected and reported on a continuous basis during the course for implementation (up to June 2019) to show whether the project activities are driving towards meeting the objectives. Research designs and protocols will be developed in the first quarter of next fiscal year to assess the impact of training that was conducted in April 2017. With the overall sensitization by MOH and RBC, the trainings conducted and equipment procured for all hospitals implementing QI projects, post caesarian infection rate is expected to reduce further from 1.05% up to 0.8% at the end of year 2019.

Issues that arose, influencing factors (positive or negative)

Unfortunately, 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 planned consultant. An alternative modality will be implemented next fiscal year (2018-19) to ensure successful implementation of the activity.

Regarding Rwanda Health Accreditation Organization:

- ToRs are available, MOH needs to delink from the accreditation assessment process (conflict of interest) but selection modality has legal implications to be sorted out.
- MSH funding for the accreditation agency is reduced and limited to "in-kind" support. It had been agreed during UB formulation that USAID would fund the accreditation body and UB would limit to technical support.
- There is a need to reconsider whether any funding from UB could be allocated to the functioning of the body in the next year.

The development of standards for specialized health facilities in orthopedics will be done in partnership with Humanity & Inclusion (i.e. Handicap International). For psychiatric standards, a request for UB support will be sent next FY.

Unexpected results?

NA

R2- Mental health

Outcome: Mental health care services are accessible, utilized at community level up to national level in sustainable way					
Indicators	Baseline value 2015-16	Value year 2016-17	Value year 2017-18	Target year 2017-18	End Target 2019-20
Mental health care services utilization rate at health facility level.	0.16%	0.26%	0.27	0.5	0.5%

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 2017-18.

Mental Health Consultations: type of disease

Type of disease	July 2015-June 2016		July 2016-June 2017		July 2017- June 2018	
	New cases	Old Cases	New cases	Old Cases	New Cases	Old Cases
Epilepsy	8649	101955	11980	111201	11998	103930
Other Psychological problems	9779	22049	8925	27278	7201	23561
Schizophrenia and other psychoses	2331	31934	2155	32322	2827	34630
Neurological problems	5189	2831	4437	3497	5053	2866
Depression	1347	5496	1350	5760	1488	6526
Psychosomatic problems	1540	3273	1105	2672	991	2511
Post-traumatic stress disorder	536	1482	482	1270	816	1527
Suicide attempted or successful	480	215	571	266	635	231

Type of disease	July 2015-June 2016		July 2016-June 2017		July 2017- June 2018	
	New cases	Old Cases	New cases	Old Cases	New Cases	Old Cases
Behavior disorders not due to alcohol and drug abuse	196	570	218	408	126	160
Behavior disorders due to use of alcohol and drug abuse	178	406	147	403	80	136
Anxiety disorders					593	618
Behavioral and emotional disorders with onset usually occurring in childhood and adolescence					136	178
Bipolar disorders					153	2011
Mania					79	577
Mental and behavioral disorder due to substance abuse					165	385
Mental and behavioral disorder due to use of alcohol					233	668
Total visits*	**30225**	**170211**	**31370**	**185077**	**32579**	**180515**

No data for two previous years as this is a new set of indicators that were not collected at onset of the program (only from July 2017)

Source HMIS, July 2017-June 2018

***Numerator**: Number of new consultations in District Hospitals during the fiscal year July 2017-June 2018 = **32,579 cases/12,000,000*100,000. As the baseline was calculated in percentage way, we kept the same calculation.** 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: Analysis of progress made

Under Ubuzima Burambye Program 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 value of FY 2016-17 (0.26%), the reported result for 2017-18 (0.27%) is showing a small increase in mental health utilization at health facility. From January 2018, the reporting format has been reviewed with the purpose to harmonize data with those of WHO Mental Health Atlas as it is indicated in the table above.

The main indicators are: anxiety disorders, behavioral and emotional disorders with onset usually occurring in childhood and adolescence, bipolar disorders, mania, mental and behavioral disorders due to substance abuse, mental and behavioral disorder due to use of alcohol.

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

Globally, the majority of activities were 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 (see section 4.10).

Issues that arose, influencing factors (positive or negative)

Construction of the national mental health day care treatment center has been removed from UB Program by S/C decision and it was agreed to integrate it into ordinary budget for the FY2018-19. However, this is still a challenge as it

not yet done. Another challenge is related to get an approved allocation for land which is not yet the case; the consequence is that the final design of the center could not be completed.

Unexpected results

Considering removal of the UB budget allocated to the construction of National Mental Health Day Care treatment and considering that it's not yet in the ordinary budget as decided by SC, there is a risk of not having it before the end of the UB program.

R3: Urban Health

Indicators	Baseline value 2015-16	Value year 2016-17	Value year 2017-18	Target year 2017-18	End Target 2019-20
Outcome R3.1: Awareness on NCDs increased (people-centered)					
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					
I3.2.1 Prevalence acute diarrhea <5	6%	5%	7%	4%	Support of UB stops in July 2018
I3.2.2 % of public places responding to at least 80% hygiene standard criteria	TBD	70%	NA	75%	
Outcome R3.3: Health facilities system in the CoK is rationalized by integrated equitable and sustainable services which are people-centered					
I3.3.1 % population living at < 1 hour walk/5 km from HC	77%	NA	Coverage plan will not take place and UB will not influence that indicator		
I3.3.2 Bed occupancy rate in different Kigali hospitals	36%	34%	38%	TBD	80%
I3.3.3 Patient and health care providers satisfaction rate	TBD	NA	UB SC decided that the activity will be supported by another program		
I3.3. 4 ANC coverage in CoK HFs	44%	25%	28%	90%	100%
I3.3.5 Deliveries rate at HF level in CoK HFs	94%	99%	98%	98%	100%
I3.3.6 Ultrasound coverage for pregnant woman (at least one ex) in the catchment area of 4 HCs equipped with ultrasound	0%	NA	This indicator was not included in the national M&E framework=> data not available and we removed this indicator		

R3 - OUTCOME: Analysis of progress made

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

Since the beginning of the project, 3 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 STEP survey conducted by MoH in partnership with WHO-RBC in 2015 serves as the baseline. Another survey could be repeated using the same methodology before the end of the Program 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.

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

Hygiene mass campaigns were conducted and financed as routine activity by CoK. The aims were to provide higher budget for the NCD mass campaigns. For the next years, this activity has been removed from the UB program.

The health environmental platform with quarterly supervision and quarterly meeting organized activity as routine but for the next years, the activities has also been removed from UB program.

The reasons to remove hygiene and sanitation activities from UB program were:

- To provide higher budget to NCD mass campaign in order to increase its impact.
- To use available CoK budget for these activities.
- Recommendation from the Mid Term Review (MTR): The 7th SC meeting has agreed in May, 2018: ***"R3. SPIU/RBC UB to inform CoK of this decision to stop UB funding for hygiene and sanitation activities".***

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

Several activities related to increasing the quality coverage of health services are ongoing: medicalization of four health centers, construction of Nyarugenge District Hospital and development of hospital network. Other activities related to better coverage could not be implemented because of the budget reduction (100.000 Euros) that really affected investments for upgrade/construct of HC and of course, it has affected the following indicators:

- **I3.3.1 % population living at < 1-hour walk/5 km from HC** cannot anymore be influenced par UB program and we propose to remove it from M&E system

Concerning the other indicators:

- **I3.3.2 Bed occupancy rate in different Kigali hospitals**

  This indicator is linked to the objective of having a better rational and coherent functioning and use of Hospitals in the CoK via mainly a hospital network for the CoK. As the development of such network is progressing very slowly, we do not expect much improvement for this indicator at this stage.

- **I3.3.3 Patient and health care providers' satisfaction rate**

  The 7th SC on 22nd March, 2018 meeting has decided to appoint another program/partner to measure that indicator and by date there is no study that have taken place. Therefore, we are not able to measure any progress on that indicator.

- **I3.3. 4 ANC coverage in CoK HFs**

  The indicator is in very slow progress and very far from the optimistic national target; it depends of other many factors/interventions.

- **I3.3.5 Deliveries rate at HF level in CoK HFs**

  The performance was already very high and continues to be maintained.

- **I3.3.6 Ultrasound coverage for pregnant woman (at least one ex) in the catchment area of 4 HCs equipped with ultrasound**

  The US have been provided to the 4 HC and serve the population of catchment area since beginning of 2018. The pregnant women are the ones who benefit from it. Nevertheless, we cannot measure this indicator because it was not selected to be in the M&E framework of the MOH/Districts.

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

Yes, the outputs are still leading to the change process envisaged: promotion of early detection and preventive message about NCDs has been successfully implemented and Action Research related to NCD will continue to improve the way it is organized and, then finally, have an impact on a better accurate NCDs and risk factors prevalence in the City of Kigali.

Effective medicalization of four Health Centers and equipment's is also contributing to the accessibility of care and services. Some activities under Kigali hospital networking such as medical skills sharing, e-health information sharing through capacity building (HR recruitment) are progressing well and the construction of Nyarugenge District Hospital will certainly improve accessibility (see section 4.11).

Issues that arose, influencing factors (positive or negative)

Existence of other sources of funds for Hygiene mass campaign influenced positively because the planned budget has been used to strengthen the results obtain through the NCD mass campaign (increased number of participants, increased impact).

Shifting Medicalization and Hospital networking to Clinical Service leadership following MTR Recommendation will strengthen ownership by MoH and sustainability of the program.

Unexpected results?

A very positive unexpected result is the success of the mass campaigns that are now generalized to other Kigali districts see section 4.11) and different cities on more regular basis with use of data collected during the mass campaign and with the action research. The appropriation of the activity and diffusion of its results is almost complete at a very early stage.

R4 Governance and Leadership

Outcome R4.1: Stewardship capacities at the level of the local health system (district) is strengthened					
Indicators	Baseline value 2015-16	Value year 2016-17	Value year 2017-18	Target year 2017-18	End Target 2019-20
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	100%
I4.1.2 % of Districts which have developed a comprehensive health strategic plan 2018-2023*	NA	0	100%	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	0	100%	NA	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	0	30	30
I4.2.2 % of selected districts visited by Joint supervision team from central level at least once a year	0	80%	0%	100	100%

R4 - OUTCOME: Analysis of progress made

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

During the fiscal year 2017-2018, the development and finalization of the fourth Health Sector Strategic Plan as well as other policy guiding documents enabled the development of the District health Strategic plan.

All 30 districts developed their Health Strategic plan, which are embed in the DDS.

The first step to undertake this process was to develop tools and methodology to better support Districts to develop the strategic plan with the support of the Ministry of Health and DPs. Workshops have been organized where all stakeholders in health at decentralized level and Districts authorities worked together to set health priorities for the five years to come.

The participation of Districts authorities was very significant, some Mayors, Vice-Mayors in charge of Social Affairs, Executive Secretaries at District level participated in the process of developing their own DHSP. The quality check of DHSPs was postponed in the following fiscal year before the validation and implementation of the DHSPs.

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

This year, technical support from the Ministry of Health and DPs to decentralized level was crucial and tremendous in the development of the Districts Health Strategic plans. All Districts have their own five-year plan and health priorities for which the implementation will start with next fiscal year 2018-2019. Capacity building in planning, monitoring and evaluation, financial management was provided to Decentralized level including administrative districts and District Hospitals, the Health Resource Tracking Tool (HRTT) was key in the planning process of the above-mentioned institutions.

The internship supervision was conducted in the 22 accredited sites and the report was finalized and shared. However, a dissemination workshop and consultation to insight the internship program was postponed for next fiscal year.

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

Yes, the outputs to the above outcome are still leading to the change process in terms of Stewardship capacities at the level and MoH/RBC capacities to support decentralized levels. This has been materialized during the elaboration of DHSP where districts completed situation analysis and then developed their respective health strategic plan.

Issues that arose, influencing factors (positive or negative)

Some new activities not planned were implemented because they were relevant to achieving the stewardship and strengthening of the decentralized level. Among the new activities, the HRTT workshop for decentralized levels and District hospitals, was very key to improving planning and financial management of health-related activities.

The most important issue in the Program implementation was Action Research. Indeed, the whole budget was transferred to R4; because the other RAs could not implement many activities related to AR this FY, has and this had a negative effect on the execution rate for R4.

The quality check of the DHSP was postponed to next fiscal year.

Unexpected results

NA

R6 – Asset management

Outcome R6: Quality of health assets in health facilities is increased based on the implementation of standards					
Indicators	Baseline value 2015-16	Value year 2016-17	Value year 2017-18	Target year 2018-19	End Target 2019-20
An asset (equipment and infrastructure) management system is put in place and is operational	Weak	PARTIALLY ACHIEVED: -Trainings on ultrasound anesthesia and patient monitor machines, on the management of Health Assets, achieved. -Bachelors Program 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.	PARTIALLY ACHIEVED: - Provincial workshops construction was done, equipment under tender process, definition of its operating procedures to be developed soon. - An asset management system MEMMS to increase the inventory collection and equipment management was deployed and implemented - The draft for medical equipment NSP is done, waiting for approval - ToRs for a consultant to develop Health Infrastructure Norms and Standards has to be relaunched. Still waiting for a consultant to develop the standards. - Initiated installation and repairs for 17 non-functional autoclaves - Guidelines for Health Infrastructure and equipment Management developed and in the approval process. COMPLETED: - 23 BMETs completed IPRC program with advanced diploma (4 from MTI and 19 from hospitals) -33 BMETs interns are being mentored in hospitals - 3 students are undergoing in a Bsc program since 2016 - 2 engineers are undergoing Masters Programs since 2017 - tools for 15 BMETs in DH were purchased - UPS for power protection of electronic equipment purchased for 41 hospitals - Provision of Oxygen pipeline systems on the Neonatology Service rooms at NYAMATA and NEMBA District Hospital.	Continuous Trainings Standards disseminated	Functional

R6 - OUTCOME: Analysis of progress made

The target set for this FY are "continuous trainings and standards related to asset management are disseminated". So far, the outcome is partially achieved to some extent: guidelines for donations and disposal of medical equipment have been finalized, and dissemination was done through different workshop and transmissions. Training of users and the implementation is ongoing.

MTI is supporting the training of MTI engineers in the management of medical and Health Infrastructure (ongoing). MTI has initiated quality initiatives of protecting sensitive machines like ultrasound and provision of Oxygen pipeline systems to the neonatology service rooms of NYAMATA and NEMBA DHs. The construction and equipment of four provincial maintenance workshops was completed.

Capacity development

In-house trainings are done continuously for BMETs of Health Facilities.

The training of 3 BMETs for Bachelors Program in Biomedical Engineering in India is ongoing and studies will be completed by July 2019.

The training of two engineers for Master's Program in Biomedical engineering is ongoing, and there is a plan to send other two for 2018-2019 intake.

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 is developing the national Strategic Plan for Health Infrastructure and Equipment.

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

The outputs are still leading to change process envisaged in terms of human resource development, improvement of inventory collection and asset management, technical assistance for UB projects especially in terms of updating, validating and disseminating policy, standards or guidelines regarding infrastructure and equipment management.
There is a higher number of trained and skilled biomedical technicians in the country. Medical equipment and infrastructure management is improving in hospitals due to an increased mentoring and communication with maintenance and management teams across the country. An internship program is underway to further facilitate access to employment and gain experience for young graduates, hence help Hospitals in the maintenance services, Inventory collection, MEMMS implementation, etc.
A National Strategic Plan is being drafted, presented to SMT and SMM for consideration and approval by July 2018.
Issues that arose, influencing factors (positive or negative)

MTR review has been an opportunity to review UB support to MTI and health assets in general. Recommendations included the need to ensure full functionality of provincial maintenance workshops and the finalization and validation of the national strategic plan for medical equipment and infrastructures.
Negative factors that arose include lack of specialized and advanced training Programs for biomedical engineers to serve

the biomedical sector in the country. There is no structure or enough positions where biomedical engineers and technicians can be employed in hospitals or other relevant institutions.

For planned short trainings abroad in 2017-2018, almost none was conducted. For planned in-house trainings, very few were able to be performed, especially due to the fact that availing the only one BMET from hospital to come for a week or more training without a replacement staff is not ideal. Capacity building becomes a challenge, which is why there is need for clear guidelines for it.

Positive collaboration with CHAI allowed the speeding up of the drafting of the National Development Plan; a consultant was availed to MTI team, and a draft was developed in time for SMT presentation. This will be a key deliverable as it is among the approved recommendation of the MTR report

In February 2012, the Ministry of Health (MoH) and Clinton Health Access initiative (CHAI) signed a memorandum of understanding for the development a Medical Equipment Management and Maintenance System (MEMMS) tool. The introduction of MEMMS tools helps Ministry of Health to:

- Enforce the establishment of standardized process for management and maintenance of medical equipment which current value is about 2 billion US Dollars.
- Contribute to evidence-based decisions by providing visibility over the management and maintenance of medical equipment and spare parts.
- Presently, MEMMS is being used despite the few bugs and the need for improvements required by all users. The system is being updated and data being input in the system so that the complete inventory of medical equipment can be available and monitoring possible remotely. The challenge remains the fact that not all equipment has been input in the system yet, and not all equipment are physically accounted for.
- MTI intends to finish the physical verification of MEMMS implementation and the inventory by September 2018, which will make the MEMMS tool ready to be operated fully.

Unexpected results?

Without a proper business plan or operational guidelines, the provincial workshops have been used and might still continue to be used differently from their intended purpose. Meanwhile these workshops are also part of MTR recommendation approved by SC

UPDATED INFORMATION: In August 2018 (after the completion of this report time period), a Cabinet decision was taken removing all MTI staff from office with immediate effect. The reason given is "inefficiencies affecting the performance of the health sector". Some preliminary discussion has been held with MOH and RBC Management regarding next steps to take and how UB program will thereafter reorient its support to this critical component of the health service delivery.

2.2.2 Potential Impact

The current progress implementation of UB Program 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	Value 2017-18	Target 2018	Revised Target HSSP4-2020
Maternal mortality ratio (per 100,000 alive birth)	210	210	200	168
U5s mortality rate (per 1.000)	50	50	42	42
Neonatal mortality rate (per 1000)	20	20	10	16
Infant mortality rate (per 1000)	32	32‰	22	28
Total Fertility Rate (%)	4.2	4.2	3.3	3.8
Utilization rate for modern contraceptive methods among women of 15-49 (%)	44	44	50	55
HIV prevalence 14-49 (%)	3	3	3	<3

R1. Quality Assurance

The Quality and safety of health services delivery improved will certainly contribute to the impact of the program in term of reducing all type of mortality. 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 expected reduction of post caesarean infection from 1,13% to <0,8% by the end of the Program, 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 national health Programs are integrated in the accreditation process (for 58% in the baseline) and this gives hope that target of 100% integration (17/17) by the end of UB program lifetime will be possible.

R2. Mental Health

The increase of mental health services utilization is key outcome which will contribute to the program impact indicators in relation with integration of services (HIV and utilization of modern contraceptive methods among women suffering from mental health illness and people center services). 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 that can impact positively the mental health of the Rwandan population and health in general (see section 4.11). The mental health service utilization increased from 160/100,000 in 2015-16 to 270/100,000 in 2016-17 and to 270/100,000 in 2017-18. The capacity building Program developed via the Mental Health Intervention targeting various health care professionals, focus on psychological aspects centered 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 Program does not 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. Development of District Health strategic plans based on the real gap influence impact indicators by developing appropriate strategies to address issued. 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 decentralization 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 contributes to the reduction of infant, neonatal, under five and maternal mortality in the country.

2.3 PERFORMANCE OUTPUT (RESULT) 1 - THE QUALITY ASSURANCE SYSTEM IS SET UP, INTEGRATED AND FUNCTIONAL AT THE LEVEL OF ALL HOSPITALS

2.3.1 Progress of indicators

Output R1.1.1: An independent accreditation body is established and functional					
Indicators	**Baseline value**	**Value year 16-17**	**Value year 17-18**	**Target year 17-18**	**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	42/42*	0/43	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%	100%**	100%	100%	100%
I1.1.2.2 # of hospitals having submitted report on incident and its management systems	5	35	35	40	42
Output R1.1.3: District hospital achieving level 2 of accreditation					
I1.1.3.1 # of DHs achieving level 2 of accreditation	0	2	1	8	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	6	10
Output R1.1.5: Health care specialized centers are enrolled in accreditation Program					
I1.1.5.1 # of specialized health care centers enrolled in the Program	0	3****	3	1	3

(*) As RHAO is not yet established all 43 hospitals were assessed by MOH including Kacyiru DH that was enrolled in QI and accreditation program in 2017

(**) QA in HCs has been established with TORs and working procedures and expected to be supervised by district hospital in the catchment area.

