Enabel

Final narrative report

UBUZIMA BURAMBYE PROGRAM

LONG HEALTHY LIFE

RWANDA

RWA 1309211

Belgian development agency

enabel.be

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0 Abbreviations

ANC	Ante Natal Care/Clinic
BMETs	Biomedical Equipment Technicians
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
ETR	End term Evaluation
GBV	Gender-Based Violence
GoR	Government of Rwanda
HCs	Health Centers
HFs	Health Facilities
HMIS	Health Monitoring Information System
HIS	Health Information System
HSSP	Health Sector Strategic Plan
HSWG	Health Sector Working Group
IFMIS	Integrated Financial Management and Information System
ITA	International technical Advisor
JHSR	Joint Health Sector review
JHSS	Joint Health Sector Support
JLCB	Joint Local Consultative Body
KHN	Kigali Hospital network
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
OA	Organizational Assessment
QA	Quality Assurance

QI	Quality Improvement
RA	Research Action
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 form

Intervention name	UBUZIMA BURAMBYE PROGRAM
Intervention Code	RWA 1309211
Location	RWANDA
Budget	€ 18 000 000
Partner Institution	MINISTRY OF HEALTH
Date intervention start /Opening steering committee	30 June 2015 (agreement) 3 December 2019 (SC1)
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, analyzed and used for evidence-based decision-making in a more correct, integrated, systematic, accessible and effective way~~ ***cancelled***
	R6. The asset management system is designed and operational in a cost-effective way
Total budget of the intervention	€ 18 Mi (Belgium) plus € 2.3 Mi (Rwanda)
Period covered by the report	Final report

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

2 Self-evaluation of performance

2.1 Relevance

	Performance
Relevance	A

The Ubuzima Burambye five interventions result areas are highly relevant (except for R6) to the needs of target groups as they are embedded and in line with local and national policies as well as the Belgian Strategy. It was fully aligned to the health Strategic Pans III and IV. Some concerns were shared for R6 (asset management – scored 'B') because of the difficulty to finalize the national strategic plan. Intervention outputs have contributed much to the health performance indicators. Following the MTR that observed interference during the implementation of program activities, some Result Areas reviewed the intervention logic to suit realities and provide more clarity in role and responsibilities of line institutions (R3). Thus, activities like medicalization and Kigali Hospital network (KHN) moved from City of Kigali to Ministry of Health/Clinical Services' responsibility to ensure ownership and provide clear strategic orientation. Thanks to its institutional anchorage, the intervention supported all levels of the health system; and in certain areas, the intervention has beenable to develop innovative interventions.

2.2 Effectiveness

	Performance
Effectiveness	B

Program interventions' outputs significantly contributed to the achievement of program outcome, though some are still 'work in progress'. For example, in result one there is still no local accreditation agency that is fully functional (this objective being overambitious in a short period).

The program had to adjust in context: a cut of 3 Million euro in total budget, large budget reallocations towards the construction and equipment of Nyarugenge District hospital, contractor not respecting agreed timelines for the construction works, etc. were challenges that the program had to face. Despite these challenges, most of the outcomes have been achieved or are on track in the spirit of national execution. The steering committee and the program management unit worked in close synergy to effectively address the above challenges. The End of term Review (ETR) report indicated a major strength of the program as having managed to mitigate these challenges.

2.3 Efficiency

	Performance
Efficiency	B

The project was well managed with efficient use of resources; efficiency was affected by the NEX modality which both partners welcomed but whose implementation was complex. There was good progress in many components, but not all outputs (R1, R2, and R6) were fully achieved due to budget cuts and reallocations, and other factors beyond the project's control. More non-financial contributions (buy-in and leadership from MoH and City of Kigali (CoK)) would have helped to address some of the challenges in innovative activities particularly in R3.

The respect of timeline in implementation of the program became very complicated and cumulatively affected the efficiency in program performance and budget execution. Delays were noted in tender processes but also in the implementation of activities across different Result Areas, for instance, implementation of Accreditation of Health Facilities (HFs) in R1; unplanned reorientation of scheduled activities in R4, Nyarugenge District Hospital construction, implementation of medicalization of HCs sustainability plan and Kigali Hospital Network (KHN) in R3; implementation of provincial maintenance workshop business plan and development of strategic plan in R6. All result areas found a need for improvement in terms of prioritization, planning and implementation to ensure timely delivery of key program outputs.

2.4 Potential sustainability

	Performance
Potential sustainability	B

The economic/financial sustainability is likely to be viable beyond the implementation period of the intervention. The Program was implemented to support the institution targets and existing policies have been generally supportive. Concerns on financial viability and ownership for urban health (R3) and asset management (R6) will need to be addressed by the MoH/RBC high-level leadership for instance, the strategic orientation on the gains made in progressing Kigali hospital network that is still awaited. We appreciate that financial sustainability has been addressed for the construction of the Mental Health Day Care Treatment Center (R2) through GoR Budget but remain with some concerns regarding the budget of Mental Health Division in RBC that was heavily dependent on UB funding.

The ownership for the intervention at the level of policy and involvement of local structures has been very high except for some innovative activities in R3 and R4 for which the intervention relied on ad-hoc arrangements and the steering committee as well as other relevant local structures to ensure sustainability. Asset management (R6) faced challenges in August 2018 when 22 of the MTI Division staff were dismissed and efforts are ongoing to rebuild the Division capacities and effectiveness.

The steering committee and other existing structures in MoH, RBC, CoK and decentralized level were much involved in all stages of implementation and decision-making. Intervention management was well embedded in institutional structures and has contributed to capacity building.

Finally, the anchorage of UB Program in the structure of RBC/MoH as well as the close alignment to the HSSP III/HSSP IV provides strong basis for maximum institutional sustainability of the Intervention.

2.5 Conclusions

- **Large infrastructure projects should be stand-alone projects with adequate time and expertise in both infrastructure planning and contract management scopes. Budget allocation must be preceded by a thorough situation analysis, needs analysis, comprehensive business plan and strategic note to guide any new project development. The appointment of a specific Task Force composed of key decision makers and technical staff from all involved parties has been extremely valuable for monitoring and decision-making.**

- A mix of management modalities needs to be available in any program as this allows for flexibility when required, particularly when emphasis is on results and budget execution. The SC should be in a position to revise modalities where relevant and needed keeping in mind that "not one size fits all".

- Institutional anchorage and support can significantly help the development partner to achieve its program objectives. When the dialogue is open and both country partner and Belgium development objectives correspond, there are additional chances for increased ownership and successful implementation with both parties sharing similar goals.

- Innovations or offshoot/new activities require clear vision, strong leadership and coordination, continuous dialogue and open communication. If seen as 'pilot projects', they can benefit from an earmarked budget in Regie or co-management with high flexibility in accounting.

- Development cooperation is a long-term process and should consider lessons from local context as well as past and ongoing programs to ensure more effective use of resources. This has been possible for the Belgian support to Mental Health program in Rwanda that dates from many years and could have a significant impact. There may have been a missed opportunity with regards to accreditation support and medical asset maintenance domains.

- UB program has been a complex program from the onset (structure, ambitious objectives, numerous stakeholders, etc.) with many challenges. The team spirit was excellent and managed to face these challenges in a proactive way with strong support from the SC and both leadership levels (MoH/GoR partner and Enabel Representation).

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3 Assessment of the intervention strategy

3.1 Evolution of the context

3.1.1 General and institutional background

The political and institutional context have been stable overall during the program intervention period. While leadership changed (three Ministers of Health and three Permanent Secretaries in MOH, change in CoK and Nyarugenge District leadership), the focus remained according to national priorities and strategic plans. This allowed for coherence and continuity in the program interventions.

Rwanda was one of the few African countries to make significant progress towards achieving the millennium development goals (MDG) and achieved all the health related MDGs. Prior to the Covid-19 pandemic it was also on track to achieve several of the current sustainable development goals (SDGs).

National decentralization policy was further implemented when the Ministry of Health decided that the construction of Nyarugenge District Hospital and the national Mental health Treatment center be done by the Districts rather than by RBC/SPIU as originally agreed upon in the TFF. An institutional analysis was done by Enabel to assess the districts' capacities and experience in implementing large infrastructure projects. The conclusions led to the use of co-management modality instead of NEX for both infrastructure projects in order to mitigate eventual implementation risks.

The decentralization and the Imihigo concept were an opportunity for good ownership and leadership by the district authorities: indeed, the infrastructure projects were part of both districts' Imihigo, meaning that they were included in the management's performance management and accountability contracts.

UB was designed in 2014 and began its implementation in 2015, when Rwanda's third health sector strategic plan (HSSP III) was current. HSSP III was replaced with the new Health Sector Strategy Plan (HSSP IV) in 2018. UB aimed specifically to support the Ministry of Health and RBC in implementation of the strategic plan for each of the intervention result areas. As the new HSSP IV maintained the same guiding principles and the UB team were involved in technical support for its development, there was no unexpected impact on the project.

During the project period, there were changes in financial administration with introduction of a new Integrated Financial Management Information & System (IFMIS) in 2016. Implementation of the system was a learning process for all parties and did have an impact on UB, which was operating under the NEX modality, as discussed in chapter 3 of this report.

The Covid-19 pandemic affected Rwanda in the last few months of the program. The Coronavirus Disease National Preparedness and Response Plan, 2019, was activated and the direct health impact at the time of writing this report had remained very low in comparison with other countries, with 1,582 people infected and 5 deaths as of July 2020. Analysis has shown that there was also an impact on the use of health services whilst the country was in lockdown and people were cautious about going to health centres for fear of infection. Full analysis of the economic impact of the lockdown was not available at time of writing, but it may affect people's capacity to pay for services in the future. Due to a high level of preparedness and previous experience with pandemics including the Ebola outbreak in neighbouring countries in 2018-20, up to the time of the evaluation, Rwanda had managed to limit the direct health impact of Covid-19. The NDH construction contractor however used the epidemic as an excuse for their extensive delays. While this can be partly appreciated, the main reasons for the contractor delays were managerial and had been evident even prior to the onset of Covid-19 epidemic.

3.1.2 Management context

Project implementation was overseen by a Steering Committee with members drawn from the Rwanda health sector (MOH and RBC) and the Belgian development cooperation office in Kigali. The Steering Committee took a very active role in overseeing the project decision-making. It was particularly instrumental to oversee the budget constraints and hospital construction needs.

Implementation was carried out by a project team of 201 staff. A core unit for project direction, management and financial administration was located in the Rwanda Biomedical Centre's (RBC) Single Project Implementation Unit (SPIU) with international and national technical assistance (ITA, NTA) personnel distributed in the health departments responsible for each result area. The directorates of the Ministry of Health and RBC divisions had counterparts to each result area as follows:

Result	Counterpart	Institution	
R1 Quality assurance	Directorate General of Clinical Services	Ministry of Health	
R2 Mental health	Mental Health Division	Rwanda Biomedical Centre	
R3 Urban health	Directorate General of Clinical Services	Ministry of Health	Involvement of CoK in certain activities
R4 Governance	Director General of Planning Financing, and Information System	Ministry of Health	
R6 Asset management	Medical Technology and Infrastructure (MTI) Division	Rwanda Biomedical Centre	

The institutional anchorage was complex but was designed to ensure that the project team was fully integrated in the Rwandan health sector.

Other important Rwandan partners were decentralised institutions involved in each project component. These included the City of Kigali (CoK), and the Nyarugenge, Kicukiro, Gasabo districts' administrative and district health management teams. UB was not designed to work with targeted districts, with the exception of the CoK for R3 and the 4 provincial hospitals for the maintenance workshops of R6 (Rwamagana, Bushenge, Ruhango and Kinihira).

The main change included the implementation modality for the infrastructure projects that were decentralized, as described above. This put more pressure on the program team that did not have the anticipated required expertise in infrastructure. The program recruited an ITA civil engineer who could not stay for the full project duration and was replaced by a part-time architect. A local engineer was recruited to ensure day to day monitoring.

Task forces were appointed by the steering committee to oversee the infrastructure projects implementation in both Gasabo and Nyarugenge districts. This approach facitilated effective coordination and active leadership on both sides and was a very useful tool to be recommended for other similar experiences, provided there is strong leadership.

3.1.2.1 Partnership modalities

Two framework agreements were signed for the infrastructure projects: one with Nyarugenge district for the hospital construction project and one with Gasabo District for the National Mental Health Treatment Center.

The agreement with Gasabo District could not reach completion following the SC decision of September 2017 "*to accept the reallocation of the budget dedicated to the construction and equipment of the Mental Health Day Care Center to the Construction of the Nyarugenge District Hospital*" (Decision 6.1 or 71). The responsibility of UB programme was to provide technical support to the finalization of the center final design.

The agreement with Nyarugenge District went through the whole period until construction and equipment completion. It was effectively implemented in particular with the creation of the Task Force to oversee the hospital construction.

Both agreements were developed following the districts Organizational Assessments (OA) that were done following MOH decision to decentralize the large infrastructure projects.

3.1.2.2 Operational modalities

TFF document identified National Execution (NEX) as the preferred modality. While this facilitated full alignment to the national system and was appreciated at strategic level, it required a learning process for both sides, UB to adjust to calendar and reallocation modalities and GoR to ensure adjustments for international funding sources. UB onset in June 2015 did not allow budget inclusion in IFMIS until January 2016 leading to first year low implementation and budget execution. The system was found much less flexible than other modalities such as Regie and the program had to adjust to that.

Overall, procedures and modalities were followed as per agreement except the change of implementation modality for the infrastructure projects. This also meant that a large part of the budget moved from NEX to co-management modality. There was however a mix as the District transfer payments were agreed upon through NEX but the contractor and suppliers payment were done under co-management. These added layers proved to slow down the payment delays though they remained within agreed upon timelines.

There was a major discontinuity in the project counterpart for result area 6 (asset management)in 2018, when the personnel of MTI Division were dismissed through a Cabinet Meeting Decision. In order to continue with project work, the UB staff team took on additional responsibilities normally handled by the national partner, which increased their workload very significantly.

With the exception of counterparts for result area 6 (R6), there were only a few changes of key staff in the national partner organisations. Significant staff changes were a new national Director of Intervention of the project in 2017, when the previous director left RBC. However, continuity was maintained under the new national director even though he was in acting position for many months.

The project also responded swiftly to the Covid-19 pandemic, providing technical assistance to the Government of Rwanda. Two of the medicalized health centres supported by the project as well as the nearly completed Nyarugenge District Hospital were urgently transformed into reception, quarantine and treatment centres for Covid-19 patients, showing the project outputs had sufficient flexibility to respond to unexpected changes.

3.2 Significant changes to the intervention strategy

The major changes were due to budget changes. The overall budget was cut from 21 Million Euros to 18 Million euros in April 2016 by the Belgium Development Cooperation Ministry because of

budget priorities in the Belgium Government. This led to the cancellation of one result area: Result area 5: "*Data are generated, analyzed and used for evidence-based decision-making in a more correct, integrated, systematic, accessible and effective way*". R1, R4, R5 and R6 were most affected (>15% cuts).

Secondly, the construction budget had not been well estimated during the formulation period. This was due to the lack of agreed upon design at the time of formulation and unclear information of cost per square meter. In addition, the equipment budget had also been severely underestimated. This led to extreme budget reallocation across the result areas: cancellation of 1 Mi Euro for the mental health treatment center, reallocations of 2.5 Mi Euros from R1 and R6 that had to cancel activities such as Quality Improvement (QI) projects. A number of hospitals that should have received funding for quality improvement and accreditation could no longer benefit from funding support hence this innovative QI approach could not be fully implemented and measured to assess its effectiveness.

Lastly, it was decided for R6 to decentralize medical equipment maintenance to provincial levels rather than strengthening 15 district hospital maintenance workshops. While this would ensure long term institutional strengthening, it delayed the original intention of strengthening medical maintenance in remote or hard-to-reach district hospitals.

4 Achieved results[2]

4.1 Performance of 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"

4.1.1 Achieved indicators[3]

R1: Quality assurance	Baseline 2015-16	End Target 2019-20	End Results	COMMENTS
Quality and safety of health services delivery improved				
Degree of patient satisfaction	TBD	TBD	72.9%	Patient satisfaction survey didn't take place because MOH wanted to use other indirect tools to measure patient satisfaction (Patient voice, Citizen report cards, etc.) According to the RGB Citizens report card, Oct.2019 72.9% of respondents were satisfied with health services offered, with increase of 2% compared to 2018; http://rgb.rw/fileadmin/Citizen_Report_Card-all/CRC_2019_Kinyarwanda.pdf
% of post CS infection rate in a given period of time	1.13%	<0.8%	3.7%	Reported data in 2018-19: Post CS infections are mostly due to inappropriate sterilization process and equipment, inappropriate laundry process and respect of IPC guidelines in some hospitals. Planned QI initiatives were not

[2] **'Results' means 'development results'**. Impact regards the general objective; outcomes regard the specific objective; output regards the expected result; intermediate outcomes regard changes resulting from the achievement of the outputs allowing progress towards the outcome of the intervention, at a higher level.

[3] *You may use the table given or replace it with your own monitoring matrix format. Add/delete columns in function of the context (certain interventions will have to add columns for preceding years while – new – interventions will not have values for the preceding year)*

R1: Quality assurance	Baseline 2015-16	End Target 2019-20	End Results	COMMENTS
				fully implemented due to delays in procurement process and initial reallocation of funds to NDH construction. It became national priority and some hospital significantly improved the rate.
# of Programs integrated in the accreditation process	7/12	12/12	18/18	The number of programs increased over the years. The integrated programs include: (1)Management of NCDs, (2) Reproductive and Maternal health care, (3) Adolescent reproductive health and rights, (4) New born and Child health care (5) HIV prevention and care, (6) TB prevention and care, (7) Malaria prevention, diagnosis and care, (8) Mental Health care, (9) GBV; (10) disabilities; (11) Integrated disease surveillance and response, (12) Nutrition; (13) Essential emergency equipment and supply, (14) safe medication use; (15) Monitoring and reporting on Communicable diseases; (16) Clean and sanitary environment; (17) stable safe water sources and (18) Health promotion and disease prevention.

