USAID
FROM THE AMERICAN PEOPLE

MIDTERM PERFORMANCE EVALUATION OF THE USAID/RWANDA STRENGTHENING THE CAPACITY OF THE HEALTH SECTOR TO DELIVER QUALITY HEALTH SERVICES (SCHS) PROJECT

September 2017

This publication was produced at the request of the United States Agency for International Development. It was prepared independently by Tariqul Khan, Katya Burns, David Kiongo, Hortense Mudenge, Lillian Mutesi, Musengimana Sylvestre, and Patrick Nsenga.

Cover Photo: A nurse inspects stock at the Kibungo Provincial Hospital Pharmacy. Photo Credit: Musengimana Sylvestre

MIDTERM PERFORMANCE EVALUATION OF THE USAID/RWANDA STRENGTHENING THE CAPACITY OF THE HEALTH SECTOR TO DELIVER QUALITY HEALTH SERVICES (SCHS) PROJECT

September 2017

USAID Contract No. AID-OAA-C-14-00067; Evaluation Assignment No.: 261

This document is available online at the GH Pro website at http://ghpro.dexisonline.com/reports-publications. Documents are also available at the Development Experience Clearinghouse (http://dec.usaid.gov). Additional information is available from:

Global Health Program Cycle Improvement Project

1331 Pennsylvania Avenue NW, Suite 300

Washington, DC 20006

Phone: (202) 625-9444

Fax: (202) 517-9181

http://ghpro.dexisonline.com/reports-publications

This document was submitted by GH Pro to the United States Agency for International Development under USAID Contract No. AID-OAA-C-14-00067.

ACKNOWLEDGMENTS

The Midterm Performance Evaluation of the USAID/Rwanda SCHS Project was completed through broad consultation with a variety of individuals and stakeholders. First and foremost, the team would like to thank everyone from the government of Rwanda (GOR)'s Ministry of Health (MOH) and Rwanda Biomedical Center (RBC) who made themselves available for key informant interviews (KIIs), group interviews, and focus group discussions. We also extend thanks to the many individuals from other GOR ministries, institutions, and facilities at the national and decentralized levels, as well as private sector entities and associations, professional councils, and academic institutions, which took a serious interest in sharing their views, ideas, and experiences. Our special gratitude goes to Dr. Jean Pierre Nyemazi (Private Sector, MOH), Dr. Jeanine U. Condo (Director General, RBC), and Dr. Parfait Uwaliraye (Director General, General Directorate of Planning, Health Financing, and Information System, MOH) for their invaluable guidance and insights. We also thank the GOR point of contacts from, Dennis Nkunda (MOH) and Edouard Niyonshuti (RBC).

We thank all of the implementing partners of the SCHS activities, including the Rwanda Health Systems Strengthening Activity (RHSSA), the African Indoor Residual Spraying (AIRS) project, the Procurement and Supply Management project (PSM), the DELIVER/Supply Chain Management System project (SCMS), and the Maternal and Child Survival Program (MCSP), for providing facilitation and sharing valuable information with the team. Special thanks go to Management Sciences for Health (MSH)'s Rwanda Health Systems Strengthening Activity (RHSSA staff, who shared valuable knowledge and ideas and provided important and extensive in-country logistical support for the field visits. We also thank the development partners, including the Belgian Development Cooperation and United Nations International Children's Emergency Fund for making themselves available and sharing their valuable advice and insights.

We also express our gratitude to many at USAID/Rwanda's Health Office (HO), including Deputy Director Jesse Josephfor providing overall and ongoing guidance to the team. We also most sincerely thank Lindsay Little of the HO for her valuable guidance and day-to-day support. Special thanks go to John McKay, Mary de Boer, Andrew Fourney, and Richard Munyaneza of the HO for providing valuable guidance and feedback to the team. We are thankful to all the other HO staff who gave the team time and shared valuable ideas and experiences. We are most grateful to USAID/Rwanda's Deputy Mission Director Leslie Marbury and HO Director Lisa Godwin for their guidance, insights, and interest in our findings. We thank Ashley Smith, Bridget McHenry, Trevor Rittmiller, and Reden Sagana from USAID/Washington for sharing useful experience, insights, and ideas.

The assessment team sincerely thanks members of GH Pro Project Team for their assistance and guidance with assignment preparation, logistics, in-country work, and final organization of the report. Our deepest appreciation goes to Melinda Pavin, technical director, and Erica Mills, GH Pro Program Manager, for providing the overall guidance and support to the assignment.

Last and most important, we thank the more than 250 respondents who generously shared their experience, thoughts, and ideas with the team to support this evaluation. We hope that this report accurately reflects the information they shared and their suggestions.

Evaluation team: Tariqul Khan (team leader), Katya Burns, David Kiongo, Hortense Mudenge, Lillian Mutesi, Musengimana Sylvestre, and Patrick Nsenga.

CONTENTS

FIGURES

TABLES.

ACRONYMS

AIRS	African Indoor Residual Spraying Project
BTC	Belgian Technical Cooperation
CBHI	Community-Based Health Insurance schemes (*mutuelles*)
CDCS	Country Development Cooperation Strategy
CHAIN	Community Health and Improved Nutrition
CHW	Community health worker
CPDS	Coordinated Procurement and Distribution System
DAAP	District Annual Action Plan DH District hospital
DHIS	District Health Information System
DHMT	District Health Management Team
DHU	District Health Unit
DO	Development Objective
DP	Development partner
EDPRS	Economic Development and Poverty Reduction Strategy
eLMIS	electronic Logistics Management Information System
ET	Evaluation Team
FGD	Focus Group Discussion
FHP	Family Health Project
GH Pro	Global Health Program Cycle Improvement Project
GI	Group interview
GOR	Government of Rwanda
HC	Health Center
HF	Health financing
HFP	Health financing policy
HFSP	Health Financing Strategic Plan
HMIS	Health Management Information System(s)
HO	Health Office
HSFP	Health Financing Strategic Plan
HSH	Health system
HSS	Health System Strengthening
HSSP III	Health Sector Strategic Plan
IFMIS	Integrated Financial Management Information System
IHSSP	Integrated Health Systems Strengthening Project
IM	Implementing mechanism
IP	Implementing Partner
IR	Intermediate Result
IRS	Indoor Residual Spraying
KI	Key informant
KII	Key informant interview