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

(****) specialized centers have been enrolled but only for existing standards, not for specialized standards (still pending)

2.3.2 Progress of main activities

Progress of main activities[20]	Progress:			
	A	B	C	D
1. Progress towards the creation of an autonomous accreditation body				
Support strategic orientation meeting of core team of Accreditation organization to its roles and responsibilities.				X
Provide Technical assistance to the development of a procedure manual for the Accreditation organization		X		
2. All HFs have functional QA committees				
Support development of Rwandan Accreditation Standards for Specialized Centers/Hospitals (Neuropsychiatric Hospital and Orthopedic Hospital including Gatagara, Rilima)				X
Conduct facilitation for implementation of accreditation standards including Baseline survey to Gatagara and Rilima and Training of internal facilitators from Gatagara and Rilima		X		
3. District hospital have achieved level 2 of accreditation				
National long-term technical assistant in accreditation, quality improvement and Quality control		X		
Carry out accreditation performance progressive assessment per semester		X		
Workshop for updating, Reviewing and standardization of policies and procedures		X		
4. Quality improvement initiatives are implemented and documented in HFs				
Monitoring of implementation of QI innovative project in DHs			X	
Reinforcement of District Hospital management			X	
Preparation for patient & staff satisfaction survey				X
TOTAL		5	2	3

Out of 10 planned activities, none activity was achieved ahead of schedule, five (5) achieved on schedule, three (3) delayed, one (1) seriously delayed, one (1) activity was cancelled (patient satisfaction survey).

2.3.3 Analysis of progress made

Accreditation body

- ToR available. MOH needs to delink from the accreditation assessment process (conflict of interest) but selection modality has legal implications to be sorted.
- Selection process not finalized (tender, award, issues of potential conflict of interest, budget issues, mentoring, etc.).
- MSH funding for the accreditation agency is reduced and limited to "in-kind" support. It had been agreed during UB formulation that USAID would fund the accreditation body and UB would limit to technical support. here is need to reconsider whether any funding from UB could be allocated to the functioning of the body in the next year.

[20] 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.

All HFs have functional QA committees

- Last year, UB provided support to QA committees at HC level. These are now under the supervision of DH.
- The development of standards for specialized health facilities (orthopedic, psychiatric) was to be done in partnership with MSH that was to provide the accreditation consultant. As MSH failed to bring the consultant, UB decided to fund baseline and generic accreditation assessment of those facilities to include them in the accreditation process while specific standards might be developed in the future.
- Strategic facilitation workshop of 527 Hospital customer care officers and Quality Improvement Focal Persons from Health Centers.
- Training of 40 certified surveyors on accreditation application software that will be used in progressive performance assessment.
- Training of 116 new surveyors from all Public Health Facilities and private health facilities.

District hospital have achieved level 2 of accreditation

Assessments are conducted once a year to measure the performance of hospitals and include 75 standards that are organized into 5 risk areas.

Each standard has 3 different levels:

- Level I: requires developing and communicating policies, procedures and plans required to describe the level of quality required in all areas within the facility
- Level II: requires implementing policies, procedures and plans that were developed in Level I
- Level III: requires monitoring the effectiveness of the processes implemented in Level II.

For level III, data will need to be used as evidence to identify opportunities for improvement and to develop action plans for improvements; the results were as follows:

- 20 hospitals achieved L1 & 1 Hospital (Masaka) achieved L2
- 16 hospitals did not achieve L1

Workshop to review 69 health policies and procedures following the identified weaknesses and lack of standardization observed during assessments visits. Updated and reviewed documents were shared for approval and validation by respective hospitals according their current situation in terms of staff, equipment and infrastructure.

Chart 2: New Referral and Provincial Hospital Level II Progress

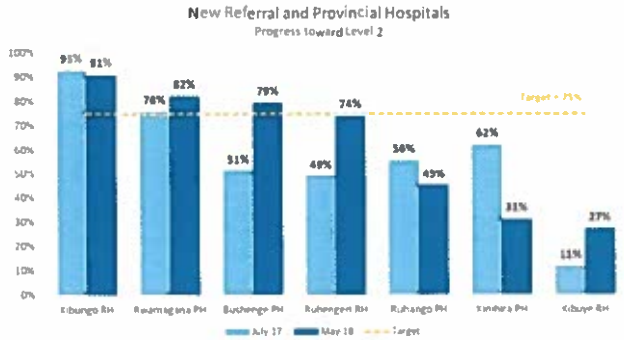


Chart 2: progress of referral and provincial hospitals towards level II accreditation (2017-2018)

DH Overall Progress Trend for Level I

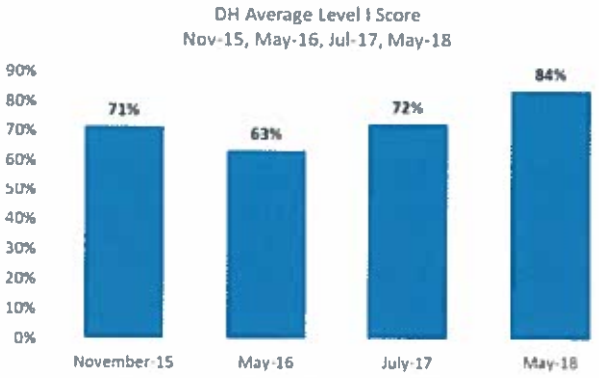
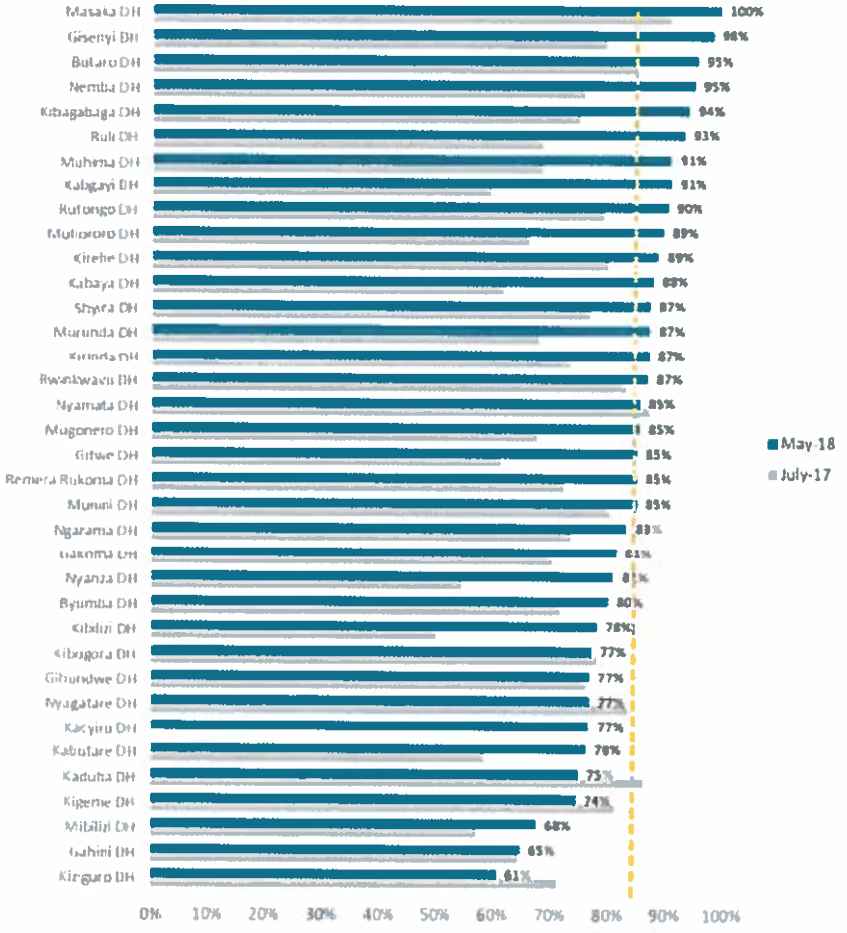


Chart 9: District Hospital Level I Progress



Quality improvement initiatives are implemented and documented in HFs

Rationale for QI projects/Initiatives

Following the recommendations of the progressive performance assessments for accreditation, many gaps in the health care services delivery were identified which were likely to negatively impact the quality of services in DHs. This called for the need of concrete improvement initiatives to improve the quality of healthcare services in Hospitals. It was in this

regard that UBUZIMA BURAMBYE program took the initiative at the fore front to address gaps identified by facilitating and creating a space for dynamic health facilities to work out on Quality improvement projects initiatives by financing the best initiatives in district hospitals. The process started with protocol development workshop with all district hospitals. 36 DHs submitted proposals to the MOH requesting for financial support. 23 proposals were retained and many of the proposals were to address gaps in surgical site infections, neonatal care and patient waiting time. Training took place in the respective hospitals and equipment list was sent for procurement. A team of facilitators and MOH staff has been following the impact of the training on the selected indicators and we expect some reports in the next fiscal year. So far, 11 QI Projects/initiatives are being implemented in DHs: the monitoring results indicate that there is progress towards the reduction of neonatal infections and surgical site infections especially post C/S infections. However, as of now, training and supervision have been done by Clinical Services and hospitals are still waiting for medical equipment's after that impact can be obtained.

For 6 DH implementing EMR projects, IT equipment composed of desktops, UPS and servers were provided to three hospitals in order to reduce waiting times and improving patient medical records management. This will be monitored during the next fiscal year.

Remera, Rukoma, Gakoma and Ngarama DH requested funding for renovation of their neonatal rooms but due to UB budget cuts in 2016 and 2017, only Ngarama will benefit for the funding in the fiscal year 2018-2019.

Site visits at NGARAMA & KIZIGURO Hospital to ascertain the root causes for the high rate of neonatal deaths took place.

Patient satisfaction survey: After several meetings with UB, MOH and stakeholders on the plans to implement patient satisfaction survey, it has been decided to cancel it from UB Program and follow the data through. This means that this indicator will be removed from the baseline document and indicators of the program.

General comment:

There has been significant progress in accreditation (facilitation, assessment and performance). This has been due to high level commitment, strong ownership and leadership from the MOH Division and active mobilization at hospital levels. It is however too premature to see significant impacts at patient level, that will be reached when facilities reach level 3 of accreditation.

The creation of the accreditation body needs to be well designed to avoid any potential conflict of interest between the body, MOH and the health facilities. It is however imperative if the system is to be fully established and recognized. Besides, issues on sustainability are also important and must be addressed prior to engaging with any formal selection.

There is a need to increase the monitoring of Quality Improvement (QI) initiatives to ensure adequate documentation of the process and its outcomes.

It is regretful that the patient satisfaction could not be timely implemented as it would have provided baseline and post intervention information on the impact of the quality assurance and accreditation Programs on the patient perspective. Such qualitative indicators are necessarily to measure our program effectiveness and it will not be possible this time.

During the reporting period, the following SC decisions were made:

- UB support to national patient satisfaction survey is no longer required by MoH although the results are useful to UB. The survey will be implemented by MOH. MoH will inform UB on progress and results of this important survey.
- DG Clinical services to present the draft terms of reference of the accreditation body and the selection process to the TWG Quality and Standards for inputs by mid-April 2018 prior to validation by SMM.
- Following MTR recommendation, UB to continue technical support in accreditation agency and will assist MOH to finalize ToR of the agency.
- MOH Quality Directorate to include MTI staff in facilitation and accreditation assessment. This has to be initiated

2.4 PERFORMANCE OUTPUT (RESULT) 2 - THE MENTAL HEALTH CARE SERVICES ARE ACCESSIBLE AND UTILIZED AT THE COMMUNITY LEVEL IN A SUSTAINABLE WAY

2.4.1 Progress of indicators

Outputs/Indicators	Baseline value	Value year 2016-17	Value year 2017-18	Target year 2017-18	End Target 2018-19
Output 1: Strengthened community interventions on mental health care					
1. Number of community mental health rehabilitation initiatives funded	0	0	0	10	16
2. Number of awareness campaign conducted at community level	1	2	3	3	4
Output 2: Integrated mental health care services & a people-centered approach at all levels of health facilities					
1. % of HCs providing integrated MH care through trained health care providers	84%	84%	100%	100%	100%
2. % of mental health provider (old and new appointed) trained in early detection & treatment of mental disorders as well as in people-centered related techniques	84%	85%	99%	100%	100%
3. Number of physicians specialized in psychiatry area	6	10	12	14	15
4. Level of completeness of Mental health Day Care Center construction	0	L0	L0	L3	L4
Output 3: 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) into multidisciplinary strategy					
1. Level of implementation of mental health component national strategy against drug abuse and prevention & treatment of mental health condition (level 1: development, level2: validation, level 3: dissemination and level 4: utilization)	L1	L1	L1	L3	L4
2. Level of Huye rehabilitation center equipment and functionality (level 1: procurement process, level 2: equipment distribution and level 3: utilization and Level 4: improved care services provided)	0	L2	L3	L3	L4

2.4.2 Progress of main activities

Progress of main activities [21]	Progress:			
	A	B	C	D
Strengthened community interventions on mental health care				
1. Conduct meetings & workshops on the implementation of mental health law within the community				X
2. Conduct mental health radio broadcasting Programs and celebration of World Mental Health and Drug abuse days		X		
3. Conduct quarterly coordination meetings on management of homeless mentally ill people		X		
4. Conduct trainings & sensitization activities of 250 AERG, 150 Volunteers of RRC, 100 RNP, 45 MH professionals from DHs Support for psychological interventions during Genocide commemoration		X		
5. Conduct trainings and sensitization sessions of 5000 Community caregivers in 5 Districts (One District/Province = local leaders, APS, representative of mentally ill and ex drug users' associations, etc.)				x
6. Provide financial support to 3 rehabilitation projects of mentally ill and 3 ex substance users Cooperatives at District level				X
7. Provide psychosocial interventions to trauma of Genocide victims		X		
Integrated mental health care services emphasizing a people centered approach at all levels of health facilities				
1. Conduct training on EEG for technicians from new referral hospitals		X		
2. Conduct training of 45 GPs of DHs on mental health care to support district & provincial & new appointed referral hospitals		X		
3. Develop MH National Strategic Plan 2018 - 2022				X
4. Provide internship for 8 GPs and 8 General nurses from Provincial hospitals at Ndera Hospitals		X		
5. Provide IT equipment to mental health referral services for remote consultations of mental health cases			X	
6. Provide medical and non-medical equipment to Mental Health Day Center in GASABO				X
7. Review, update and develop new protocols and guidelines for mental health care and substances abuse disorders		X		
8. Support MMed Psychiatry specialization		X		
9. Support MMed Psychiatry: coordination meeting		X		
10. Support referral hospitals - purchase of 4 EEG machines		X		
11. Training of 250 GNs from HCs on mental health care		X		
12. Conduct mentorship on EEG for technicians from new referral Hosp		X		
13. Construction and Surveillance of Gasabo Day Care Center				x
14. Surveillance of Gasabo Day Care Center				x
Integrated mental health strategies and actions with regard to the fight against abuse of psychoactive sub				
1. Conduct a prevalence study on substance abuse and assessment of illicit narcotic and precursors in Rwanda				X
2. Conduct awareness activities on drug abuse issues targeting anti-drug clubs in schools and other youth groups in 11 most affected districts		X		
3. Prevention & treatment of substance abuse disorders specialist		X		

[21] 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

Progress of main activities [21]	Progress:			
	A	B	C	D
4. Support inter-ministerial committee responsible for fighting against illicit narcotic drugs, psychotropic substances and precursors		X		
5. Support rehabilitation center in Huye - purchase of lab equipment				X
Total	**0**	**16**	**1**	**9**

2.4.3 Analysis of progress made

1. **Strengthened community interventions on mental health care**

- Much effort was given to the mental health intervention in the community because previous years' mental health care services were only delivered by Referral and district hospitals.
- Community interveners have been trained on mental health care to help the people who may experience trauma and emotional crisis during the Genocide commemoration period: 55 AERG members, 75 Volunteers of Rwanda Red Cross, 55 policemen and Officers representing health units, 37 mental health professionals from DHs
- Coordination meetings with Rulindo district for the implementation of management of homeless mentally ill people were organized with the objective to support the reintegration and rehabilitation of the mentally ill homeless individuals: 172 patients without health insurance were identified and supported.

Action Research

- Using MRC-RBC resource as recommended by SC decision 7/5 of April 2018, MHD developed a protocol on 'situation analysis and development of a model for long term management of trauma cases identified during the Genocide commemoration period.
- The draft of protocol, road map and estimated budget are available to be implemented during the next fiscal year 2018-19.

Challenges

- **Provide financial support to 3 rehabilitation projects of mentally ill and 3 ex substance users Cooperatives at District level**

  This activity is 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. Instead of providing project financial support to rehabilitation projects, the focus will be the community sensitization, initiation of support groups for patients with mental illness.

- **Conduct meetings & workshops on the implementation of mental health law within the community**

  Workshops on the implementation of mental health law did not take place because the law is still in parliament and not yet approved.

- **Conduct trainings and sensitization sessions of 5000 Community caregivers in 5 Districts (One District/Province = local leaders, APS, representative of mentally ill and ex drug users' associations, etc.)**

2. The activity was revised and budget oriented to the capacity building for long term follow up of trauma cases. The priority in next fiscal year 2018-19 will be given to the sensitization of community opinion leaders on management of mentally ill persons including homeless mentally ill persons, drug users in different districts.

Integrated mental health care services & a people-centered approach at all levels of health facilities

- Mental health care services are successfully integrated in the primary health care system. The result is that currently 100% of DHs and 99% HCs are managing mental health cases. This has been achieved by the contribution of health care providers who were trained on the assessment and management of mental disorders:
    - 43 general practitioners from district hospitals
    - 187 general nurses working in health centers
    - 33 general nurses working in prisons
    - 8 EEG technicians
    - 5 general practitioners and 4 general nurses from DHs and 8 general nurses from HCs performed a one-month internship on mental health care at Ndera Neuropsychiatric Hospital.
- The supply of four EEG machines has much contributed in the improvement of quality for assessment and management of epilepsy in health facilities.
- The quality of mental health care services has been improved through the regular clinical case sharing, mentorship and supervision done by mental health professionals from referral hospitals.

Challenges

- **Develop MH National Strategic Plan 2018 – 2022**

  Mental Health National Strategic Plan is under development, even if has delayed but fortunately the inception report has been approved. The plan will be finalized next FY 2018-19.

- **Construction and Surveillance of Gasabo Day Care Center**

  The steering committee decision of May 2018 recommended MH/RBC to follow up with planning /RBC to ensure the ordinary budget is secured during 2018-19 Budget revision.

3. **Integrated mental health strategies and actions with regard to the fight against abuse of psychoactive substance**

- Three activities out of five were fully completed:
    - There were meetings with head masters of secondary schools from Kicukiro, Bugesera, Nyagatare, Gatsibo, Nyanza, Gisagara, Muhanga, Rusizi, Nyabihu, Nyamasheke and Karongi. Participants committed to initiate anti-drug abuse clubs in their respective schools
    - Inter-ministerial committee responsible for fighting against illicit narcotic drugs, psychotropic substances and precursors was supported to conduct campaign in bordering districts
    - The National Symposium on Substance abuse was held to discuss on the strategies to be put in place in order to prevent the supply and demand of illicit narcotic drugs, psychotropic substances.

Challenges

- **Conduct a prevalence study on substance abuse and assessment of illicit narcotic and precursors in Rwanda**
  The study was integrated as part of the Rwanda Mental Health Survey and it started in March and data collection will be ending by August 2018.
- **Support rehabilitation center in Huye - purchase of lab equipment**
  All planned equipment has been provided. Although Huye Isange Rehabilitation Center identified later another need of Elisa machine but its technical specification is still a challenge.

During the reporting period, the following SC decisions were made and below implementation period.

1. RBC/MHD to work on legal and budget status of the center 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. Until now, the budget is not secured.
2. According to MTR Recommendation, Mental Health Day Treatment Center 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.
3. Alternative strategy for Mental Health 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: Instead of supporting associations, Mental Health Division organized training for mental health professionals in DHs on psychoeducation for rehabilitation.