R2: Mental Health				COMMENT
Mental health care services are accessible, utilized at community level up to national level in sustainable way				
Mental health care services utilization rate at health facility level (per 100)	0,16%	0,5%	0,28%	Decentralization and integration of mental health care and services, availing qualified staff and training of existing staff are key strategies implemented under the support of UB program to ensure quality of care and services and geographical accessibility. However, the vulnerable people still have a problem of financial accessibility.

R3: Urban Health				Comments
Awareness on NCDs increased (people-centred)				
Prevalence of NCD diabetes (raised fasting blood glucose)	7%	TBD	Non result available	Due to the lack of funds, the STEP survey has not yet been done.

Prevalence of hypertension in adult population in CoK	14%	TBD	Non result available	Screening done through the program during 2018 NCD mass campaigns revealed that 70% of people screened are not aware of their condition (high blood sugar level, high blood pressure, etc.); 36% had overweight, 15% were smokers/ex-smokers, 20% had harmful use of alcohol, 26% had hypertension and 4% had fasting hyperglycaemia.
Prevalence of overweight BMI≥ 25 (& BMI≥ 30)	19% and 10%	TBD	Non result available	
Environmental health management improved at different levels (integrated services and people-centred)				
Prevalence acute diarrhea <5	6%	3%	4%	UB Program support to this output stopped I July 2018 as CoK had other partners
% of public places responding to at least 80% hygiene standard criteria	TBD	80%	75%	UB Program support to this output stopped I July 2018 as CoK had other partners
Health facilities system in the CoK is rationalized by integrated equitable and sustainable services				
% population living at < 1 hour walk/5 km from HC	77%	100%	77%	UB Program contributed to the development of the Master Facility List which is a mapping of all health facilities in Rwanda and CoK health strategic plan, which will be used to develop the health services coverage plan
Bed occupancy rate in different Kigali hospitals	TBD	TBD	71.5%	Low bed occupancy reflecting health centers beds that are underutilised as well as the preferred use of private facilities for hospitalization in City of Kigali
Patient and health care providers satisfaction rate	TBD	TBD	Cancelled	The planned survey to assess the health care providers' and patients' satisfaction was cancelled (mentioned under R1).
ANC coverage in CoK HFs (four standards visits)	44%	100%	36%	This is the most challenging indicator not only for CoK but also for the whole country. While the majority of deliveries take place in health facilities (98%), too often pregnant mothers delay in the first ANC consultation and therefore do not get ample time to complete 4 visits before delivery.
Deliveries rate at HF level in CoK HFs	94%	100%	98%	The MoH objective is to maintain the HF deliveries rate at >95%.

R4: Leadership and Governance				
Stewardship capacities at the level of the local health system (district) is strengthened				
% 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	0%	100%	100%	Before starting to develop district health strategic plans and following the MoH Mid Term Review of HSSP III, all districts conducted situation analysis prior to inform their Strategic Plans.
% of Districts which has developed a comprehensive health strategic plan 2018/2023	0%	100%	100%	It was a process initiated at central level and then decentralized level with the technical support from MoH and Partners involved in health in each district
% of Districts functioning in a SWAp model (all health activities and stakeholders are integrated/aligned district)	0%	100%	100%	This was evidenced during the development and implementation of District health strategic plan
MoH and RBC are supporting decentralized levels according to their respective roles (policy, regulation, coordination, M&E, and implementation)				
Number of District Health Strategic Plans (DHSP) 2018-2023 with Quality assessment done by Central level	0	30	30	The Ministry of Health shared all district health strategic plans to DPs' technical staff for review and quality check and then provide feedback to Districts.
% of districts visited by Joint supervision team from central level at least once a year (among the selected ones)	0%	100%	100%	MoH/RBC and DPs representative compose the joint supervision team. Once a year, MoH selects a certain number of Districts to be visited (Rusizi and Nyamasheke for FY2018_19) and the team supervise and assess the implementation progress of Key health programs, identify the gaps and formulate recommendations that are assessed during the following year's supervision.

R6: Asset management				
Quality of health assets in health facilities is increased based on their implementation of standards				
An asset (equipment and infrastructure) management system is put in place and is operational	Weak	Operational	Partially operational	The main activities to make asset (equipment and infrastructure) management system functional have been: (i) placement of at least one trained BMET at each District Hospital has, (ii) recruitment of qualified staff at central level; (iii) development of database for technical specifications of medical equipment, (iv) establishment of maintenance framework contracts for complex equipment (i.e. lab, radiology), (v) procurement of equipment for MTI Division call center, (vi) operationalisation of [4]MEMMS to provide regular report on status of medical equipment; (vii) Infrastructure and equipment needs assessment done once year, (viii) annual procurement plan prepared and revised, (ix) provincial maintenance workshop constructed, equipped and waiting for staff recruitment;(x) installation of and repair of autoclaves in DHs. The remaining activity is the development of norms and health infrastructure, recruitment of staff for four provincial maintenance workshops and deployment of all trained BMETs.

4.1.2 Analysis of the achievement of the outcome

It is not an easy task to comprehensively review and appreciate the achievement of the outcome of an institutional support program as the outcome is very broad and cannot be attributed to achievement of one indicator only. The outcome reads as follows: **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.** The five results areas have been five entry points to support both MOH and RBC to achieve the objective and targets.

Result 1 – The quality assurance system is set up and integrated and functional at the level of all hospitals. The system is in place since an accreditation policy and guidelines have been established and all public hospitals are assessed every year.. There was no baseline on patient satisfaction to have a comparative assessment. Furthermore, the patient satisfaction survey that was planned at baseline and end of program was not implemented

[4] Medical Equipment Maintenance Management System

as MOH replaced it with Patient Voice program (a program whereby anyone can air concerns to MOH and MOH is to respond to them accordingly). The Citizen's Report Card is another tool used by GoR through the Rwanda Governance Board every year and it showed some improvement in satisfaction with services provided at health facilities over the years.

Result 2 – The mental health services are accessible at the community level up to the national level in a sustainable way. The support towards decentralization of mental health services through appointment of mental health staff in each hospital and each of the 517 health centers, with supportive supervision and further training, together with the training of 57,000 Community health Workers (CHW) have significantly sensitized the community to mental health and has increased accessibility to mental health services.

Result 3 – The urban health service coverage is rationalized and extended in line with the three guiding principles of the National Health Sector Policy. While waiting for data on NCDs prevalence (latest done in 2015), NCDs screening done during mass campaigns show the need to further screen and sensitize communities on NCDs existence and risks. Geographical access to health services has improved in some sectors though all are not yet covered with health centers as per policy requirement. Since UB did not have any specific district to work, some of the indicators on access, ANC coverage and bed occupancy were not really under the control of the program.

Result 4 The leadership and governance are reinforced, specifically regarding district stewardship, the respective roles of the MoH and RBC and the public private partnership. All indicators were fully achieved. This however does not mean that governance and leadership were fully achieved in all districts at satisfactory level. Tile is needed to see how the planning exercises will have an impact of quality of services and health indicators improvements. There is further room to develop public private partnership

Result 6 The asset management system is designed and operational in a cost-effective way. This dismissal of the entire MTI division in August 2018 put a halt in UB support effectiveness to the program as there was no longer any institution to support. UB contribution was directed to assist in asset management decentralization through the set up of provincial workshops that aimed to oversee asset management in each province. While workshops have been constructed or renovated, staffing is not yet in full capacity and work is ongoing to complement the staffing positions. The national strategic plan for asset management has been drafted but need to be validated to ensure that clear asset management vision and goals.

4.2 Performance of output 1[5] The quality assurance system is set up and integrated and functional at the level of all hospitals

4.2.1 Achieved indicators

RESULT/OUTPUTS/ INDICATORS	Baseline	End Target	End Result	comments
An independent accreditation body is established and functional				
An independent accreditation body in place and functioning	No	Yes	No	During UB program implementation, the following achievements were realized for the accreditation program: (i) The national policy and strategy for quality healthcare services have been developed, (ii) The autonomous accreditation body (private company) has been recruited in order to strengthen the link between purchasing of services and quality improvement evaluation (separation functions and roles for purchaser versus payer); (iii) Rwanda Primary Healthcare Accreditation Standards have been developed and all health centers are implementing the standards. As strong and independent accreditation body is awaited. It will take years for an independent fully accredited body to be functioning. The target was too ambitious
# of NR,PH& District assessed per year by the RHAO/MOH	0/42	42/42	42/42	While waiting the RHAO establishment. UB program supported MoH to carry out (every year), Hospital Progressive Performance Assessment by using national trained surveyors and at the end of the program. An external Rwanda Health Accreditation Organization was hired to perform health accreditation.
All HFs have functional QA committees				

[5] The template provides for up to 3 outputs (chapters 2.2, 2.3 and 2.4). In case the intervention has more outputs, simply copy paste. In case the intervention has fewer than 3 outputs, simply delete the superfluous chapter(s). For the outcome level you may also replace this table by the intervention's own format (e.g. your operational monitoring tool)

RESULT/OUTPUTS/ INDICATORS	Baseline	End Target	End Result	comments
% of HCs with functional QA committees	90%	100%	100%	Achieved at 100%. All health centers have functional Quality Assurance committees
# of hospitals having submitted report on incident and its management systems	5	42	42	There is a focal person at each hospital. Achieved at 100%. The critical incidents are reported directly to the Ministry of Health through HMIS using a reporting format prepared for
District hospital achieving level 2 of accreditation				
# of DHs achieving level 2 of accreditation	0	10	0	In 2018, 2 hospital achieved L2 and no Hospital achieved L2 in 2019. This was a disappointing result and shows how much accreditation requires support and continuous facilitation to be achieved
Quality improvement initiatives are implemented and documented in HFs				
# of HFs with quality improvement initiatives documented	0	10	18/23	23 District hospitals implemented quality improvement initiatives and 18 were documented (as sample) through action research ongoing activity
Health care specialized centers are enrolled in accreditation program				
# of specialized health care centers enrolled in the program	0	3	3	Concerned health services are: (1) Ndera mental health care centers, (2) Gatagara and (3) Rilima orthopedic heath care center were enrolled into existing standards Gatagara

4.2.2 Analysis of the realization of the output

Accreditation is a very long path to implement and results may take long before being seen. It requires extensive leadership support at all levels and cannot be taken for granted. Furthermore, accreditation may not automatically lead to immediate effect or impact. It is a long process that requires clear vision at central level and strong support system at central and facility level. One success has been the integration of accreditation with the Performance Based Financing (PBF) system that has been in place over 10 years in Rwanda. This allowed a coordinated supervision and monitoring system as well as a motivation for accreditation implementation.

UB also made important contributions to resourcing quality improvement (QI) projects in the hospitals, providing technical assistance and material inputs. Stakeholders agreed that identification and implementation of QI projects were important steps towards increasing quality and achieving accreditation. They were also an important motivator for the hospital staff. Detailed reports prepared by partners on the QI projects showed they had tangible results on the technical quality of service provision. Some hospitals are committed to continuing with QI projects using their own budget resources.

"An independent accreditation agency is necessary to avoid conflict of interest of MOH which cannot be at the same time the provider of services (through its public health facilities) and the evaluator of quality of those services. There are outstanding needs to develop the accreditation system further,

strengthen awareness of the link between accreditation and service quality, and implement regular accreditation survey cycles. The Ministry of Health has already taken some steps in this direction although there are challenges in defining the most appropriate organizational structure for the medium and long-term, and whether the accreditation agency should be an NGO, public sector institution, or a private sector body. The Rwanda Agency for Accreditation and Quality Health care (RAAQH) – a registered NGO - has mobilized trained surveyors and successfully completed one survey round with funding from MSH and UB in 15 and 28 hospitals respectively. However, RAAQH is still new, lacks required funding for regular accreditation survey cycles and does not have a formal mandate for the role of independent accreditation agency".

Health Facilities could contribute towards accreditation sustainability provided they would pay the agency for assessment and get rewards from insurance in case of good accreditation performance. UB main achievement was on support to accreditation guidelines, facilitation of health facilities in good coordination with MSH and set up of quality improvement initiatives.

MOH is keen to take the process further and get an independent accreditation agency. UB budget cuts however did not allow to repeat a second set of QI initiatives or to fund the set up of the accreditation agency.

4.3 Performance of output 2[6] The mental health services are accessible at the community level up to the national level in a sustainable way

4.3.1 Achieved indicators

RESULT/OUTPUTS/ INDICATORS	Baseline	End Target	End Result	comments
R2: Mental Health				
Strengthened community interventions on mental health care				
Number of community mental health rehabilitation initiatives (Group psycho-educative) funded	0	16	cancelled	Due to the difficulties of implementing this activity and after approval of SC, the planned budget used for training and sensitize 5,000 Community caregivers
Number of awareness campaign conducted at community level	1	4	5	Achieved at 100%. Each year, one awareness mass campaign was organized except in 2019 where mass campaigns were organized.
Integrated mental health care services & a people-centered approach at all levels of health facilities				
% of HCs providing integrated Mental Health care through trained health care providers	84%	100%	100%	The trained health providers include mental health nurses, General Nurses and clinical psychologists, general practitioners from district hospitals and from HCs, General Nurses working in prisons and EEG technicians. 99% of HCs are managing mental health cases and the 1% represents new HCs that are not yet included into the HMIS reporting system.
% of mental health provider (old and new appointed) trained in early detection & treatment of mental	84%	100%	100%	Due to the problem of staff turnover, the reported results is subject to change but general achievements were good.

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RESULT/OUTPUTS/ INDICATORS	Baseline	End Target	End Result	comments
disorders as well as in people-centered related technique				
Number of physicians specialized in psychiatry area	6	15	12	Achieved at 80% with those who have completed (6) and 3 who have to complete the specialization this year and next year.
Level of completeness of Mental health Day Care Centre construction	0	L4	Cancelled	Budget added on the Nyarugenge District Hospital (Refer to the SC decision). UB supported design of Day care center and government will support the construction of day care center
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				
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	L4	L4	Achieved at 100%. The component of strategic plan related to the drug abuse has been incorporated in the Mental Health National Strategic Plan
Level of Huye rehabilitation center equipment and functionality (level 1: procurement process, level 2: equipment distribution and level 3: utilization and improved care services provided)	0	L4	L4	Achieved at 100%. Huye rehabilitation center is specialized in addiction and disintoxication. It has been equipped and now running well.

4.3.2 Analysis of the realization of the output

Most of the outputs have been achieved, except the National Mental Health Day Center of which UB supported the design and construction will be done in 2021 with GoR funding.

Mental health is critical for the comprehensive wellbeing of communities. It is particular in Rwanda considering the history of genocide against the Tutsi. The program contributed to extensive decentralization of mental health services, training all CHWs up to MMED in Psychiatry. The whole country system is now inclusive of mental health services and the next step is to ensure continued quality of services. Other support included sensitization and action support on drug and substance abuse that is a growing concern in Rwanda.

UB contributed to the Rwanda mental health survey held in 2018 that provided valuable information such as: 11.9% of the population aged 14-65 suffers from major depressive illness (it is 35% among genocide survivors aged 24-65, with 27.9% post-Traumatic Stress Disorder and 26.8% Panic disorder in the same population). Results also showed that few people reported utilization of mental health support. This call for a continued comprehensive approach to the general population as well as the genocide survivors. While Belgium support to Mental Health Division withdrew in 2018, more support is needed and calls for further reflection. Sustainability here will depend on availability of resources and support from GoR.

There are still important areas of mental health to be addressed. Drug and substance abuse gained prominence as a growing social and health problem only in 2017, when the Government of Rwanda set up an inter-ministerial committee to highlight its cross-sectoral nature, and the need for a holistic approach. UB funded a NTA for drug and substance abuse, supported community sensitization activities and provided internet equipment for connecting Huye Rehabilitation Center used for mental health rehabilitation and re-integration (Huye One-Stop Center).

4.4 Performance of output 3[7] The urban health service coverage is rationalized and extended in line with the three guiding principles of the National Health Sector Policy

4.4.1 Achieved indicators

RESULT/OUTPUTS/ INDICATORS	Baseline	End Target	End Result	comments
R3: Urban Health				
Health Promotional activities on NCDs are integrated in CoK Health plan				
Number of NCD detected during the mass campaigns	0	3,000	At least 3,875	Since 2016, UB supported the City of Kigali to organize five NCDs mass campaigns and the number of screening people increased each year from 3604 in 2016 to more than 6000 in 2019 thanks to the increase of screening sites and the NCDs detected increased also from 674 in 2016 to more than 1200 in 2019.
Hygiene and sanitation activities are routinely done				
Situation analysis on Hygiene on sanitation in public places notified by TWG health environmental platform	NA	Identified areas of improvement	Stopped aft Mid Term Review	The city of Kigali identified areas of improvement by type of public place (school, markets, and butcheries). However, this activity has been stopped following the Mid Term Evaluation Recommendation.
% of TWG health environmental platform recommendations implemented	0	80%	Stopped aft Mid Term Review	Achieved in Y2 when UB supported CoK and after MTR, UB stopped support to avoid duplication.
10-years solid waste management plan	N/A	10-year plan adopted	Cancelled	During the program implementation we found that solid management plan had been developed before and could be used by CoK; But all planned activities under hygiene and sanitation were stopped after Mid Term Evaluation
The Kigali Hospital Networking formalized (functional KHN)				

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RESULT/OUTPUTS/ INDICATORS	Baseline	End Target	End Result	comments
Appointed members from different hospital and other stakeholders	N/A	All stakeholders	All stakeholders	Achieved at 100% Task forces, TWG and Steering committees appointed as planned
TOR and objectives approved/Concept note and joint initiatives	No	Yes	Yes.	Achieved at 100% The concept note and joint initiatives were developed
Road map Operational plan	No	3-year plan	3-years plan developed	Developed and approved by SC
Inventory of joint/ shared initiatives	0	8	3	Only three joint initiatives were identified: (1) Improvement of patient referral system and (2) Integrated emergency management system and (3) Medical skills sharing. The medical skill sharing was implemented starting December 2017, 8 training modules have been shared to the providers in 4 district hospitals: **Traumatology & orthopaedic emergency:** management of head & c-spinal injury and management of extremity injuries, including open and closed fractures, and dislocation **General surgery emergency:** resuscitation of surgical/trauma patient and management of acute abdomen **Maternal emergency**: techniques of caesarean section and management of Post-Partum Haemorrhage, including technic of "Uterine balloon tamponade"
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)				
Monthly number of new cases seen by MD per HC	0	TBD	769	The number of cases seen by medical doctors increased over the year. For example, in 2018_19 9,229 patients were seen by medical doctors which correspond to an average of769 per month. The number increased with the availability of ultrasound machine and dental chair.
Number of laboratory able to make Folate Binding Protein (FBP) and biomedical analysis	3	4	4	Achieved at 100% All medicalized health centers are able to perform FBP and biomedical analysis.