L&G	Leadership and Governance
LMO	Logistics Management Office
M&E	Monitoring and evaluation
MCH	Maternal and child health
MCSP	Maternal and Child Survival Program
MDG	Millennium Development Goal
MINALOC	Ministry of Local Government
MOH	Ministry of Health
MPPD	Medical Production and Procurement Division
MSH	Management Sciences for Health
NSCSP	National Supply Chain Strategic Plan
OFH	One Family Health
PBF	Performance-Based Financing
PH	Provincial Hospital
PHQS	Primary Healthcare Quality Standards
PMI	U.S. President's Malaria Initiative
PMP	Performance monitoring plan
PPP	Public-Private Partnership
PSE	Private sector engagement
PTA	Provincial technical advisor
QGIS	Quantum Geographic Information System
QI	Quality Improvement
QR	Quadrant
RAMA	Rwanda Medical Insurance Agency
RBC	Rwanda Biomedical Center
RHSSA	Rwanda Health Systems Strengthening Activity
RPPA	Rwanda Public Procurement Authority
RSSB	Rwanda Social Security Board
SCHS	Strengthening the Capacity of the Health Sector
SCM	Supply chain management
SCMS	Supply Chain Management System
SOP	Standard operating procedure
SOW	Scope of Work
SPS	Strengthening Pharmaceutical Systems project
TA	technical assistance
ToT	Training-of-trainers
TWG	Technical Working Group
USAID	United States Agency for International Development

EXECUTIVE SUMMARY

INTRODUCTION

Rwanda has made tremendous strides in improving the health and well-being of its citizens over the past decade and attained health Millennium Development Goals ahead of schedule. To sustain these impressive gains and go further, the government of Rwanda (GOR), its development partners (DPs), and key stakeholders recognize the urgent need to have a well-capacitated and sustainable health system (HS). Through the five-year, $294 million Strengthening Capacity of the Health Sector to Deliver Quality Health Services (SCHS) Project, USAID/Rwanda is strengthening the Rwandan HS to deliver affordable, responsive, high-quality health services. This is an independent midterm performance evaluation of SCHS.

EVALUATION PURPOSE AND QUESTIONS, PROJECT BACKGROUND, AND CONTEXT

The purpose of this evaluation is to better understand the effectiveness of the SCHS project activities toward the expected results, and provide specific learning and evidence for design, planning, implementation, and management decisions by the SCHS team going forward. The evaluation answered three primary questions:

1. To what extent has the design of the SCHS Project facilitated or hindered USAID's support to strengthen the capacity of the health sector to deliver high-quality services? In this context, design refers to the relationships between the elements of the SCHS Project matrix, including the interactions and dependencies of stakeholders, as well as activities implemented as they relate to the results framework. Consider elements such as structure, coordination among implementing partners (IPs), and engagement of stakeholders.
2. To what extent has the SCHS Project strengthened the capacity of Rwandan HS in relation to Sub-purposes 3, 4, and 5? What is the level of capacity of the GOR in these areas?
3. Does SCHS target the most important and changeable factors that contribute to the GOR's capacity to sustain a strong system that will provide high-quality services? Are there other more important and changeable areas?

Evaluation Questions 2 and 3 should be answered in relation to Sub-purposes 3-5 of the SCHS results framework. Sub-purpose 3: Essential medical products available and accessible at service delivery points; Sub-purpose 4: Increased domestic resources for the health sector used equitably and efficiently; and Sub-purpose 5: Leadership and governance (L&G) of HS at central and local levels strengthened.

The SCHS Project, which began in 2013, was initially called the Decentralized Health Systems Strengthening Project. The change in name resulted from a shift in USAID's planned implementation modality in late 2014. The project has an overall goal to have "Health and nutritional status of Rwandans improved" and purpose "To strengthen capacity of health sector to deliver affordable, responsive and high-quality services."

Per the scope of work (SOW), this evaluation considered three specific SCHS activities/implementing mechanisms: the Rwanda Health Systems Strengthening Activity (RHSSA), the DELIVER/Supply Chain Management System (SCMS) project, and the Africa Indoor Residual Spraying (AIRS) project.

EVALUATION DESIGN AND METHODS

The evaluation was conducted by an independent Evaluation Team (ET) between January and March 2017. The ET used a mixed evaluation methodology combining review and analysis of quantitative data

and application of qualitative techniques. The mixed methodology approach involved the systematic integration of different kinds of data, using different methods. This approach helped the ET to glean objective insights into the performance of SCHS activities and their interventions, and analysis of complementary quantitative and qualitative data, which led to findings and conclusions, as well as formulation of practical and actionable recommendations based on facts and evidence. Data sources included document and data review; key informant interviews (KIIs); secondary data analysis; group interviews (GIs); and site visits. *Altogether, the ET conducted 59 KIIs and GIs, meeting more than 250 people, and visited 18 field sites covering 21 entities.* Please see the methodology section on page 7 and the evaluation matrix in Annex VI for details.

KEY FINDINGS AND CONCLUSIONS

Evaluation Question 1: Health Sector Strengthening

Strengths and Key Achievements: i) SCHS design and results framework are strategically and closely aligned with broader USAID (e.g., Country Development Cooperation Strategies) and GOR strategies (e.g., Economic Development and Poverty Reduction Strategy [EDPRS 2] and Health Sector Strategic Plan [HSSP III]), and international standards and best practices such as the World Health Organization's Health System Strengthening [HSS] components); ii) the restructuring of the USAID/Rwanda SCHS team, driven by the SCHS design, seems to have an early positive impact on the team's internal coordination; iii) SCHS supported meaningful "country ownership" and built synergies by engaging GOR entities at both central and decentralized levels; iv) effective coordination between USAID and IPs resulted in improved focus on results, effective planning and monitoring, and program efficiency; v) pockets of effective coordination among the IPs at central and decentralized levels have yielded important complementarity and efficiency gains in planning and implementation; and vi) there has been effective coordination between the Mission, the GOR, IPs, and other DPs in planning, formulating strategy and policy, and project development, implementation, and monitoring at central and decentralized levels.