2.5 Performance output (result) 3 – Urban Health services coverage is rationalized and extended in line with the three guiding principle of the National Health Sector Policy

2.5.1 Progress of indicators

R3-Urban Health-Output/Indicators	Baseline value	Value 2016-17	Value 2017-18	Target 2017-18	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	674	1200	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	Identified	Identified	Identified	No more target as activity stopped July 2018
I3.2.1.2 % of TWG health environmental platform recommendations implemented	NA	60%	NA	75%	No more target as activity stopped July 2018
R3.3.1 The Kigali Hospital Networking formalized (functional KHN)					
I3.3.1.1 Appointed members from different hospital and other stakeholders	NA	Complete	NA	NA	All stakeholders
I3.3.1.2 TOR and objectives approved	NA	Yes	NA	NA	Yes
I3.3.1.3 Road map Operational plan	NA	Partially (HIN)	Proposed b HNW Consultant report but not validated by MoH	NA	3-year plan
I3.3.1.4 Inventory of joint/ shared initiatives	NA	3 identified but not yet implemented	4 identified, one implemented	4	8 To be reduced to 4
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	134 new cases per month and per HC	170 new cases per month and per HC	Not determined	TBD
I3.3.2.2 Number of laboratory able to make FBP and biomedical analysis	3	3	4	4	4
I3.3.2.3 Number of HC equipped with ultrasound machine	0	0	4	4	4
I3.3.2.4 % of drugs for NCD and chronic diseases available at HC level	0	0	100%	70%	100%
R3.3.3 A comprehensive and equitable urban Health Facilities coverage plan is developed and validated					

R3-Urban Health-Output/Indicators	Baseline value	Value 2016-17	Value 2017-18	Target 2017-18	End Target 2019
I3.3.3.1 Updated mapping of health facilities (public and private)	NA	NA	Not available (on doing activity with consultant firm under DG Planning)	Mapping available	Mapping available
I3.3.3.2 Recommendations and operational plan proposal for improving coverage	This activity will be replaced by developing Health strategic plan for CoK after the completion of mapping = expected activity for 2018-2019				
I3.3.3.3 TWG on coverage plan in place with coordinator identified					
I3.3.3.4 Framework PPP available					
I3.3.3.5 Number of private investors engaged to finance new HC					
I3.3.3.6 MOU insurance coverage public & private					
I3.3.3.7 Number of HF up-graded					
I3.3.3.8 Quality standard per HF 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	Available	NA	NA	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	NA	TBD

2.5.2 Progress of main activities

R3- Urban Health - Progress of main activities	Progress[22]:			
	A	B	C	D
Develop promotional activities on social determinants of health in CoK				
Organize NCD mass campaign:				
Organize hygiene mass campaign				
Organize quarterly joint supervision				
Organize quarterly TWG meeting of health environmental platform				
Develop and validate a sound concept and equitable coverage plan for HC				
Development of health strategic plan for the CoK				
Medicalization of HCs: PBF for Medical doctor				
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				
Upgrade existing HCs ultrasound				
Create a functional, autonomous and efficient hospital network				
Finance Laptop or computer, printer, retro projector)				
Preparation (selection topics) of training module for activity to be defined and budget				
Training of actors (KMH, KFH, Muhima, Kibagabaga, Kacyiru, Poly Clinique la Médicale)				
Recruit a Consultant to develop dashboard for shared monitoring				
Acquisition of PACS system				
Acquisition of Other ICT Equipment, software and Assets				
Develop concept of telemedicine by the network coordinator (60 days consultancies on topics)				
Field facilitation to medical skills sharing (once a quarter or when needed)				
Short course training of CoK staff on planning & management				
Design, build and equip a 120 beds Hospital in Nyarugenge District articulated with the CoK coverage plan				
Transfers the budget To Districts Current				
TOTAL	**0**	**11**	**3**	**3**

2.5.3 Analysis of progress made

General comment

Overall and compared to last year, much progress has been made in carrying out activities; also, and in response to the recommendations of the MTR, some activities have been removed / reoriented. In view of the reorganization and in view of the decisions of the Steering Committee, some outcome indicators should be deleted / reviewed.

- From 17 activities, 12 were done on time, which represent an important improvement compared to previous years. Routine activities like medicalization, mass campaigns on NCD, skill sharing (specialists going to DH), etc. are taking place regularly and on time.

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

- Three activities are delayed because procurement process still on going.
- Two activities related to KHN have long delay due to difficulty to validate and implement plan for Hospital information network development.

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

- **Non-communicable Disease (NCD) mass campaign was conducted with success**
    - Analysis of data collected the previous year was done showing important number of abnormal results (more than 600)
    - The follow-up of patients detected with abnormal values was conducted with validated protocol and questionnaire as an action research (AR)
    - The recommendations from evaluations of previous mass campaign were implemented:
        - Central role of RBC and districts to support CoK and partners
        - Better advertisement and better engagement of the press
        - Better questionnaire formulation on risk factor habits (duration, quantity, etc.)
        - Increased number of screening spots
        - Increased number of volunteers
        - Increased budget
        - Improved management of serious cases detected (transfer to hospital) with the consequence that
    - The consequence is higher visibility with broader scope of intervention:
        - The number of people screened during one week increased to around 6500 (from 2800 in 2017)
        - The car free day is now twice a month and screening of people is done in the same time
        - The screening and car fee day have started in different cities
    - The protocol for AR on the follow-up of the people with abnormal value will be improved and will be validated by scientific and ethical committees in order to disseminated the results of AR broadly
    - Despite the MTR recommendation to stop to support this activity the SC May 2018 has decided: ***"R3. UB to continue support to NCD for CoK to organize NCD mass campaign in May 2018"***
- **Hygiene and sanitation activities with TWG**
    - Hygiene mass campaigns were conducted and financed as routine activity by CoK. The aims were to provide higher budget for the NCD mass campaigns. For the next years, this activity has been removed from the UB program.
    - The health environmental platform with quarterly supervision and quarterly meeting organized activity as routine but for the next years, the activities has also been removed from UB program.
    - The reasons to remove hygiene and sanitation activities from UB program were:
        - To provide higher budget to NCD mass campaign in order to increase its impact

- Recommendation from the Mid Term Review (MTR): The SC has agreed in May 2018: ***"R3. SPIU/RBC UB to inform CoK of this decision to stop UB funding for hygiene and sanitation activities"***

2. Support the implementation of the coverage plan through various strategies

- **Medicalization of four Health Centers**
  - The four Ultrasound (US) machines were provided and are in use:
    - For the first trimester of 2018, around 200 US exams were performed by Doctors and Nurses in the 4 HC
    - The equipment provides a lot of satisfaction and contributes to the increase number of patients at HC level and to the decrease of patients sent to District Hospital
  - Now the MD are going twice a week to all HC on regular basis with higher number of patients seen by doctors: for 2017, a total of 7690 patients were seen by doctors during 358 visits (against 410 expected)
  - The medicalization was integrated the HSSP4
  - Following the MTR recommendation on this activity the SC has taken the following decisions in May 2018: ***"7/3.SC approves the implementation modalities put in place for a conducive implementation mechanism to ensure effective achievement of medicalization and hospital networking objectives. (Note: no budget reallocation implied)"***
    - To reduce the fragmentation of responsibilities for specific (MOH, CoK, District hospitals) outputs among multiple program partners, a meeting was held on 13th April including MOH Clinical Services, CoK Environment Health Unit and UB program:
      - MOH responsible for:
        - Ministerial instructions on tariffs for Medicalized Health Centers (MHC)
        - Validation of MHC package and include in accreditation
        - Develop legal framework for referral system between Public and Private health facilities
        - Oversee Task Force for Hospital network and coordinate the network
        - Validate Hospital networking consultancy report for implementation
        - Develop sustainability plan for MHC and hospital networking
      - CoK responsible for:
        - Active member of Hospital networking and administrative supervision of DHUs and DH
        - Receive progress reports from HC (through DH and DHUs)
        - Takes the lead Organize NCD mass campaigns in coordination with RBC/NCD
      - District Hospitals and DHMT
        - Technical Supervision of MHC activities and reporting
  - Challenges:
    - Sustainability → see Risk management Section

- Still need for legal framework with the standard package; SC decision in May 2018 confirmed the importance to get it rapidly: ***"R3. DG CPHS to present final package of medicalized HC to SMM for final validation for June 2018"***

- **The Kigali Hospital Network**
  - Only one joint initiative has been implemented with success: skill sharing activity:
    - 15 modules were selected and identified by senior medical specialists and per priority specialty: Traumatology & orthopedic emergency, General surgery emergency, Obstetric emergency, Pediatrics and neonatology:
      - From December 2017 to June 2018, 2 modules per specialty were taught in 4 District Hospitals as planned. The next 7 modules will follow next years
    - Main challenges during this first year of skill sharing implementation:
      - Regular changes of the initial plan by trainers
      - Minimum support offered to the training team
      - Insufficient information on the success of training by trainees
      - Practice not performed to some facilities and few hours allocated to practical session to some other facilities
      - Few GPs attend training as per attendance list
      - To some facilities, lack of equipment and drugs for the specialized services
      - Delayed and incomplete reports by hospitals
      - Budget available
      - Sustainability
  - The PACS system has been delayed several times because the technical specifications could not be validated and are still circulating
  - Operational plan HIN with 5 Work Package Groups defined during the previous year could not be implemented because the work package groups are not working, the nominated chaired having no interest, no technical capacity and no time to develop all the activities proposed
  - The equipment of the different hospitals with e-equipment for future dashboard and shared information is delayed because of procurement slow process
  - A team of consultants came to guide and provide a strategic orientation towards the development of a sustainable hospital network in the City of Kigali with a HIN feasibility study taking into account the context of the 11 hospitals members of Kigali hospital network. The report provided by consultants resented the necessary activities with a roadmap, aiming at implementation of a fully integrated HIN dashboard with also the requirement of different human resources with different profiles
  - Challenges:
    - The MoH has not yet validated the consultants' report
    - The Human resources
    - The limited budget

- **Health strategic plan for the CoK**
    - The CoK has requested to support the development of its health strategic plan to replace the initial "Waste management plan"
    - The draft of ToR to recruit a consultant team was prepared but public tender process was then postponed. This is because of a new activity in the Result 4: Master Facility List study. The output of this activity is a national census of all health facilities (HF) in Rwanda, including the private sector and projections for the next decades in terms of population and in terms of needs for infrastructures and human resources. Therefore, the ToR for the CoK strategic health plan needs to be adapted considering the fact that mapping of CoK HF with needs for future will be soon available

    ➔ This activity will take place next year.

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

  The construction works contract was signed on 15 December 2017, for an execution period of 16 months, starting from the 15 January 2018 (including one month for the mobilization), with MASS Design Group for the supervision.

  On the 9th February 2018, the first stone of the Nyarugenge District Hospital was laid by Hon. Minister of Health, Dr. Diane Gashumba and by His Excellence Belgian Ambassador Benoit Ryelandt with the presence of The Mayor of Kigali and the Mayor of Nyarugenge.

    - Issues on side of the Contractor:

      The construction works started slowly, with insufficient personnel and equipment, and the project was accusing about 2 months of delay by end of April 2018.

      Reasons for construction delay include:
        - The Contractor did not use the mobilization month for the site installation (construction of offices, storage, temporally latrines, etc.). The said works were performed after the 14th January when the proper construction works should have started;
        - The Contractor did not mobilize the competent key personnel as committed in bid document. The absence of the Project Manager among others contributed to a poor management from the beginning of the construction works.

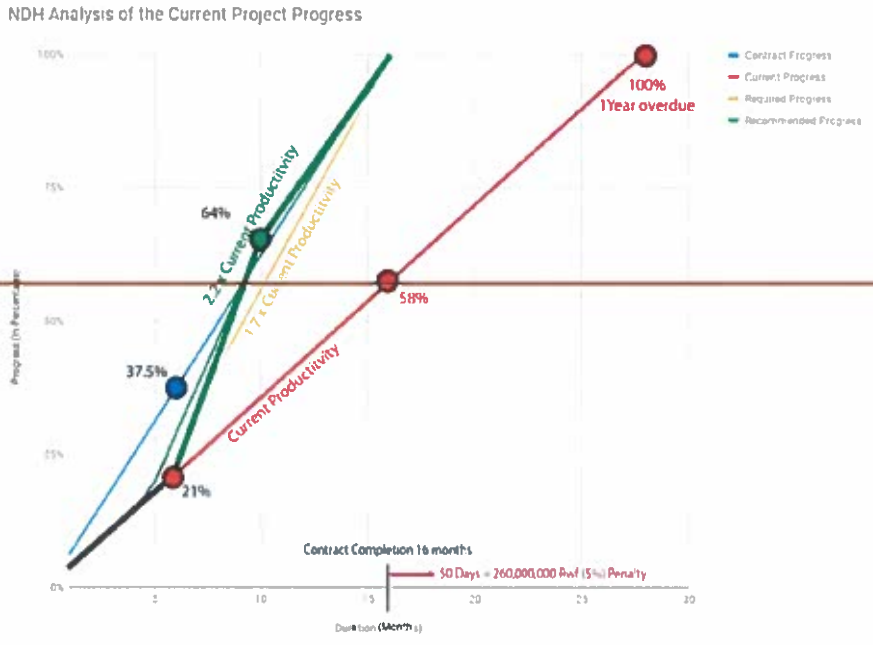
- Lack of planning of works, human resources, procurement
- Additional to the lower rhythm of work demonstrated by the contractor, we had a heavy rain season from March to May 2018, contributing more to the delay of works progress.

- Issues on Supervision firm side:

The supervision started without convincing supervision, acting more as witness than a supervisor does.

Areas of concerns with the supervision firm include:

- The Supervision firm started as well with key personnel that was not fulfilling the requirements of the contract; and until now, some of the key personnel aligned lives abroad and cannot respond on call to solve the issues happening on site. They are available following a tentative calendar that vary much depending on the progress of work on site.
- The supervision firm shows a non-constraining attitude vis-a-vis to the Contractor, and this situation makes the time to solve each problem on site taking more time than needed;
- The Supervision firm delays to react on different situation including delivering warning letters, reporting issues to the Client, producing monthly reports, providing feedback to the contractor... Such situation contributes more on increasing the delay than to push or to encourage the Contractor to catch-up the delay.
- The delay is very important even if 20% was reached at the end of June: according to the supervising firm, if the works continue with the actual progress speed, we will have 12 months of delay before the completion of the project, as it is illustrated in the Figure below:



- Equipment for the hospital

It is planned that, by July 2019, the hospital's construction works will be completed; the hospital will be fully equipped and fully operational.

In preparation for the tender of equipment, the task force meeting held on 21st February 2018 has nominated the technical core team composed by members from MOH, Enabel, RBC/SPIU and RBC/MTI,

with the objective to prepare a list of equipment needed for the hospital and technical specifications for the tender document.

- Actions taken
  - The District, RBC and Enabel started to remind the contractor and the Supervision firm to respect the work schedule from February 2018, to change the trend and catch-up the delay.

    The Mayor of Nyarugenge District and UB Program Coordinator to monitor implementation of catch-up plans and decisions have initiated additional management site meetings.

    District with Enabel and RBC has called different task force meetings where they met the management of the contracting company and highlighted their concern in regards to the delay of works. For some of the breach of the contract observed by the Client, warning letters were written to the Contractor and to the Supervision calling him to a prompt alignment to contractual terms and responsibilities. Despite the numerous warning letters, no corrective measures have been taken by date; it is why the surveillance firm will **notify a provision suspension for undetermined period** in order to encourage the management to comply with terms of contract:

    "In accordance with Clause 8.8 [Suspension of Work] of the General Conditions of Contract, this is to instruct that works on the construction of 120 beds Nyarugenge District hospital be suspended on all of parts effective July 23rd 2018 for a period not less than one (1) week. Reasons for the suspension is the failure to meet contractual obligations listed below:

    1. *Non-compliance on Contractor's Key Personnel and staffing (Attached).*
    2. *Non-compliance on Procurement of Plant, Materials and Workmanship / Procurement Schedule (Attached).*
    3. *Non-compliance on Health and Safety (Attached).*
    4. *Non-compliance on Contractor's Documents (Attached).*
    5. *Non-compliance on Contractor's Progress Reports (Attached).*

    Please note that the reasons for suspension outlined above are the Contractor's responsibility.

    In conformity with Art 8.8 of the general condition of the contract, the causes of suspension being the responsibility of the contractor, art 8.9 (Consequences of suspension), 8.10 (payment for Plant and Materials in event of suspension) and 8.11 (prolonged suspension) shall not apply".
  - Regarding the tender for the equipment, The Task Force appointed a core team that is responsible to identify the list of required equipment, oversee the development of specifications and procurement process. The main challenge lies with the budget constraints. The core team for equipment has already listed all equipment required with its cost (around 2.5 Million Euros for 1.5 available). The technical specification is ongoing to be completed by phase according the category of equipment and all should be ready by September 2018. The roadmap with budget estimates will be presented to the next Steering Committee (planned in August 2018).
- **SC Decisions (May 2018) concerning the construction of NDH following the risk and difficulties explained and following the MTR:**
  - MTR 9 SC R3 Construction Nyarugenge DH: ***"Ensure strict monitoring and close involvement of all actors and stakeholders. Regular reporting to senior management"***

- MTR 10 SC R3. Nyarugenge DH equipment: ***"Core team to present list and budget estimates for hospital equipment to Task Force & Task Force to refer to SC in case of budget estimates excess"***

  ➔ It is done

- SC R3-R6 UB program: ***"to develop a business plan for the construction of Nyarugenge DH with the support of external consultant from Enabel framework contract – due date Q2 2018/19"***

  ➔ ToR have been drafted and sent to Enabel HQ for validation

- **New activity based on MTR recommendation (MTR 8) validated by SC May 2018**

  "R3 MOH in coordination with CoK, districts and district hospitals to develop a vision for first line health services in urban area that includes the concept and operationalization of 'medicalized health centers for Aug 2018".

  For that activity, the Health experts from Enabel Rwanda and Enabel HQ are working on a model of first line services.

2.6 PERFORMANCE OUTPUT (RESULT) 4 -THE LEADERSHIP AND GOVERNANCE IS REINFORCED, SPECIFICALLY REGARDING DISTRICT STEWARDSHIP, THE RESPECTIVE ROLES OF MOH AND RBC AND THE PUBLIC PRIVATE PARTNERSHIP

2.6.1 Progress of indicators

Indicators	Baseline value	Value year 2016-17	Value year 2017-18	Target year 2017-18	End Target 2018-19
Output 1: All DHMT/DHU are fully functional					
% DHU operational with at least 3 DHMT meeting held per year under the secretary of DHU	TBD	83%	80%	100%	100%
% of districts submitting to MoH the quarterly reports on selected key indicators		100%	80%	100%	100%
% district with integrated health plan		NA	TBD	100%	100%
Number of action researches Studies/Short courses initiated, completed and documented by district unit	0		0	5	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	3	3	3/year	3/year
% of DHU with two staff per District trained on planning, M&E, Finance and management	0	TBD	TBD	80%	100%
Number of supervisions done to evaluate the Medical internship Program at district hospitals (DH)	NA	0	1	2	2
Number of action researches Studies/Short courses initiated, completed and documented by Central level	0	0	0	1	3

2.6.2 Progress of main activities

Leadership and Governance- Progress of main activities [23]	Progress:			
	A	B	C	D
All DHMT/DHU are fully functional				
1. Strengthen the implementation, monitoring and evaluation of governance and health system at hospital levels (Training on HMIS)			X	
2. Organize a workshop with DHU on methodology and tools for developing new DHSPIII (2018-23)		X		
3. Support 30 district to finalize the development DHSP 2018-2023		X		
4. DHSP-Quality check				X
5. Support action researches for protocols, realizations by decentralization level			X	
MoH and RBC have provided support and capacity building regarding the gaps and needs identified				
6. Strengthening Medical Doctors' Internship program: mentorship/supervision				X
7. Support councils and professional bodies and MOH conferences		X		
8. Conduct mapping of Health facilities			X	
9. Organize joint supervision at District level twice a year				Not done
10. Strengthening Medical Doctors' Internship program: development of internship monitoring tools (done using other source of funds)			X	
11. Support action researches for protocols and short courses for planning staff			X	
Total	0	3	5	3

2.6.3 Analysis of progress made

Output 1: All DHMT/DHU are fully functional

Under this output, three main activities and two sub-activities (2) were planned. The main activity targeted in this output was to support all 30 Districts to develop their Health Strategic Plans for 2018- 2024 that will be aligned to the Health Sector Strategic Plan 4, the District Development Strategy, the National Transformation Strategy 1 and other policy guiding documents. All 30 Districts developed their health strategic plan. The developed Strategic Plan will give a long-term plan of health priorities and strategic interventions to achieve health priorities with the coordination of the Ministry of Health through the Directorate General of Planning and the support of Development Partners and the financial support of Ubuzima Burambye project.