RESULT/OUTPUTS/ INDICATORS	Baseline	End Target	End Result	comments
Number of HC equipped with ultrasound machine	0	4	4	Achieved at 100%. Ultrasound machine and dental chair were provided
% of drugs for NCD and chronic diseases available at medicalized HC level	0	100% available	100% available	All medicalized health centers have recommended NCDs drugs for especially Hypertension and diabetic disease
A comprehensive and equitable urban Health Facilities coverage plan is developed and validated				
Updated mapping of health facilities (public and private)	N/A	Mapping available	Mapping of Health facilities available	The mapping of health has been done (countrywide) by a consultant under R4 and this includes City of Kigali health facilities
Recommendations and operational plan proposal for improving coverage	N/A	Operational Plan available	Health Strategic plan	The health coverage plan has been developed but the health strategic plan includes all needed information for CoK to develop operational plan
TWG on coverage plan in place with coordinator identified	NA	Coordination mechanism in place	NA	The planned budget for these TWGs on coverage plan has been reallocated to the development if City of Kigali Health Strategic Plan
Framework PPP available	NA	Approved framework	NA	The planned budget has been reallocated to the development if City of Kigali Health Strategic Plan
Number of private investors engaged to finance new Health centers	N/A	3	NA	The planned budget has been reallocated to the development if City of Kigali Health Strategic Plan
MOU insurance coverage public & private		MoU signed	NA	The planned budget has been reallocated to the development if City of Kigali Health Strategic Plan
Number of HF upgraded	N/A	TBD	four health centers upgraded	Four Upgraded health centers up to the level of medicalized health centers
Quality standard per HF category	Old one	Quality standard per HF updated	Health package for medicalized health center revised	The health services package has been revised for medicalized health centers
District hospital is developed, built and equipped in an innovative way (in terms of organization and patient flowing, healthy working conditions, respect for environmental priorities, sound waste management, energy saving, isolation and network connection) in				

RESULT/OUTPUTS/ INDICATORS	Baseline	End Target	End Result	comments
Nyarugenge District which is articulated with the CoK HF coverage plan				
Standard design for an innovating model District Hospital validate	No	Yes	Yes	The Nyarugenge District Hospital has been constructed using validated standard design which is a high model
120 bed-hospital equipped	No	Yes	Yes	Achieved – consultations started on 1st December 2020
Number of hospital beds for the CoK	2060	TBD	2784	The number of beds include public and private health facilities except King Faisal Hospital Gasabo district count 1092, Kicukiro district 749 and Nyarugenge 943

4.4.2 Analysis of the realization of the output

This result area counted numerous challenges either because of innovative activities (medicalization, hospital network), by the complexity of roles and responsibilities of stakeholders (MOH, RBC, CoK, Districts authorities, DHMT, DHU, Hospitals, private sector, etc.) or by the funding challenges (Nyarugenge hospital construction and equipment). It also called for specialized expertise (IT development) and for strong leadership.

Achievement include the medicalization concept that was finally validated as a new package of care. Data have showed that the service meets a definite need and that potential for better quality of care is high (through medical doctor consultation, availability of ultrasound services for pregnant mothers, dental services, etc.). However, in the context of medical doctor shortage, it will need time to be fully implemented, even though study showed its financial sustainability.

Hospital network has been a challenging concept as it involved numerous stakeholders at different levels (central, referral district health facilities as well as private facilities). A major obstacle was the lack of available expertise to develop the required IT systems and an interoperability system to allow patient data sharing in full confidentiality. Initial steps have been put in place and a dashboard is under development to gather initial information of use for the network i.e.: bed availability, specialist services availability and appointment system, equipment availability and ambulance system. The overall objective being to improve patient referral and counter referral in urban setting (CoK as a start)

UB contribution on NCD sensitization, awareness, screening and management has been highly appreciated. While MTR proposed to discontinue the support, UB SC did not take the recommendation and NCD support continued. It is a pity that the national survey on NCD (commonly using STEP method from WHO) has been postponed for funding reasons. UB support highlighted the reality of increasing NCD in the community and the need to better take care of NCD patients. It is up to MoH and RBC to step up the response to NCD increase in terms of sensitization, prevention and care.

The construction of Nyarugenge hospital took a toll on UB program in term of technical expertise, time and budget. It was initially anticipated in NEX for SPIU/RBC was to take the lead in the project. Upon the decision to go for co-management, UB had no resources to get a full time ITA civil engineer or architect. Part-time engineer (in support to Enabel Burundi projects) assisted in the design phase and part-time architect did the supervision part. A NTA engineer was recruited for daily follow up and reporting to the Task Force. Had the consultant and contractor been more professional and

experienced in their work, UB technical team together with SPIU/RBC engineers would have managed very well. Unfortunately, both consultant and contractor were weak and did not fulfill their contract agreement. Lessons learnt include the need for a preliminary business plan, a strong expert technical team, strict selection of consultant and contractor, strict contract management, specific budget and stand-alone project (in order to not undermine other result areas *(See best practice document on infrastructure experience for further information)*

4.5 Performance of output 4[8] The leadership and governance is reinforced, specifically regarding district stewardship, the respective roles of the MoH and RBC and the public private partnership

4.5.1 Achieved indicators

RESULT/OUTPUTS/ INDICATORS	Baseline	End Target	End Result	comments
R4: Leadership and Governance				
All DHMT/DHU are fully functional				
% DHU operational with at least 3 DHMT meeting held per year under the secretary of District Hospital	TBD	100%	100%	Achieved at 100% The operationalization of DHMT is monitored through HealthAppex
% of districts submitting to MoH the quarterly reports on selected key indicators	0	100%	100%	The fourteen selected key indicators are reported on monthly basis through HMIS, analyzed and feedback sent to Districts (1) Proportion of children who receive the second dose of Measles & Rubella (MR1 as denominator); (2) Number of health center constructed for the considered period, (3) Proportion of monthly community screening of malnutrition for under 5 year children; (4) Proportion of children in yellow; (5) Proportion of children in red; (6) Family Planning Modern contraceptive utilization rate, (7) Number of Malaria cases (all); (8) Under five mortality rate (per 1000 live birth); (9&10) Percentage of teenage pregnancies (Age group 15 to 19 years; (11) Institutional Infant mortality rate (per 1000 live birth); (12) ANC 4th standard visit coverage rate (BCG Denominator); (13) Maternal deaths at HF; (14) Health Facility delivery coverage rate (BCG denominator);
% district with integrated health plan	TBD	100%	100%	Achieved at 100% All developed district health strategic plans have main component of Health Sector Strategic Plan (HSSP4)

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RESULT/OUTPUTS/ INDICATORS	Baseline	End Target	End Result	comments
Number of action researches Studies/Short courses initiated, completed and documented by district unit (DHU)	0	10	13	Planning and Finance Directorate didn't conduct AR but supported Districts to develop protocols and implement Operational research through District Operational Research Challenge Funds initiative (DORCF)
MoH and RBC have provided support and capacity building regarding the gaps and needs identified in terms of planning, M&E, finance, management and implementation				
Quarterly coordination meeting with DHU on data analysis and use, and on management with identification of gaps and needs	0	3 per year	At least 3 meetings	Achieved at 100% Sometimes more than three coordination meetings were organized per year
of DHU with two staff per District trained on planning, M&E, Finance &Management	0	100%	100%	All staff were trained as planned and the topics changed according to the needs and priorities (training on HRTT, Planning and M&E and PFB indicators)
Medical internship program at district hospitals is evaluated and weaknesses addressed	0	One internship report	Internship report available	Planning and Finance Directorate organized an assessment of DHs capacities to receive interns and organized training workshop on logbook as management tool.
Number of researches /studies/Short courses initiated	0	3	>20	During the UB program implementation, Short courses: 11 staff beneficiated short courses in different areas, three main action researches performed and thirteen District Operational researches. In addition to this, mapping of health facilities has been carried out.

4.5.2 Analysis of the realization of the output

Most outputs were achieved, if not exceeded. This has been more to the benefit of the central level than the districts as the support requested by MOH was at central level and there was not earmarked district to be supported (unlike previous or later Enabel programs). It is therefore unclear whether the central support will have an effect at decentralized level.

There were numerous requests for action plan and budget modification over the months and years of implementation. This led to implementation difficulties, narrowing the intended scope of the result area. It also meant that the technical support was very limited and actually not much requested than the financial support.

The health facility mapping is a tool that will assist MOH and RBC to better plan infrastructure and equipment requirement in the future, also anticipating population growth. It includes projections over time and identify priority areas for support *(see best practice document on health facility mapping)*

There was no systematic action research protocol developed but the program identified topics for either best practice of policy documents or abstracts for publication as follows (there will be published in a booklet or separately as relevant):

Result area	Title	Output
1. R1:	Quality Improvement Initiatives effectively help improve quality of health care and safety in Rwandan hospitals	Abstract, poster and presentation
	The Accreditation Program improves quality of care in hospitals in Rwanda	Best practice
2. R2	Situation analysis for trauma cases during the commemoration period of the genocide against the Tutsi in Rwanda	Report
3. R3:	Upgrading standard health centers to improve accessibility to quality care in urban settings	Best practice
	Lessons learned from Hospital Information Network platform implementation with the aim of contributing to the improved management of emergencies, referrals and resource in the city of KIGALI	Best practice
	Hospital construction in Rwanda: lessons learnt	Best practice
	The City of Kigali Mass Campaigns Are Effective for Prevention and Control of Non-Communicable Diseases: An Action Research Study in Kigali, Rwanda	Abstract, poster
	NCD Mass Campaigns in the City of Kigali for prevention and detection of hypertension and diabetes: Evaluation Study	Abstract
	Mass Campaign On Non-Communicable Diseases - City Of Kigali 2017: Assessing Utility And Effectiveness	Abstract
4. R4	Health Facility Mapping contributes to improve health care services by rational redistribution of health resources	Best practice
5. R6	Improving quality of services through decentralized medical maintenance workshops	Abstract
	How to strengthen healthcare technology management	Policy brief
	Safety is vital: radiation protection in healthcare facilities	Best practice

In summary, 6 best practices, 5 abstracts,2 posters, 1 presentation and 1 policy brief were produced

Besides, posters and presentations were accepted and given during international conferences (ECTMIH Liverpool 2019, AHAIC 2019, BeCause health 2019, ICFP Kigali 2018.

UB significantly contributed to the capacity building of action research within UB staff but also to all districts and health staff through the knowledge management Technical working Group (TWG) in coordination with Swiss cooperation and USAID (MSH). This led to the District Operational Research Challenge Fund whereby 13 research protocols were developed, implemented and some of them published

4.6 Performance of output 5[9] Data are generated, analyzed and used for evidence-based decision-making in a more correct, integrated, systematic, accessible and effective way

4.6.1 Achieved indicators

This result was cancelled following Belgium budget cut of 3 Million Euros in April 2016.

4.6.2 Analysis of the realization of the output

The cancellation of this result area was inevitable and had a significant impact on the monitoring of the program as well as on the support to MOH and RBC in use of quality data for decision making. As a result, ITAs and NTAs had to include significant time for developing the baseline monitoring tool and the program had to recruit consultants for baseline data as well as for action research activities. While it is understood that M&E is integral part of technical assistance, additional expertise would have been of great benefit to the program as well as to the partner.

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4.7 Performance of output 6[10] The asset management system is designed and operational in a cost-effective way

4.7.1 Achieved indicators

RESULT/OUTPUTS/ INDICATORS	Baseline	End Target	End Result	comments
R6: Asset management				
The policy, (standards and/or guidelines regarding health assets management) is updated, approved, and disseminated				
Availability of a national policy regarding health asset management system	N/A	National Policy Available	National Policy developed	Guidelines for medical equipment management, donation and decommissioning and health infrastructure management were developed
Technical support towards harmonized, standardized effective acquisition, distribution and disposal of medical equipment at the level of all health facilities				
Database of technical specifications of medical equipment and inventory of medical equipment in health facilities	N/A	Database available	Database available	The database of technical specifications has been developed and it is updated on regular basis
Health facilities are designed according to standards and guideline				
Norms and standards for Health infrastructure developed and approved.	Existing service packages	Approved norms and standards	Cancelled	The tender has been launched and due to the lack of successful bidders (two times) this has been abandoned and budget reallocated to other program activities
Improved capacity of biomedical and health infrastructure engineers and biomedical technicians at central and district level				
% of medical equipment curatively maintained upon HF request	0	70%	85%	Good achievement thanks to the maintenance contract signed with RBC;
Number Staff trained and Upgraded the education levels in	A1: 50 MSc: 3	A1:80 A0: 2	A1: 73 (50+23)	In addition to the three BMETs for Bachelors Program in Biomedical Engineering and two engineers for Master's Program in Biomedical

[10] *The template provides for up to 3 outputs (chapters 2.2, 2.3 and 2.4). In case the intervention has more outputs, simply copy paste. In case the intervention has fewer than 3 outputs, simply delete the superfluous chapter(s). For the outcome level you may also replace this table by the intervention's own format (e.g. your operational monitoring tool).*

RESULT/OUTPUTS/ INDICATORS	Baseline	End Target	End Result	comments
R6: Asset management				
Biomedical engineering and Health infrastructure		MSc: 5	AO: 2 MSc: 5(3+2)	engineering, in-house trainings were done for BMETs of Health Facilities which increased the number of trained and skilled biomedical technicians in the country and an internship program to further facilitate access to employment and gain experience for young graduates
Better utilization of assets in health facilities				
Health facilities benefiting improvement initiatives	0	95%	95%	The improvement initiatives include installation of and repair of autoclaves in 17 district hospitals, procurement and distribution of medical and non-medical (IT) equipment in 18 hospitals, construction/renovation and equipping of four provincial hospital maintenance workshops, as well as implementation of measures taken for radiation safety in six district hospitals.

4.7.2 Analysis of the realization of the output

Medical asset represents a huge and expensive component of the health services in any country. It is a huge investment that needs particular expert attention both on technical expertise and on managerial expertise. As an example, equipment budget for Nyarugenge hospital has reached RWF 3Bi (over Euro 2.5 Mi). This requires expertise in recent technologies, capacity to select appropriate models and procure them, training of the users (preventive and curative training) and enough qualified engineers and technicians to maintain them at central and facility levels.

Through the in-depth hospital infrastructure and equipment assessment in 2016-17, UB program assisted MOH and RBC in advocacy as well as problem identification in the medical infrastructure and equipment field. It has been a potential basis for benchmarking, priority setting, resource mobilization and needs assessment. Unfortunately, the whole MTI Division was dismissed in August 2018 and numerous planned activities could not be implemented. This included the finalization and validation of the national strategic plan for medical asset that is still pending. With the appointment of the MTI Division Manager, it is likely that the validation will be done in the near future. The challenges of the strategic plan lie in the need for many stakeholder's contribution (MOH leadership, RBC leadership, biomedical engineers, health facility engineers, donors, funders, private sector etc.). Furthermore, strategic directions have very different cost implications as well as responsibilities. Through UB advocacy and support, some progress has been made including framework contracts for equipment procurement and maintenance contracts, training of engineers and technicians, database of medical equipment (Medical Equipment Maintenance Management System - MEMMS). This includes the establishment of four provincial maintenance workshops. The initial plan was to equip 15 District hospitals with maintenance equipment and training to address at least preventive maintenance as well as first level of curative maintenance. The objective being to assist the most remote hospitals in minimum medical equipment expertise and

equipment. However, in the line of long-term decentralization and the dismissal of the central unit, UB SC decided to rather concentrate on four provincial workshops with good expertise and tools for repairs with a vision ofthese provincial centers becoming hubs for all medical equipment in the respective provinces. As a result, four workshops are operational and functional. Only additional staff is needed to make them fully operational. A preliminary guideline was developed to make these workshops self-sufficient within 3 to 5 years of operations.

While progress has been evidently made, some big challenges remain in the field of asset management: the strategic vision and plan must be finalized to provide direction; human resources gap in biomedical engineering must be addressed; development of standards of infrastructure and equipment is needed; strengthening of maintenance decentralization must come with adequate budget and procedures for procuring spare parts; collaboration with the private sector should be further explored to be a win-win situation for the benefit of effective medical asset management in the country.

5 Synergies and complementarities

5.1 With other interventions of the Portfolio

There was a clear synergy within the health portfolio with the other intervention of Joint health Sector Support (JHSS) that worked at strategic level with MOH as well as the end of the Capacity Development Pool Fund (CDPF). This allowed for an exchange of perspectives between the project from either strategic or more operational perspectives. This was facilitated by regular coordination meeting of all ITAs and representation staff involved.

Synergies with other sector portfolio were limited either because of geographic distribution, either because of scope or because of expertise being too distant. It is only late in the program that we had synergies with the new urban development program in terms of sharing expertise on architectural design for some extension to the hospital construction works (rehabilitation of existing church building to provide for additional meeting rooms, storage, canteen and laundry/kitchen area for patients relatives'/helpers).