Key Gaps and Challenges: i) Inadequate coordination and collaboration among IPs in the planning and implementation of specific project activities have hindered overall efficiency (i.e., "value for money"); ii) there were occasional planning, coordination, and communication gaps among IPs and the GOR, such as temporary inefficiencies in supply chain management (SCM) activities immediately after the closure of DELIVER/ Supply Chain Management System (SCMS); iii) in recent months, some of the Technical Working Groups (TWGs) have not been effectively functional due to weak leadership, inadequate participation, and limited coordination among members; and v) there are insufficient high-level advocacy and GOR resources to support the RHSSA embedded and provincial technical advisor (PTA) positions in the longer run to ensure sustainability.

In summary, the design of SCHS is well aligned with GOR and USAID strategic priorities, and has so far facilitated USAID support to strengthen the capacity of the Rwandan health sector to deliver high-quality health services, with some gaps and challenges remaining in specific areas, including inadequate coordination and collaboration among IPs in specific program activities, hindering overall efficiency.

Evaluation Question 2: HS Strengthening

Sub-purpose 3: Essential medical products available and accessible at service delivery points

Strengths and SCHS Contributions: i) DELIVER/SCMS strengthened key institutions at central (e.g., Coordinated Procurement and Distribution System [CPDS], Medical Production and Procurement Division [MPPD]) and decentralized levels (e.g., district pharmacies) and enabled key information systems such as the eLMIS; ii) AIRS has contributed to improving insecticide distribution systems and some aspects of warehousing; iii) SCHS strongly supported human resource technical capacity building for effective use of systems (DELIVER/SCMS) and built district-level capacity to organize and conduct

indoor residual spraying (IRS) (AIRS); and iv) DELIVER/SCMS supported warehouse improvement through innovations such as "warehouse in a box," and development of framework contracting to optimize tendering.

Challenges in SCHS Support and Gaps in GOR Capacity: i) Institutional structures, processes, and effectiveness stand out as key issues due to a non-semi-autonomous Medical Production and Procurement Division (MPPD), sub-optimal Logistics Management Office (LMO) effectiveness, parallel procurement of essential medicine, and sub-optimal contribution of AIRS to build GOR institutional capacity for procurement of insecticides for IRS; ii) inadequate utilization of eLMIS full functionalities, especially consumption, and persistent concurrent use of paper and electronic systems at decentralized levels; iii) human resource technical capacity for full eLMIS use remains weak due to lack of refresher training, especially at the decentralized levels; iv) stockouts, primarily of essential medicine procured and managed by MPPD (and small instances of program commodities); v) slow review and approval of key SCM policies and strategies, possibly limiting significant efficiency gains and cost savings; and vi) conflicting priorities in supply chain goals and activities among DPs, IPs, and the GOR — mainly based on needs on the ground and situational urgencies.

In summary, while some gaps and challenges remain, DELIVER/SCMS made critical contributions in significantly improving SCM systems in Rwanda.

Sub-purpose 4: Increased domestic resources for the health sector used equitably and efficiently

Strengths and SCHS Contributions: i) RHSSA played a key role in supporting coordination for health financing (HF) by co-leading and facilitating critical TWGs on health finance; ii) RHSSA built the capacity of GOR financial systems in health by supporting the development of key policies and strategies, building Ministry of Health (MOH) capacity to conduct costing, supporting key revisions to the tariff list, facilitating the rollout of Integrated Financial Management Information System (IFMIS), and strengthening financial systems and capacity at all levels; iii) RHSSA provided critical support to the Community-Based Health Insurance schemes (CBHI, or *mutuelles*) system by supporting the transition of their management from the MOH to Rwanda Social Security Board (RSSB); and iv) RHSSA supported income generation activities by helping to develop private sector engagement (PSE) awareness and capacity, strategies, roadmaps, and business case frameworks; strengthening the community health worker (CHW) cooperatives; and contributing to evaluations of the CHW cooperatives and community HSs.

Challenges in SCHS Support and Gaps in GOR Capacity: i) Domestic resources for health are not increasing at the scale needed; the MOH lacks the necessary technical and advocacy skills to conduct evidence-based negotiations to increase the domestic budget for health, and inadequate domestic resources to support IRS in all 13 malaria-endemic districts; ii) CBHI enrollment remains sub-optimal, and faces a number of entrenched challenges to further expansion; iii) inadequate income-generation activities and low PSE in health, plans for public-private partnerships (PPPs) yet to be implemented, and weak business capacity at all levels; and iv) most CHW cooperatives are still not generating profits and lack the support and capacity to be financially viable.

In summary, RHSSA has played a critical role in supporting and strengthening GOR capacity in HF, including domestic resource generation and effective mobilization. However, as stated, some challenges remain.

Sub-purpose 5: Leadership and Governance (L&G) of HS at central and local levels strengthened

Strengths and SCHS Contributions: i) Strong RHSSA support facilitating and building management and planning capacity at district and provincial levels has resulted in District Health Management Teams (DHMTs) gradually becoming more effective and functional, and having increasingly integrated planning and decision-making process and improved human resource management; ii) AIRS has effectively built HS and human capacity for IRS, enabling the GOR to take over districts previously covered by AIRS; iii)

at the facility level, RHSSA has effectively supported the development, deployment, customization, and training for a number of information systems, and monitoring and evaluation and analytical tools (e.g., Health Management Information System [HMIS]/District Health Information System [DHIS2], Quantum Geographic Information System [QGIS], Integrated Financial Management Information System [IFMIS], Health Resource Tracking Tool [HRTT]) at central and decentralized levels, thereby strengthening business processes, planning, implementation, and monitoring capacity at facilities; and iv) mechanisms for stakeholder coordination at all levels and for coordination between central and decentralized levels are in place and are reasonably functional.