A Quality assessment of the DHSPs was planned to review and provide comments to improving the plans before their validation by Local authorities, the Quality assessment was postponed for 2018-2019 as the process of developing DHSPs was finalized almost at the end of the current 2017-2018 fiscal year.

A new activity was added in the plan in the context of strengthening Districts to fill the gap in monitoring and evaluation and enhance the health system coordination at the decentralized level. This lead to achievement of 3 out 4 indicators, which represents an average of 75% achievement. .

[23] 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.

Challenges: The Quality check and assessment for DHSP has been postponed to next FY.

During the reporting period, District Health Operational Research Challenge Funds has been initiated and Development partners (Enabel, MSH and Swiss Cooperation) supported this initiative. Out of 181 submitted proposals, 13 were recommended to be funded. However, the challenge funds should not be confused with the Action Research program and if some protocols have been presented and activity started (R1 and R3), none has been completed yet.

The SC has decided to transfer the budget of AR to regie to facilitate the activities; more flexibility was requested to achieve results in that category.

Output 2: MoH and RBC have provided support and capacity building regarding the gaps and needs identified

Five activities were planned under this output and only one completed. Others were initiated and will continue in the 2018-2019 fiscal year.

1. **Conduct the mapping of Health facilities**

Rwanda Health care system has evolved and this success is result of rapid infrastructure development and expansion to match the needs of Rwanda's growing population. Currently, MoH aims at setting up at least one health center per sector and one health post per cell.

In this regard, MoH would like to make a census of all existing health facilities, including private HF, map their location, categorize them, analyze their capacity in terms of human resources and services and, constitute a National Health Facility Registry. As well, MoH plans to model keys services against population growth trends, so as to anticipate future needs in equipment, essentials resources, infrastructure development and/or expansions, including localizations where facilities will have maximum impact.

A consultant firm has been recruited to develop this Rwanda Master Facility List (MFL). It is a necessary step before to initiate a Service Availability and Readiness Assessment (SARA) that will take place in 2018-2019 fiscal year. During the implementation, the firm faced some challenges and could not provide the final report on the MFL that was expected in May 2018. The causes of delay were independent of the firm and extension of the contract was given up to 31 of July 2018. The delay was due to end-user (MoH) that decided to change some ToR and deliverable leading to delay to get authorization for collecting data.

It is important to note that this MFL is also a prerequisite to develop the next Health Strategic Plan for the CoK and therefore this delay affected also the development of this activity in the R3.

2. **Strengthening Medical's Internship program through mentorship and supervision in 22 different sites**

The supervision was conducted in the 22 sites; the dissemination of key findings was postponed to the next fiscal year.

3. **Support Action researches for protocols**

Directorate of Planning and HFIS prepared a draft concept note but it has not yet been reviewed and it has been postponed to FY 2018-19. Other Result Area (R1 and 2) are benefitting technical support from MRC. R3 is progressing well in AR related to NCD mass campaign.

4. **Support councils and professional bodies and MOH conferences**

Two different councils were supported (1) on surgery and (2) on Dental Surgery through support to two conferences.

5. **Organize joint supervision at District level twice a year**

This activity did not take place due to the fact that the new DHSP development process covered all health issues that would be subject to motivate any supervision at District level given that all stakeholders at decentralized level were involved in the DHSP development.

Bottlenecks:

- **One of the major challenges for result 4 execution rate is the implementation of Action research program because it includes all results and it has been delayed to be implemented**
    - Steering committee approved to allocate balance of action research budget to Regie modality by 1st July 2018 considering the type of activities and their unpredictability.
- **Many activities were planned in Q4 and were not implemented due to the conflict agenda**
    - The planning of next FY will take into consideration lessons learnt and few activities will be planned in the last quarter
- **The implementation of some activities mainly with decentralized level depends on decentralized level agenda**

During the reporting period, the following SC decisions were taken and implementation progress below

1. DG Planning and HFIS to develop action research implementation plan linked to Quality Improvement initiatives by end of April and to present the progress to next SC with a deadline of 31/07/2017.

   → This has not been implemented

2. To utilize resources of RBC/MRC Directorate for scientific support towards action research topics under each result area. Avoid use of external consultants wherever possible. This decision has been implemented for R1 and R2.

   → With the support of MRC, Mental Health Division has developed protocols on 'Situational Analysis and Development of a model for a long-term management of trauma cases identified during the commemoration period of the Genocide against Tutsi'. The next step is to support R1 to finalize their protocol.

3. To allocate balance of action research budget to Regie modality by 1st July 2018 to ensure effective implementation of action research.

2.7 PERFORMANCE OUTPUT (RESULT) 6 – THE ASSET MANAGEMENT IS DESIGNED AND OPERATIONAL IN A COST-EFFECTIVE WAY

Preliminary note: it was considered in the steering committee that the above expected result needs to be well defined as it appears unrealistic and ambitious to reach within the course of the program. The indicators may need to be revised for the next fiscal year to ensure that the program provides assistance in the initial steps towards the design and operations of the asset management are cost-effective. This includes the existence of a national strategic plan for asset management, policies and guidelines as well as some capacity building development.

2.7.1 Progress of indicators

Indicators	Baseline value	Value year 2016-17	Value year 2017-18	Target year 2017-18	End Target 18-19
Output 1: Better utilization of assets in health facilities					
Health facilities benefiting improvement initiatives	0	51.25%	63%	80%	95%
Output 2: Health facilities are designed according to standards and guideline					
Norms and Standards for Health infrastructure developed and approved	Existing service package	Not yet achieved	Partially achieved. ToRs to be refined and relaunched	approval	approved norms and standards
Output 3: Improved capacity of biomedical and health infrastructure Engineers and Biomedical technicians at central and hospital level					
% of medical equipment curatively maintained upon HF requests	NA	63%	Reduced: MTI no longer handle curative maintenance works. Responsibility shifted to Hospitals instead of Central level. MTI now handles curative and preventive maintenance contracts management. There is need for more contracts to satisfy all maintenance needs, this year 95 % of curative maintenance contracts were handled successfully.	60%	70%
Number of Staff trained and Upgraded the education levels in Biomedical engineering and Health infrastructure.	A1: 50 MSc: 3	33 are looking for A1. 3 BMETs for District hospitals	A1:23 A0:3 MSc:2	A1: 80 A0: 2 MSc: 5	A1:80 A0: 2 MSc: 5
Output 4: Technical support towards harmonized, standardized effective acquisition, distribution, and disposal of medical equipment					

Indicators	Baseline value	Value year 2016-17	Value year 2017-18	Target year 2017-18	End Target 18-19
Database of technical specifications of medical equipment and inventory of medical equipment in health facilities	NA	Achieved. - Bank of technical specifications available - Inventory for DH is done. - Inventory for HC is ongoing.	MEMMS has been updated and is currently being deployed and implemented across all public health facilities. The electronic inventory is currently being updated.	Database and inventory available	Database available
Output 5: The policy and standards and /or guidelines regarding health assets management is updated, approved and disseminated					
Availability of a national policy regarding health asset management system	NA	Not achieved. -Guidelines for -donation of medical equipment -guidelines for disposal of medical equipment	Guidelines for donation and commissioning completed, has been disseminated. -NSP draft ready, waiting for approval. -Guidelines for Health Infrastructure and Equipment Management under approval process.	National Policy Available	National Policy Available

2.7.2 Progress of main activities

Progress of main activities [24]	Progress:			
	A	B	C	D
Output 1: Better utilization of assets in health facilities				
1. Implementation of Measures taken for radiation safety suggested the consultant six hospitals (Kinihira, Kirinda, Munini, Butaro, Rwamagana, Murunda) in short term				X
2. Implementation of strategic improvement initiatives on medical equipment and maintenance for district hospitals			X	
3. Purchase electromechanical tool boxes for district hospitals			X	
4. Purchase Engineering Testing tools for MTI staff			X	
5. Setting call center at MTI Office and recruitment of call center staff and purchase software				X
6. Pre-installation works of autoclaves				X
7. Provide piped oxygen lines for neonatology services in Nyamata and Nemba DHs.			X	
Output 2: Health facilities are designed according to standards and guideline				
1. Develop technical standards for HF in infrastructure and equipment				X
Output 3: Improved capacity of biomedical and health infrastructure Engineers and Biomedical engineers/technicians at central and hospital level				
1. Master's degree in Biomedical Engineering for MTI staff				X
2. Short courses for MTI staff				X
3. Short Trainings for Biomedical Technicians from central and district level		X		
4. Support in the payment of bursary fees for 3 candidates pursuing Bachelor's degree in Biomedical Engineering		X		
5. Provide training for Provincial maintenance workshop staff				X
Output 4: Technical support towards harmonized, standardized effective acquisition, distribution, and disposal of medical equipment				
1. Construction of 1 Biomedical Technology Workshops and rehabilitation of 3 Biomedical Technology Workshops		X		
2. MEMMS – provided support for the improvement and implementation of the system in public hospitals		X		
Output 5: The policy and standards and /or guidelines regarding health assets management is updated, approved and disseminated				
1. Validate and disseminate policies for HF in infrastructure and equipment (Donation, Decommissioning and disposal)		X		
2. Develop, validate and disseminate the National Strategic Plan for medical and infrastructure assets			X	
3. Validation of In-depth assessment report			X	
Total	0	5	6	7

2.7.3 Analysis of progress made

Out of eighteen (18) planned activities, none activity achieved ahead schedule, five (5) achieved on schedule, six (6) are delayed and need corrective measures, and seven (7) have been seriously delayed.

[24] 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.

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

1. Construction of 1 Biomedical Technology Workshops and rehabilitation of 3 Biomedical Technology Workshops: workshops were completed on time, but they are not being utilized fully as intended due to lack of a comprehensive business plan and especially lack of trained manpower and non-flexible recruitment procedures.

2. Support in the payment of bursary fees for 3 candidates pursuing Bachelor's degree in Biomedical Engineering: This is currently being done, but timely payments are still a challenge due to long administrative procedures.

3. Short Trainings for Biomedical Technicians from central and district level: 4 trainings were conducted. Calling all BMETs from the hospitals is a **challenge due to lack of replacement staff**.

4. Validate and disseminate policies for HF in infrastructure and equipment: 2 guidelines were validated and disseminated (donation and decommissioning), but the implementation is still low due to lack of training and information in some HFs. There is still need for developing guidelines for all steps of equipment management.

5. MEMMS - provided support for the improvement and implementation of the system in public hospitals: A consultant was hired to conduct aa study about further needs to correct and improve the system. Due to a delayed hand-over by the system developer, the suggested improvements are yet to be planned. It will be done in the next fiscal year 2018-19.

   A physical verification of the deployment and implementation of the system in public hospitals was conducted and the report show-cased different challenges namely lack of enough training, lack of medical equipment nomenclature and lack of knowledge or information needed to accurately input data in MEMMS. A monitoring system must be put in place to complete the data inputting and accurately manage the inventory. *MTI/RBC with the help of SPIU/RBC to develop a proposal to upgrade or update MEMMS for funding consideration to be presented to SMT in July 2018 for validation.*

   There are however practical challenges in Data management. There is a lack of systematic coding system (No bar code reader, printer and stickers to identify equipment for fast inventory). Biomedical Equipment technicians (BMETs) lack Lap tops for BMETS and did not receive sufficient training in data entry to MEMMS. The Hospitals do not allocate sufficient budget for internet payments.

The following activities were **delayed, some corrective measures needed**:

1. Implementation of strategic improvement initiatives on medical equipment and maintenance for district hospitals: Site visits of the 23 recommended hospitals were conducted to assess the needs for improvements. Some of the needs were confirmed, technical specs were prepared, tender launched, **some items didn't get bidders and delayed**, contracts signed now but equipment still at MAGERWA.

   Ngarama and Remera Rukoma renovation works for Neonatology rooms were identified as a need but the revised budget exceeded the planned one. It has been recommended to cancel Remera Rukoma, and Ngarama postponed for the next fiscal year 2018-19.

   IT equipment and software were requested by 7 hospitals (Shyira, Masaka, Muhima, Muhororo, Nyanza, Ruli and Kigeme). In the 1st phase, Masaka Nyanza and Ruli were considered.

2. Purchase of 26 electromechanical tool boxes for district hospitals: Tender evaluated, Notification has been done. This will follow with contract and then delivery in the next fiscal year 2018-19. **The utilized technical specifications did not include 1 critical item** (multimeter). The missing item was included in the re-advertised tender for Testing Tools, the evaluation of the tool boxes tender was not done on time.

3. Purchase Engineering Testing tools for MTI staff: the tender went through, but **there was no qualified bidder.** It was resent, and currently under tender. **The procedure of cancelling the tender and relaunching delayed the process.**

4. Provide piped oxygen lines for neonatology services in Nyamata and Nemba DHs: **Tender documents were not clear enough** on the planned work for oxygen lines in Nyamata Neonatology block and Nemba Operating Theatre. **The contractor undertook the work in Nemba for the Neonatology instead of Operating Theatre and it was directed by Nemba hospital administration based on the tender document which was confusing.** The works have been completed for both oxygen lines for Neonatology blocks in Nyamata and Nemba. Operating Theatre in Nemba hospital still requires piped oxygen lines. Close supervision on such projects is needed!

5. Develop, validate and disseminate the National Strategic plan for medical and infrastructure assets: A National Strategic Plan for medical equipment and infrastructure draft is ready. *It will be finalized and presented to SMM for validation by Mid-July 2018 in the next fiscal year 2018-19.*

6. Validation of In-depth assessment report: The assessment was validated. **There is no clear validation process for such a document** which generated significant delays.

The following activities were **seriously delayed (over 6 months); Substantial corrective measures are required**:

1. Implementation of Measures taken for radiation safety suggested the consultant six hospitals (Ruli, Kabgayi, Kirinda, Butaro, Rwamagana, Murunda) in short term: This activity is ongoing, 6 hospitals were visited, 4 (Ruli, Kabgayi, Kirinda, Rwamagana) have been considered for the radiation safety, contract signed, civil work will commence in July 2018. The supplier has to order and get other items needed for personal protection. Butaro was not considered due to budget constraints. **Site visits were not conducted on time due to shortage of manpower and shifting of priorities at MTI, procurement delays in SPIU.** Planning and coordination needs to be improved.

2. Setting call center at MTI Office and recruitment of call center staff and purchasing of software: Some equipment has been procured, the NAS server, bar code reader, printer, and scanner remain to be procured, still under tender stage. **The technical specifications preparation delayed due to a long need assessment period, and procurement process delayed because of budget constraints. Grouping with other equipment for purchase took some time, and this delayed the process as well.**

3. Pre-installation works of autoclaves: Contract was sent to supplier Ki Pharma for signature and scheduling of activities. MTI engineer / Technician shall be going with contractor while contractor is undertaking various jobs. Suggest close follow up and monitoring. **Finalizing the technical specifications delayed the procurement process, there were some budget constraints and the whole tender will not be done.** Lot 1 for pre-installation and completion of installation, Lot 2 for repairs will be done, and Lot 3 for maintenance of 1 year was put on hold.

4. Develop technical standards for HF in infrastructure and equipment: The expression of interest for the development of infrastructure standards was launched, **but the firms who expressed interest did not meet the advertised conditions**. MTI Infrastructure team shall help to improve the TORs developed for the previous tender notification. RBC/SPIU needs to meet with MTI Infrastructure team.

5. Masters' degree in Biomedical Engineering for MTI staff: 4 were selected, but only 2 were sent for Masters in Biomedical Engineering. **2 were postponed due to shortage of staff** and will be sent for studies in the next fiscal year 2018-19. They are planned to leave for studies in September 2018.

6. Short courses for MTI staff: **due to administrative procedures and a long and complicated selection process,** there hasn't been any short training for MTI staff this year. **Policy is not clear on the selection and approval process.**

7. Provide training for Provincial maintenance workshop staff: Provincial workshops were visited and an introductory training conducted. Needed equipment is being purchased within the tender for Testing Tools for MTI. **Due to lack of organizational structure of provincial workshops, decision about their ownership, the functionalities and operational procedures of the workshops,** there is still need for developing a business plan, trained and skilled personnel, and a targeted recruitment process. In the meantime, the workshops are being utilized as provincial hospital workshops. MTI with the support of external consultant from Enabel framework contract to develop a business plan and to ensure the functionality of provincial maintenance workshop by December 2018 – due date Q2 2018/19.

2.8 TRANSVERSAL THEMES

2.8.1 Gender

- The program 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 center 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, other, etc.
- The challenge to take gender into consideration is that there is no specific budget on gender issue
- A gender scan took place during formulation (see TFF). However, following the initiative from the representation, there have been some initiatives to review the gender issues at MOH level through a large Gender Profile of the Health Sector conducted by Rwanda Accuracy Development Consult Ltd (through the Study and Expertise fund)
- A gender mainstreaming exercise for UB program has been initiated with the support of Rwanda Accuracy Development Consult Ltd. A report is expected next fiscal year

R1 - Quality

High morbidity and mortality in postpartum period do affect women in childbearing age. This is being addressed through quality improvement initiatives. QI projects have a strong attention to women health with a specific output of reducing post caesarean infection

R2 - Mental Health

As UB program does not 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 Program action plan and not foreseen by TFF, the result didn't organize awareness activity for the staff
- The Program is collaborating with the Associations targeting genocide survivor widows AVEGA as one of the stakeholders Program

R3- Urban Health

The main gender gaps are:

- Insufficient 4 ANC visits for ANC coverage in the CoK (29%)

- Higher prevalence of overweight and obesity among women in the CoK
- 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
    - The US is now available in 4 medicalized HC and it serves mainly for pregnant women for better and early diagnosis
    - 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

R4 -Leadership and Governance

Leadership and Governance are crucial to the general wellbeing of the population, and this includes gender issues. Districts health priorities for the developed DHSP are gender equality related.

- 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 Program were not threatened by any form of gender violence. However, the Program 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

2.8.2 Environment

1. 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. Example: ensure regular inspection for safe environment, fire safety Program and waste management
2	As it not part of the UB Program 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

2. 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, etc)

3. 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, etc.)