5.2 With third-party assignments

Not applicable for UB program

5.3 Other synergies and complementarities

There were some initial but limited synergies in the area of mental health with Broeders van Liefde who operate the psychiatric hospital of Ndera and with Humanity and Inclusion that has a project on epilepsy. Some contacts took place with Johnson & Johnson on the management of epilepsy and on the mental health survey in 2018.

Close collaboration with other development partners took place either through the TWG (planning, quality and standards, knowledge management, maternal and child health, mental health, asset management were some of the TWG where UB staff participated). Two particular examples must be noted:

1. Knowledge management and creation of District Operational Research Challenge Fund: a joint basket was created with Swiss Cooperation and Enabel through UB; technical support was provided by USAID through MSH. This led to making available funding to promote research by the actors, at district or facility level
2. Quality assurance and standards TWG: close collaboration with USAID via MSH health system strengthening project whereby MSH brought accreditation expertise to develop policies, standards and guidelines and UB provided facilitation as well as funding for accreditation assessments and quality improvement initiatives.

6 Priority themes

Specific transversal themes were identified during the formulation and included the following: gender and environmental protection. Digitalization was not a cross-cutting theme in the TFF bit was included in particular for the Nyarugenge hospital and for the hospital network.

6.1 The environment and climate change

There were no specific activities oriented towards the environment either in the TFF or during implementation. Only some environment friendly focus was included in the design of the hospital: green walls, use of rainwater for cleaning and bathrooms, green external works, etc. Had budget constraints not been there, UB would have included solar electricity supply and new technologies for waste treatment. There was an opportunity for private investment in the solar installation with cost recovery over twenty years which would have been highly feasible but it was not endorsed by MOH at the time.

There were no planned interventions with regards to climate change though the health sector is likely to be greatly affected by climate change transformations and impact on health.

It is recommended that this area be better developed with clear activities and budget with the formulation and TFF to ensure better chances of implementation

6.2 Gender

The project TFF included gender as a cross cutting them and a gender budget analysis had estimated that up to 85% of the activities could be gender-sensitive or potentially gender transformative. There were however no specific activity nor earmarked budget for gender theme. This was identified in previous annual reports but not well addressed either due to lack of expertise in the field or lack of time and no identified gender focal person in the program. Furthermore, the gender aspect was not seen as a priority both at MOH and RBC level.

Gender was rather intuitively assumed to be taken care of through quality improvement initiatives aiming at reducing maternal and neonatal mortality and morbidity, through increased accessibility to mental health services, through NCD mass screening, through the provision of Ultrasound machines at health center levels for pregnant mothers monitoring, etc.

As for environmental theme, it is recommended to identify at formulation level and in the TFF specific gender-oriented activities and to identify gender based focal person in the program team.

6.3 Digitisation

Digitisation was not included in the formulation and TFF. However, during the hospital design phase, UB program saw an opportunity to innovate and promote a paperless hospital as a 'première' in Rwanda. UB used the e-health framework contract to recruit a firm to design, install, train and provide one year on site support for the management of all medical records at the hospital. Workstations have been installed at reception, consultations, laboratory, pharmacy, radiology, emergency as well as in all wards, including operation theatre. Patients will have a unique identifier number and all investigations results will be uploaded as soon as available. Imaging will be available at the bedside or in consultation rooms, prescriptions will be at pharmacy

before the patients comes foe drug collection, revenues and bills will be automated. The whole system is provided with backup system and uninterrupted power supply.

In parallel, the hospital will be linked to other hospitals through the Kigali hospital network. A Picture Archiving and Communication System (PACS) has been developed to facilitate the confidential transfer of patients imaging particularly when patients are referred from one hospital to another. A dashboard is under development to allow immediate access to bed occupancy, specialist appointment, ambulance services and equipment availability.

7 Sustainability

Sustainability of an institutional support program has the potential to be highly sustainable if well aligned to the partner priorities and objectives. High level of ownership is expected as well as project steering. This process has generally been well implemented during UB program implementation overall though it was less in innovative interventions like hospital networking and medicalization, or in interventions that were challenged by the context such as the dismantlement of the MTI Division on 2018. However, the sustainability cannot be seen as a whole for such a complex program as there are differences between or within result areas

- *What is the economic and financial viability of the results of the intervention? What potential risks are involved? Which measures have been taken?*

Economic and financial sustainability for R1,R2,R6 will highly depend on GoR funding and other partners' support. This appears more for R1 in terms of pursuing the accreditation process and setting up an accreditation agency; and for R6 for the provincial workshops' effective full operations. R2 financial sustainability has received commitment from GoR for the construction on the Mental Health Day Treatment Center but it is less clear for other operational activities such as addressing high prevalence of mental health disorders, drug and substance abuse, etc.

R3 sustainability is high for the hospital and likely for NCD management that have now received high level attention. Time will tell for medicalization and hospital networking

Measures included advocacy through best practice documents, commitment request from MOH and RBC management, continuous support within the sector at strategic level (RBF) and operational level (Barame), securing budget for hospital network through EU funding and handover of the activity to the ITA RBF, continued support to Nyarugenge district that will include aspects on accreditation, quality of care and support to 2 medicalized health centers. Advocacy to other partners for support to mental health (PIH), accreditation (USAID)

- *What is the extent of ownership of the intervention by the target groups and will it last after the external assistance ends? What potential risks are involved? Which measures have been taken?*

All results areas were aligned to national priorities included in the HSSP IV. Ownership on accreditation, mental health quality and accessible services, urban health governance and asset management is very high. It was in fact reassuring to note the appointment of MTI Division Manager who has been in close working relationship with UB program in the last two years.

Risks are rather financial except on the hospital networking whereby MOH ownership has been weaker all along and where the institutional framework is not yet very established as this activity was rather a bottom up activity, coming from the users who were facing long patient waiting time in referral hospitals.

- *What level of policy support has been delivered and what is the degree of interaction between the intervention and the policy level? What potential risks are involved? Which measures have been taken?*

R1 now has accreditation policy, accreditation standards defined, and guidelines established. Training modules for assessors, guidelines for supervision and assessment are all in place

R2 has a five-year strategic plan developed with the UB support; guidelines for supportive supervision, training modules and MMED PSY were also developed and validated

R3: package of care for medicalized health centers has been approved; NCD guidelines are in place; CoK has a health strategic plan in place

R4: mapping of all health facilities is now available, and each district has a health strategic plan

R6 guidelines for donations and for equipment scrapping are validated. A draft MTI strategic plan is due for finalization and validation

There was always direct involvement between UB and policy makers in a continuous dual communication way, policy informing the field operations and field operations guiding the policies.

- *To what degree has the intervention positively contributed to institutional and management capacity? What potential risks are involved? Which measures have been taken?*

As showed above, numerous policy documents and guidelines were developed with the support of UB. This includes the HSSP IV as well as HRH plans, and health policy document. Number of staff (11) received training in various areas including Masters in Public Health, Masters in epidemiology, Masters in Biomedical Sciences. environment engineering Masters, quality of care short courses and of course 6 completed MMED Psychiatry program, with 3 additional ones pending completion. Such trainings are long lasting as there is staff commitment to stay in service after completion of the training. (retention policy)

8 Lessons learned

8.1 Successes

Many success or achievements have been seen in each of the result areas:

Result 1: Accreditation guidelines, policies, facilitation and assessment guidelines are all in place. A local NGO has been identified and has the potential to become an accreditation agency provided resources and support is given. Quality improvement initiatives have helped hospitals in addressing quality of care issues and should be further extended as a tool for improving health care services

Result 2: following years of Enabel support, the National Division is now well structured, staffed, established and has a budget. Mental health services have been decentralized down to the community level and all levels receive training and supportive supervision. The MMED Psychiatry training done in collaboration with Belgian and Swiss universities has successfully seen the graduation of 6 candidates, 3 more are in the cursus. It can be self-sustained and should continue to fulfill the needs of the country. Long term institutional support has here proven very effective.

Result 3:

- Four health centers have benefited from medicalized services that significantly responded to a population need particularly for NCD management, maternal care and dental care. The package has now been validated
- NCD mass campaigns and screening have been successful and CoK now has the budget to continue them on regular basis. The initiative has been extended to all secondary cities in Rwanda
- The hospital network now has imaging transfer capacity (PACS) and a dashboard that will help patents' referral in in the making. All stakeholders have been very active
- Lessons of the three points above include the need for consensus of stakeholders about supporting innovations and the need for specific expertise at punctual moments.
- Nyarugenge now has a district hospital that is effective and will respond to the area population needs. It has been fully equipped and both MOH and the district have taken over the management. It will still be part of the new project (Barame) and may benefit further from Enabel support in maternal and child health. See best practice document for lessons learnt.
- Result 4: the mapping of health facilities gives a full picture of infrastructure, equipment and staffing as well as services provided in all hospitals and health centers of the country. It should be continuously updated to ensure relevant use for planning purposes.
- Result 6: the in-depth assessment of all public hospitals has given a picture of the extend of the available infrastructures and medical equipment in the country. It has been an advocacy tool for improving preventive and curative medical maintenance. MEMMS database now allows the central level to know the status of hospital equipment in the country and its usage. It is also a monitoring and planning tools to identify priority needs in terms of equipment in the country. Provincial workshops are now set and ready to operate, allowing for decentralization and transfer of capacity to a mid-level and provide more effective support to the districts. A draft MTI strategic plan is ready for validation.

The main lesson is that the above are institutional changes that require support beyond the lifespan of one program. There should be continuity in the development support of such extend.

- Program management Unit: there has been an effective approach towards the complexities and challenges of the program. Despite 3 Mi Euros budget cuts and budget reallocation for the hospital construction a number of achievements have been successfully reached. Team building and staff training and empowerment have been among the positive lessons of UB experience.

8.2 Failures

The project has faced numerous challenges as mentioned above. There were no strict failures recorded as such but rather incomplete achievements due to either budget, time, overambitious objectives or ownership issues.

Result 1: the accreditation agency is not fully established: this objective was overambitious as there was no identified organization at the onset of the program and MOH was still working on options. Further, an accreditation agency requires to be accredited prior to be defined as an accreditation agency. That in itself can take 5 years to achieve.

Result 2: the MH center is not yet constructed but alternative funding has been secured and constructions will take place in 2021

Result 3: the Hospital Network not fully functional as expertise was not available in UB and the vision not fully endorsed by MOH as it was rather a bottom-up initiative. Further support, technical and financial will be necessary to achieve its objectives. Health centers medicalization faced the challenge of lack of medical doctors in the country as doctors are also in shortage in the hospitals. It is probably a medium to long term innovation that has the benefit of being now recognized with a validated package of care. The hospital construction took much longer than anticipated. Lesson include the need for initial business plan, well defined budget, availability of full-time expertise to accompany such large project

Result 6: lack of biomedical engineers and technicians in the country has stopped the provincial workshops from being fully effective. Solutions include provincial hospital full take over, Public Private Partnership (PPP), external gap funding until self-sustainability, etc.

8.3 Strategic learning questions

The following learning questions have been developed and discussed along UB program implementation:

- Does accreditation improve quality of health services?
- Can medicalization improve access to health care?
- Does the hospital network improve patient's referral?
- How to construct a district hospital; the do's and the don'ts
- Can NCD mass screening assist in sensitization at community and individual level
- Health facility mapping can be a tool for planning use of resources in health sector
- How to decentralize medical asset maintenance in Rwanda: lesson from provincial workshops
- Does alignment to country priorities brings better ownership

Inventory of documented experiences	Documentation products (available material per experience)	(Scientific) publications	Communication (sharing moments at national and international forums in the course & at the end of the intervention)
Accreditation and quality of care	Best Practice document		ECTMIH Liverpool presentation, posters
Quality improvement initiatives	Abstract, posters, individual reports		
Lessons from hospital construction	Best Practice document		
Medicalization of HC	Best Practice document		Poster presentation
Hospital networking	Best Practice document		
NCD screening and mass campaigns	Abstracts and posters		Oral and poster presentations
HF mapping	Best Practice document		
Provincial workshops	Best Practice document		ECTMIH presentation
Radiation protection	Best Practice document		

8.4 Summary of lessons learned

Lessons learned	Target group
Institutional strengthening takes time (i.e. mental health long term support was extremely beneficial; it should have been the same for medical asset and for accreditation)	EST and OPS Enabel, DGD, Partner country, representation, interventions
One size does not fit all. There must be a mix of modalities within one intervention to allow the SC to shift from one to another if proven more effective or efficient. There should be a comprehensive appreciation during formulation before decision making	DGD, Formulation teams (Enabel and partner), representation
UB program was complex in terms of large scope (5 results areas), large number of stakeholders, different institutions involvement, technical expertise required, budget constraints, etc. Ensure balance between complexity, innovations and simplicity.	DGD, Formulation teams (Enabel and partner), representation

Expectations on project priorities may be different between partners. GoR had UB expectations on hospital construction and infrastructure as well as mental health and institutional strengthening; Enabel had expectations on system strengthening through some innovations rather than focus on infrastructure; and in the following portfolio (RBF and Barame) Belgium took a unilateral stand on maternal and child health rather than the country need analysis. Consider well both parties priorities and expectations	DGD, Formulation teams (Enabel and partner), representation
NDH construction project was underestimated in terms of expertise and budget requirements. Large infrastructure projects, if to be considered in the future, must be stand-alone than integrated in a program to avoid siphoning the program other activities and budget; it requires specific long-term expertise in infrastructure and in contract management	Formulation teams (Enabel and partner), Enabel HQ, DGD, representation
The appointment of a task Force to oversee the large infrastructure projects has been effective to ensure ownership and buy-in of key stakeholders	Intervention, representation, formulation team
Transversal themes did not receive adequate attention unlike indicated in the TFF. They must have specific activities and budget identified during formulation and may require punctual expertise support	Formulation teams (Enabel and partner), Enabel HQ, representation
Digitisation requires expertise in three specific moments: need identification (activity), implementation and follow up support (up to one year). There is room to be more creative in the field of digitization for better results: • For the project activities: NDH IT system is likely to be very effective provided the continued IT support from the firm; any digitization project must include a follow up support system by the provider • For the project management: MONOP, Pilot, UBW, etc. many tools have been proposed but no real solution so far and parallel reports are systematically required; there is need for a pragmatic project monitoring tool that is user friendly, action oriented, informative and light	Enabel HQ IT logistics, OPS, representation
Experience with framework contract varies according to expected level of expertise required vs expertise available: the Tractebel infrastructure contract did not work and the project lost over one year; the BXL 1735 eHealth has been very successful.	Enabel HQ IT logistics, OPS, representation

UB program structure was complex, under MOH PS with anchorages in MOH, RBC, CoK and Nyarugenge District that was sometime stretching resources too far or that made lines of responsibilities unclear or contradicting	Formulation
SC leadership was strong and therefore significantly contributed to effective decision-making in challenging issues such as budget reallocations	Formulation, OPS, EST, representation
Strong leadership however had to take difficult decisions such as cutting one full result area that weakened the architecture of the program and made M&E and action research less effective. It led to some results less resourced to fully implement their objectives: fewer QI initiatives, no construction of MH center, lower support to asset maintenance division	SC, intervention,
UB program management worked by consensus and high motivation. While this approach sometimes takes time, it has proven very effective here to overcome obstacles, identify local solutions and ensure everyone's ownership	Intervention, representation

9 Recommendations

Recommendations	Actor	Deadline
Infrastructure projects must be stand-alone with specific expertise and budget. A business plan is required prior to budget decision-making. Overall, there is need to ensure that adequate technical and financial resources are in the TFF	DGD	Identification
Appointment of specific task force to oversee construction project is very useful to ensure buy-in, close progress monitoring and prompt decision making	SC	SC1-2
Institutional support programs require long term commitment beyond one program/project lifespan	Minister cooperation BE	PIC
Transversal themes must have specific activities and budget identified during formulation and may require punctual expertise support if to be considered	Formulation team	formulation
Flexibility in the use of modalities is needed to ensure best effectiveness and efficiency. SC should not be afraid of taking bold informed decisions	SC	MTR or before
Need for more effective, user friendly, action oriented, informative and light project monitoring tool; web-based can be cumbersome if internet connection is not fast or alternative uploading methods should be provided	OPS	2021
Need to identify strong leadership to chair the SC	Formulation team	formulation
Need to balance budget cuts and carefully consider consequences in some result areas	SC	SC meetings
Continue or develop further framework contracts for "horizontal support" that provide a pool of expertise in various domain (IT, internal and external communication, digitization, etc.) and that have excellent and proven level of expertise (strong selection criteria required)	HQ	
Reconsider project management structure if too complex or too heavy and consider splitting management unit across main actors	SC	MTR or before
Innovations require buy-in for the stakeholders and policy makers	Formulation team	formulation

10 Annexes

10.1 Quality criteria

1. RELEVANCE: extent to which the intervention is in line with local and national policies and priorities as well as with the expectations of the beneficiaries.		
Calculate the total score for this quality criterion as follows: at least one 'A', no 'C' or 'D' = A; two 'B's = B; at least one 'C', no 'D' = C; at least one 'D' = D		
Assessment of RELEVANCE: total score	A: X	B / C / D:
1.1 What is the current degree 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: extent to which the resources of the intervention (funds, expertise, time, etc.) have been economically converted in results.		
Calculate the total score for this quality criterion as follows: at least two 'A's, no 'C' or 'D' = A; two 'B's = B, no 'C' or 'D' = B; at least one 'C', no 'D' = C; at least one 'D' = D		
Assessment of EFFICIENCY: total score	A / B: X	C / D:
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 outputs 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: extent to which the outcome (specific objective) is achieved as planned at the end of year N		
Calculate the total score for this quality criterion as follows: at least one 'A', no 'C' or 'D' = A; two 'B's = B; at least one 'C', no 'D' = C; at least one 'D' = D		

Assessment of 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).		