Challenges in SCHS Support and Gaps in GOR Capacity: i) The culture and capacity for data analysis and use at decentralized levels remain weak; ii) AIRS IRS continues to face some challenges in the districts due to social and cultural stigma, intolerance for the insecticide smell, and timing of some spraying exercises; iii) inadequate interoperable capacity of existing information systems and absence of new systems are causing management and operational inefficiencies at decentralized levels; iv) there are limitations in the RHSSA ToT training model, contributing to uneven and weak transfer of know-how and skills, especially to the decentralized levels; v) ineffective coordination between government organizations in decentralization adversely affects district-level planning and decentralized health service delivery; and vi) high staff turnover at central and decentralized levels affects delivery of high-quality health services, undercuts the HS's gains from capacity building, and undermines sustainability.

In summary, SCHS activities, particularly RHSSA, have meaningfully contributed to building leadership and governance capacity in health at central and decentralized levels; however, some gaps and challenges remain.

Evaluation Question 3: Factors That Contribute to Sustainability

Most "Important" and "Changeable" Factors for a Sustained HS: The ET identified four elements as the "important" and "changeable" factors underpinning a well-capacitated and strong Rwandan HS toward the path of "sustainability":

1. Leadership and advocacy
2. Governance, and policy and planning
3. Management, coordination, and implementation (institutional effectiveness; capacity/competency; resources; focus on results; coordination, communication and collaboration; change management)
4. Learning and innovation

As depicted in the main report, the ET used a 2x2 matrix of "important" and "changeable" factors, provided by USAID/Rwanda, to frame the answers to this question.

Quadrant (QR) 1- Part1: More Important and Changeable Factors: Targeted and Well-Addressed

Sub-result 3: Critical Factors in SCM Addressed: "Governance" and "coordination" addressed well by DELIVER/SCMS and RHSSA through supporting institutional standard operating procedures and key policies, strategies, and plans; and *"Capacity Building"* and *"Innovation'* were also well addressed well by DELIVER/SCMS through strengthening MPPD and introduction of "warehouse in the box."

Sub-result 4: Critical Factors in HF Addressed: RHSSA has addressed "governance," "institutional effectiveness," and "capacity building" well by bolstering policy, planning, and strategy development and implementation in the HF area; and strengthening the Rwanda Social Security Board's overall institutional capacity for CBHI transition and management.

Sub-result 5: Critical Factors in L&G Addressed: RHSSA addressed "governance" well by supporting the development of policies, strategies, and standards for the health sector as a whole, and "coordination" by strengthening multi-stakeholder coordination and communication for effective

planning at the district level through the DHMTs. RHSSA also addressed "capacity building" and "institutional effectiveness" well through overall strengthening of leadership, management, monitoring and evaluation, planning, and quality improvement (QI) capacity of both health facilities and administrative bodies (DHMT/District Health Unit) at the provincial and district levels; and supporting the Rwanda Social Security Board for CBHI transition and management.

QR1- Part2: More Important and Changeable Factors —Targeted but Not Well-Addressed

Sub-result 3: Critical Factors in SCM: "Leadership and ownership" is an issue due to inefficient management and procurement of essential medicine, which is done in parallel, and not under the CPDS; and the LMO has limited clout and profile. "Governance" is also an issue due to ineffective enforcement of an MOH directive decommissioning the paper-based eLMIS system. Inadequate coordination (at early stage) between the supply chain IP and MPPD, and among the IPs on strategic SCM results, highlights "coordination" as an issue. "Capacity building" is also an issue because LMO significantly lacks capacity, MPPD needs further capacity, and there is inadequate refresher training for electronic Logistics Management Information System (eLMIS).

Sub-result 4: Critical Factors in HF: "Leadership and advocacy" is highlighted because domestic resources in the health sector are not increasing at the scale needed. "Governance" stands out as a key issue for not effectively creating an enabling environment for income generation. Inadequate CBHI management capacity at most decentralized health facilities, and lack of ongoing mentorship and supportive supervision for CHW Cooperatives, highlights the weakness in "institutional effectiveness." "Capacity building" becomes an important issue that was not addressed well in the area of domestic resource generation — focusing on actual capacity, concepts, and implementation.

Sub-result 5: Critical Factors in Leadership and Governance: "Leadership" and "governance" stand out here due to high staff turnover and the absence of an effective retention strategy; recent ineffectiveness among TWGs; lack of clarity on roles and responsibilities and coordination among GOR entities; and inadequate PSE engagement, all of which hinder ownership and implementation. "Capacity building" is also triggered due to ineffectiveness of the ToT model and its graduates, and weak PPP capacity.

QR1- Part3: More Important and Changeable Factors: Should Be Targeted Moving Forward

Sub-result 3: Critical Factors in SCM: "Advocacy" and "governance" would be most important to bring essential medicine procurement under CPDS, as well as to expand its membership, gradually increase procurement responsibilities of MPPD, and expedite approval of key policies and strategies in SCM. "Change Management," "resources," and "innovations" will be critical factors upon which to focus for the effective transition of MPPD to a semi-autonomous body.

Sub-result 4: Critical Factors in HF: "Advocacy" and "innovation" will be crucial to expand CBHI through spreading out premiums on a monthly basis, to foster PSE, and to increase GOR resources for health. "Governance" will need to be focused on to better align CBHI benefit packages with current and changing health needs. "Capacity building" will be important in building technical and business skills among CHW Cooperative committee members and business thinking among health facility mangers.

Sub-result 5: Critical Factors in L&G: "Advocacy" and "innovation" will have to be focused on to effectively promote Primary Healthcare Quality Standards (PHQS), address staff retention and incentive schemes, ensure better functioning of the TWGs, and foster increased PSE. "Resource" will have to be addressed well to support the cascading ToT model and for IRS to occur in all malaria-endemic districts. Raising key stakeholders' (e.g., high-level GOR officials) awareness and understanding of the USAID/Rwanda supported high-level results will require collective attention to "Focus on results."