2.9 RISK MANAGEMENT AND PROCUREMENT

2.9.1 Procurement-Planned tenders and implementation progress

RA	Title: description of tender	Implementation process
R1-R6	Consultancy services to Develop technical standards for HF in infrastructure and equipment	**Not completed** and waiting for revised ToRs. Terms of Reference were elaborated by both MTI and Clinical Services but tender launched without successful bidders. Now, the ToRs have to be revised by End-users
R1-R6	Renovation of Neonatology room of Ngarama and Remera-Rukoma	**Not implemented** After approval of the project submitted by Ngarama and Remera Rukoma, a team composed by SPIU and MTI conducted a field visit to confirm the needs. A revised BoQs has been prepared and submitted. However, the program faced budget constraint as revised BOQs were very expensive compared to the initial request. Therefore, it has been decided to cancel the project for Remera & Rukoma and consider Ngarama for next FY18-19. The remaining balance was used for Autoclaves.
R1-R3	Patient satisfaction Survey	**Cancelled** After two years of discussion on the methodology and the possibility to use external consultancy without tangible decision, this tender has been cancelled from the UB Program and MoH will conduct the survey himself. Results of the survey will be shared.
R1	Procure IT Equipment for open MRS software for district hospitals	**Partially Completed** Item list received: Desktops and UPS have been delivered to the beneficiaries. Printers and Switches are in the tender which has been opened since 4th/05/2018 and now is under evaluation and soon the contract will be signed.
R2	Supply of IT equipment (printer and scanner and photocopier)	**Completed (to be confirmed)** Purchase order to procure 3 laptops had been sent to RDB and we were still waiting for RDB to deliver those laptops
R2	Purchase of lab equipment to Support rehabilitation center in Huye	**Not completed** and waiting for technical Specifications Almost equipment is planned for Huye Rehabilitation Center. However, the End-user choose to have ELISA Chain Machine to test hepatitis to replace the remaining items not procured, but there is no Technical specification for it
R2	Purchase of medical and non-medical equipment to Mental Health Day Center in GASABO	**Cancelled** Due to the use of planned budget for the construction of Nyarugenge District Hospital, this tender for medical equipment was cancelled. SC decided that it should be planned in Ordinary budget.
R2	Recruitment of consultant for Development of National Strategic Plan on Mental Health	**Contract under execution** Inception report was submitted and approved by Mental Health. The invoice for 20% payment was submitted later in June 2018, it will be paid in July 2018.
R2	Purchase of IT equipment to mental health referral services for remote consultations of mental health cases	Videoconference rooms have been installed at RBC and in Karongi, invoice was submitted without original purchase order and it was rejected by RBC-SPIU Finance
R2	Design for Mental Health day care center for Gasabo	**Partially implemented** It was last year tender which was brought forward in this fiscal year. So now we are waiting for RPPA to decide whether we can still use the same firm to finalize the design which can fit in the new plot

RA	Title: description of tender	Implementation process
R2	Consultancy services related to Prevalence study on drug abuse	**Ongoing** The tender changed into Rwanda Mental Health Survey and it is implemented out of SPIU-UB procurement plan as it is benefitting support from other partners
R3	Purchase of ICT Equipment and software for Implementation of e-health work packages (HNW)	**Partially executed** A purchase order was used to procure items form framework contract and now UPS are ready be delivered to the beneficiaries. For the Servers, Internet cables and Switches they are in the tender which will have been opened on 4th/05/2018 and now it is under evaluation
R3	Recruit a Consultant to develop dashboard for shared monitoring (HNW)	**Completed** Tender executed under Regie
R3	Purchase of Equipment to Upgrade existing HCs (Dental Chairs)	**Ongoing** This tender was cancelled, because none of the company qualified to be awarded the tender. The team reviewed technical specification and tender is being re-launched in next FY
R3	Consultancy Services Related to the Development of CoK - Health Strategic Plan (R3)	**Not done** The tender has been postponed to the FY 2018-19 as waiting for the finalization of mapping of health facilities
R4	Purchase of Stationery & Printing Consumables	**Tender Removed** from the procurement plan
R4	Service availability through Rwanda master facility list – (national up-dated health facility register)	**Contract under execution but late delivery** The contract had been extended till 30th/July/2018
R4	Support action researches for protocols, realizations	**Cancelled** There will be no need of External Consultant
R6	Purchase of hardware equipment for MTI Call Center	**Ongoing** Purchase order has been issued for the Desktop and UPS are ready for the end user to take them. For the Printer, Scanner and Barcode they are in the tender which was opened on 4th/05/2018 and now it is under evaluation
R6	Purchase electro-mechanical tool boxes for district hospitals	**Not completed** Ahmed to explain more
R6	Purchase Engineering Testing tools for MTI staff	**Not completed** The tender was advertised and we failed to get a qualified bidder. The tender was again re-advertised then it was opened on 27th/06/2018 now evaluation will start on 11/07/2018. (Ahmed to update)
R6	Supply of radiation safety materials (Kinihira, Kirinda, Munini, Butaro, Rwamagana, Murunda)	**Under contract execution** The Contract was signed and advance of 20% was been given to the company
R6	Installation and repair of Autoclave	**Contract not yet signed** by RBC because of issues on taxes to be applied on the spare parts which is needed to be agreed upon
R6	Provide Oxygen Lines for Neonatology services in Nyamata and theatre room of Nemba DH	**Completed**
R6	Miscellaneous medical equipment for DH	**Partially implemented** The Equipment have been delivered and installed to the site but they are not yet done with installation in Kiziguro DH. The Delivery period ended since 09th/06/2018, we are still waiting for supply.

There were 23 tenders in the procurement plan:

- 4 were never implemented due to change of decision or priorities (equipment for mental health treatment center, tender for satisfaction survey)
- 8 were awarded
- 11 still ongoing

The procurement process is under e-procurement and is well established. However, its implementation has been too slow and an analysis took place during the annual report workshop. The following bottlenecks were identified:

- Before launching the tender:
    - Delay in preparing the specifications
        - Lack of market analysis
        - Technical delays (lack of expertise, etc.)
        - Administrative delays (no formal transmission of specifications, delay in signing documents)
    - Incomplete specifications leading to poor bidding or difficulty in evaluation process
    - Absence of coordination in the administrative documentation leading to inadequate tender documents (ie evaluation criteria) and risk of cancellation and retendering
- Evaluation:
    - Delay in initiating the evaluation
    - Lack of communication from procurement to ITC and technicians (MTI)
    - Technical staff not always available
    - ITC meetings
- Contract preparations:
    - Delay in bidder certificates
    - Lack of coordination between users, technicians and procurement on contract content: lack of inputs and validation
    - Delay in approval
- Implementation:
    - Limited of proactive follow up: much delays in case of ineffective supplier
    - Delays in inspection (lack of planning and communication)

Recommendations

- Change our mindset in regards to procurement: every step is important and need to be done effectively; planning and communication of activities related to procurement need to be much improved
- Procurement to engage with senior management on signature approval and delays (enquire on the need to go via several layers and committees)
- Procurement officer to organize:
    - Share to all end-users the monthly planning of evaluations, site visits, reception
    - Organize monthly update of tender progress with end-users and share updated procurement plan

    - Proactively involve end-users at tender specifications, tender documentation, evaluation, contract writing, supervision
    - Share draft and final contract documents with end-users
- Procurement officer to proactively remind suppliers and anticipate delays
- Procurement officer to share checklist for payment request with the supplier

2.9.2 Risk management

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)	Responsible	Deadline	Progress	Status
R1										
Lack of independent accreditation assessment due to failure to get competent local organization to become RHAO	Baseline	Effectiveness	Medium	High	High risk	finalize modality for selection of body with MSH and MOH	Dir QS MOH	Q1 2018-19	Preliminary meetings held with UB, MSH, MOH	
						Present to UB SC request for co-funding of the body	PMU	Q1 2018-19	NA	
						Assist MSH and MOH in the evaluation and selection of the body	ITA	Q2 2018-19	NA	
Incapacity to reach level 2 (and 3) due to lack of necessary resources to implement recommendations (HR,	Baseline and review June 2018	Sustainability	Medium	High	High risk	Organize training on QI and accreditation for Vice mayors in charge of social affairs in the districts, all hospital BODs, new directors of hospitals, hospital DAF and directors of DHUs, as recommendation from Feb 2017 workshop	Dir QS MOH	Q3 2017-18	achieved	

Risk Identification			Risk analysis			Risk Treatment			Follow-up of risk	
Description of Risk	Period of identification	Risk category	Probability	Potential Impact	Total	Action(s)	Responsible	Deadline	Progress	Status
finance, systems)						Engage with Hospital leadership and write Health facility performance management letter compliance with standards where applicable	Dir QS MOH		ongoing process	
						Identify specific needs at central level and ensure that adequate support is provided (i.e. procurement of equipment, renovations, etc.)	Dir QS MOH		ongoing process ex: installation, repair and maintenance of 17 autoclaves at DH levels (due Q1-2 2018-19)	

R2 MENTAL HEALTH

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**
Non availability of suitable plot for the construction of the national mental health treatment center with additional risk that MoH may request to reallocate those funds to the Nyarugenge DH	Results Delivery	Very high risk	High	High		Meeting district authorities to address clarifications needed (relocation of road, exact siting, area for extension, etc.)	UB PC DI	31/07/2017	Plot in Kininya has been selected but the district needs to redesign the road before architectural design can be re-initiated	Late
						Obtain final plot description and title deeds copies	UB PC DI	31/08/2017	Pending drafting of extension	
						Develop joint strategy AMBABEL-BTC on how to reply to a possible request of reallocation of funds to NDH (also in view of the current budget review exercise)	PC FA RR PO	31/08/2017	Request was made and accepted by SC of 11 Sept 2017	
Psychiatrists trained overseas do not return in their country	Results Delivery	Low risk	Low	Medium		Attentive selection criteria, monitoring and support/coordination with residents while abroad	UR: Faculty of Medicine and Pharmacy – Coordination of MMed Psychiatry	December-2019	5 Residents were selected on April 2017; 4 have left with delay	On track
						Retention Contract signed and "A qui de droit" granted before departure	MoH & Mifotra	December-2019	Documents were signed and provided before departure abroad	
						Offer attractive contract upon training completion by the Ministry of Health	HR MOH	December-2019	On track	

R3 URBAN HEALTH

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 STEP survey to measure prevalence on NCD	RBM Baseline	Effectiveness	Medium	Medium	Medium risk	- Advocacy with evidence from NCD mass campaigns reports - Collaborate with RBC-NCD division and other potential donors	ITA PH DM NCD RBC	December 2018	- Advocacy and reports had good effect = importance of action is now well recognized - Agreement with DM – NCD, if partners not ready for national survey, can organize STEP study	On going
Financial constraint to repeat NCD mass campaigns	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	December 2017	CoK has not yet started the planning activity for health plan	Late
Sustainability medicalized HC	Annual report	Sustainability	Medium	High	High risk	Recruit a consultant team to study feasibility and to develop sustainability plan	CoK UB MoH DH	September 2018	ToR submitted to Enabel headquarters	On track
Failure to have a Kigali Hospital Networking formalized	MTR	Effectiveness & sustainability	High	High	High Risk	Recruited a consultant team to guide and provide a strategic orientation towards the development of a sustainable hospital network in the City of Kigali with a HIN feasibility study taking into account the context of the 11 hospitals members of Kigali hospital network.	RBC-SPIU-UB Coordination	April 2018	Report of consultants available with feasibility recognize if more efforts is put in place (recruitment of experts)	Done
						Implementation of consultants recommendations like recruitment of e-health specialists (short and medium term) and continue close mentoring	RBC-SPIU-UB Coordination	July 20187	Still waiting validation by MoH for implementation	On track
NDH: Risk of delay on construction works Delay in making the hospital fully functional Insufficient budget for equipment	MTR & Quarterly report	Effectiveness	High	High	High risk	**SC Decision May 2018 (MTR 9):** Ensure strict monitoring and close involvement of all actors and stakeholders. Regular reporting to senior management	ITA Arch & Ing Nyarugenge district	Monthly	- The District, RBC and Enabel started to remind the contractor and the Supervision firm to respect the work schedule - Additional management site meetings and task force meetings have been initiated by The Mayor of Nyarugenge District and UB Program Coordinator - Warning letters to the Contractor calling him to a prompt alignment to contractual terms - Meetings with and warnings to Supervising to be more efficient.	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
						SC Decision May 2018 (MTR 10): Nyarugenge DH equipment: Core team to present list and budget estimates for hospital equipment to Task Force Task Force to refer to SC in case of budget estimates excess	Nyarugenge district ITA PH UB Procurement RBC ITA MTI UB	May 2018	Core team has finalized the cost estimate and is preparing the technical specifications The total cost is around 2.5 Million Euros The roadmap with budget estimates will be presented to the next SC	Done and transmitted
						SC Decision May 2018: R3- UB program to develop a business plan for the construction of Nyarugenge DH with the support of external consultant from Enabel framework contract	ITA Enabel MoH Nyarugenge DH	Q2 2018/19	ToR have been drafted and submitted to HQ Enabel	On track

R4 GOVERNANCE AND LEADERSHIP

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**
Risk 1: Delay of implementation or no implementation of planned activities		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		juil-17	Roadmap discussed and implemented No focal Person for UB activities. Draft of DHSP available waiting for quality check	On track
						meeting DG Planning FP to discuss implementation calendar and identify mitigating measures to avoid postponement where possible		juil-17	Still changing as some planned activities were not implemented	
Risk 2: Low implementation of action research						Assist DG Planning to validate action research implementation plan linked to Quality Improvement initiatives			DG planning is no longer responsible of AR	On track
						Identify support mechanism (SPH, consultants) according to result areas			All Results will manage its AR topic and budget moved to regie to facilitate implementation	
						Identify support mechanism (SPH, consultants) according to result areas				

R6 ASSET MANAGMENT

Risk identification			Risk analys s			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 equipment's (management)	RBM baseline	Efficiency	Medium	High	High risk	Develop and enforce policy for equipment standardization	MTI Div Mgr	Dec - 2017	In depth assessment completed data collection and provides information and guidance in this regards. The final report was validated.	Completed
						Technical assistance to the Medical Technology and Infrastructure department for policy development	ITA Biomed	Dec – 2017	Ongoing. Policy development was stopped because MTI division has become a part of BIOS department. BIOS policy draft has been developed, currently waiting for validation.	Late
						implement in depth study recommendation on standardization	MTI Div Mgr	Dec – 2017	Ongoing. A medical equipment management system is being deployed and implemented, a National Strategic Plan under finalization stage, standards for infrastructure being developed.	On track
Suboptimal care due to non-functional medical equipment and inadequately maintained infrastructures	Results delivery	Effectiveness	High	High	Very high risk	Establishment of strong pre-service and in-service training for MTI and decentralized maintenance staff	MTI Div Mgr	Dec-17	Many administrative delays in approval of trainings (short and long term). Long term training Programs are being done for 2 MTI staff and 3 DH BMETs.	On track
						Decentralization of maintenance services: construction/renovation of 4 provincial maintenance workshops	MTI Div Mgr	Jun-18	Renovation of 3 and construction of 1 provincial workshop were done. The workshops are not in service due to lack of an approved structure and business plan.	Late
Insufficient coverage of DH maintenance workshops	RBM Baseline	Effectiveness	High	Medium	High Risk	Support MoH efforts for resource mobilization for this strategic investment area: ensure inclusion in HSSPIV	ITA	Sep-17	Ongoing.	On track
						construction of 4 provincial maintenance workshops	MTI Div Mgr	Jun-18	Completed	Completed
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	It is currently included in the development of Infrastructure standards.	Late
						Ensure adequate inclusion of infrastructure standards in the accreditation system	MTI Div Mgr	Dec-17	Not yet done - see recommendation of MTR. MTI should be part of the accreditation team.	Late
						Development of norms and standards for infrastructure	MTI Div Mgr	Mar-18	Ongoing	Late
High workload at MTI may delay implementation of plans	Start-up	Effectiveness	High	High	Very High Risk	Assist MTI in completing all staffing recruitment (including the one identified for UB funding)	ITA Biomed Engr	Dec-17	Done	Completed
						Assist MTI Director Planning to ensure tasks and activities are properly delegated and implemented	ITA Biomed Engr	Jun-18	Done	Completed
						Assist in the development of MTI strategic plan that includes adequate institutional component (HR, procurement, finance, etc)	ITA Biomed Engr	Jun-18	Done. The draft is ready for submission to SMT	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 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	Aug-17	Done	Completed
						Assist in developing plan and implementing the relevant in-depth assessment recommendations	ITA Biomed Engr	Dec-17	Ongoing. MEMMS, NSP and Infrastructure standards development ongoing.	On track

3 STEERING AND LEARNING

3.1 STRATEGIC RE-ORIENTATIONS

R1: During the formulation of the program, it was agreed with USAID that they were going to provide financial support to the accreditation agency through the health system strengthening program so that UB support would be technical only. However, this financial support has not materialized yet and funding needs to be identified to launch the agency with the view that it would soon become autonomous. MOH has been asking for partner's commitment to the creation of the agency and UB may need to consider providing financial support while ensuring the sustainability of the agency in medium term.

R2: While the mental health treatment center is still very much part of the Mental health Division Program priorities, additional alternative such as treatment centers in provincial hospitals may need to be considered if the center construction funding delays to materialize. Besides, the Mental Health Division will continue the full implementation and monitoring of UB funded activities even after the departure of the ITA.

R3: Following the MTR report and further discussion with all stakeholders, SC recommended to reorient the management of R3 under MOH for what concerns policies, guidelines and strategic orientations. This particularly concerns the medicalization and hospital networking components.

- Medicalization: need for a legal framework and the validation of the package of care by SMT
- Hospital network: need to agree upon its scope and ensure adequate human and financial resources

R4: We take note that action research budget has been shifted to regie to provide some flexibility for implementation, with support from RBC/MRC

R6: it has become critical for RBC/MTI Division to finalize its strategic plan and have it validated. It is now a priority for UB Program to ensure coherence and effectiveness. Without the validation of the strategic plan, it will be very difficult to provide meaningful support. **We would like to recommend that any further support to MTI is conditioned to the validation of the strategic plan.**

MEMMS: a decision by MOH and CHAI must be taken by end July 2018 to address or not the need for upgrade of the system that is necessary to ensure adequate use of MEMMS at facility and central levels.

UB support to capacity development: there is a significant shortage of skilled personnel in the area of medical equipment management. Funding is available for short and medium-term training but there have been numerous operational difficulties that have made the support ineffective.

- A clear HR development strategy for MTI is urgently needed, including on staff retention after training
- Consider closer involvement and support to IPRC
- Should funding shift to regie modality?
- Should funding balance be reoriented to other activities

Procurement: there is need to ensure better management and monitoring of procurement to increase its effectiveness. This does not require any strategic reorientation but needs high level management support.

3.2 RECOMMENDATIONS

Recommendations	Actors	Deadline
R1: Quality Assurance Consider financial support to the creation of the accreditation agency provided a roadmap has been validated and sustainability is being adequately addressed	UB SC	Q1
R2- Mental Health MHD would recommend that Enabel continue supporting Mental Health. For more than a decade, the Belgium has been the only one substantial funding partner for mental health in Rwanda. So, literally, most of the Mental Health achievements were due to Enabel's support. To continue mobilization of funds for Mental Health Day Care center To continue mobilization of funds for Community mental health, Psychiatric care and Drugs Consider recruiting quickly a Specialist in Charge of Prevention and Treatment of Substance Use Disorders Continue adequate monitoring of UB funded activities after the departure of Dr Achour Ait Mohand, ITA	UB SC	Q1-2
R3 -Urban Health Assist MOH in validating a legal framework for medicalization and hospital networking mechanism	DG CPHS MOH	Q2
Support a sustainable plan for medicalized HC	DG CPHS MOH	Q2
Ensure adequate human and financial resources for Hospital network development	DG CPHS	
Close collaboration with NCD Division during the planning and implantation of NCD mass campaign	MOHUB-RBC	Q3-4
Close monitoring of Nyarugenge DH construction and surveillance with involvement of high level authorities (PS MOH, Mayor CoK, Mayor Nyarugenge, Belgian embassy, China embassy Consul, Minecofin) should the progress be unsatisfactory	UB PMU	Q1-Q4
R6-MTI Validation of national strategic plan is a condition to the continuing UB support to MTI Stop any new HR capacity development funding until RBC provide clear guidance on MTI HR development; review best modality approach (regie, NEX, IPRC, Biomedical engineer association, etc.)	UB SC	Q1-Q4

R1,2,3,4,6 Close collaboration with MRC -RBC for Action Research development and implementation Change our mindset in regards to procurement: every step is important and need to be done effectively; planning and communication of activities related to procurement need to be much improved	UB SC UB-SPIU-RBC-MOH-	Q1-Q4

3.3 LESSONS LEARNED

Lessons learned	Target audience
Choice of implementation modalities: the use of NEX has allowed full alignment and use of Rwanda system. The orogram is also fully aligned to Minecofin Planning and Budgeting side. Attention is required at all stages but particularly at the planning stage to ensure adequate labelling of activities to be funded. Challenges exist for unplanned activities or activities that cannot be fully described at planning stage (ie action research) whereby the flexibility of the system has limitations. This may delay those activities until the step of budget revision. See document on use of NEX	MOH, RBC, Minecofin, Enabel, DGD, other DPs
Hospital construction is a major activity that requires adequate expertise to oversee the design and construction implementation. It requires adequate business plan and financial planning to avoid any risk of underfunding. The initial TFF underestimated the budget as well as the specific technical assistance required. This led to SC to force some reallocation from R1, R2 and R6 to R3 with the reduction of the scope of those affected results. MTR recommended that such large infrastructure projects should be standalone project than included in a larger program.	MOH, RBC, Mininfra, DPs
Avoid activities that are co-funded with other partners unless the financial commitment is fully secured (experience of R1 with lack of MSH contribution for expertise in specialized standards development as well as accreditation agency)	Enabel, DPs
Challenges in implementation of activities that Involve different actors without a clear coordination mechanism in place (R3, MOH/CoK).	MOH, Enabel, DPs
Lack of technical specifications/ToRs when developing procurement plan have the greatest risk of delaying tender process and the low budget execution	RBC, MOH
Avoid activities that do not have a clear legal framework as this may seriously delay the implementation. For example, Hospital network/digitalization were not yet clearly defined in the national strategy: ownership, vision, budget, partners involvement etc need to be identified at the onset and adequate technical assistance must be considered	

National Patient satisfaction survey: While the activity is highly relevant, modalities for implementation were not clearly defined and a lot of time was spent to finally decide that the survey will not be done. Indicator will be removed from the indicator list and result from the national citizen record card will be used as a proxy for MOH to monitor the impact of quality assurance program. Therefore, choice of indicators and data source will need to be critically reviewed when developing future strategic programs	MOH, RBC, Minecofin, Enabel, DGD, other DPs
Action research requires flexible funding as it is an intervention that develops from its iterative steps. SC decision to move the funding to regie is therefore welcomed to ensure that this intervention will take place. The program regrets the earlier decision to remove R5 from the program as its technical assistance has been missed to support the action research agenda	
~~Challenges in Data management.~~ • ~~Lack of coding system – No bar code reader, printer and stickers to identify equipment for fast inventory.~~ • ~~Lack of Lap tops for BMETS.~~ • ~~Insufficient training in data entry to MEMMS.~~ • ~~Hospitals do not allocate sufficient budget for internet payments.~~	
The absence of a validated strategy for medical equipment and infrastructure has prevented the program to effectively implement activities, particularly around capacity development and system strengthening. Priorities must be identified AND AGREED UPON; Guidance from high level is needed to ensure that UB support is relevant and effective	PS MOH, DG RBC

4 ANNEXES

4.1 QUALITY CRITERIA – R1

For each of the criteria (Relevance, Efficiency, Effectiveness and Potential Sustainability) a number of sub-criteria and statements about those sub-criteria have been formulated. By choosing the statement that fits your intervention best (add an 'X' to select a statement), you can calculate the total score for that specific criterion (see below for calculation instructions).

