# EXECUTIVE SUMMARY

## MTR RWA1309211 Ubuzima

#### The UB Programme

Ubuzima Burambye (UB) is one of three bilateral health sector cooperation initiatives between Rwanda and Belgium. It was developed in a highly participatory process involving all potential and future national partners to assure its full alignment with the Rwandan Third National Health Sector Strategic Plan 2012-2018 (HSSPIII), and the City of Kigali (CoK) Strategic Plan for Health Development 2012-2016. UB aimed at maximising country ownership by devolving programme management roles and functions to the greatest degree possible to the Rwandan partners.

The objectives of UB are the three guiding principles of the Rwanda National Health Sector Policy: People centred services, integrated services, and sustainable services. The programme, as developed in 2014, had six interlinked and mutually reinforcing results to be achieved over four years with a budget of Euro 28.25 million, including the Belgian and the Rwandan contributions. Subsequent budget cuts and adjustments changed the thematic scope of UB. At the time of the MTR, the Belgian budget contribution was set at Euro 18 million with 38 percent earmarked for the construction of a new district hospital in Nyarugenge. By September 2017, 18 percent of the budget had been disbursed.

#### The mid-term review

The external mid-term review of UB was commissioned by BTC to provide an in-depth analysis of strategies and activities and to assess the level of performance of the programme. 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 BTC, the terms of reference included specific questions in five areas: (i) Programme modalities and approaches; (ii) accreditation; (iii) mental health; (iv) urban health; and (v) asset management.

The MTR team organised the evaluation questions under the parameters of relevance, efficiency, effectiveness, sustainability, gender sensitivity, environmental protection and governance. Data were collected through document reviews and individual and group interviews of programme partners and other key informants in Rwanda in October 2017. Qualitative and quantitative data were triangulated to generate findings that contribute answers to the evaluation questions. The findings were discussed individually with key stakeholders and presented for discussion to an extraordinary meeting of the UB Steering Committee. Written comments by BTC to an end-of-mission aide memoire and to the draft evaluation report were also considered in the final evaluation report.

The dual requirement of the terms of reference to provide and in-depth analysis of strategies and activities, and to assess the level of programme performance proved to be a limitation. These tasks demand distinct methodological approaches that were difficult to combine and implement in the available time with available resources. The MTR team therefore focused on a high-level strategy analysis and on assessing programme performance at the level of the evaluation parameters. The absence of a theory of change framework for UB that could be reviewed in a participatory evaluation workshop was a further constraint to the strategic analysis. Finally, despite efforts to obtain appointments throughout the mission, meetings with the Minister of Health and the Permanent Secretary could not be organised, and the Director General of RBC met only to be briefed and was not available for an interview.

#### Main findings

##### Relevance

The UB programme delivers a relevant contribution to health system development in Rwanda. It is well articulated with the national health sector strategy. Constraints of programme relevance are largely due to changes in programme scope because of budget changes. The elimination of the former Result 5 affected other result areas and disrupted the strategic cohesion of the programme. Reallocations of budgets, especially for the urban health component, reduced some activities to a level where their potential to leverage health system development becomes doubtful. This does not *per se* affect the relevance of the UB strategy, but it affects the effectiveness of activities.

##### Efficiency

The UB programme implementation rate at mid-point is low, with the risk that several key results will not be achieved in time. The low rate of implementation is explained in part by the initial difficulties of the programme to adapt to the planning, budgeting and financing cycle and procedures of the Rwandan systems. These difficulties may by now have been overcome, which should be reviewed after the 2017/18 fiscal year. The issues that persist are the fragmentation of partnerships for operational management and technical leadership and the divided technical and financial accountability for results among different institutions of the Government of Rwanda. This is not a conducive situation for the achievement of strong appropriation and efficient co-management. The efficiency of UB support to the MTI Division under Result 6 is of particular concern. The outcome in this result area is threatened unless action is taken to reorient UB support and focus it on a limited number of achievable results.