Note: The findings and conclusions for QR2, QR3, and QR4 — factors that are "less important" and/or "less changeable" — can be found in the main body of the report.

In summary, so far, SCHS and its activities (RHSSA, AIRS, and DELIVER/SCMS) have targeted well most of the "important" and "changeable" factors that help contribute to the GOR's capacity to sustain a strong system. To successfully realize the recommendations made, SCHS and its activities will have to focus on "important" and "changeable" factors of sustainability specific to each recommendation, as laid out in the report and Annex XII.

KEY PRIORITIES AND HIGH-LEVEL RECOMMENDATIONS

Evaluation Question 1: Health Sector Strengthening

- USAID/Rwanda should continue with SCHS' current design, structure, and management practices for overall project management and implementation, including continuing to regularly communicate and coordinate with IPs to enhance the relationship between the Mission and IPs, and coordination among IPs.
- USAID/Rwanda should replicate the RHSSA activity design model to have the GOR engaged in the design phase of all future SCHS activities, keeping an eye on and in line with USAID procurement restrictions. The Mission should also make joint work planning of IPs and the GOR at both central and decentralized levels (through TWGs, DHMTs, and Joint Action Development Forum) a standard practice for all SCHS activities.
- Strengthen and ensure effective meaningful coordination and communication among the IPs to improve focus on results, collaboration, and attain "value for money" through efficiency gains in common areas of work. USAID/Rwanda should formally hold IPs accountable and ensure that sharing and collaboration take place through meaningful coordination and communication (e.g., work plans, chiefs of party review, and coordination meetings), ensuring that each IP clearly identifies and shares activities and areas of collaboration with other IPs. The Mission should also require IPs to report on actual progress in these areas through quarterly and annual reports, and monitor progress and provide necessary guidance on an ongoing basis.
- IPs should continue current practices of embedding staff in the GOR at central and provincial levels for effective implementation and capacity building for now and the medium term. At the same time, they should support high-level advocacy and explore and analyze strategies for increased GOR commitment and resources to take over these positions in the longer term, thus ensuring sustainability.
- All IPs should actively participate, support, and facilitate TWGs while ensuring improved GOR leadership and ownership of these groups.

Evaluation Question 2: HS Strengthening

Sub-purpose 3: Recommendations for the Next Supply Chain Activity

- Build on past successes and lessons learned to further strengthen institutional capacity in procurement and distribution systems
- Continue supporting and strengthening CPDS for enhanced and expanded coordination across programs, improved procurement and SCM, and to reduce essential medicine stockouts
- Strengthen the use of eLMIS to reduce stockouts and gain efficiencies
- Strengthen supply chain governance and policy frameworks

Sub-Purpose 4: Recommendations for RHSSA

- Further strengthen business skills at all levels

- Strengthen CHW Cooperatives toward financial viability and sustainability
- Strengthen CBHI to increase enrollment and through institutional strengthening
- Strengthen income generation capacity among health professionals and support increased PSE

Sub-purpose 5: Recommendations for RHSSA and AIRS

- Continue strengthening District Health Units, DHMTs, District Hospitals, Provincial Hospitals
- Support data systems and their interoperability
- Strengthen training and mentorship and support cascade training events
- Support improvement of intra-governmental coordination
- Continue current effective IRS model and activities and capacity building, and advocate for expanding IRS coverage to all malaria-endemic districts
- Develop and implement strategies to reduce staff turnover

Evaluation Question 3: Factors That Contribute to Sustainability

Recommendations for IPs and USAID/Rwanda

- Continue current efforts and build on the gains on the more "important" and "changeable" factors identified as currently "targeted and well-addressed" under QR1 in the context of the recommendations outlined in Evaluation Question 2 in relation to SCHS Sub-results 3-5. The critically "important" and "changeable" factors for which focus needs to be continued are:
    - *Sub-result 3 (SCM): governance; coordination and communication; capacity building; innovation*
    - *Sub-result 4 (HF): governance; institutional effectiveness; capacity building*
    - *Sub-result 5 (L&G): governance; coordination; capacity building; institutional effectiveness*
- Heighten current efforts and focus to better address the more "important" and "changeable" factors identified as currently "targeted, but not well-addressed" under QR1 in the context of the recommendations outlined in Evaluation Question 2 in relation SCHS Sub-Results 3-5. The critically "important" and "changeable" factors for which current focus needs to be better addressed and improved are:
    - *Sub-result 3 (SCM): leadership and ownership; governance; coordination; capacity building*
    - *Sub-result 4 (HF): leadership and advocacy; governance; institutional effectiveness; capacity building*
    - *Sub-result 5 (L&G): leadership; governance; coordination; capacity building*
- Effectively plan for and employ new efforts to better address the more "important" and "changeable" factors identified as currently "not targeted, but should be targeted well moving forward" under in the context of the recommendations outlined in Evaluation Question 2 in relation to SCHS Sub-results 3-5. The critically "important" and "changeable" factors that need to be newly focused on and addressed are:
    - *Sub-result 3 (SCM): advocacy; governance; change management; resource; innovation*
    - *Sub-result 4 (HF): advocacy; governance; capacity building; innovation*
    - *Sub-result 5 (L&G): advocacy; resource; change management; focus on results; innovation*
- In light of the recommendations above, the USAID/Rwanda SCHS management team should provide effective guidance and ensure that the relevant activities focus on and effectively address the common critical factors that are more "important" and "changeable" under QR1 (within the context and areas identified), underpinning the sustainability of the HS.