Calculate the total score for this quality criterion as follows: at least three 'A's, no 'C' or 'D' = A; maximum 2 'C's, no 'D' = B; at least three 'C's, no 'D' = C; at least one 'D' = D					
Assessment of 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 extent of ownership of the intervention by the target groups and will it last after the external assistance ends?					
X	**A**	The Steering Committee and other relevant local entities 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 entities, 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 entities to ensure sustainability. Continued results are not guaranteed. Corrective measures are needed.			
	D	The intervention depends completely on ad-hoc entities 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 the 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 entities 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 entities 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 entities instead of institutions; capacity building has not been sufficient to fully ensure sustainability. Corrective measures are needed.			
	D	Intervention is relying on ad hoc entities and capacity transfer to existing institutions, which could guarantee sustainability, is unlikely unless fundamental changes are undertaken.			

10.2 Updated Logical framework and/or Theory of Change

We refer to the amended TFF signed in September 2016 that refers to the budget changes, monitoring revision and agreement on construction management.

	Original TFF	Amended	Comments
Duration of the specific agreement (Start date/End date)	72 months (i.e. 30.06.2015/29.06.2021)	60 months (i.e. 30.06.2015/29.06.2020)	Note that there was an error in the initial TFF that indicates 72 months of legal duration, though the specific agreement indicates 60 months of legal duration. The initial legal duration of 60 months of SA remains the reference.
Duration of the implementation period	48 months	-	
Start date of the implementation period:	-	4th December 2015	This date refers to the Steering committee meeting in which the first operational planning of the program was approved.
End date of the implementation period:	-	3rd December 2019	This date is calculated from the start date + 48 months.

INTERVENTION FRAMEWORK – REVISED

	Original TFF	Amended	Comments
General objective	Strengthening the quality of primary health care and health services in Rwanda	nil	nil
Indicators	**IOG1** Maternal mortality ratio/100,000	nil	nil
	IOG2 < 5 mortality rate/1000 live births		
	IOG3 Neonatal mortality rate/1000		
	IOG4 Infant mortality rate/1000 live births		
	IOG5 Total Fertility Rate		
	IOG6 Utilization rate of modern contraceptive methods among women of 15-49 years		

	IOG7 HIV prevalence 15-49 years		
<u>Important note:</u> During the Result Based Management (RBM) workshop held in June 2016 with representatives of all result areas, each group responsible for a Result area identified 'outcomes' to be achieved by the end of the program. These come at intermediary levels below the level of the specific objective. All the indicators were proposed during this workshop.			
Specific objective	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	nil	nil
Indicators	TFF had only some suggested indicators and most significant changes that were used as examples. The program was intended to conduct an outcome mapping workshop with representative groups to develop progress markers	**R1-Outcome: R1.1 Improvement of quality and safety of health services delivery**	The indicators are related to one expected outcome: R1-Outcome R1.1: Improvement of quality and safety of health services delivery
		I1.1.1 Degree of patient satisfaction	
		I1.1.2 Degree of health professional satisfaction	
		I1.1.3 % of post CS infection rate in a given period of time	
		I1.1.4 # of programs integrated in the accreditation process	
		R2-Outcome R2.1: Mental health care services are accessible and utilized at the community level up to the national level in a sustainable way	The indicators are related to one expected outcome: R2-Outcome R2.1: Mental health care services are accessible and utilized at the community level up to the national level in a sustainable way
		I2.1.1 Mental health care services utilization/consultation rate at health Facility level (HC&DH)	
		R3- Outcome R3.1: Awareness on NCDs increased (people-centered)	The indicators are related to three expected outcomes:
		I3.1.1 Prevalence of NCD: diabetes (Raised fasting blood glucose)	

			I3.1.2 Prevalence of NCD: hypertension	R3-Outcome R3.1: Awareness on NCDs increased (people-centered) R3-Outcome R3.2: Environmental health management improved at different levels (integrated services and people-centered) R3-Outcome R3.3: Health facilities system in the CoK is rationalized by integrated equitable and sustainable services which are people centered
			I3.1.3 Prevalence of risk factor NCD: overweight: BMI ≥ 25 (BMI ≥ 30)	
			R3-Outcome R3.2: Environmental health management improved at different levels (integrated services and people-centered)	
			I3.2.1 Prevalence acute diarrhea < 5	
			I3.2.2 % of public places responding to hygiene standards	
			R3-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 less than 1 hour walk or 5 kms from HC	
			I3.3.2 Bed occupancy rate in different Kigali hospitals	
			I3.3.3 Patient and health care providers' satisfaction rate	
			I3.3.4 Four ANC coverage	
			I3.3.5 Deliveries rate at HF level	
			I3.3.6 Ultrasound coverage for pregnant woman (at least one ex) in the catchment area of 4 HCs equipped with ultrasound	
			R4-Outcome R4.1: Stewardship capacities at the level of the local health system (district) is strengthened	The indicators are related to two expected outcomes:
			I4.1.1 % of Districts which have conducted Mid Term Review of their	

		Strategic Plan 2013/18 and developed a clear and sound Implementation plan to address the gap identified	R4-Outcome R4.1: Stewardship capacities at the level of the local health system (district) is strengthened R4-Outcome R4.2: MoH and RBC are supporting decentralized levels according to their respective roles (policy, regulation, coordination, M&E, and implementation)
		I4.1.2 % of District health which develop a comprehensive strategic plan 2018/2023	
		I4.1.3 % of District functioning in a SWAp model	
		R4-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 Strategic Plan with Quality assessment done by Central level	
		I4.2.2 % of districts visited by Joint supervision team from central level at least once a year	
		R5 NIL	Removal of R5 as a result: the component of 'data quality and use' will be embedded in each result area ; the component 'action research' is moved under R4
		R6-Outcome R6.1: Quality of health Assets in Health facilities is increased based on the implementation of standards	The indicators are related to one expected outcome: R6-Outcome R6.1: Quality of health assets in health facilities is increased based on the implementation of standards
		I6.1.1: An asset (equipment and infrastructure) management system is put in place and is operational	

INDICATORS REVISION

Result 1: Output indicators

	Original TFF		Amended	Comments
Result	**The quality assurance system is set up and integrated and functional at the level of all hospitals**		Nil	Nil
OUTPUTS				
A_01_01	Progress towards the creation of an autonomous accreditation body		**R.1.1.1** An independent accreditation body is established and functional	No major change but rather a rewriting of the initial outputs from activity type to output wording
A_01_02	Update, disseminate norms standards and models (MOH)		**R.1.1.2** All HFs have functional QA committees	
A_01_03	Facilitate and implement the accreditation process at all hospitals		**R.1.1.3** District hospitals achieving level 2 of accreditation	
A_01_04	Finance people centered improvement projects		**R.1.1.4** Quality Improvement initiatives are implemented and documented in HFs	
			R.1.1.5 Health care specialized centers are enrolled in accreditation program	
Indicators				
			An independent accreditation body is established and functional	
	An independent accreditation body is set-up and is accredited by ISQUA (S: ISQUA report)		**I1.1.1.1** Independent accreditation body in place and functioning	
			I1.1.1.2 # of hospitals assessed per year by the RHAO	
	The number of national programs that integrate their norms &		Not kept	

	checklists (existing or new ones) into the ongoing accreditation process (S: accreditation checklists and guidelines)		
		All HFs have functional QA committees	
	% District Hospitals with a functional (= regular meetings, analysis of reports, issues addressed, recommendation reported to the Hospital administration management) QA team (S: minutes meetings)	Not kept as already achieved as per assessment reports	
	Number of external facilitators trained compared to required number (S: training reports)	**I1.1.2.1** % HCs with functional QA committees	
		I1.1.2.2 # of hospitals having incident reporting and management systems	
		District hospital achieving level 2 of accreditation	
	* % District Hospitals (> 70%) and provincial hospitals (100%) eligible for accreditation (>70%) by 2018 (S: accreditation report)	**I1.1.3.1** # DHs achieving level 2 of accreditation	
	% of DH and provincial hospitals with accreditation for the full package of SRHR/HIV/ASRH/ SGBV related services (S: accreditation report)	**I1.1.4.1** # of HFs with Quality Improvement initiatives documented	
		Health care specialized centers are enrolled in accreditation program	

		I1.1.5.1 # of specialized health care centers enrolled in the program	
	Satisfaction rate of the users in relation to the quality of care (S: surveys, focus-group discussions)	Degree of patient and staff satisfaction	This has been moved to outcome indicators instead of output (see baseline report)

Result 2: Output indicators

	Original TFF	Amended	Comments
Result	**The mental health services are accessible from the community level up to the national level in a sustainable way**	Nil	Nil
OUTPUTS			
A_02_01	Strengthen community interventions on mental health	Nil	Nil
A_02_02	Consolidate Mental Health Care Services & a people-centered approach at the level of health Centers & hospitals and extend referral outpatient & inpatient Mental Health Care at the level of the provincial and national referral hospitals	Nil	Nil
A_02_03	Develop multidisciplinary strategies and actions with regard to the fight against abuse of psychoactive substances and with regard to mental health issues related to HIV/Aids and Gender Based Violence (GBV)	Develop multidisciplinary strategies and actions with regard to the fight against abuse of psychoactive substances	The budget reduction will negatively influence this outcome particularly on: - actions targeting the cross-cutting issues with regard to mental health issues related to HIV / Aids and Gender Based Violence

			- collaboration with CoK (urban health component) - supporting Huye Rehab Center as the section dedicated for the equipment was reduced
A_02_04	Long term technical assistance in mental health and people centered approaches	Nil	Nil
Indicators			
	% of CHWs, General Nurses, General Practitioners and Psychiatrists compared to the targets trained in early detection & treatment of Mental disorders as well as in people-centered related techniques	Nil	
		R2.1.1 Strengthened community interventions on mental health care services.	
		I2.1.1.1 Number of community mental health rehabilitation initiatives (Group psycho educative) funded.	
		I2.1.1.2 Number of awareness campaign conducted at community level.	
		R2.1.2 Integrated Mental Health Care Services & a people-centered approach at all levels of health Facilities.	
	Proportion of Health Centers providing integrated Mental Health Care (S: HC reports)	**I2.1.2.1** % of HCs providing integrated MH care through trained health care providers.	
	% Mental Health cases referred from HC to DH MH services as a proportion	**I2.1.2.2** % of Mental Health Provider (old &new appointed) trained in early detection &	

	of all DH MH cases (S: hospitals annual reports)	treatment of Mental disorders as well as in people-centered related techniques	
	% of all MH cases referred from DHs to provincial (4) and national (3 plus Ndera Hospital and MH Day Care Center) mental health referral structures (S: hospitals annual reports)	**I2.1.2.3** Number of physicians specialized in psychiatry area	
	A National Mental Health Day Care Center constructed (according technical and environmental standards), equipped and operational (S: business-plan; annual report Day Care Center	**I2.1.2.4** Level of completeness Mental Health day treatment center	
		R2.1.3 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)	
	The operational strategy for integration of drug and alcohol abuse prevention (with active involvement of community actors) in 2 new Health Centre related Sectors of the CoK is documented, published and disseminated' (S: publication of article)	**I2.1.3.1** Level of implementation of Mental Health Component National Strategy against drug abuse and prevention & treatment of mental health conditions. Level 1: Development Level 2: Validation Level 3: Dissemination Level 4: Utilization	
	Multidisciplinary strategies and action with regard to mental health and psychoactive substance abuse are in place and operational at the	**I2.1.3.2** Level of Huye Rehabilitation Center equipment and functionality Level of Huye Rehabilitation Center equipment and functionality Level 1: Procurement process	

	rehabilitation center of Huye (S: annual report Huye)	Level 2: Equipment Distribution Level 3: Utilization and Improved care services provided	

Result 3: Output indicators

Remarks: No major changes have been made as such but indicators have been added according to the baseline report (**Ref to baseline report**). The budget cut that occurred in June 2016 (total cut of 189,000 Euros out of 6,559,000) does not affect directly the results.

	Original TFF	Amended	Comments
Result	**The urban health service coverage is rationalized and extended in line with the three guiding principles of the National Health Sector Policy**	No	
OUTPUTS			
A03 01	Develop promotional activities on social determinants of health in CoK	No but more detailed: **R3.1.1** Health Promotional activities on NCDs are integrated in CoK Health plan **R3.2.1** Hygiene and sanitation activities are routinely done	Mostly, only numbering and order have been modified
		R3.3.2 Four 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)	
A03 02	Develop and validate a sound concept and equitable coverage plan for HC	Extended to all types of HF, not only the HC: **R3.3.3** A comprehensive and equitable urban Health Facilities coverage plan is developed and validated	
A03 03	Support the implementation of the coverage plan through various strategies: upgrades of existing HF, or	Is associated with the above output and linkage is done with indicators	

	PPP initiatives in the most vulnerable sectors of CoK		
A03 04	Create a functional, autonomous and efficient hospital network	**R3.3.1**The Kigali Hospital Networking formalized	
A03 05	Design, build and equip a 120 beds hospital in Nyarugenge district articulated with the CoK coverage plan	Minor changes: **R3.3.4** District hospital is developed, built and equipped in an innovative way plan	
A03 06	Long term technical assistance in public health, hospital networking and urban health	No	
Indicators			
	Inventory of innovative activities of CoK in relation to health promotion taking into account the socio-cultural determinants and changing epidemiological profile	**I3.1.1.1** Number of NCD detected during the mass campaigns **I3.2.1.1** Situation analysis on Hygiene and sanitation in public places notified by TWG Health environmental platform **I3.2.1.2** % of TWG Health environmental platform recommendations implemented **I3.2.1.3** 10-year Solid waste management plan	Not kept as such because the CoK preferred to invest more on a solid waste management study and plan rather than making studies on health determinants. Different actions were decided to reflect the Output proposed above (**R3.1.1 & R3.2.1**)
	Availability of a long-term comprehensive coverage plan for 1st and 2nd line health care (including private facilities) within CoK	**I3.3.3.1** Up-dated mapping of health facilities (public and private) **I3.3.3.2** Recommendations and operational plan proposal for improving coverage **I3.3.3.3** TWG on coverage plan in place with coordinator identified **I3.3.3.4** Framework PPP **I3.3.3.5** Number of private investors engaged to finance new HC **I3.3.3.6** MOU insurance coverage public & private HF	We have detailed the indicators related to this output **R3.3.3**

		I3.3.3.7 Number of HF up-graded **I3.3.3.8** Quality standard per HF category	
	% of registered private clinics and dispensaries reporting routinely to HMIS	Not retained	The MoH said that it is already an obligation for private institutions to report routinely and this cannot become a target
	An article documenting the experience of the public-oriented (whether private or public Health Centers), medicalized Health Centers is published and disseminated'	No	The possible research actions still need to be identified and planned
	KHN functional Hospital network in CoK: functional secretariat, mission statement and organization, minutes meetings, inventory of joint initiatives	As was already an output, we indicate the indicators related to output **R3.3.1**The Kigali Hospital Networking formalized: **I3.3.1.1** Appointed members from different hospital and other stakeholders **I3.3.1.2** TOR and objectives approved **I3.3.1.3** Road map and Operational plan **I3.3.1.4** Inventory of joint/shared initiatives	
	A new district hospital is constructed and equipped in Nyarugenge District according to an architectural, technical and functional design & business-plan supporting the 3 outcomes of the national policy (people-centeredness, integration, sustainability) and proper asset and waste management (hospital design, business-plan)	We detailed the indicators: **I3.3.4.1** Standard design for an innovating model District Hospital validated **I3.3.4.2** 120 bed-hospital equipped **I3.3.4.3** Number of hospital beds for the CoK	
	-	**Indicators related to R3.3.2:**	

		I3.3.2.1 Monthly number of new cases seen by MD per HC **I3.3.2.2** Number of laboratory able to make FBP and biochemical analysis **I3.3.2.3** Number of HC equipped with ultrasound machine **I3.3.2.4** % of drugs for NCD and chronic disease available at HC level	

Result 4: Output indicators

Remarks: Changes in the scope of the R4 overall objective (more focus on district level) as well as its outcomes, output and activities are due to the three following reasons : 1. Revised priorities from the Ministry of Health that has identified some duplication of funds for the same activities, changes in priorities, and insufficient budget. 2. The support dedicated to the reinforcement of leadership and governance concerning the roles of MoH and RBC was affected by the budget cut with a reduction of 280,000 Euros out of the initial 342,000 Euros. 3. It has been decided to transfer 240,000 Euros from R5 to R4, for action-research.