##### Effectiveness

The assessment of programme effectiveness varies widely between Result 2 (mental health) which was assessed to be highly effective, and Result 6 (asset management) which, despite generating outputs, appears to be missing the orientation towards the outcome target and can therefore not be considered effective. The urban health programme (Result 3) has different effectiveness issues. The component has three quite disparate outcomes that are neither well integrated among themselves, nor necessarily linked to the overall UB goal. Two of the outcomes, increased NCD awareness and improved environmental health management, are pursued with minimal resources. They are topping up activities that are already pursued under the CoK Development Plan without providing a strategic input to strengthening systems or developing innovative approaches.

##### Sustainability

The programme was developed in cooperation with the national partner, it is well embedded in the structure of the national health system, and many of the programme inputs are delivered by staff of the partner institutions. Human resource capacity building, including pre-service and in-service training, is prominent in R2 and R6. These are characteristics of sustainable programming. Questions of sustainability arise for the environmental health and health promotion activities under Result 3 that are supporting delivery of services rather than systems strengthening. Substitution of national MoH, RBC or CoK staff by national and international technical assistants is limited. The international technical assistant to MTI has a very operational role, but this reflects the functioning of MTI as a service delivery unit, as well as the low human resource capacity and the need for extensive skills transfer.

##### Gender sensitivity

Gender mainstreaming in UB intended to include gender-transformative and gender-sensitive improvement actions in relation to hospital accreditation, action-research, prevention and care in relation to sexual and gender-based violence and substance abuse, gender-sensitive health promotion in CoK, gender audits, and gender disaggregated data. The MTR found that none of the potentially gender transformative activities were implemented and that the programme is fully gender-blind. At the time of the MTR, BTC commissioned a company to undertake a critical gender review, identify gender mainstreaming opportunities, and develop a gender action plan for UB. Results are not yet available.

##### Environmental protection

Issues of environmental protection in UB are primarily raised by the activities concerning infrastructure and medical equipment, and by issues related to standards of waste disposal in hospitals as part of the interventions for quality improvement and accreditation. Environmental sanitation is also formally still part of the outcome of environmental health management of the urban health component under R3, but the activity supported under this component affects environmental protection issues only marginally. Generally, environmental protection has a high priority in several components of the UB programme.

##### Governance and leadership

Questions of governance and leadership were primarily raised in the context of the adoption of the national execution modality for procurement and financial management. The adoption of this modality was a reason for delays in implementation at the start of the programme. This was, however, primarily a question of adaptation of programme planning procedures and cycles to the Rwandan systems. It should be re-evaluated after the end of the 2017/18 fiscal year. A persistent issue that is distinct from national execution but often conceived as part of it, is the fragmentation of partnerships of the UB programme with public institutions in Rwanda. For three of the five results areas (R1, R3 & R4) financial accountability, management responsibility and technical leadership are split between two or three institutions. In addition, since the UB Programme formulation, reforms on the Rwandan health sector have changed the remit of some partners, for instance of the RBC/SPIU. This situation has resulted in inefficiencies, weak appropriation of the programme by partners, and management weaknesses.

##### Monitoring

The performance of UB programme implementation is monitored on a quarterly basis with the aid of a framework that includes 78 indicators of which seven are at the impact level, 21 at the outcome level and 50 at the output level. The MTR team assessed the quality of the indicator framework as poor. Although the majority (but not all) of the indicators reflect the areas of programme intervention thematically, many of them have no plausible link to programme performance.

#### Conclusions

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 programme relevance and sustainability. The risks, which in the remaining programme period can still be mitigated, are reflected in low efficiency of implementation which has also contributed to a lower than expected programme effectiveness. Issues that affected efficiencies are:

1. The adoption of the national execution modality required the integration of UB management with Rwandan planning, budgeting, procurement and financial management systems.
2. National execution, as defined by BTC, is only partial as perceived by the Rwandan partners who point to inefficiencies due to parallel processes in financial management and procurement.
3. 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 programme leadership.
4. 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 decentralised authority.