I. INTRODUCTION

Known as "the land of a thousand hills," Rwanda is a small, vibrant country characterized by the rapid adoption of dynamic vision, new approaches, strategies, and programs. Landlocked in Central/Eastern Africa, its population density (471 people per sq. km[1]) is among the highest on the continent. It is also one of the world's poorest countries, but much has changed since the 1994 genocide that killed more than 800,000 people. Rwanda has made remarkable progress in developing national and local government institutions, maintaining security, promoting reconciliation, and strengthening its justice system. The number of people living below the poverty line has dropped from 56.7 percent in 2005/06 to 39.1 percent in 2013/14,[2] and GDP per capita soared to $698 in 2015, a 25 percent increase since 2010.[3]

Globally, Rwanda is recognized for its bold national leadership and executive-level commitment to health. The country has made tremendous strides in improving the health and well-being of its citizens over the past decade. It has attained health Millennium Development Goals (MDGs) ahead of schedule, especially in child health (MDG4), maternal health (MDG5), and disease control (MDG6).

Rwandan Achievements in Five Years (2010-2014/15)

- Under-5 mortality rate reduced from 72 to 50 per 1,000 live births
- Infant mortality declined from 86 to 32 deaths per 1,000 live births
- Total fertility rate declined from 4.6 to 4.2
- Birth in facilities increased from 61 percent to 91 percent
- Maternal mortality reduced from 476 to 210 per 100,000 live births
- Prevalence of stunting decreased from 44 percent to 38 percent

Source: Rwanda Demographic and Health Survey 2014-15

These gains, among numerous others, reflect improved delivery of public health services, Rwandans' increased adoption of effective health practices, high levels of external financing, and targeted strategic investment in key areas, including health financing — toward universal health coverage. Furthermore, enrollment in the Community Based Health Insurance (CBHI) scheme increased to 81.3 percent in 2016 (Rwanda Social Security Board [RSSB]); maternal, community, and child health care, prevention of mother to child transmission services, have reached 94 percent; modern contraceptive use among married couples has increased to 47.5 percent[4]; the number of training courses at decentralized levels have increased, focused on topics such as antenatal care, essential newborn care, basic obstetric, and newborn care; 96 percent of children under 5 are treated within 24 hours of malaria symptoms[5]; and nine additional "Isange" One Stop Centers for victims of sex- and gender-based violence opened in 2016 at the district level, bringing the total to 31.[6]

Despite the impressive progress, challenges persist. One child in 13 dies by age 5,[7] and 44 percent of children suffer from chronic malnutrition.[8] The fertility rate remains high at 4.2 children per woman. The entire population is at risk for malaria, the fourth leading cause of mortality. Rwanda also faces a complex HIV/AIDS epidemic, with a prevalence of 3 percent among the general population but as high as 46 percent among the most at-risk populations. Women and girls are also disproportionately affected.[9]

[1] World Development Indicators Database, the World Bank Group.
[2] www.statistics.gov.rw/publication/rwanda-poverty-profile-report-results-eicv-4.
[3] World Development Indicators Database, the World Bank Group.
[4] Rwanda Demographic and Health Survey 2014-15 Key Indicators. http://dhsprogram.com/pubs/pdf/PR65/PR65.pdf.
[5] Ministry of Health. (2016). Health Sector Annual Report (July 2015-June 2016).
[6] Ibid.
[7] Health Sector Strategic Plan (HSSP) III.
[8] World Development Indicators Database, the World Bank Group.
[9] World Development Indicators Database, the World Bank Group.

The critical challenge now is to sustain the gains made and build beyond to achieve the key objectives outlined in the government of Rwanda's (GOR) third Health Sector Strategic Plan (HSSP III), which include, but are not limited to:

- Reducing under-5 mortality to 42 per 1,000 live births, exceeding the MDG for child health (50 per 1,000 live births)
- Reducing maternal mortality to 220 per 100,000 live births, exceeding the MDG for maternal health (227.5 per 100,000 live births), which Rwanda has already accomplished
- Sustain HIV prevalence at 3 percent or lower
- Reducing total fertility rate to 3.4

Key Financing Issues for Sustainability

- HSSP III underfunded: Gap of *$372-$697 million* (mid & pessimistic — the reality)
- Donor funding comprises *more than 61 percent of annual total health expenditure*
- Declining donor financing trend
- Declining Net official development aid per capita: $120 (2011) to $91 (2014) → *–24%*

Based on several financing scenarios, HSSP III is underfunded, and this could be exacerbated if external financing continues to decline. The plan's total cost is $3.7 billion over six years, an average of approximately $600 million per year.[10] A joint USAID-GOR gap analysis in late 2014 showed a funding gap of between $372 and $697 million under pessimistic and mid-level scenarios. An optimistic scenario showed virtually no gap, but after nearly four years of implementation, this scenario appears unlikely. Donor funding to the health sector makes up 61 percent, and the largest donors, the U.S. government and Global Fund, are experiencing a declining trend.[11] The GOR will need to assume a greater share of the recurrent costs through "increasing domestic financing/resources" and "efficiency gains" as these funding streams decline.

As such, to sustain the impressive gain and go further, the GOR, its development partners, and key stakeholders recognize the urgent need to have a well-capacitated and sustained health system. Along with other initiatives, through the five-years (October 2014 – September 2019), $294 million Strengthening Capacity of the Health Sector to Deliver Quality Health Services (SCHS) Project, USAID/Rwanda is strengthening the Rwandan health system and promoting host country ownership by increasing capacity to manage a variety of systems and operations in delivering affordable, responsive, and high-quality health services. The project is implemented in close collaboration with the Ministry of Health (MOH) and directly supports the HSSP III and the GOR's overall Economic Development and Poverty Reduction Strategy (EDPRS 2). In collaboration with the MOH) and other GOR entities at central and decentralized levels, the SCHS aims to maximize the financial envelope of Rwanda's domestic health resources and ensure the sustainability of the health system and the sector as a whole in the medium and longer terms.

As SCHS crosses the mid-point of its lifecycle, USAID/Rwanda, through GH Pro, commissioned a team of independent consultants to conduct the SCHS Midterm Performance Evaluation, an inward-looking examination. (Such evaluations are standard practice within USAID.) This evaluation does not necessarily reflect any impact in actual programming, but rather, is part of a constant effort to improve the Agency's support to the GOR in a more effective and efficient manner. As such, the USAID/Rwanda Health Office (HO) and SCHS Project Team are the primary audience for this document; both will use the results to understand performance — "what works well" and "what does not work well," adjust course as necessary, and inform future programming based on findings. Implementing partners (IPs) and other health stakeholders may also be interested in the results in order to maximize program efficiency toward achieving GOR health results.