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	D
			X		
2.1 How well are inputs (financial, HR, goods & equipment) managed?					
	A	All inputs are available on time and within budget.			
X	B	Most inputs are 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 is the implementation of activities managed?					
	A	Activities implemented on schedule			
X	B	Most activities are on schedule. Delays exist, but do not harm the delivery of outputs			
	C	Activities are 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 are 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 are/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 Are 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.

4.2 QUALITY CRITERIA – R2

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.			

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 are inputs (financial, HR, goods & equipment) managed?					
	A	All inputs are available on time and within budget.			
X	B	Most inputs are 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 is the implementation of activities managed?					
	A	Activities implemented on schedule			
X	B	Most activities are on schedule. Delays exist, but do not harm the delivery of outputs			
	C	Activities are 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 are 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 are/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?					
X	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.			
	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 Are 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: 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.

4.3 QUALITY CRITERIA – R3

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?				
	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.		

RELEVANCE: B

*The Ubuzima Burambye's interventions in R3 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*

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.
	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.

EFFICIENCY: B

Certain outputs were not achieved according to time and plan, such KHN and NDH, 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 KHN

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.
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.

EFFECTIVENESS: C

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**
		X
	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.
	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?		
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.

SUSTAINABILITY: B The ownership for the intervention at the level of policy and involvement of local structures is likely to be high, ***but*** the technical/financial sustainability is a challenge even beyond the implementation period of the intervention especially *for KHN and Medicalization (no legal framework and standard packages)*

4.4 QUALITY CRITERIA – R4

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?		
	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 / 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.
	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?		
	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?					
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.			

4.5 QUALITY CRITERIA – R6

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?					
	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	D
			X	

2.1 How well are inputs (financial, HR, goods & equipment) managed?		
	A	All inputs are available on time and within budget.
	B	Most inputs are 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 is the implementation of activities managed?		
	A	Activities implemented on schedule
	B	Most activities are on schedule. Delays exist, but do not harm the delivery of outputs
X	C	Activities are 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 are 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 are/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 Are 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 X
	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.
	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.
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?		
	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.

4.6 DECISIONS TAKEN BY THE STEERING COMMITTEE AND OTHER AND FOLLOW-UP

N°	Decision			Follow up		Action needed to implement Decision				Follow up of Decision	
	Decision	Date	Responsible	Progress	Status	Action	Org	Resp.	Deadline	Progress	Status
12	**R6** Adoption of action plan for the implementation of the recommendations of the "in-depth assessment on medical equipment, procurement and maintenance system and health infrastructure in the public sector in Rwanda" by 30/11/2016	26-août-16	R6 DM	Not yet.	Late	follow up workshop outputs to be brought to SMT and SMM	R6	SN OR	Oct 2016	Final report validated in Dec 2017 Action plan identified for implementation	Late
13	**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	Agreement within SMT to develop strategic plan during a workshop end January 2018 postponed to March 2018 **Action plan to cover 5 years period**	Late

N°	Decision			Follow up		Action needed to implement Decision				Follow up of Decision	
	Decision	Date	Responsible	Progress	Status	Action	Org	Resp.	Deadline	Progress	Status
14	**R6**: Approval to use technical consultant to assist in the development of standards for health care infrastructure (Health center, District Hospital, Provincial Hospital, Referral Hospital). ToR to be approved by 30/09/2016	26 Aug 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 as inclusion in imihigo	PMU	PC/DI	14/10/2016	Expression of interest launched end February 2018????	Late
5	**R2 RBC/MHD to work on legal and budget status of the center** 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 **refer to decision 66 and 76**	29/03/2017	R2 DM	Ongoing - As the Day Treatment Center 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 health facilities, discussion with them is scheduled to determine the	On Track	need follow up meeting MOH Clin Serv and RBC/MHD	R2	ITA	31/07/2017	On halt since budget for construction has been shifted to Nyarugenge DH construction	Not yet due

N°	Decision			Follow up		Action needed to implement Decision				Follow up of Decision	
	Decision	Date	Responsible	Progress	Status	Action	Org	Resp.	Deadline	Progress	Status
				structure of the center							
6b	**R2 - National Mental Health Treatment Center**: Need to speed up finalization of design, procurement process of construction, purchase of equipment and recruitment of staff **refer to decision 76**	29/03/2017		on hold due to recurrent change of plot location Plot identified in Kininya: One Stop center agreement on conditions: - district to move the road upwards in order to provide land demarcation (current and future extension). - resume finalization of design after the above is done	Late	follow up implementation of One Stop Center to Gasabo district regarding the plot preparation	UB	NTA Infra	31/12/2017	Meeting held, demarcation for phase 1 and 2 defined; district still to move the road to enable contacting the RPPA to get authorization for single source of the design of the construction	On Track
						contact RPPQ to get approval for single source and ask the design firm to finalize the design as per new plot	SPIU	PROC OFF;	31/01/2018	not yet done	Late
						finalize the architectural design to be ready when funding for	SPIU	PROC OFF;	31/05/2018	Not yet done	Late

N°	Decision			Follow up		Action needed to implement Decision				Follow up of Decision	
	Decision	Date	Responsible	Progress	Status	Action	Org	Resp.	Deadline	Progress	Status
						construction is available					
11	**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	for presentation to SC	Late
13	**R6 MTI with support from RBC/PMEBS and RBC/SPIU/UB to develop business plans for provincial workshops** to be functional and self-sustained and present to the next SC	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	follow up meeting following MTR review and BS mission. UB-ITA is working on the ToRs for a consultant who will work on business plan	Late
						new concept involving IPRC graduates to be validated by SMT prior to presentation to SC	R6	DM	15/03/2018	for presentation to SC	On Track
	UPDATED DECISION DM/MTI to share concept note and roadmap to develop full business plan (with	22/03/2018									

N°	Decision			Follow up		Action needed to implement Decision				Follow up of Decision	
	Decision	Date	Responsible	Progress	Status	Action	Org	Resp.	Deadline	Progress	Status
	DG Planning MOH and RBC/Planning/Business development unit) to be validated by SMT by end June 2018										
15	**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 program in sandwich vs full time training to present to DG RBC for validation for SC e-decision	POSTPONED	R6 DM	No sandwich program 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	R6	DM	18/07/2017	only 2 were selected and sent in 2017 ongoing discussion to increase the number	Late
						Agreement for 2 additional students to go for Masters in 2018-2020 - need to finalize their acceptance and registration	R6	DM	30/04/2018	2 candidates selected	On Track
2	**R1/R3 - Concept note on 'national patient satisfaction survey':** A technical team (RBC, MoH-Clinical Services,	20/06/2017	R1 DG	draft concept with DG for discussion with senior management	Late	meeting DG Clin services for follow up	R1	PC	15 July 2017	concept never validated by MOH MOH likely to have funding	Late

Nº	Decision			Follow up		Action needed to implement Decision				Follow up of Decision	
	Decision	Date	Responsible	Progress	Status	Action	Org	Resp.	Deadline	Progress	Status
	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.									and support from USAID UB may do it in CoK area only MOH to provide further guidance on this issue	
	UPDATED DECISION: UB support to national patient satisfaction survey is no longer required by MoH although the results are useful to UB. The survey will be implemented by MOH. MoH will inform UB on progress and results of this important survey	22/03/2018	PMU								
3	**R1 - Comprehensive accreditation strategy and related action plan:** Clinical services to present it at the next steering committee meeting.	20/06/2017	R1 DG	EXPECTED NEXT QUARTER	On Track	Contact Edward to prepare the document	R1	PC	15/03/2018	for presentation to SC	On Track
4	**R2 - Alternative strategy for MH community-based initiatives:** MHD will present an alternative to the initial proposal	20/06/2017	R2 DM	alternative community support has been provided while developing a future strategy	On Track	Assist MHD to prepare document	R2	ITA	30 June 2017	BS Jan 2018 recommends MH to develop strategy on community mental health	Not yet due

N°	Decision			Follow up		Action needed to implement Decision				Follow up of Decision	
	Decision	Date	Responsible	Progress	Status	Action	Org	Resp.	Deadline	Progress	Status
	(the one aiming to fund one NGO in Musanze) by identifying other community rehabilitation initiatives (MHD feedback to UB Program management by June 30, 2017)									services - tbc validation of the recommendation	
	R3 - DECISIONS ON NYARUGENGE DISTRICT HOSPITAL										
1.2	**R3** to request MINECOFIN, MoH and Nyarugenge District to integrate in the budget revision of FY 2017/2018 a resourced budget line for it's funding contribution to ensure payment of net invoices and taxes as stipulated in contract	11/09/2017	PS MOH	to be discussed during next budget revision	On Track						
1.3	**R3** to request Nyarugenge District with support of MoH Directorate of Clinical and Public Health Services : to elaborate a comprehensive plan to ensure the functioning of the Nyarugenge DH to be validated by the Steering Committee by June 2018	11/09/2017	Nyarugenge District	To be discussed at next Task Force meeting	On Track	organize a task force in January/February to ensure that all actors are on track to follow up the implementation of the construction	PMU	PC	28/02/2018	Task Force held on 11 Feb and chaired by Hon Mayor Agreed to meet monthly	Completed

Nº	Decision			Follow up		Action needed to implement Decision				Follow up of Decision	
	Decision	Date	Responsible	Progress	Status	Action	Org	Resp.	Deadline	Progress	Status
						creation of core team for the procurement of equipment for the hospital	Task Force	Chair	28/02/2018	core team created need to implement roadmap for procurement	Completed
1.4	R3 to request MoH Directorate of Clinical and Public Health Services to accelerate the implementation of the Kigali Hospital Network that will integrate the Nyarugenge District Hospital	11/09/2017	MOH Clin Services	monitoring meeting planned including review of MTR recommendations on this output	On Track	????					
	R2 - DECISIONS ON MENTAL HEALTH DAY TREATMENT CENTER (also refer to decision 46, 47, 66)										
2.1	**R2** MoH and MINECOFIN to plan the construction, equipment and the running costs of the Day Care Center starting by FY 2018-2019 and the MTEF	11/09/2017	PS MOH	A budget for the construction has been included in Ordinary Budget of RBC for 2018-19 A plan still need to be developed	On Track	Meeting RBC/MHD and MOH Clin Services to develop the plan	RBC/MHD	DM	???	???	
						finalize the design of the construction so it will be ready for tendering	RBC/SPIU	Proc Off	31/03/2018	???	
2.2	**R2 to request RBC/Mental Health Division to**	11/09/2017	RBC MHD	- No plan yet - CoK to share the response of One	On Track	meeting Gasabo district to follow up on road work	RBC/SPIU	Proc Off	31/01/2018	meeting held	Completed

N°	Decision			Follow up		Action needed to implement Decision				Follow up of Decision	
	Decision	Date	Responsible	Progress	Status	Action	Org	Resp.	Deadline	Progress	Status
	- elaborate a comprehensive plan by end of October 2017 (with MoH Directorate of Clinical and Public Health Services) - secure a suitable plot by November 2017 (with MoH and CoK) - finalize the design by January 2018 (with SPIU) - launch the tender (with the selected district)			Stop Center regarding the plot availability **New decision timeline (SC7 22/3/2018): the comprehensive plan need to be done by July 2018 and presented to next SC**		and plot demarcation					
						engage with RPPA to get authorization for single source contracting for the design	RBC/SPIU	Proc Off	15/02/2018	???	
						contract with firm to finalize the design	RBC/SPIU	Proc Off	30/05/2018		Not yet due
						launch construction tender	Gasabo District	Proc Off	??		Not yet due
	UPDATED DECISION RBC/SPIU to request RPPA for single source tender to enable the same firm that developed the design	22/03/2018									

Nº	Decision			Follow up		Action needed to implement Decision				Follow up of Decision	
	Decision	Date	Responsible	Progress	Status	Action	Org	Resp.	Deadline	Progress	Status
	to adjust and present the final architectural design for validation by May 2018										
2.3	**R2** to request that UB Technical Assistance continues to assist this process	11/09/2017	PCU	waiting for confirmation on the plot availability	On Track	assist in the above activities (meeting district, follow up RPPA, finalize design and launch the construction tender	UB	NTA Infra and ITA R2	Dec-18	???	
1	PMU: The identified a core team to propose and share a final amended version of the MTR report. This report will include recommendations that will be useful for an effective program implementation. The report will be submitted within two weeks in order to be validated at an extraordinary SC to be held mid-April 2018 (latest 20th April).	22/03/2018		review team took place and report is ready for extraordinary SC (SC8)	Implemented					Report ready for extraordinary SC validation	
2	SC agrees to extend strategic and operational UB support to Mental Health	22/03/2018	PCU	action plan already approved and included in	Implemented						

N°	Decision			Follow up		Action needed to implement Decision				Follow up of Decision	
	Decision	Date	Responsible	Progress	Status	Action	Org	Resp.	Deadline	Progress	Status
	Division until end of UB implementation period (31/12/2019) based on existing budget balances on R2 and approval of action plans.			next fiscal year budget							
3	DG Clinical and Public Health Services and UB Program managers to call for a meeting and closely collaborate with CoK, districts and hospitals to put in place a conducive implementation mechanism in order to ensure effective achievement of R3 objectives.	22/03/2018	R3 DG	meeting was held at MOH and recommendations will be presented to extraordinary SC	Implemented						
4	DG Clinical services to present the draft terms of reference of the accreditation body and the selection process to the TWG Quality and Standards for inputs by mid-April 2018 prior to validation by SMM.	22/03/2018	R3 DG	due to be presented to the next TWG meeting planned in May 2018	Implemented						
5	To utilize resources of RBC/MRC Directorate for scientific support towards action	22/03/2018	ALL	Meeting was held with RBC/Planning/RBC and support to	On Track						

Nº	Decision			Follow up		Action needed to implement Decision				Follow up of Decision	
	Decision	Date	Responsible	Progress	Status	Action	Org	Resp.	Deadline	Progress	Status
	research topics under each result area. Avoid use of external consultants wherever possible.			action research was agreed; MRC Division has met all focal persons and roadmap will be shared							
6	to allocate balance of action research budget to Regie modality by 1st July 2018 to ensure effective implementation of action research	22/03/2018	PCU	budget reallocation done as soon as minutes signed	Implemented						
7	SC requests UB program to prepare the projections of expenses per result and for general means including Regie up until end of program to ensure effective implementation and to enable SC decision on staff contract extension according to needs – to be presented to the forthcoming extraordinary SC planned mid-April	22/03/2018	PCU	ready for presentation to extraordinary SC	Implemented						
8	Appro val of 2018-19 action plans	22/03/2018	PCU	Approval of 2018-19 action plans for implementation	Implemented	ready for implementation in next fiscal year					

N°	Decision			Follow up		Action needed to implement Decision				Follow up of Decision	
	Decision	Date	Responsible	Progress	Status	Action	Org	Resp.	Deadline	Progress	Status
	Updated decisions from previous SC meeting										
	SC approves the revised MTR report	04/05/2018	SC	NA	Implemented						
	SC approves the implementation modalities put in place for a conducive implementation mechanism to ensure effective achievement of medicalization and hospital networking objectives. (Note: no budget reallocation implied)	04/05/2018	PMU	MOH now in charge of coordinating R3 activities as per agreement	Implemented						
	SC approves to allocate balance of action research budget to Regie modality by 1st July 2018 considering the type of activities and their unpredictability.	04/05/2018	PMU	UB Financial staff to do the budget modification as per decision (waiting for signature of SC minutes	On Track						
	Recommendations from MTR report:										
	SC approves the revised MTR report	04/05/2018	SC	NA	Implemented						
	SC approves the implementation modalities put in place for a conducive	04/05/2018	PMU	MOH now in charge of coordinating R3	Implemented						

N°	Decision			Follow up		Action needed to implement Decision				Follow up of Decision	
	Decision	Date	Responsible	Progress	Status	Action	Org	Resp.	Deadline	Progress	Status
	implementation mechanism to ensure effective achievement of medicalization and hospital networking objectives. (Note: no budget reallocation implied)			activities as per agreement							
	SC approves to allocate balance of action research budget to Regie modality by 1st July 2018 considering the type of activities and their unpredictability.	04/05/2018	PMU	UB Financial staff to do the budget modification as per decision (waiting for signature of SC minutes	On Track						
	list of actions from position note (sorted per result area)										
	R1. UB to continue technical support in accreditation agency: - Assist MOH to finalize ToR of the agency	04/05/2018	ITA R1	draft ToR available Discussions with MOH, MSH, Enabel on the process to select local agency	On Track	Meeting MOH MSH	MOH DGCPHS	Dir Quality MOH	Aug-18		
	- Assist MOH to select the accreditation agency				On Track						
	R1. MOH Quality Directorate to include MTI staff in facilitation	04/05/2018	Dir Quality MOH		On Track	MOH to invite MTI Division in accreditation	MOH DGCPHS	Dir Quality MOH	31/08/2018		

Nº	Decision			Follow up		Action needed to implement Decision				Follow up of Decision	
	Decision	Date	Responsible	Progress	Status	Action	Org	Resp.	Deadline	Progress	Status
	and accreditation assessment					meetings and process					
	R2. refer to SC decision 7/2: R2: SC agrees to extend strategic and operational UB support to Mental Health Division until end of UB implementation period (31/12/2019) based on existing budget balances on R2 and approval of action plans.	04/05/2018	PMU	Activities and budget included in IFMIS 2018/19	Implemented						
	R2. MHD/RBC to follow up with Planning/RBC to ensure OB secured during 2018-19 budget revision for the construction of the national mental health treatment center	04/05/2018	RBC/MHD	No budget identified so far, RBC/Planning advised to include it in budget revision	On Track	need follow up by RBC/MHD	RBC/MHD	DM	31/10/2018		
	R3. UB to continue support to NCD for CoK to organize NCD mass campaign in May 2018	04/05/2018	ITA R3	mass campain done in May-June 2018	Implemented						
	R3. SPIU/RBC UB to inform CoK of this decision to stop UB funding for hygiene and sanitation activities	04/05/2018	SPIU Coord	CoK informed	On Track	prepare memo for official transmission once SC minutes are signed	UB	PM	31/08/2018		