	Original TFF	Amended	Comments
Result	**The leadership and governance is reinforced, specifically regarding district stewardship, the respective roles of the MOH and RBC and the public private partnership**	**Not for the formulation but the effort is now concentrated at district level: *The leadership and governance is reinforced at district level***	**The central level was not requesting support and it was agreed to make the biggest part of the budget cut in that component (280,000/342,000 for R4)**
OUTPUTS			
A04 01	Strengthen stewardship capacities at the level of the local health system (district)	Yes, because that one became an outcome **R4.1** **R4.1.1** All DHMT/DHU are fully functional	
A04 02	Provide support to MoH and RBC with regard to their respective roles (separation of	Yes, to reflect the change of the outcome **R4.2** **R4.2.1** MoH and RBC have provided support and capacity building regarding	Changed to increase the support to the decentralized level: MoH and RBC are supporting decentralized levels according to their

	regulatory/coordination/M&E, and implementing role)	the gaps and needs identified in terms of planning, M&E, finance, management and implementation **R4.2.2** MoH and RBC have provided support and capacity buildings regarding the gaps and needs identified	respective roles (policy, regulation, coordination, M&E, and implementation)
Indicators			
		1.1 District Health Units (DHU) are supported in M&E of decentralized health systems	
		1.2 All stakeholders active in health at district level are involved in health sector review and planning (SWAp) and are aligned to the national health plans	
		2.2 MoH and RBC have provided support and capacity building regarding the gaps and needs identified	
Indicators	% DHU operational (at least 3 DHMT meeting held per year under the secretary of DHU, using quality health information for decision making) S: comprehensive participative district annual planning, budgeting, reporting timely)	No but different formulation for **R4.1.1**: **I4.1.1.1** % DHU operational with at least 3 DHMT meeting held per year under the secretary of DHU **I4.1.1.2** % of districts submitting to MoH the quarterly reports on selected key indicators **I4.1.1.3**% district with integrated health plan **I4.1.1.4** Number of action researches Studies/Short courses initiated, completed and documented by district unit (DHU)	

	% GOR funds disbursed to districts (grants: national health budget plus district transfers) (not kept as not related to UB Program)	Not kept	Not related to UB Program
	% districts with regular district reviews meeting quality standards (participation of all stakeholders in health, representative taking into account gender-balance, regularity, well-prepared, concrete action points & recommendations	Not kept	
	% of district/provincial hospitals accredited for their financial management processes	Not kept	Not seen as relevant by MoH
	% of health facilities (District and provincial hospitals) providing comprehensive financial reports in a timely manner	Not Kept	Not in a priority for MoH
	% of DHU having conducted a gender audit (S: audit reports)	Not kept	Not in the scope of R4 objective
	% of Development Partners providing resources through the Health Resource Tracking Tool	Not kept	Not in the scope of R4 objective
	MOH and Private sector providers Forum is functional (S: bi-annual meetings)	Not kept	Cut in Central support
	Number of new contracts (for maintenance or with private health facilities) signed based on the public-private partnership policy and roadmap developed (S: roadmap)	Not kept	Not in the scope of R4

		Related to Output **R4.2.1** **I4.2.1.1** Quarterly coordination meeting with DHU on data analysis and use, and on management with identification of gaps and needs	Indicators related to the change made
		Related to Output **R4.2.2** **I4.2.2.1** % of DHU with two staff per District trained on planning, M&E, Finance and management **I4.2.2.2** Medical internship program at district hospitals (DH) is evaluated and weaknesses addressed **I4.2.2.3** Number of action researches/studies/Short courses initiated and documented by central level	

Result 5: Output indicators

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

Rationale for removing this Result from the logical framework:

During the inception of the program, the recruitment of an ITA for M&E and data use was initiated. However, after an unsuccessful recruitment process, MOH indicated that the context had changed and the position was no longer seen as necessary. Furthermore, interventions and activities described in the TFF had either been implemented or were being implemented through the ordinary budget and other DP support (MSH).
The content of this Result and its expected outcome were reviewed during the budget cut process and it was suggested to remove the entire result as a specific result but to keep its rationale embedded in each of the remaining results: therefore, the component of 'data quality and use' is now included under each result, where a specific attention will be put on data quality management, while the component on 'action research' has been shifted to R4. DG Planning, Health Financing and Information Systems will oversee that this action research is promoted through the program.
By doing so, the coherence of this result contribution has been preserved while the removal of the result will reduce the complexity of implementation of the UB Program.

However, it is to be noted that an amount of 15.656,76 EUR had already been committed, paid and recorded in the accounting when the budget cut was announced. These expenditures relate to the ITA recruitment process and the purchase of laptops for Planning, Monitoring and Evaluation Unit.

Result 6: Output indicators

	Original TFF	Amended	Comments
Result	**R6.1 The asset management system is designed and operational in a cost-effective way**	Not amended	
OUTPUTS			
A-06-01	Develop, validate and disseminate policies, technical standards for HF in infrastructure and equipment, acquisition standards including donation, procurement & replacement standards, collaboration with private sector	**R6.1.1** The policy, (standards and/or guidelines regarding Health assets management) is updated, approved, and disseminated	No real change, only reformulation
A-06-02	Develop a functional procurement & maintenance system at operational level	**R6.1.2** Technical support towards Harmonized, standardized effective acquisition, distribution, and disposal of Medical equipment at the level of all Health Facilities	No real change, only reformulation
		R6.1.3 Health Facilities are designed according to standards and guidelines	New output created to specifically include the aspect of infrastructure (output 1 and 2 specific to medical equipment)
A-06-03	Develop a waste management policy, strategy and baseline	Not kept	A consultancy took place and a policy is being developed by MOH Clinical and public health services
A-06-04	Finance strategic improvement projects with impact on the asset management	**R6.1.5** Better utilization of Assets in Health Facilities through strategic improvement projects	No real change, only reformulation

A-06-05	Develop domestic human capacity with regard to asset management	**R6.1.4** Improved capacity of Biomedical and Health Infrastructure Engineers and Biomedical technicians at central and district levels.	No real change, only reformulation
Indicators			
	Number of new health infrastructures built according to approved norms and standards, taking into account access/quality & environmental issues ((S: national policy & guidelines regarding health infrastructure, architectural plans, physical inspection)	**I6.1.3.1** New health infrastructures designed according to approved standards	
	A standardized and rationalized medical equipment procurement & replacement system, taking into account environmental standards, is in place (S: medical equipment policy/guidelines/procedures, integration in HMIS)	**I6.1.1.1** Availability of a national policy regarding the health asset management system	
	* % District Hospitals with effective maintenance workshops (S: annual report MTI)	**16.1.4.1** % of medical equipment curatively maintained upon HF request	
	* % of HF with online tracking system for all procurement entities (e-LMIS) (S: e-LMIS)	**16.1.2.1** Database of technical specifications of medical equipment and inventory of medical equipment in health facilities	
	Number of intervention-requests collected by the maintenance/asset management call-center handled with adequate response (S: register and requests and responses, satisfaction surveys)	Not kept	
	% of the national health budget and hospital budget allocated to asset management (S: hospital budgets, national budgets)	Not kept	

	Availability of a national policy and strategy on waste management (S: policy and strategy documents)	Not kept Policy under Clinical Services	
	* % of Health Facilities with effective waste management Systems (S: annual report MTI)	Not kept	
	Inventory of improvement projects (through program fund) in districts/district hospitals related to a secure working environment or asset management with documented increased satisfaction of the benefitting institution and/or their clients (S: program-related reports)	**I6.1.5.1** Health facilities benefiting from improvement initiatives	
	The % of health facilities in the accreditation program complying with the minimum standards for a safe, hygienic and secure working environment	Not kept See R1	
	Number of biomedical engineers who started their Bachelor Degree at CST (S: inscriptions CST of candidates)	Not kept (kept under activity indicator)	

BUDGET MODIFICATION

Budget Modification of RWA1309211

Project Title: **Improving the quality of health care and services**
Ubuzima Burambye
Last Budget Version: **D1**
Donor: **DGD**
Currency: **EUR**

New Budget Version: **Z11NEW**
Donor:
Currency: **EUR**

	Status	Fin Mode	Last Amount	New Amount	Difference
07 National long term technical assistance in public health, hospital networking and urgent medi		CDGEST	95 000,00	72 000,00	-24 000,00
04 The leadership and governance is reinforced, specifically regarding district stewardship, the			1 326 000,00	1 223 000,00	-103 000,00
01 Strengthen stewardship capacities at the level of the local health system (districts)		CDGEST	950 000,00	1 050 000,00	210 000,00
02 Provide support to MoH and RBC with regard to their respective roles (separation of		CDGEST	380 000,00	100 000,00	-280 000,00
03 Long term technical assistance in district capacity building		REGIE	0,00	0,00	0,00
04 National long term technical assistance in district capacity building		CDGEST	96 000,00	63 000,00	-33 000,00
05 Data are generated, analysed and used for evidence-based decision-making in a more correct,			1 330 000,00	14 000,00	-1 316 000,00
01 Assure the integration of different systems of information and further develop HMIS tools, methods and		CDGEST	120 000,00	3 500,00	-116 500,00
02 Assure the production of quality data		CDGEST	140 000,00	0,00	-140 000,00
03 Develop strategies for effective utilization of data for monitoring, evaluation decision making and actio		CDGEST	350 000,00	0,00	-350 000,00
04 Long term technical assistance in HMIS development and M&E		REGIE	720 000,00	10 500,00	-709 500,00
06 An asset management system is designed and operational in a cost-effective way			3 820 500,00	3 097 000,00	-723 500,00
01 Develop, validate and disseminate policies, technical standards for HF infrastructure and equipment,		CDGEST	85 000,00	85 000,00	0,00
02 Develop a functional procurement & maintenance system at operations level		CDGEST	1 021 500,00	578 000,00	-443 500,00
03 Develop a waste management policy, strategy and baseline		CDGEST	90 000,00	0,00	-90 000,00
04 Finance strategic infrastructure projects with impact on the asset management		CDGEST	1 300 000,00	1 100 000,00	-200 000,00
05 Develop domestic human capacity with regard to asset management		CDGEST	485 000,00	485 000,00	0,00
06 Long term technical assistance in maintenance of biomedical equipments and in construction of healt		REGIE	918 000,00	918 000,00	0,00
07 National long term technical assistance in maintenance of biomedical equipments and in construction of		CDGEST	72 000,00	72 000,00	0,00
CONTINGENCY			450 000,00	300 000,00	-150 000,00
01 Contingency			450 000,00	300 000,00	-150 000,00
01 contingency CO-MANAGEMENT		CDGEST	400 000,00	250 000,00	-150 000,00
		REGIE	4 651 000,00	4 081 000,00	-570 000,00
		CDGEST	16 349 000,00	13 919 000,00	-2 430 000,00
		TOTAL	21 000 000,00	18 000 000,00	-3 000 000,00

Budget Modification of RWA1309211

Project Title : **Improving the quality of health care and services**
Ubuzima Burambye
Last Budget Version: **D1**
Donor: **DGD**
Currency: **EUR**

New Budget Version: **211NEW**
Donor:
Currency: **EUR**

	Status	Fin Mode	Last Amount	New Amount	Difference
02 Contingency BTC-management		REGIE	50.000,00	50.000,00	0,00
GENERAL MEANS			2.322.800,00	2.378.800,00	56.000,00
01 Personnal costs			1.450.800,00	1.396.800,00	-54.000,00
01 ITA Public Health – Program Coordinator (co-manager)		REGIE	720.000,00	720.000,00	0,00
02 Program manager		COGEST	72.000,00	72.000,00	0,00
03 Finance and admin team		COGEST	388.800,00	334.800,00	-54.000,00
04 Technical team		COGEST	0,00	0,00	0,00
05 RAF / PFM expert		REGIE	270.000,00	270.000,00	0,00
02 Investments			55.000,00	55.000,00	0,00
01 cars		REGIE	0,00	0,00	0,00
02 Office equipment		REGIE	25.000,00	25.000,00	0,00
03 IT equipment		REGIE	30.000,00	30.000,00	0,00
04 Office refurnising		REGIE	0,00	0,00	0,00
03 Functional costs			337.000,00	337.000,00	0,00
01 Functioning costs cars		REGIE	60.000,00	60.000,00	0,00
02 Tele communication		REGIE	40.000,00	40.000,00	0,00
03 Office material		REGIE	10.000,00	10.000,00	0,00
04 Missions		REGIE	30.000,00	30.000,00	0,00
05 Representation costs and external communication		REGIE	40.000,00	40.000,00	0,00
06 Training (including on HIV workplace policy)		REGIE	30.000,00	30.000,00	0,00
07 Consultancy costs - PFM support		REGIE	48.000,00	48.000,00	0,00
08 Financial transaction costs		REGIE	2.000,00	2.000,00	0,00
		REGIE	4.651.000,00	4.081.000,00	-570.000,00
		COGEST	16.349.000,00	13.919.000,00	-2.430.000,00
		TOTAL	21.000.000,00	18.000.000,00	-3.000.000,00

Budget Modification of RWA1309211

Project Title: **Improving the quality of health care and services**
Ubuzima Buremere
Last Budget Version: D1
Donor: DGD
Currency: EUR

New Budget Version: 211NEW
Donor:
Currency: EUR

	Status	Fin Mode	Last Amount	New Amount	Difference
09 Costs VAT		REGIE	0.00	0.00	0.00
10 Other functioning costs		REGIE	10 000.00	10 000.00	0.00
11 Cost VAT		COGEST	0.00	0.00	0.00
12 Financial transaction costs		COGEST	3 000.00	3 000.00	0.00
13 Workshops and meeting		COGEST	25 000.00	25 000.00	0.00
14 Office materials & Services		COGEST	40 000.00	40 000.00	0.00
8 Audit, monitoring and evaluation			480 000.00	580 000.00	110 000.00
01 M&E costs (baseline, 1 EVP + 1 EF)		REGIE	130 000.00	130 000.00	0.00
02 Audit		REGIE	50 000.00	50 000.00	0.00
03 Capitalisation		REGIE	40 000.00	40 000.00	0.00
04 Backstopping expert department BTC		REGIE	60 000.00	25 000.00	-35 000.00
05 Scientific support		REGIE	200 000.00	200 000.00	0.00
06 DA procurement medicines (Hemoserie, Quinesulfone)	%EVP	REGIE	0.00	45 000.00	45 000.00
07 Technical & Procurement support for constructions	%EVP	REGIE	0.00	100 000.00	100 000.00
9 Conversion rate adjustment					

REGIE	4 [illegible] 000,00	4 [illegible] 000,00	-570 000,00
COGEST	16 [illegible] 000,00	13 [illegible] 000,00	-2 430 000,00
TOTAL	21 [illegible] 000,00	18 [illegible] 000,00	-3 000 000,00

To be noted that a small amount of expenditure had already been committed, paid and recorded in the accounting for this result, when the budget cut was announced. These expenditures relate to the ITA recruitment process (12.183,06 EUR) and the purchase of laptops for Planning, Monitoring and Evaluation Unit (3.473,70 EUR).

IMPLEMENTATION MODALITIES (SEE CHAPTER 5 IN TFF)

The SC of 26 August 2016 approved the following changes on implementation modalities:

- Switch from National execution to Direct-management (Regie) for scholarships of psychiatrist (150.000 EUR) as they will study in Belgium for the first year of the program. Along the same line, a budget of 10.000 EUR was transferred from R4 to Regie General Means for short courses of 2 MoH staff, for which BTC HQ scholarship service provides the necessary logistical support.

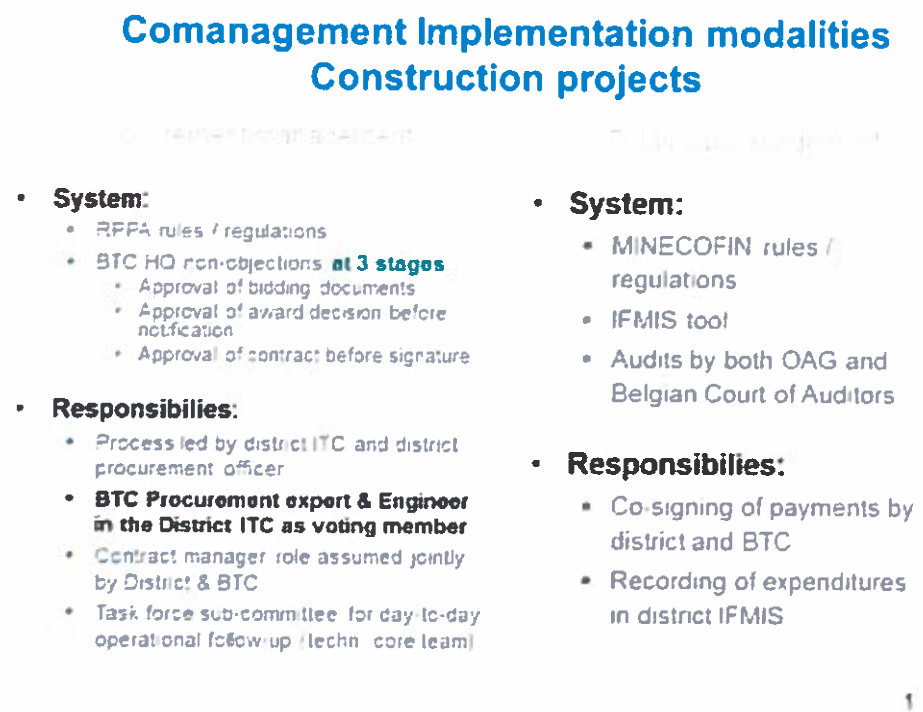
- Switch from National execution to Co-Management of constructions and equipment purchase of the Nyarugenge District Hospital and Gasabo National Mental Health Day Care Center :

Indeed, the original TFF in its chapter 5.6 had identified the use of National Execution modality (use of Rwandan systems and full Rwandan Responsibility) for Financial and Procurement management processes and the centralized SPIU/RBC as the responsible entity, this was applicable to manage constructions and equipment purchase.
However, following the request of Ministry of Health for health infrastructure projects to be managed at district level (tenders, contract management, monitoring, etc.) so as to support the implementation of the decentralization policy, BTC facilitated an organizational assessment in both districts in April 2016 to assess the risks of this important change of responsibility.

The conclusions of these assessments, for the districts to be allowed to manage the constructions and equipment purchase in compliance with existing procedures and in respect of the implementation timeframe, are that systems are well in place but the capacity at this stage does not allow for the option of National Execution modality to be rolled out at decentralized level because of the risks identified:

- in Organizational assessment reports (strengths and weaknesses)
- In OAG findings (fiduciary & implementation of previous recommendations)
- In Lessons taken from BTC experience in CoK/District
- In Management of 'scope'/technical content
- In Process, planning & budgeting

The report recommended to use the Co-management modality between each district and BTC with the following procedures:



The steering committee held on 26 August 2016 reviewed the OA recommendations and the final proposal. The switch to co-management modality between BTC and the districts was approved. It was noted that CoK will formally request confirmation from RPPA whether BTC procurement and engineer staff will have voting powers within the district internal tender committee.

With regards to the construction of the district hospital, with respect to the chapter 4.3.2, particular attention will be given to ensure that the construction and equipment purchase is implemented in a timely and effectively to make the hospital functional before the end of the program. Numerous risks have been identified and mitigation measures defined. The program will perform a very close monitoring and will keep all stakeholders informed of progresses.