[10] Health Sector Strategic Plan III.
[11] Rwanda Health Resource Tracker.

II. EVALUATION PURPOSE AND EVALUATION QUESTIONS

EVALUATION PURPOSE

The purpose of this midterm performance evaluation is to better understand the effectiveness of the Strengthening Capacity of the Health Sector to Deliver Quality Health Services Project activities toward the expected results so far, and provide specific learning and evidence for design, planning, implementation, and management decisions by the SCHS Project Team going forward.

EVALUATION QUESTIONS

1. To what extent has the design of the SCHS Project facilitated or hindered USAID's support to strengthen the capacity of the health sector to deliver high-quality services? In this context, design refers to the relationships between the elements of the SCHS Project matrix, including the interactions and dependencies of stakeholders, as well as activities implemented as they relate to the results framework. Consider elements such as structure, coordination among implementing partners, and engagement of stakeholders.
2. To what extent has the SCHS Project strengthened the capacity of Rwandan health system in relation to Sub-purposes 3, 4, and 5? What is the level of capacity of the GOR in these areas?
3. Does SCHS target the most important and changeable factors that contribute to the GOR's capacity to sustain a strong system that will provide high-quality services? Are there other more important and changeable areas?

Note: *The performance evaluation should answer questions 2 and 3 in relation to Sub-purposes 3-5 of the SCHS results framework (Medical Products & Pharmaceuticals, Health Financing, Leadership & Governance)*

CUSTOMIZED PROBING QUESTION SETS FOR DIFFERENT CATEGORIES OF STAKEHOLDERS

Please see Annex II for the customized question sets that the team had prepared for the different categories of stakeholders (defined in Section IV). These questions were intended to seek important information needed to answer the three evaluation questions.

III. PROJECT BACKGROUND AND CONTEXT

The current Strengthening Capacity of the Health Sector to Deliver Quality Health Services Project began in 2013 as the Decentralized Health Systems Strengthening Project. According to USAID/Rwanda, it was the first supply-side health project it had undertaken in line with USAID's project definition guidance at the time. The project was renamed in late 2014. SCHS is now a five-year (October 2014 – September 2019), $294 million project with an overall goal to have "[h]ealth and nutritional status of Rwandans improved" and a purpose "[t]o strengthen the capacity of the health sector to deliver affordable, responsive and high-quality services."

STRATEGIC ALIGNMENT TO RWANDAN GOVERNMENT AND USAID STRATEGIES

USAID/Rwanda's Country Development Cooperation Strategy (CDCS) 2015-2019 Goal is closely aligned with key GOR priorities for the next five years and mirrors the overarching goal of the Economic Development and Poverty Reduction Strategy (EDPRS 2). SCHS contributes to the achievement of the Development Objective (DO) 3, "Health and nutritional status of Rwandans improved" and CDCS goals, and corresponds to its Intermediate Result (IR) 3.1, "Strengthened capacity of health sector to deliver high-quality services." SCHS is complemented by another USAID health project, CHAIN, which is focused on the demand side (corresponding to the CDCS IR 3.2, "Strengthened capacity of households and communities to improve their own health"). Together, these projects contribute to the achievement of DO 3.

The SCHS Project also aligns with USAID Forward by promoting sustainable development through high-impact partnerships, identifying and scaling up innovative local solutions, and strengthening local capacity. SCHS aims to support the institutions and private sector partners that serve as engines of growth and progress in Rwanda. It aims to strengthen Rwanda's health system in the medium and long terms to increase the efficiency of the health sector through engaging the GOR and other development partners in the sector in health financing dialogues, and in line with the government's Vision 2020, to gradually decrease the country's dependence on foreign aid.

In order to continue strengthening the management capacity of the MOH and to help the GOR increase its level of financing of the health system, USAID's investments in health systems strengthening (HSS), particularly through SCHS, directly contribute to key goals of the GOR's third Health Sector Strategic Plan.

TARGETED GOAL AND RESULTS

The overall purpose of the SCHS Project is to strengthen the capacity of the health sector to deliver affordable, responsive, and high-quality services, which contributes to the CDCS goal "to improve the health and nutritional status of Rwandans." SCHS activities support five sub-purposes that together contribute to the achievement of the project purpose and goal:

- Sub-purpose 1: Delivery of health services improved
- Sub-purpose 2: Accurate and timely data use for decision-making institutionalized
- Sub-purpose 3: Essential medical products available and accessible at service delivery points
- Sub-purpose 4: Increased domestic resources for the health sector used equitably and efficiently
- Sub-purpose 5: Leadership and governance of health system at central and local levels strengthened

By the end of SCHS, some of the key anticipated results are:

- District health and local government authorities will provide administrative support and oversight to decentralized health facilities according to the health sector decentralization policy,

resulting in an increase of births taking place in health facilities, from 85 percent to 90 percent; increased percentage of pregnant women who attend at least four antenatal care visits, from 35.4 percent to 50 percent; increased family planning protection in U.S. government-supported programs, from 803,268 to 819,332; maintain the percentage of HIV-positive pregnant women who received antiretroviral to reduce mother-to-child transmission during pregnancy and delivery at 95 percent.

- Management and productivity of health care workers at the facility level and sustained delivery of community-based health interventions by cooperatives of community health workers (CHWs) will be improved.
- The framework for private sector engagement in health will have improved as the GOR continues to graduate from external donor funding in its transition to a lower-middle-income country, to enable its reduced donor dependency in delivering essential health services.
- Out-of-pocket expenditures on health will be reduced and financial access to affordable and high-quality health care services will be increased (i.e., a reduced ratio of household out-of-pocket expenditures on health to total expenditure on health from 15 percent to 11 percent).
- Gender integration into SCHS activities will result in enhanced gender sensitivity, knowledge, and skills for planning in the health sector at the central and decentralized levels, improving the delivery and quality of health services for all by health professionals.