Nº	Decision			Follow up		Action needed to implement Decision				Follow up of Decision	
	Decision	Date	Responsible	Progress	Status	Action	Org	Resp.	Deadline	Progress	Status
	R3. DG CPHS to present final package of medicalized HC to SMM for final validation	04/05/2018	DGPHCS	package not yet presented to SMM MOH	Implemented	Follow up with Dr Nathalie and DG on package presentation	UB	ITA R3	31/07/2018		
	R3 MOH in coordination with CoK, districts and district hospitals to develop a vision for first line health services in urban area that includes the concept and operationalization of 'medicalized health centers'	04/05/2018	UB	draft note under discussion with Health ITAs coordination	Implemented	present draft note to MOH in August (? UB SC?)	UB	ITA R3	31/08/2018		
	R3 Construction Nyarugenge DH: Ensure strict monitoring and close involvement of all actors and stakeholders. Regular reporting to senior management.	04/05/2018	UB	Weekly monitoring and regular meeting necessary to force the contractor to progress and reach target	Late						
	R3. Nyarugenge DH equipment: Core team to present list and budget estimates for hospital equipment to Task Force. Task Force to refer to SC in case of budget estimates excess	04/05/2018	UB	document ready for TF meeting in July	Implemented	present to TF in July and SC in August in case of budget implications	UB	ITAR3	31/08/2018		

N°	Decision			Follow up		Action needed to implement Decision				Follow up of Decision	
	Decision	Date	Responsible	Progress	Status	Action	Org	Resp.	Deadline	Progress	Status
	R6. Ensure the functionality of provincial maintenance workshop	04/05/2018	UB	Workshops renovation done, equipment under tender process; need RBC validation for staffing	Late	ITA to discuss with MTI DM to present plan for validation by SMT	UB	ITA R6	31/07/2018		
	R6. MTI Division to finalize the proposed national strategic plan for validation by SMM	04/05/2018	RBC/MTI	DM to present to senior management and SMT RBC	Late	ITA to assist DM presentations	UB	ITA R6	31/07/2018		
	ALL RESULTS - refer to SC decision 7/5: To utilize resources of RBC/MRC Directorate for scientific support towards action research topics under each result area. Avoid use of external consultants wherever possible. refer to updated decision 7/6: SC approves to allocate balance of action research budget to Regie modality by 1st July 2018 considering the type of activities and their unpredictability	04/05/2018	UB	Contacts with RBC/MRC workshop held for R2 action research in June and due in July for R1	On Track	Follow up roadmap for implementation	UB	PM	31/08/2018		

N°	Decision			Follow up		Action needed to implement Decision				Follow up of Decision	
	Decision	Date	Responsible	Progress	Status	Action	Org	Resp.	Deadline	Progress	Status
	ALL R: MRC/Planning/RBC to develop roadmap and support to implementation of action research and report implementation progress to the next SC	04/05/2018		see above		see above					
	SPIU/RBC with support of UB to prepare summary estimates of Rwandan financial contribution to UB as per TFF for next SC meeting in August	04/05/2018	RBC/SPIU	to be prepared in July	On Track	RBC/SPIU to prepare data to present to SC in August	RBC/SPIU	COORD	31/07/2018		
	Additional recommendations from SC8 meeting proceedings	04/05/2018									
	SC takes note of financial projections in NEX, co-management and regie and approves the staff extension as proposed in annex 6	04/05/2018	UB	NA	Implemented						
	SC requests the program to review the budget projections for FY18-19 and 19/20 and activities in order to steer implementation and reduce the projected budget of the	04/05/2018	UB	Financial advisor has prepared a revised version for consideration	On Track	Follow up with SPIU coordinator and PS on the revised version and adjust according to procurement plans	UB	PMU	15/08/2018		

N°	Decision			Follow up		Action needed to implement Decision				Follow up of Decision	
	Decision	Date	Responsible	Progress	Status	Action	Org	Resp.	Deadline	Progress	Status
	final year of the program to be presented to the next SC)										
	SC approves budget reallocation within regie budget as per annex 7	04/05/2018	UB	waiting for signature of minutes to implement the reallocation in the system	On Track	need f/up of signature of minutes	UB	Admin Ass	31/07/2018		
	R3-R6 UB program to develop a business plan for the construction of Nyarugenge DH and the provincial workshops with the support of external consultant from Enabel framework contract – due date Q2 2018/19	04/05/2018	UB	draft ToR in circulation	On Track	finalize ToR and send PO to contractors	UB	ITAR3	31/07/2018		
	R6 MTI/RBC with the help of SPIU/RBC to develop a proposal to upgrade or update MEMMS for funding consideration to be presented to SMT in July 2018 for validation	04/05/2018	RBC/MTI	note ready, needs validation by SMT	On Track	ITA to assist DM to present document for validation	UB	ITAR6	31/07/2018		

4.7 DECISIONS FROM THE MID TERM REVIEW

The following recommendations were developed after the MTR mission and during the subsequent backstopping mission. They were approved by SC8 in April 2018

Recommendations from MTR report:		
8/1	SC approves the position note on MTR and the follow up actions; the progress on actions will be reported to next SC in the decision list (where applicable)	**Y**
	list of actions from position note (sorted per result area)	**due date**
MTR 1	R1. UB to continue technical support in accreditation agency: - Assist MOH to finalize ToR of the agency - Assist MOH to select the accreditation agency	**Sept 2018**
MTR 2	R1. MOH Quality Directorate to include MTI staff in facilitation and accreditation assessment	**Sept 2018**
MTR 3	R2. refer to SC decision 7/2: R2: SC agrees to extend strategic and operational UB support to Mental Health Division until end of UB implementation period (31/12/2019) based on existing budget balances on R2 and approval of action plans.	**May 2018**
MTR 4	R2. MHD/RBC to follow up with Planning/RBC to ensure OB secured during 2018-19 budget revision for the construction of the national mental health treatment center	**Sept-Oct 2018**
MTR 5	R3. UB to continue support to NCD for CoK to organize NCD mass campaign in May 2018	**May 2018**
MTR 6	R3. SPIU/RBC UB to inform CoK of this decision to stop UB funding for hygiene and sanitation activities	**May 2018**
~~MTR 7~~	~~R3. DG CPHS to present final package of medicalized HC to SMM for final~~ validation	~~June 2018~~
MTR 8	R3 MOH in coordination with CoK, districts and district hospitals to develop a vision for first line health services in urban area that includes the concept and operationalization of 'medicalised health centers'	**Aug 2018**
MTR 9	R3 Construction Nyarugenge DH: Ensure strict monitoring and close involvement of all actors and stakeholders. Regular reporting to senior management.	**monthly**
MTR 10	R3. Nyarugenge DH equipment: Core team to present list and budget estimates for hospital equipment to Task Force Task Force to refer to SC in case of budget estimates excess	**May 2018**
MTR 11	R6. Ensure the functionality of provincial maintenance workshop	**Dec 2018**

MTR 12	R6. MTI Division to finalise the proposed national strategic plan for validation by SMM	**Mid - July 2018**
MTR 13	**ALL RESULTS - refer to SC decision 7/5:** To utilize resources of RBC/MRC Directorate for scientific support towards action research topics under each result area. Avoid use of external consultants wherever possible. **refer to updated decision 7/6:** SC approves to allocate balance of action research budget to Regie modality by 1st July 2018 considering the type of activities and their unpredictability **ALL R: MRC/Planning/RBC to develop roadmap and support to implementation of action research and report implementation progress to the next SC**	**Aug 2018**
MTR 14	**SPIU/RBC** with support of UB to prepare summary estimates of Rwandan financial contribution to UB as per TFF for next SC meeting in August	**August 2018**

4.8 UPDATED LOGICAL FRAMEWORK

Not applicable

4.9 MORE RESULTS AT A GLANCE

Logical framework's results or indicators modified in last 12 months?	NO
Baseline Report registered on PIT?	YES
Planning MTR (registration of report)	DONE in OCTOBER 2017
Planning ETR (registration of report)	OCTOBER 2019
Backstopping missions since 01/01/2015	YEARLY: June 2015, June 2016, December 2016, January 2018

4.10 "BUDGET VERSUS CURRENT (Y – M)" REPORT

Annex (separate sheet)

4.11 COMMUNICATION RESOURCES

You will find below some pictures and papers that were developed for the Belgian embassy in Kigali or for local conferences. These are part of the program communication strategy

R3-NCD MASS CAMPAIGN:

Newsletter of Belgian Development Cooperation in Rwanda
3rd edition – August 2017

Preventing & countering NCDs in Rwanda

Last June, a non-communicable diseases mass campaign took place in the car-free zone of Kigali. This initiative was funded by BTC through its health sector programme "Ubuzima Burambye" and its component on urban health. *"The programme supports initiatives taken by the City of Kigali (CoK) to fight against non-communicable diseases (NCD) and the associated risk factors. Indeed, there is a continued rising burden of NCDs particularly in urban areas which represents an additional challenge with major implications"* explains Public Health Expert Veronique Zinnen. By financing an annual mass campaign, Ubuzima Burambye addresses one of the challenges of rapid growing urbanization and contributes to early detection and prevention of NCDs.

Patricie Mukangarambe Director of the Public Health and Environment Unit of the CoK explains: *"Each year, the City of Kigali, in partnership with the Rwanda Biomedical Centre and with the funding of BTC, is organizing a campaign to mobilize the population on early detection and prevention of NCDs and associated risk factors. The campaign lasts for one week and enables us to examine and counsel between 3000 and 6000 people."*

NCDs, a major health challenge

NCDs are one of the major health and development challenges of the 21st century. General public awareness regarding risk factors, prevention and early detection of NCDs is essential. If nothing is done, the human, social and economic costs of NCDs will continue to grow and overwhelm the capacity of countries to address them.

Promoting healthy life style

The theme of the 2017 campaign was "Promote healthy life style to prevent NCDs". Throughout the campaign, free screening and counseling activities took place in the car free zone of Kigali. The screening for risk factors such as overweight and obesity (BMI), blood sugar and blood pressure, detecting diabetes and hypertension was done in collaboration with the Rwanda Association of Diabetes and Cardio-vascular foundation and conducted by the Rwanda Pharmaceutical Students Association. Dr. Agarwal's Eye Hospital provided equipment and staff for the measurement of visual acuity and intraocular pressure.

NCDs screening activities, Kigali car free zone, June 2017 © BTC Rwanda

"The problem with the main NCDs - the diabetes & hypertension - is that they are not symptomatic and people do not get themselves spontaneously tested unless complications occurred. Those "silent" diseases do lots of damages and it is why we support this early detection and prevention campaign. We try also to raise awareness on risks associated with NCDs such as overweight, obesity, alcohol consumption, tobacco, etc. This is a very important activity" states Veronique Zinnen.

Free counselling was also provided in order to guide patients to adequate health care facilities. The patients who had abnormal measures were referred to hospitals.

In addition, prevention messages were broadcasted on the radio and disseminated in district hospitals in order to reach more than the population living in Kigali. We estimate that around 3000 people were reached by the 2017 campaign.

For more info, contact Veronique.Zinnen@btcctb.org

2 abstracts to be presented at a national conference: 2018 Health Research & Policy Day - Marriott Hotel * Friday, 24 August 2018 * Kigali, Rwanda:

1. 2017 KIGALI NON-COMMUNICABLE DISEASES MASS CAMPAIGN: STRENGTHS, LIMITS AND RECOMMENDATIONS

Background

Non-communicable Diseases (NCDs) are leading cause of mortality worldwide. Rwanda has the vision having its population protected from premature morbidity and mortality related to NCDs. Among different strategies, mass campaigns on NCDs were implemented in the City of Kigali (CoK). The study aimed to understand how they could reach more at-risk population and contribute better to the reduction of NCDs burden.

Methods

During one-week mass campaign in Kigali, persons who came for screening were registered. Volunteers collected information on risk factors (BMI, tobacco and alcohol), blood sugar and blood pressure. Odds ratios at 95% confidence interval were used to measure association between elevated blood pressure, elevated blood sugar, socio-economics characteristics and risk factors.

Results

From 2147 registered people, 65% were men, 71% were less than 45 and 45% came from Nyarugenge district. Overweight was present in 36%, obesity in 11%. 6% were smokers and 36% consumed daily alcohol. 24% had elevated blood pressure. 6% had glycaemia ≥126 mg/dl and 1% ≥ 200. Overweight was significantly associated with women, age and live in Kigali. Elevated blood pressure was associated with age, overweight, alcohol use and elevated blood sugar. Elevated blood sugar was associated with age, overweight and elevated blood pressure.

Conclusion

The campaign was successful with important mobilization and high attendance. Findings show high prevalence of overweight, especially among women, of harmful use of alcohol, especially among men, and high prevalence of hypertension; those results are coherent with other studies. This study revealed also some limits: (i) women, elderly people, inhabitants of Gasabo and Kicukiro districts were much less represented in the screening; (ii) there was no assurance that participants with abnormal values were seen and controlled at HF; and (iii) Information about the usefulness of the screening was missing. In conclusion, for the next mass campaigns, there is needs to better mobilize women and elderly, to increase screening spots, to better formulate questionnaires on risk factors habits and to assure counselling and management of cases are properly done. It is also essential to initiate Action Researches to know the usefulness and the impact of the mass campaigns.

2. UTILITY AND EFFECTIVENESS EVALUATION OF NON-COMMUNICABLE DISEASE MASS CAMPAIGN IN CITY OF KIGALI 2017

Background

Since 2015, City of Kigali is organizing Non-Communicable Diseases (NCDs) Mass campaign to improve awareness of population for early detection and increase physical activities through mass sport. During the campaigns, thousands of people are screened for free, education messages provided and people found with abnormal values receive counselling. This evaluation aimed to understand utility and effectiveness of the mass campaign.

Methodology

Close follow up of people screened during 2017 mass campaign: from statistical analysis of data, we extracted all cases with abnormal values to standard definition of hypertension and hyperglycemia. A structured questionnaire was prepared to interview by phone the selected people who consent to participate.

Results

From 674 people with abnormal values, 439 could be reached and consented. 63% were informed about campaign by passing to the screening site, very few was informed by media. The main reason to attend the screening place (94%) was to know their status and 73% didn't know it before. 90% received counselling, mainly about physical activities and healthy diet and not much about use of alcohol (23%) and smoking (12%). 35% were advised to go to health facility to confirm diagnosis for further management. Concerning knowledge about NCDs and risk factors, the majority knows hypertension (61.6%), diabetes (60.5%) and unhealthy diet (46%). Following the campaign, 39% changed their life habits like regular physical activities, eating more fruits and vegetables, reducing use of salt and sugar. The majority found this campaign very useful for detection (63%) and declared to recommend it to others (94%) and to increase the frequency.

Conclusion

The mass campaign contributed to detect NCDs as 70% didn't know their status. People received information and counselling. However, this was not covering all risk factors (tobacco, alcohol, stress, etc.), only 35% were advised to go to the health facility while all had abnormal values. After this campaign, only 39% changed the life habits. In conclusion, the NCDs mass campaign seems to be useful with a room of improvement especially in education and case management. This kind of evaluation should be repeated including all screened people and continuously improve its impact.

Construction of Nyarugenge District Hospital- FIRST STONE

Newsletter of Belgian Development Cooperation in Rwanda
6th edition - April 2018

On the 9th February 2018, the first stone of the Nyarugenge District Hospital was laid by Hon. Minister of Health, Dr. Diane Gashumba and by His Excellency the Ambassador of Belgium, Mr. Benoit Ryelandt, in the presence of the Mayor of Kigali and the Mayor of Nyarugenge.

The Nyarugenge District Hospital is the largest infrastructure project to be managed by the district, funded by the Kingdom of Belgium and the Government of Rwanda. The project is co-managed by Enabel's Ubuzima Buramboye program (more info on the UB program on page 7) and benefits from technical support from Rwanda Biomedical Center and the Ministry of Health.

The hospital responds to a high demand from more than 300,000 Nyarugenge residents. It is expected to become a model of excellence and innovation in terms of organization, patient flow, standards of care, healthy working conditions, respect for the environment, sound waste management, energy saving, isolation and network connection.

The construction will take place in 2 phases: the first one will provide a fully equipped and functional 120-bed hospital by July 2019, including outpatient, inpatient, emergency and support services and utility buildings. Phase 2 will increase the capacity up to 300 beds to better cover needs of district population.

Follow @EnabelinRwanda on Facebook and Twitter

Digital for Development

Kigali Hospital Network under the UBUZIMA BURAMBYE Program

The Ubuzima Burambye (Long Healthy Life) Program is supported by Enabel and implemented under the management of Rwanda's Ministry of Health (MoH) in partnership with Rwanda Biomedical Center (RBC) and the City of Kigali (CoK). This program officially started in July 2015 and its implementation phase is scheduled to last 48 months. The general objective of this intervention is to "strengthen the quality of primary health care and health services in Rwanda".

To properly manage the complexity of health issues in the CoK, intensified by the rapid population growth with fast urbanization, several strategies have been proposed. One of them, supported by Ubuzima Burambye (UB), is the development of a hospital network for the CoK in order to produce efficient, organized, rationalized and integrated health supply of services in an urban context. Integration of resources (human, logistics, etc.), better articulation between all actors, shared harmonized health information, improved reference system, merged technically complex services can all considerably improve health services efficacy as well as the continuity of care. It will also reduce the costs and the fragmentation thanks to an increased efficiency.

In line with the national health policy, Kigali Hospital Network is mandated to *"Promote complementarity between hospitals in their common production of qualitative, continuous and accessible and integrated healthcare to face the rapid evolution of the needs of the citizens in the city of Kigali who are increasing rapidly and face profound demographic and epidemiologic changes"*

The development of the network concerns 11 Hospitals in CoK: 3 National Referral Hospitals, 4 public District Hospitals (DH) and 4 Private Hospitals/Polyclinics (see details below).

The main strategic interventions that are currently supported by UB include:

- Optimization of specialized and quality services delivery through regular exchange of experience/expertise, skills and information. In 2018, this includes 16 training modules elaborated by specialists to be shared at district hospital level for medical staff;
- Define the vision, strategies, mechanisms and the resources needed towards a sustainable Hospital Information Network program by digitalization;
- Improve the information sharing between hospitals in the City of Kigali through a web-based dashboard for the 11 health facilities. At this moment, the development of a plan to share real-time information to improve the referral system (availability of beds, ambulance, specific medical specialities, specific diagnostic equipment, etc.) is ongoing;
- Develop a tele-medicine system initially directed to tele-diagnostic: this year, a "Picture Archiving and Communication System" (PACS) will be procured.

In a second phase, the set-up of a harmonized electronic patient file between network member facilities to keep a continuum of care and consistency in service delivery will be developed.

Newsletter of Belgian Development Cooperation in Rwanda
5th edition - January 2018

Governmental Cooperation

Integration of mental health care in primary health care to increase accessibility in Rwanda

Mental health, a serious health challenge in the world

Mental health is one of the most serious health challenges in the world. Globally, 700 million people are estimated to suffer from mental and behavioural disorders and one out of four people will develop one or more of these disorders during their lifetime. Three out of four people with mental health problems live in low- and middle-income countries (LMIC) and yet up to 90% of people living with mental illness in these countries do not receive mental health services. One of the biggest reasons behind this "treatment gap" is underinvestment. Low-income countries spend less than 1% of their health budgets on mental health, while less than 1% of global development funding for health is spent on mental health. In spite of the chronic and long-term nature of some mental disorders, with the proper treatment, people suffering from mental disorders can live productive lives and be a vital part of their communities.

Mental disorders represent a huge cost to health care systems and to the global economy, and affect some of the world's most vulnerable people, through stigma and lack of understanding. In 2015 the world took a huge step forward by including mental health in the *Sustainable Development Goals* (SDGs), which fixed the global development agenda for the next three decades.

Mental health, priority area in Rwanda

In Rwanda, the available data show that the country faces an exceptionally large burden of mental disorders and much of the country's burden of mental disorders can be linked to the Genocide against the Tutsi in 1994. Furthermore certain mental disorders such as depression and post-traumatic stress disorder (PTSD) are described with proportions beyond international averages. One out of four people suffers from PTSD and prevalence of depression is 15.5 to 21% depending of the study. Drug abuse, particularly among young people, is a new mental health challenge in Rwanda and prevalence of epilepsy is high (5%), making mental health a serious public health problem in the country.

Mental health is clearly identified within the overall Health Sector Policy as a priority area of intervention. The policy recommends the integration of mental health services into all national health system structures, including at the community level. Rwanda is on the forefront in terms of developing a sustained and sustainable national response to the burden of disease caused by psychological and neurological disorders, as well as substance abuse.