Any other content from the initial TFF remains valid.

10.3 Decisions taken by the Steering and monitoring committee

Give an overview of important strategic decisions taken by the Steering Committee in the course of the year and ensure the follow-up of these decisions.[11]

Decision			Follow-up of decision			
Decision	Date	Responsible	Progress	Status	Action	Deadline
Approval of the SC internal working regulations	4-déc.-15	PGM COORD	discussion with chair and cochair prior to SC meeting	Implemented		
			Done during SC meeting			
Request derogation to DGD to align reporting periods with Rwandan Government reporting periods to allow annual reporting end of July (June-July period)	4-déc.-15	UB. Program and MOH	PMU letter sent to BTC and embassy waiting for response	Implemented	To sign letter request to Embassy	31-01-16
Perform a review of existing monitoring and reporting formats used by partner and BTC	4-déc.-15	UB PO	PO UB to meet PO Reprwa	Implemented	review of existing documents	29-02-16
					M&E workshop	29-02-16
					feedback to next SC	next SC
Request a sustainable plan for the development of the deaprtment of Psychiatry at University of Rwanda	4-déc.-15	MHD	MHD to send letter to UR	Implemented	develop concept with CMHS	01-03-16
			ITA MH to prepare concept and engage with UR	Implemented	approve concept between parties	15-03-16
					present sustainability plan to SC	next SC
Ceate a task force for the implementation and follow up of the constructions in Nyarugenge and Gasabo District	4-déc.-15	UB. Program	task Force created and active for Nyarugenge District	Implemented	To prepare a nomination letter to be signed by PS	
					meeting TF Nyarugenge to approve MP PD	29-02-16

[11] *You may use the table of this template or replace it with your own format (e.g. the one for your operational monitoring) provided it shows the same information.*

			task Force created and active for Gasabo District	Implemented	To prepare a nomination letter to be signed by PS	
					first meeting TF t olook at preliminary design	
A meeting between MOH, COK and BTC on management modalities for the construction works will be organized before the end of the year	4-déc.-15	MOH, CoK and BTC	meeting not called as waiting for PS internal discussions	Implemented	To request PS to confirm meeting	2d week July
			Meeting finally held on 16 Feb 2016		organise a meeting with PS and key actors with BTC to agree on recommendations and way forward	2d week July
					SC to approve recommendations and validate modality for infrastructure management	next SC
Approval of the operational and financial planning with emphasis on the need to ensure that any additional delay towards the implementation of the action plans must be strongly avoided in particular in regards to constructions	4-déc.-15	voting members	communicate to Division of the approval of the plans and the need to implement without delays	Implemented		
Approval of budget modification : 475.000 EUR from BTC managed budget lines (Regie) to RBC managed budget (NEX) upon approval by BTC HQ	4-déc.-15	FA	prepare memo motivation to BTC HQ for approval	Implemented		
			if approved, enter the budget modification into FIT			
SC 2 26 AUGUST 2016						
R1 Director General Clinical and Public Health Services/ MOH to provide clear roadmap for the next steps for the setup of the accreditation organization by 15/09/2016	26 Aout 2016	DG Clinical Service	discussions with Edward, waiting for final doc by 14 October	Implemented	presentation of roadmap to next SC	next SC
R2: Approval in principle for MMed Psychiatry scholarships funding (150 000 Euros) to be moved from NEX to Regie modality to enable BTC scholarship unit in Brussels to coordinate the	26-août-16	MHD & UB	done,	Implemented	Follow up RBC by Pieter	oct 2016
			no feedback yet from RBC on procedures			

students' scholarships (only for those who study in Belgium). UB program and RBC to work out the required procedures			change has been adopted withn the TFF addendum			
R3: Approval of the Co-management modality with Nyarugenge and Gasabo Districts for Constructions and Equipment.	26-août-16		comanagement modality approved	Implemented	implentating modalities to be initiated after signature of exchange of letters	Q4
R3: Approval of ToR of infrastructure construction & equipment management Task Forces in Nyarugenge and Gasabo Districts, with their governance but with a reduction on their composition (annex 4a and 4b)	26-août-16		ToR signed for Nyarugenge, waiting for next TF meeting for Gasabo	Implemented	ensure signature for Gasabo TF	Q4
R4. Validation of RBM matrix developed in June-July and recorded in the baseline report by first week of September	26-août-16	DG	validation received from DGPFHI	Implemented		
R6-R1 Approval of principle of developing a joined approach between R1 and R6 for quality and strategic initiatives by end of Q2 FY16-17	26-août-16	DG	one day workshop planned - draft concept note	Implemented	meeting on concept paper 21/10/2016	21-10-16
		DM			approval by SMM	1st week November
					workshop to disseminate concept note	November
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.	Implemented	follow up workshop outputs to be brought to SMT and SMM	Oct 2016

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	Oct 2016
R6: Principle approval to establish a call center for MTI (a full concept note with budget to be developed by end of October for validation).	26 Aout 2016	R6 DM	Ongoing discussion will be further discussed at validation workshop	Repealed	escalate issue to head of biomedical services and confirm relevance of activity as well as inclusion in imihigo	14-10-16
An analysis is made of the inclusion of the key program activities in the institutional imihigos of the respective entities for the next steering committee	26 Aout 2016	DGPFHIS	to be further discussed with focal person	Implemented	Dr Turate cvommitted feedback on behalf of DG RBC by end June 2017	30-06-17
Updated Decision 2/16: Each Division Manager/DG to select 2 to 3 indicators per results to be shared to SC for e-decision by end of May	29-03-17	RBC DG		Implemented	Dr Turate cvommitted feedback on behalf of DG RBC by end June 2018	
Validation of Baseline report (Result Based Management) (annex 6).	26 Aout 2016		done	Implemented		
Operational reporting to SC by result should, for each result, give a performance score with regard to scope, time, quality and budget. Budget execution follow-up should be based on annual/quartely forecast and annual/quarterly execution	26 Aout 2016	PMU	Done on scope, time and budget in last Q meeting but needs further strengthening	Implemented	To discuss modality and feasability at next planning meeting	Nov 2016
An analysis will be presented in the next steering committee of the impact of using the national system for budget management on the flexibility of the program (capacity to adjust activites), compared to the former co-management system	26 Aout 2016	Fin Adv		Implemented	Collect information and prepare analysis	

Updated Decision SC2/19: NEX analysis report is ready and will be shared with PS MOH and MINECOFIN representative for review by the end of April	29-03-17	UB		Implemented		
Approval of budget modification (annex 7).	26 Aout 2016		done	Implemented		
Approval by e-decision by 15/9/2016 of the addendum to TFF (annex 8) to be sent by 30/09/2016 to DGD Belgium.	26 Aout 2016	PO	done	Implemented		
Reporting to the SC on Indicators to be included in the operational updates at least once a year.	26 Aout 2016	PMU	agreed a,d will be done as per M&E plan	Implemented	waiting DGD response on calendar of reporting	31-10-16
					PO to follow up DGD decision with BTC HQ	31-10-16
The Program should ensure close follow up of the timeline for the construction, in particular to ensure that the hospital construction will be completed by 30 June 2019 at the latest to follow it to be fully functional before the end of the program implementation (December 2019)	1st November 2016	UB Coordination	Ongoing deadline for final detailed design due 8 Feb 2017	Implemented	regular meetings with MASS Group	Before December 2019
					develop and monitor checklist of pending corrections in the expected deliverables	weekly

After careful analysis of the different options, the Steering Committee agrees that funding for construction and eauipment of Nyarugenge District Hospital will come from following source : - Ubuzima Burambye Budget : Maximum € 5.500.00, composed of - The initial budget of € 4,717.800 (incl. contingency) as per TFF, minus amount of +/- € 200.000 already committed for payment of the contract with MASS group (144.817.643 RWF tax exclusive) - A budget transfer of € 1,000,000 from R1 and R6. A detailed budget change proposal will be submitted to the next SC. -Global Fund envelope : Lab and radiology equipment (up to max € 5 00,000 VAT exclusive) - Government of Rwanda Ordinary Budget : - All VAT due - Any amounts due for construction or equipment in excess of the budget allocated by BTC and Global Fund (estimated during the meeting at ≥ € 566,436 (the exact amount will be known at the time of awarding the construction contract).	1st November 2016	PMU	waiting for final detailed design documents and BoQ estimates	Implemented	inform TF and SC in case budget estimates are beyond the agreed upon budget	
The Program will prepare mitigation measure for R1 and R6 at the next steering commitee meeting	1st November 2016	PMU	for R6: request by PS to renovate existing buildings rather than constructing new ones for the hospital maintenance workshops; consentrate on 4 provincial hospitals sites	Implemented	follow up for specifications of renovations	
			for R1: need discussion with MSH and other DP to join the initiaive (although ongoing audit at MSH delayed their implementation)	Implemented	include topic on next TWG Q&S meeting	Q1 2017

The co-chair reminded that evidence of availability of ordinary budget for the completion of the works and procurement of goods is a condition for BTC no-objection for awarding the tenders. The Chair and the members took note of the remark.	1st November 2016	PMU	PMU to draft letter for PS to sign	On Track	Reminder letter sent to PS	30-06-17
R1 Approval of selection and funding of QI initiatives with acknowledgement that selection criteria identified in TFF have been respected (MTI will provide technical specifications) A list of projects with title, objectives and outcomes will be shared by UB program to PS MOH and DG RBC	29-03-17	UB	list shared	Implemented		
R2 Mental Health Division community rehabilitation of chronic mentally ill patients (support to NGO): MHD with the support of RBC/SPIU and UB to prepare a concept note or strategy to clarify the process for selecting NGOs and the payment modalities	29-03-17	MHD	no strategy identified Activity cancelled Related budget is proposed to be reprogrammed and alternative activities presented to UB programme by end June	Repealed		
R2/R3 SC endorses the participatory process of drafting framework agreement to be signed between RBC, BTC and (Nyarugenge/Gasabo) districts, while it is acknowledged that the responsibility for its content is assumed by the 3 signatory parties	29-03-17			Implemented		
R2 RBC/MHD to work on legal and budget status of the centre with all stakeholders including MIFOTRA and MINECOFIN to secure Ordinary Budget for 2018-19 and present proposal and address sustainability conditions in next SC meeting **refer to decision 66 and 76**	29-03-17	R2 DM	Ongoing - As the Day Treatment Centre is considered a National Referral MH structure, it will be functioning according to the national standards for national referral health facilities in terms of HR and running budget. As MoH/Clinical Services is the one in charge of health facilities, discussion with them is scheduled to determine the structure of the centre	On Track	need follow up meeting MOH Clin Serv and RBC/MHD	31-07-17

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	29-03-17	R4 DG	Revised plan is under finalization due end of June	On Track	follow up meeting with DG Parfait	31-07-17
R6 MTI focal person to present roadmap to implement all activities including strategic improvement projects for 2017-18 by end of April 2017 during UB monthly meeting	29-03-17	R6 FP	In process – to be presented in July UB coordination meeting	Implemented		
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	29-03-17	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	31-07-17
					new concept involving IPRC graduates to be validated by SMT prior to presentation to SC	15-03-18
UPDATED DECISION **DM/MTI to share concept note and roadmap to develop full business plan (with DG Planning MOH and RBC/Planning/Business development unit) to be validated by SMT by end June 2018 REPLACED BY SC9/7**	22-03-18	R6 DM	contacts taken but no draft presented	Implemented	SC May decision to use regie funding to recruit consultant to assist the Division to develop business and sustainability plan (regie funding)	02-11-18
Admin Fin - Validation and approval of the Ubuzima Burambye program implementation guidelines	29-03-17	UB		Implemented		
Admin Fin - Approval of budget modification in line with previous SC decisions (with exception of PBF for CoK)	29-03-17	UB		Implemented		
R1/R3 - Concept note on 'national patient satisfaction survey': A technical team (RBC, MoH-Clinical Services, UB) to meet by June 30, 2017 to finalize the Concept Note for presentation to MOH senior management to obtain guidance and a decision by July 15, 2017 at the latest.	20-06-17	R1 DG	draft concept with DG for discussion with senior management	Repealed	meeting DG Clin services for follow up	15 July 2017

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**	22-03-18	PMU		Implemented		
R1 - Comprehensive accreditation strategy and related action plan: Clinical services to present it at the next steering committee meeting.	20-06-17	R1 DG	EXPECTED NEXT QUARTER	Implemented	Contact Edward to prepare the document	15-03-18
R2 - Alternative strategy for MH community-based initiatives: MHD will present an alternative to the initial proposal (the one aiming to fund one NGO in Musanze) by identifying other community rehabilitation initiatives (MHD feedback to UB programme management by June 30, 2017)	20-06-17	R2 DM	alternative community support has been provided while developing a future strategy	Implemented	Assist MHD to prepare document	30 June 2017
R3 - Hospital networking: RBC/SPIU and UB to revise the concept note to seek confirmation from PS-MoH by July 15, 2017 on the option to bring international consultants to mentor the development of hospital networking in Rwanda	20-06-17	RBC/SPIU	concept note revised and shared	Implemented	RBC/SPIU Coordinator to seek appointmnet with PS	15 July
to accept the reallocation of the budget dedicated to the construction and equipment of the Mental Health Day Care Center to the Construction of the Nyarugenge District Hospital	11-09-17	SC	N/A	Implemented		
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	11-09-17	PS MOH	to be discussed during next budget revision	Implemented		

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	11-09-17	Nyarugenge District	To be discussed at next Task Force meeting	Implemented	organize a task force in January/February to ensure that all actors are on track to follow up the implementation of the construction	28-02-18
					creation of core team for the procurement of equipment for the hospital	28-02-18
					SC May decision to use regie funding to recruit consultant to assist the MOH and District to develop business plan (regie funding)	02-11-18
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	11-09-17	MOH Clin Services	monitoring meeting planned including review of MTR recommendations on this output	Late	recruit two staff to assist DG to implement the dashboard and first steps of network	Dec 2018
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	11-09-17	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	???
					finalize the design of the construction so it will be ready for tendering	31-03-18
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).	22-03-18		review team took place and report is ready for extraordianry SC (SC8)	Implemented		

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.	22-03-18	PCU	action plan already approved and included in next fiscal year budget	Implemented		
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.	22-03-18	R3 DG	meeting was held at MOH and recommendations will be presented to extraordinary SC	Implemented		
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.	22-03-18	ALL	Meeting was held with RBC/Planning/RBC and support to action research was agrered; MRC Division has met all focal persons and roadmap will be shared	Implemented		
to allocate balance of action research budget to Regie modality by 1st July 2018 to ensure effective implementation of action research	22-03-18	PCU	budget reallocation done as soon as minutes signed	Implemented		
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	22-03-18	PCU	ready for presentation to extraordinary SC	Implemented		
approval of 2018-19 action plans	22-03-18	PCU	Approval of 2018-19 action plans for implementation	Implemented	ready for implementation in next fiscal year	
SC approves the revised MTR report	04-05-18	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)	04-05-18	PMU	MOH now in charge of coordinating R3 activities as per agreement	Implemented		
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)	04-05-18	PMU	see list of actions below	Implemented		

R1. UB to continue technical support in accreditation agency:- Assist MOH to finalize ToR of the agency	04-05-18	ITA R1	draft ToR availableDiscussions with MOH, MSH, Enabel on the process to select local agency	Implemented	Meeting MOH MSH	août-18
- Assist MOH to select the accreditation agency				Implemented		
R1. MOH Quality Directorate to include MTI staff in facilitation and accreditation assessment	04-05-18	Dir Quality MOH		Implemented	MOH to invite MTI Division in accreditation meetings and process	31-08-18
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.	04-05-18	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	04-05-18	RBC/MHD	No budget identified so far, RBC/Planning advised to include it in budget revision	Implemented	need follow up by RBC/MHD	31-10-18
R3. UB to continue support to NCD for CoK to organize NCD mass campaign in May 2018	04-05-18	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	04-05-18	SPIU Coord	CoK informed	Implemented	prepare memo for official transmision once sC minutes are signed	31-08-18
R3. DG CPHS to present final package of medicalized HC to SMM for final validation	04-05-18	DGPHCS	package not yet preesented to SMM MOH	Implemented	Follow up with Dr nathalie and DG on package presentation	31-07-18
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'	04-05-18	UB	draft note under discussion with Health ITAs coordination	Implemented	present draft note to MOH in August (?UB SC?)	31-08-18
R3 Construction Nyarugenge DH: Ensure strict monitoring and close involvement of all actors and stakeholders. Regular reporting to senior management.	04-05-18	UB	Weekly monitoring and regular meeting necessary to force the contractor to progress andreach target	Implemented	Weekly meetings with Mayor and ES to facilitate significant acceleration to reach 20% by end June	weekly

					High level site meeting with PS MOH, Mayor, Enabel resrep, Repr Chinese embassy and CEO CCECC Horizons	aug 2018
					continue high level monthly meetings	monthly
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	04-05-18	UB	document ready for TF meeting in July	Implemented	present to TF in July and SC in August in case of budget implications	31-08-18
R6. Ensure the functionality of provincial maintenance workshop	04-05-18	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	31-07-18
					SC May decision to use regie funding to recruit consultant to assist the Division to develop business and sustainability plan (regie funding)	02-11-18
R6. MTI Division to finalise the proposed national strategic plan for validation by SMM	04-05-18	RBC/MTI	DM to presnet to senior management and SMT RBC	Late	ITA to assist DM presentations	31-07-18
ALL R: MRC/Planning/RBC to develop roadmap and support to implementation of action research and report implementation progress to the next SC	04-05-18		see above	Implemented	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	04-05-18	RBC/SPIU	to be prepared in July	Implemented	RBC/SPIU to prepare data to present to SC in August	31-07-18