##### Result Area 1 (Quality assurance system)

UB support is contributing to the achievement of the expected outcomes but has experienced significant budget cuts which constrains the ability to fully implement some key interventions, such as the hospital quality improvement initiatives.

##### Result Area 2 (Mental health services)

Support for mental health care is an effective and efficient area of cooperation under UB. The Mental Health Division of RBC has successfully expanded service delivery to the health centre level. This result is still fragile as effective structures for formative supervision of this level of care have not yet been established. The objective of establishing a community mental health care system which would also address psycho-social issues of alcohol and drug use, gender-based violence, and psychological effects of HIV infection has so far not been achieved. With progressive budget cuts in this component of R2 it will be difficult to achieve major progress towards this objective.

##### Result Area 3 (Urban health)

The effectiveness of the urban health programme of UB was assessed to be low. The largest component, the construction of the Nyarugenge District Hospital, has not yet started. The Kigali Hospital Network is still in the development phase although some progress has been made. Under the objective of rationalising urban health services, UB supports equipment donations to health centres and funds the secondment of physicians from district hospitals to four health centres. According to field observations and records reviewed by the MTR team, this activity could be more effective if the modalities of implementation were reviewed and revised. The remaining UB activities for environmental health and for health promotion on non-communicable diseases are top-up service delivery activities of the City of Kigali and not effective contributions towards systems and strategy development.

##### Result Area 4 (Leadership and governance)

UB is supporting the development of health systems governance at district level which shows evidence of progress. This initiative is also supported by a USAID health system support project and the contribution of UB is therefore difficult to measure. A budget to support operational research under R4 has not been mobilised as there appears to be no consensus among partners on how to programme this support.

##### Result Area 6 (Asset management)

The effectiveness of UB programming for support of asset management is low. There are many constraints to the development of an operational cost-effective asset management system. They include the absence of a functional asset management software and of a national equipment management policy, the shortage of qualified technicians in the country, and the profile of the current MTI Division as a service provider for equipment maintenance rather than a centre for systems development.

#### Main recommendations

The MTR formulated 17 recommendations to different stakeholders in the programme. The five most important recommendations are:

##### To BTC

1. Continue to pursue the modality of national execution in future health sector cooperation programmes with Rwanda, despite some difficulties with this modality in the UB programme. Capitalise on lessons learnt from UB and plan for a longer start-up phase to optimise the synchronisation of programme activities with the Rwandan planning and budgeting cycle.
2. Review the apparent trend to phase out the collaboration with Rwanda in the mental health sector. This collaboration has been effective and has generated sustainable results. There is still a large unfinished agenda of community programming in mental health that should be considered for further support in future cooperation programmes.

##### To RBC

1. Assure that the SPIU fully exercises its role as the implementing institution of the UB Programme to provide leadership in programme management, even if this may at times be difficult because the responsibility for programme implementation is distributed among several institutions of government.

##### To the UB Steering Committee

1. Review the scope of the UB strategy in view of the budget reductions and reallocations. Prioritise the activity areas and assure that each area has sufficient financial and technical resources to raise reasonable expectations that outputs will contribute to the UB programme outcome. Eliminate outputs from the UB programme envelope that are under-resourced to a level that they will not likely provide an effective contribution to achieving the outcome. Activities to consider for elimination could include:
	* Development of an autonomous hospital accreditation body (this is a zero-budget output)
	* Integrate health promotional activities on NCDs in the CoK Health Plan (activities funded from the budget for this output are not contributing to the output)
	* Hygiene and sanitation activities are routinely done (this is not a strategic output and activities are not likely to contribute to the Result 3 outcome)
2. Review the expected outcomes and outputs of UB Programme Result 6 (asset management), reduce the outcome expectations and focus the programme on achievable priority outputs. These could include:
	* The acquisition, installation and implementation of a medical equipment and medical infrastructure management software
	* The development of the four provincial hospital maintenance workshops that were constructed or rehabilitated with UB support into model facilities for training and mentoring biomedical technicians