On the right side of the picture, a lady is holding a poster with a message in Kinyarwanda "*No Development without Mental Health*" during the International Mental Health Day celebration in Kigali, in October 2016

Mental health in the Belgium Cooperation in Rwanda

The Belgian Cooperation supports the development of mental health services in Rwanda over more than a decade and is the only bilateral donor working in this area.

The Mental Health intervention provides technical and financial support to decentralize mental health care into general care and integrate mental health care into primary health care. This support is mainly through capacity building, equipment, mentoring & supervision and training of health professionals to deal with mental disorders including substance abuse related issues. This intervention supports also psychological interventions during the Genocide commemoration period. In order to ensure the success and quality of the integration of mental health care, the intervention supports the Mental Health Division of Rwanda Biomedical Center / Ministry of Health as well as the national mental health reference structures.

Governmental Cooperation

Key progress in the decentralisation and integration of mental health care

The officially-approved Mental Health Policy, (introduced in 1995 and reviewed in 2011) has initiated a process of decentralization and integration of mental health care as well as the creation of referral services. At the central level, there is the Mental Health Division within the Rwandan Biomedical Center in the Ministry of Health. Its main mission is to implement the Mental Health Policy through a strategic plan under the guidance of the Health Sector Strategic Plan.

Mental health is now integrated into the package of care of health centers, district hospitals, provincial hospitals and referral hospitals. As a consequence mental health services and resources were shifted from the psychiatric hospital to the community health facilities: District Hospitals (DH) and Health Centers (HC)

Mental health services are effectively decentralised. Each of the country's District & Provincial Hospitals (43), through the Mental Health Unit, delivers a comprehensive mental health care package according to the national standards. Within this framework, each mental health unit provides inpatient and outpatient mental health care, including analysis and diagnosis, treatment and follow-up, rehabilitative measures, counselling and interaction with families. If necessary, the patient will be referred to mental health referral settings. Mental health units are staffed by a permanent team comprising one or two psychiatric nurses and one psychologist providing a broad range of mental health services under the supervision of a physician trained in mental health care. There are 66 psychiatric nurses and 41 psychologists working in mental health units in district hospitals and at least one GP gets hands-on training. Each mental health team receives on-site formative supervision and participates in regular case review sessions led by a mental health team from the national referral structures.

General Nurses working in health centers and CHWs were trained to ensure an integrated mental health care component in health centres and at community level. CHWs serve as an important link between the community and health providers. In this context 766 General Nurses in Health Centers, more than 15,000 CHWs and important number of volunteers (local NGOs & association) were trained annually. A stepped-care approach is provided: from health centres in rural areas, to district hospitals and then mental health referral settings in Kigali. Consequently, patients are treated as near as possible to their home and receive hospital treatment only after community treatment has failed.

A specific list of essential psychotropic drugs has been established for each level of the health system. These psychotropic medicines are part of the national list of essential medicines.

Mental health care is integrated into the community-based health insurance (CBHI) scheme (Mutuelles de santé), which allows mentally ill people, similar to other patients, to pay at most a 10% co-payment for psychotropic medicines and services. There is no co-payment for the lowest incomes.

By decentralizing mental health services and integrating mental health care into CBHI, access was increased, and the number of transfers to mental health referral structures was reduced. Data from the national health management information system (HMIS) shows that in 2016, all mental health units at DHs level received 26,060 new mental health cases and performed 201,902 outpatient consultations and 3,236 hospitalizations, with only 779 transfers to mental health referral structures.

Rwanda still lacks staff with an educational background in psychiatry. Up to 2017 there were only 7 psychiatrists in the health system. In 2013, the University of Rwanda launched a third-cycle specialization in psychiatry to increase the pool of trained psychiatrists in the country. Specialists can ensure quality of care and expand health care provision. The first 3 psychiatrists were graduated in August 2017 and 10 students are enrolled within the program in collaboration with universities from Belgium and Switzerland.

In the area of prevention of drug abuse, regular awareness campaigns are conducted targeting young people. A specialized structure for the treatment of drug-related disorders has just been set up.

Integrating mental health care into Primary Health Care is a great opportunity to intervene early and prevent chronicity. It is also an opportunity to involve communities and increase accessibility to mental health care which can be provided close to the community.

Car free day exercises

SPIU and UB team for NCD Screening

Car free day March

NCD Screening Mass Campaign

Budget vs Actuals (Year to Month) of RWA1309211

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

Budget Version: **F02** Year to month : 30/06/2018
Currency : EUR
YtM : **Report includes all closed transactions until the end date of the chosen closing**

	Status	Fin Mode	Amount	Start to 2017	Expenses 2018	Total	Balance	% Exec
A A PEOPLE-CENTERED, INTEGRATED AND SUSTAINABLE			15.291.200,00	2.579.037,71	**2.280.199,20**	4.859.236,91	10.431.963,09	**32%**
01 The quality assurance system is set up and integrated			950.500,00	235.984,01	**132.919,95**	368.903,96	581.596,04	**39%**
01 Progress towards the creation of an autonomous		COGES	0,00	0,00	**0,00**	0,00	0,00	?%
02 Update & disseminate norms, standards and models		COGES	43.627,00	43.627,28	**0,00**	43.627,28	-0,28	100%
03 Facilitate and implement the accreditation process at all		COGES	99.517,00	99.517,24	**0,00**	99.517,24	-0,24	100%
04 Finance people-centered improvement projects		COGES	17.498,00	17.497,89	**0,00**	17.497,89	0,11	100%
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,		COGES	72.000,00	32.414,80	**14.531,25**	46.946,05	25.053,95	65%
07 An independent accreditation body is established and		COGES	0,00	0,00	**0,00**	0,00	0,00	?%
08 All HFs have functional QA committees		COGES	51.373,00	14.068,04	**26.988,07**	41.056,11	10.316,89	80%
09 District hospital have achieved level 2 of accreditation		COGES	161.483,00	2.086,52	**76.436,20**	78.522,72	82.960,28	49%
10 Quality Improvement initiatives are implemented and		COGES	482.502,00	26.185,12	**14.964,43**	41.149,55	441.352,45	9%
11 Health care specialized centres are enrolled in		COGES	22.500,00	587,12	**0,00**	587,12	21.912,88	3%
02 The mental health services are accessible from the			2.074.200,00	1.023.149,71	**308.093,82**	1.331.243,53	742.956,47	**64%**
01 Strengthen community interventions on mental health		COGES	72.944,00	72.944,20	**0,00**	72.944,20	-0,20	100%
02 Consolidate Mental Health Care Services & a people-		COGES	207.615,00	207.657,59	**0,00**	207.657,59	-42,59	100%
03 Develop multidisciplinary strategies and actions with		COGES	149.251,00	149.883,78	**0,00**	149.883,78	-632,78	100%
04 Long term technical assistance in mental health and		REGIE	440.000,00	366.543,47	**81.465,68**	448.009,15	-8.009,15	102%
05 National long term technical assistance in mental health		COGES	72.000,00	25.363,89	**9.085,53**	34.449,42	37.550,58	48%
06 Scholarship for training in psychiatry in Belgium		REGIE	200.000,00	60.602,06	**0,00**	60.602,06	139.397,94	30%
07 Strengthened community interventions on mental health		COGES	177.056,00	9.032,39	**30.629,43**	39.661,82	137.394,18	22%
08 Integrated mental health care services emphasizing a		COGES	514.585,00	90.933,05	**72.882,23**	163.815,28	350.769,72	32%
		REGIE	4.141.000,00	1.994.964,97	**472.038,73**	2.467.003,70	1.673.996,30	60%
		COGEST	13.859.000,00	1.744.061,86	**2.086.331,56**	3.830.393,42	10.028.606,58	28%
		TOTAL	18.000.000,00	3.739.026,83	**2.558.370,29**	6.297.397,12	11.702.602,88	35%

Budget vs Actuals (Year to Month) of RWA1309211

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

Budget Version: **F02**
Currency : EUR
YtM : **Report includes all closed transactions until the end date of the chosen closing**

Year to month : 30/06/2018

	Status	Fin Mode	Amount	Start to 2017	Expenses 2018	Total	Balance	% Exec
09 Integrated mental health strategies and actions with regard		COGES	240.749,00	40.189,28	**114.030,95**	154.220,23	86.528,77	64%
03 The urban health service coverage is rationalized and			8.441.000,00	435.343,43	**1.247.253,72**	1.682.597,15	6.758.402,85	**20%**
01 Develop promotional activities on social determinants of		COGES	19.264,00	19.329,35	**0,00**	19.329,35	-65,35	100%
02 Develop and validate a sound concept and equitable		COGES	26.157,00	26.157,14	**0,00**	26.157,14	-0,14	100%
03 Support the implementation of the coverage plan through		COGES	0,00	0,00	**0,00**	0,00	0,00	?%
04 Create a functional, autonomous and efficient hospital		COGES	11.346,00	11.346,05	**0,00**	11.346,05	-0,05	100%
05 Design, build and equip a 300 beds Hospital in Kicukiro		COGES	70.857,00	70.857,05	**0,00**	70.857,05	-0,05	100%
06 Long term technical assistance in public health, hospital		REGIE	688.000,00	266.931,18	**70.450,54**	337.381,72	350.618,28	49%
07 National long term technical assistant in public health,		COGES	72.000,00	27.458,19	**9.085,53**	36.543,72	35.456,28	51%
08 Health promotional activities on NCDs are integrated in		COGES	45.368,00	1.293,06	**17.120,10**	18.413,16	26.954,84	41%
09 Hygiene and sanitation activities are routinely done		COGES	45.368,00	959,93	**521,46**	1.481,39	43.886,61	3%
10 The Kigali Hospital Networking formalized (functional KHN)		COGES	306.854,00	2.207,65	**39.825,32**	42.032,97	264.821,03	14%
11 HCs are medicalized (beneficiate of MD visits on regular		COGES	300.000,00	0,00	**58.298,67**	58.298,67	241.701,33	19%
12 A comprehensive and equitable urban Health Facilities		COGES	55.843,00	8.803,83	**26.861,60**	35.665,43	20.177,57	64%
13 District hospital is developed, built and equipped in an		COGES	6.799.943,00	0,00	**1.025.090,50**	1.025.090,50	5.774.852,50	15%
04 The leadership and governance is reinforced, specifically			1.150.000,00	268.574,15	**238.556,65**	507.130,80	642.869,20	**44%**
01 Strengthen stewardship capacities at the level of the local		COGES	219.304,00	219.669,15	**0,00**	219.669,15	-365,15	100%
02 Provide support to MoH and RBC with regard to their		COGES	42.099,00	42.154,30	**0,00**	42.154,30	-55,30	100%
03 Long term technical assistance in (district) capacity		REGIE	0,00	0,00	**0,00**	0,00	0,00	?%
04 National long term technical assistance in (district) capacity		COGES	0,00	0,00	**0,00**	0,00	0,00	?%
05 All DHMT/DHU are fully functional		COGES	600.696,00	6.750,70	**156.320,80**	163.071,50	437.624,50	27%
06 MoH and RBC have provided support and capacity		COGES	47.901,00	0,00	**45.486,81**	45.486,81	2.414,19	95%
		REGIE	4.141.000,00	1.994.964,97	**472.038,73**	2.467.003,70	1.673.996,30	60%
		COGEST	13.859.000,00	1.744.061,86	**2.086.331,56**	3.830.393,42	10.028.606,58	28%
		TOTAL	18.000.000,00	3.739.026,83	**2.558.370,29**	6.297.397,12	11.702.602,88	35%

Budget vs Actuals (Year to Month) of RWA1309211

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

Budget Version: **F02**
Currency : EUR
YtM : **Report includes all closed transactions until the end date of the chosen closing**

Year to month : 30/06/2018

	Status	Fin Mode	Amount	Start to 2017	Expenses 2018	Total	Balance	% Exec
07 Promote reflective action and action-research initiatives at		COGES	240.000,00	0,00	**36.749,04**	36.749,04	203.250,96	15%
05 Data are generated, analysed and used for evidence-			15.500,00	15.737,79	**0,00**	15.737,79	-237,79	**102%**
01 Assure the integration of different systems of information		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		COGES	0,00	0,00	**0,00**	0,00	0,00	?%
04 Long term technical assistance in HMIS development and		REGIE	12.000,00	12.264,09	**0,00**	12.264,09	-264,09	102%
06 An asset management system is designed and			2.660.000,00	600.248,62	**353.375,06**	953.623,68	1.706.376,32	**36%**
01 Develop, validate and disseminate policies, technical		COGES	10.947,00	10.947,35	**0,00**	10.947,35	-0,35	100%
02 Develop a functional procurement & maintenance system		COGES	38.917,00	38.917,09	**0,00**	38.917,09	-0,09	100%
03 Develop a waste management policy, strategy and		COGES	0,00	0,00	**0,00**	0,00	0,00	?%
04 Finance strategic improvement projects with impact on the		COGES	34.534,00	34.534,19	**0,00**	34.534,19	-0,19	100%
05 Develop domestic human capacity with regard to asset		COGES	60.096,00	60.095,52	**0,00**	60.095,52	0,48	100%
06 Long term technical assistance in maintenance of		REGIE	816.000,00	354.283,98	**91.582,89**	445.866,87	370.133,13	55%
07 National long term technical assistance in maintenance of		COGES	72.000,00	0,00	**2.735,32**	2.735,32	69.264,68	4%
08 The policy and standards and /or guidelines regarding		COGES	34.053,00	294,61	**7.572,68**	7.867,29	26.185,71	23%
09 Technical support towards harmonized, standardized		COGES	289.083,00	60.322,38	**143.811,59**	204.133,97	84.949,03	71%
10 Health facilities are designed according to standards and		COGES	21.000,00	0,00	**125,14**	125,14	20.874,86	1%
11 Improved capacity of biomedical and health infrastructure		COGES	404.904,00	27.513,17	**59.334,50**	86.847,67	318.056,33	21%
12 Better utilization of assets in health facilities		COGES	815.466,00	0,00	**39.127,41**	39.127,41	776.338,59	5%
13 Medium term technical assistance architect for support to		COGES	63.000,00	13.340,33	**9.085,53**	22.425,86	40.574,14	36%
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%**
		REGIE	4.141.000,00	1.994.964,97	**472.038,73**	2.467.003,70	1.673.996,30	60%
		COGEST	13.859.000,00	1.744.061,86	**2.086.331,56**	3.830.393,42	10.028.606,58	28%
		TOTAL	18.000.000,00	3.739.026,83	**2.558.370,29**	6.297.397,12	11.702.602,88	35%

Budget vs Actuals (Year to Month) of RWA1309211

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

Budget Version: **F02**
Currency : EUR
YtM : **Report includes all closed transactions until the end date of the chosen closing**

Year to month : 30/06/2018

	Status	Fin Mode	Amount	Start to 2017	Expenses 2018	Total	Balance	% Exec
01 contingency CO-MANAGEMENT		COGES	250.000,00	0,00	**0,00**	0,00	250.000,00	0%
02 Contingency BTC-management		REGIE	50.000,00	0,00	**0,00**	0,00	50.000,00	0%
Z GENERAL MEANS			2.408.800,00	1.159.989,12	**278.171,09**	1.438.160,21	970.639,79	60%
01 Personnel costs			1.416.800,00	786.406,18	**189.288,07**	975.694,25	441.105,75	69%
01 ITA Public Health – Program Coordinator (co-manager)		REGIE	720.000,00	405.836,90	**81.507,93**	487.344,83	232.655,17	68%
02 Program manager		COGES	72.000,00	11.627,87	**10.549,89**	22.177,76	49.822,24	31%
03 Finance and admin team		COGES	334.800,00	196.366,86	**38.643,18**	235.010,04	99.789,96	70%
04 Technical team		COGES	0,00	0,00	**0,00**	0,00	0,00	?%
05 RAFi / PFM expert		REGIE	270.000,00	163.839,94	**54.987,19**	218.827,13	51.172,87	81%
06 BTC Driver		REGIE	20.000,00	8.734,61	**3.599,88**	12.334,49	7.665,51	62%
02 Investments			55.000,00	35.098,11	**361,40**	35.459,51	19.540,49	64%
01 cars		REGIE	0,00	0,00	**0,00**	0,00	0,00	?%
02 Office equipment		REGIE	25.000,00	5.271,92	**0,00**	5.271,92	19.728,08	21%
03 IT equipment		REGIE	30.000,00	29.826,19	**361,40**	30.187,59	-187,59	101%
04 Office refurnising		REGIE	0,00	0,00	**0,00**	0,00	0,00	?%
03 Functional costs			347.000,00	141.066,81	**43.324,07**	184.390,88	162.609,12	53%
01 Functioning costs cars		REGIE	60.000,00	43.118,43	**11.969,30**	55.087,73	4.912,27	92%
02 Tele communication		REGIE	40.000,00	23.752,94	**6.162,48**	29.915,42	10.084,58	75%
03 Office material		REGIE	10.000,00	1.291,06	**2.233,33**	3.524,39	6.475,61	35%
04 Missions		REGIE	30.000,00	14.605,02	**3.262,11**	17.867,13	12.132,87	60%
05 Representation costs and external communication		REGIE	40.000,00	397,02	**1.174,44**	1.571,46	38.428,54	4%
06 Training (including on HIV workplace policy)		REGIE	40.000,00	11.396,98	**11.446,74**	22.843,72	17.156,28	57%
		REGIE	4.141.000,00	1.994.964,97	**472.038,73**	2.467.003,70	1.673.996,30	60%
		COGEST	13.859.000,00	1.744.061,86	**2.086.331,56**	3.830.393,42	10.028.606,58	28%
		TOTAL	18.000.000,00	3.739.026,83	**2.558.370,29**	6.297.397,12	11.702.602,88	35%

Budget vs Actuals (Year to Month) of RWA1309211

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

Budget Version: **F02** Year to month : 30/06/2018
Currency : EUR
YtM : **Report includes all closed transactions until the end date of the chosen closing**

	Status	Fin Mode	Amount	Start to 2017	Expenses 2018	Total	Balance	% Exec
07 Consultancy costs - PFM support		REGIE	48.000,00	21.188,46	**0,00**	21.188,46	26.811,54	44%
08 Financial transaction costs		REGIE	2.000,00	169,06	**135,71**	304,77	1.695,23	15%
09 Costs VAT		REGIE	0,00	2.779,43	**2.944,55**	5.723,98	-5.723,98	?%
10 Other functioning costs		REGIE	10.000,00	4.714,21	**3.557,01**	8.271,22	1.728,78	83%
11 Cost VAT		COGES	0,00	-124,82	**384,99**	260,17	-260,17	?%
12 Financial transaction costs		COGES	3.000,00	275,36	**53,41**	328,77	2.671,23	11%
13 Workshops and meeting		COGES	24.000,00	3.997,30	**0,00**	3.997,30	20.002,70	17%
14 Offie materials & services		COGES	40.000,00	13.506,36	**0,00**	13.506,36	26.493,64	34%
04 Audit, monitoring and evaluation			590.000,00	197.384,88	**45.197,55**	242.582,43	347.417,57	**41%**
01 M&E costs (baseline, 1 EMP + 1 EF)		REGIE	130.000,00	58.668,40	**876,78**	59.545,18	70.454,82	46%
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	9.129,09	**24.830,71**	33.959,80	166.040,20	17%
06 QA procurement medicines (membership Quamed		REGIE	45.000,00	0,00	**0,00**	0,00	45.000,00	0%
07 Technical & Procurement support for constructions		REGIE	100.000,00	107.316,70	**19.490,06**	126.806,76	-26.806,76	127%
99 Conversion rate adjustment			0,00	33,14	**0,00**	33,14	-33,14	**?%**
98 Conversion rate adjustment		REGIE	0,00	33,14	**0,00**	33,14	-33,14	?%
99 Conversion rate adjustment		COGES	0,00	0,00	**0,00**	0,00	0,00	?%
		REGIE	4.141.000,00	1.994.964,97	**472.038,73**	2.467.003,70	1.673.996,30	60%
		COGEST	13.859.000,00	1.744.061,86	**2.086.331,56**	3.830.393,42	10.028.606,58	28%
		TOTAL	18.000.000,00	3.739.026,83	**2.558.370,29**	6.297.397,12	11.702.602,88	35%