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 final year of the program to be presented to the next SC)	04-05-18	UB	Financial advisor has prepared a revised version for consideration	Implemented	Follow up with SPIU coordinator and PS on the revised bersion and adjust according to procurement plans	15-08-18
SC approves budget reallocation within regie budget as per annex 7	04-05-18	UB	waiting for signature of minutes to implement the reallocation in the system	Implemented	need f/up of signature of minutes	31-07-18
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	04-05-18	UB	draft ToR in circulation	Implemented	finalize ToR and send PO to contractors	31-07-18
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	04-05-18	RBC/MTI	note ready, needs validation by SMT	Repealed	ITA to assist DM to present document for validation	31-07-18
SC approves the UB program annual report 2017-18	**06-12-18**			Implemented		
R3: SC confirms the importance of medicalization and the need for close monitoring and support by MOH and RBC:	**06-12-18**			Implemented		
- Guidelines to be validated and signed by 31 December 2018 (Resp: Dr Nathalie)			guidelines done in 2019, package validated in 2019	Implemented		
- US machines to be returned to HC within 3 months (Resp: DG DH)			done with minor delay	Implemented		
- Development and launch of maintenance framework contract for US machines by March 2019 (Resp: RBC/SPIU)				Implemented	framework contract progress for CT Scan, not US yet	
- Implementation of validated medicalization sustainability plan by April 2019: detach/recruit a Medical Doctor (roadmap) (Resp: MOH DGCPHS, DH DH, DHU and CoK)			principles agreed, implementation will depend of staff availabilities	PARTIAL	f/up with DG Clinical Services	

R4: DG PHFIS to coordinate validation of mapping for presentation to SMM and SMT before end December	**06-12-18**			Implemented		
R6: SC recommends to identify a 5th site for a provincial workshop establishment for CoK; a team (CoK, DG of DH, Biomed engrs, BIOS, SPIU/RBC and UB) to do site assessment and recommendation to location and budget to SMT, SMM and SC by end January 2019	**06-12-18**		cHUK has been identified but no formal confirmation	ongoing	MTD to do site reviews for advice	
R6: SC agrees to support the start-up fund including the transfer of RWF 200 Mi from NEX (R6) to regie to facilitate the initial kick off of the provincial workshop activities	**06-12-18**		abandoned, some fund will be used but in NEX as initially anticipated, waiting for MIFOTRA approval to recruit	Repealed	F/up on recruitment of staff and engage with MIFOTRA to create the positions	
Ensure the functionality of provincial maintenance workshop (100) and provide costing scheme and tariffs for services at provincial workshops (117): **SC recommends to involve CEBE (UR) to assist with the development of a business model for the provincial maintenance workshops - by July 2019**	**06-12-18**		CEBE not contacted by RBC	NOT done		
R3 NDH: SC approves Scenario 2 additional funding gap leaving a gap of 151 k€ and the necessary budget reallocations	**06-12-18**		see reports	Implemented		
R3 NDH: SC requests Nyarugenge District to identify budget availability to assist in addressing the gaps – a separate meeting with MOH, UB to be held in January 2019	**06-12-18**		letter sent, District confirmed support	Implemented		
R1 Quality Assurance: Approval to transfer 92 Mi to regie to launch a tender for an organization to implement accreditation assessment of 28 district hospitals	24-05-19		done - assessment done by RAQQH	Implemented		
R6 asset management. Approval to extend the contract of ITA Biomedical Engineer Sankaran Narayanan until 31 December 2019 (6 months extension)	24-05-19		contract extension signed	Implemented		

R2: SC recommends that Mental Health Division, with the support of DG RBC, engage with UR School of Medicine to strengthen academic staff and curriculum implementation – by Q1	19-06-19	RBC MHD	RBC/%MHD and specialists identified and included in the list and teaching program	Implemented		
R3: medicalization: SC confirms the importance of medicalization and the need for close monitoring and support by MOH and RB SC endorses the way forward presented by UB Program (see full table on slide 25):	19-06-19	MOH DGPHCS		Implemented		
- Ensure a permanent medical doctor for each HCs from 1st July from DH until MD fully recruited: (Resp DG CPHS)	19-06-19	MOH DGPHCS	shortage of MD	NOT done		
o MOH to instruct DH to avail a MD in 4 HC from 1 July	19-06-19	MOH DGPHCS	shortage of MD - some DH continued providing part-time support	Implemented		
o Finalize funding mechanism	19-06-19	MOH DGPHCS	see feasability study	NOT done		
- Engage with RSSB to adjust tariffs for Medicalized HC through Ministerial Instruction to RSSB (Resp DG CPHS) - - 1st week July	19-06-19	MOH DGPHCS	US ok dental NOK, refused by RSSB, DG Parfait letter to appeal	Implemented		
- Train Nurses on US: SC decision to use regie for UB to launch tender to recruit trainers	19-06-19	MOH DGPHCS	ok	Implemented		
- Recruit A1 nurses (8) to fill existing gaps: MOH to instruct HC to recruit (8 nurses) (Resp: DG CPHS +Corporate)	19-06-19	MOH DGPHCS	memo prepared to MoS for approving recruitment but not sent - then MOH to do appointment (Dr Nathalie)	partial		
- Include missing indicators to HMIS reporting system at HC: Meeting with HMIS (Resp DG CPHS)	19-06-19	MOH DGPHCS	done	Implemented		
R3: SC appoints a core team under the leadership of DG CPHS to review NDH business plan for validation by SMM and to oversee its effective and timely implementation. The core team must ensure budget cost containment and will include representatives from Planning MOH, Planning RBC, Corporate MOH, Nyarugenge District and UB program among others; Business plan to be validated by end July 2019	19-06-19	DGPHCS	plan was presented and used as a guide though it could not be fully implemented as some references used were not applicable	Implemented		
PMU: SC approves the budget projections for 2019-2020	19-06-19	PMU		Implemented		

PMU: : SC approves UB action plan for 2019-2020	19-06-19	PMU		Implemented		
PMU: SC takes note of UB program closure	19-06-19	PMU		Implemented		
1. In order to facilitate the construction of Nyarugenge District hospital and the payment of addendum No 2 to the construction contract amounting to RWF 876,824,400 VAT included, SC approves the funding reallocation as follows:	30-08-19					
'- Allocate the overall UB efficiency saving of RWF 500,000,000 to the hospital construction		PMU		Implemented		
'- Allocate unused balance of RWF 200,000,000 for provincial workshops to the hospital construction		PMU		Implemented		
'-Identify other sources of funding than UB for the consultancy on norms and standards		PMU	not found yet, will depend when teh MTI division manager will be appointed	Ongoing		
. SC approves the arrangement provided that the ambulances are procured under UB funding and UB activities are covered to the equivalent of 200,000 euros by the other Enabel funding (that was initially committed to cover for Ebola preparedness)	30-08-19	PMU	JHSS has funded the IT tender for the hospital and US training	Implemented		
R2: Sustainability question: SC recommends RBC to consider alternative funding sources (OB, partners, current grants) for MHD activities	13-12-19	RBC	some private support, Johnsons & Johnson, CDC options	Ongoing		
R3: Considering the difficulty to recruit MD for HC, it is suggested to reallocate this UB budget to activity with funding gap. DGPHCS to meet hospitals DG and MOH will continue efforts to ensure recruitment and MD presence at medicalized HC	13-12-19	DGCPHS		Implemented		

R3: MOH to define and allocate coordination of hospital network to a specific unit.	13-12-19	DGCPHS	eHealth MOH	Implemented		
R3: SC agrees to Funding of Hospital Network integration layer and dashboard development using unused budget from other result up to RwF 55 Mi. MOH e Health, HMIS and RBC to be involved in a coordinated way	13-12-19	DGCPHS	consultants will deliver dashboard by April 2021	Ongoing		
R4: Considering the unlikelihood of prompt initiation of STEP, MOH e Health, HMIS and RBC to be involved in a coordinated way and to reallocate the UB budget (59 Mi) to activity with funding gap	13-12-19	PMU	See budget reallocation	Implemented		
R6: SC recommends to use UB funding for one year contract in order to facilitate the recruitment of the much needed staff for provincial wokshops	13-12-19	SC	Staffing never recruited in 2020 - funding saving will be reoriented to Covid-19 response	repealed		
NDH: A high level meeting with MOH, RBC, Nyarugenge District, consultant and contractor top managers to be held on 18th December 2019 to confirm construction project completion time and management	13-12-19	PS	Numerous meetings took place in the following quarters including high level authorities such as CoK Hon Mayor	Implemented		
NDH: MOH (DGPHCS) and District to prepare NDH implementation plan and present to SMM and UB SC by 18 December 2019	13-12-19	DGCPHS	DGPHIS prepared plan and start up budget	Implemented		
PMU: SC approves the above Budget projections	13-12-19	SC		Implemented		

PMU: As exact budget balances cannot be known until all equipment tender contracts are finalized, Chair and Co-chair will review them when available and validate reallocations accordingly	13-12-19	SC	revised in May 2020	Implemented		
PMU: SC approves the full list of commitments as described above and in the annex 1	13-12-19	SC		Implemented		
PMU: SC approves the UB budget reallocations (annex 2)	13-12-19	SC		Implemented		
PMU: Approval of Program closure plan including the closing ceremony in June 2020 and the HR funding commitments	13-12-19	SC	no closing ceremny because of Covid-19 epidemic restrictions	repealed		
PMU: SC approves the inventory and asset management upon program closure (annex 4)	13-12-19	SC		Implemented		
CoK to fund batch 3 'medical accessories' for FRW 149,344,512 instead of Enabel/UB (option a-1)	10-03-20	COK	CoK funded medical equipment - tender with Future health	Implemented		
Enabel/UB to Re-launch batch 4 (lot3) and batch 5 (lot 1-2-3) through regie	10-03-20	PMU	equipment supplied	Implemented		
Batch 4 lot 2: Use RBC framework contract to procure – funding from Global Fund source	10-03-20	SPIT	lab equipment supplied	Implemented		
Use Abbott-MOH agreement to procure hematology and chemistry machines	10-03-20	PS	Letter signed, equipment installed	Implemented		
Considering the delay in the construction of the hospital, SC approves the extension of ITA Infrastructure support for 2 additional months (until 31 May 2020)	10-03-20	PMU	contract signed	Implemented		
approval of budget balances and commitment	02-04-20	SC		Implemented		

SC members requested an update on the construction progress as well as the equipment procurement to identify eventual gaps	11-06-20	PMU	Regular updates shared	Implemented		
SC appointed a Task Force to oversee the hospital preparedness. The task Force is led by DG Clinical services and include staff from MOH Clinical Services and Planning, MPPD, SAMU, Laboratory services, MTI, Pharmaceutical services, supply chain and District as well as CoK	11-06-20	DGCPHS	Task Force has met but could not solve the drugs and consumables issues	Implemented		
The Task Force need to ensure that a three months buffer stock of drugs and consumables is provided to the hospital to facilitate its starting operations. The chair requested that Nyarugenge hospital be on top priority for MPDD supplies to ensure adequate supplies to treat patients including surgical operations. Registration to RSSB and	11-06-20	DGCPHS	the hospital is facing shortages at MPPD for drugs and consumables that are out of stock	Ongoing		
MOH to secure at least two ambulances from the RBF supply of 40 ambulances to be posted to Nyarugenge hospital	11-06-20	DGCPHS	2 ambulances on site	Implemented		
Options for the balance were presented and SC agreed with option 1: to pay for any urgent pending payment for Covid-19 (on the basis that R1 balance was meant for Covid-19 support)	11-06-20	PMU	Payment done	Implemented		
In view of the delay in the hospital construction, it is agreed to recommend to extend the contract of UB coordinator for an additional funding using budget from Barame project (pending approval by Barame SC)	11-06-20	SC	consract extension signed	Implemented		

10.4 Complete monitoring matrix

See above section 10.2

10.5 Resources in terms of communication

There was no systematic action research protocol developed but the program identified topics for either best practice of policy documents or abstracts for publication as follows (there will be published in a booklet or separately as relevant):

Result area	Title	Output
1. R1:	Quality Improvement Initiatives effectively help improve quality of health care and safety in Rwandan hospitals	Abstract, poster and presentation
	The Accreditation Program improves quality of care in hospitals in Rwanda	Best practice
2. R2	Situation analysis for trauma cases during the commemoration period of the genocide against the Tutsi in Rwanda	Report
3. R3:	Upgrading standard health centers to improve accessibility to quality care in urban settings	Best practice
	Lessons learned from Hospital Information Network platform implementation with the aim of contributing to the improved management of emergencies, referrals and resource in the city of KIGALI	Best practice
	Hospital construction in Rwanda: lessons learnt	Best practice
	The City of Kigali Mass Campaigns Are Effective for Prevention and Control of Non-Communicable Diseases: An Action Research Study in Kigali, Rwanda	Abstract, poster
	NCD Mass Campaigns in the City of Kigali for prevention and detection of hypertension and diabetes: Evaluation Study	Abstract

Result area	Title	Output
	Mass Campaign On Non-Communicable Diseases - City Of Kigali 2017: Assessing Utility And Effectiveness	Abstract
4. R4	Health Facility Mapping contributes to improve health care services by rational redistribution of health resources	Best practice
5. R6	Improving quality of services through decentralized medical maintenance workshops	Abstract
	How to strengthen healthcare technology management	Policy brief
	Safety is vital: radiation protection in healthcare facilities	Best practice
	Booklet on main achievements in asset management support	Booklet

In summary of the above, 6 best practices,5 abstracts,2 posters, 1 presentation and 1 policy brief were produced as well as one booklet. Contacts will be taken with communication for the best approach to disseminate them

Besides, posters and presentations were accepted and given during international conferences (ECTMIH Liverpool 2019, AHAIC 2019, Be-Cause health 2019, ICFP Kigali 2018.

A documentary film has been produced for the whole program (15 min) and for each of the result area (3 minutes each)

10.6 Personnel of the intervention

Personnel (title and name)	Sex (M/F)	Term of employment (start and end date)
National staff made available by the partner country:		
PS MOH, SC Chair Dr Solange Hakiba,	F	
Dr Jean Pierre Nyemazi	M	
Dr Zuberi Muvunyi	M	
Dr Theophile Dushime	M	
Dr Yvonne Kayiteshonga	F	
Dr Parfait Uwaliraye	M	Not applicable
Dr Gilbert Biraro, Director of Intervention	M	Permanent staff employed by the partner
Egr Donat Habukuri, procurement civil engineer	M	
Francine Umutesi, Biomedical engineer	F	
Denyse Ingeri, MOH Planning	F	
Aline Nyonkuru, MOH Planning	F	
Gervais Baziga, MOH Planning	M	
Edward Kamuhangire, MOH Quality and standards	M	
Modeste Gashayija, MOH Clinical Services	M	

Dr Nathalie Umutoni, Clinical Services	F	
Nancy Misago ; RBC MHC	F	
Jean Damascene Iyamuremye	M	
Frederic Nsanzumuhire	M	
Support staff, recruited locally by UB program (NEX):		
Diogene Rurangwa, R1 QA	M	
Jeanne d'Arc R2 Drug substance abuse	F	
Benjamin Ruyatasire, R3 medicalization and networking	M	
Faustin Maniragena, HIN	M	
Ladislas Havugimana, NDH construction	M	
Chantal Imusonere, architect	F	
Gentille Uwamahoro, financial specialist	F	
Florence Uwimana, financial specialist	F	
Donata Nyirandinda, Admin Assistant	F	
Phocas Mundeke, driver	M	
Vital Marara, driver	M	
Dieudonne Uwingabe driver	M	

International experts (Enabel):			
Dr Vincent Tihon Program Coordinator		M	06/2015-12/2020
Dr Veronique Zinnen, ITA Public Health		F	03/2016-2020
Dr Achour Ait Mohand, ATI Psychiatry		M	06/2015-08/2018
Pieter Deparcq, RAFI		M	06/2015-04/2018
Meïssa NDIR, RAFI		M	04/2018-2020
Mathieu Lefebvre, ITA Infr, part-time		M	01/2016-04/2017
Karine Guillevic, ITA Infra, part time		F	05/2017-Covid19 April 2020

10.7 Public procurement

See MONOP and procurement tables

10.8 Grants

No grant

10.9 Specific Cooperation Agreements

1. Framework agreement between RBC, Enabel and Nyarugenge District for the construction and equipment of Nyarugenge District Hospital

2. Framework agreement between RBC, Enabel and Gasabo District for the construction and equipment of the National Mental health Day Treatment center

10.10 Equipment

List of equipment acquired during intervention

See SC13 annex

Type of equipment	Cost		Date of delivery		Remarks
	Budget	Actual	Budget	Actual	

10.11 Financial execution as of 31 December 2020

Project output Code	Project output	Total Budget	Actuals	Available
RWA1309211_A01	The quality assurance system is set up and integrated and functional at the level of all hospitals	1.233.969	1.298.807	-64.838
RWA1309211_A02	The mental health services are accessible from the community level up to the national level in a sustainable way	2.033.252	2.033.192	60
RWA1309211_A03	The urban health service coverage is rationalized and extended in line with the three guiding principles of the National Health Sector Policy	9.236.904	8.293.900	942.278
RWA1309211_A04	The leadership and governance is reinforced, specifically regarding district stewardship, the respective roles of the MOH and RBC and the public private partnership	678.453	678.336	117
RWA1309211_A05	Data are generated, analysed and used for evidence-based decision-making in a more correct, disaggregated, integrated, systematic, accessible and effective way	15.764	15.738	26
RWA1309211_A06	An asset management system is designed and operational in a cost-effective way	1.947.507	1.940.209	7.298
RWA1309211_X01	Reserve	0	0	0
RWA1309211_X02	Reserve	0	0	0
RWA1309211_Z01	Personnel Costs	1.679.935	1.678.598	1.337
RWA1309211_Z02	Investments	71.497	71.473	24
RWA1309211_Z03	Functional costs	409.985	396.399	12.634
RWA1309211_Z04	Audit, Monitoring and Evaluation	692.735	540.452	152.283
RWA1309211_Z99	Conversion rate adjustment	0	34.401	-34.401
Grand Total		18.000.000	16.981.507	1.016.816