PROJECT ACTIVITIES

SCHS was designed taking into account the existing health portfolio of USAID/Rwanda, and new activities under the same DO are planned and designed under the aegis of the project. SCHS mainly focuses on the supply side (i.e., the systems that deliver prevention, care and treatment) and includes several past and present key activities or implementing mechanisms (IMs), as shown in Table 1. The activities in the shaded rows are evaluated in this report. Please see Annex III for the relationship between SCHS sub-purposes, outputs, and activities/IMs.

Table 1. SCHS Project Activities/IMs (Supporting CDCS DO3, IR3.1)

Name	USAID Office	Implementing Partner	SCHS TEC (millions)	Activity Period	Active Geographic Regions
IRS2 TO 4	Washington	Abt Associates, Inc.	$29.9	2009-2014	2-3 districts per spray round
Integrated Health Systems Strengthening Project (IHSSP)	Rwanda	Management Sciences for Health	$24.9	2009-2014	National
Family Health Project (FHP)	Washington	Chemonics	$18.9	2012-2015	20 districts
DELIVER II TO 4 Family Planning	Washington	PFSCM	$1.9	2011-2017 *(in-country activities completed in 2016)*	National
DELIVER II TO 7 Malaria	Washington	PFSCM	$14.7	2011-2017 *(in-country activities completed in 2016)*	National
Supply Chain Management System	Washington	PFSCM	$45.5 (Rwanda)	2009-2017 *(in-country activities completed in 2016)*	National

Name	USAID Office	Implementing Partner	SCHS TEC (millions)	Activity Period	Active Geographic Regions
Central Contraceptive Procurement	Washington	PFSCM	$9.5	Ongoing	National
Africa Indoor Residual Spraying (AIRS)	Washington	Abt Associates, Inc.	$25.3	2014-2017 *(extended to 2018)*	1-3 districts per spray round
Rwanda Health Systems Strengthening Activity (RHSSA)	Rwanda	Management Sciences for Health	$24.9	2014-2019	National
Maternal and Child Survival Program (MCSP)	Washington	Jhpiego	$43	2015-2018	20 districts
Global Health Supply Chain — Procurement & Supply Mgt.	Washington	Chemonics	TBD	2015-2020	National

Since its inception, SCHS has simultaneously implemented four to six activities, primarily focused on the following;

- Commodity procurement and supply chain strengthening for family planning, HIV, and malaria (approximately 51 percent of the budget)
- Indoor residual spraying to combat malaria
- Maternal and child health and family planning service delivery
- Health sector leadership and governance, health finance, and health information systems

PROJECT ACTIVITIES/IMS COVERED UNDER THE MIDTERM EVALUATION

Per the scope of work, this evaluation considered three IMs: the RHSSA, the DELIVER/Supply Chain Management System project, and the Africa Indoor Residual Spraying project. See Annex IV for a brief description of each activity and their associated goals, objectives, and results. Please note that, since the beginning of the project, there have been no substantive modifications made to the activities.

IV. EVALUATION METHODS AND LIMITATIONS

THE TEAM

GH Pro enlisted an Evaluation Team (ET) of seven independent consultants to carry out this evaluation, including three international evaluators (Team Leader and health systems strengthening capacity and organizational development expert Tariqul Khan; evaluation expert Katya Burns; and public health expert David Kiongo) and four national evaluators (Lillian Mutesi, Patrick Nsenga, Sylvestre Musengimana, and Hortense Mudenge. Ms. Mudenge joined the ET for last two weeks of the in-country phase). The team's in-country work, conducted from January 17 to February 25, was facilitated by the USAID/Rwanda SCHS Project Team, IPs; and the GOR points of contact, Dennis Nkunda from the MOH and Edouard Niyonshut from the Rwanda Biomedical Center or RBC).

THE OVERALL PROCESS

As discussed in the sections below and illustrated in the figure in Annex V, the evaluation took a phased approach, beginning with the preparatory background research; review and identification of key institutional structures, stakeholders, and informants; and in-briefs with USAID/Rwanda, IPs, and the GOR to solicit feedback on the proposed work plan and evaluation protocol. The second phase was followed by data collection and analysis using the tools and instruments discussed below. Next, the ET prepared matrices of key findings and formulated conclusions and recommendations — as well as illustrative activities, priority levels, and associated responsible and/or collaborating parties — to address the key findings/conclusions, including opportunities and/or underlying key barriers.

THE APPROACH

The ET used a mixed evaluation methodology, combining review and analysis of quantitative data and application of qualitative techniques to collect data from key stakeholders. The approach was based on two key elements:

1. Focus on results, which included assessing the effectiveness of the SCHS Project and its activities
2. Broad consultations with different categories of key informants (KIs), outlined below

Evaluation Matrix: Please see Annex VI for the evaluation matrix outlining evaluation questions; data sources; sampling, data collection, and analysis methods; and limitations.

Data Collection Methods and Sources: Following the USAID Evaluation Policy and Performance Evaluation best practices, the ET used three approaches in analyzing and selecting stakeholders to be interviewed: a purposive approach based on recommendations from USAID/Rwanda and IPs, as well as sources identified in documents reviewed; a systematic approach based on whom the team considered to be relevant; and a random selection, particularly for group interviews (GIs) and focus group discussions (FGDs).

Document and Data Review: Prior to arriving in Rwanda, the ET conducted a detailed desk review of documents indicated in the SOW data from sources provided by the Mission (e.g., project documents and GOR publications), and international reports. This review was critical in helping to shape the evaluation's approach; more specifically, it provided the ET with the necessary background information to facilitate conducting stakeholders' analysis; drafting all qualitative guides; gaining a complete understanding of the SCHS Project and the health sector environment; and finalizing the evaluation work

plan, schedules, and protocol. The review process also included many other relevant formal and informal documents provided by stakeholders throughout the field work period. Annex VII contains a complete bibliography of all documents reviewed/consulted.

Secondary Data Analysis: The secondary data analysis included information from the Rwanda Demographic and Health Survey, the most recent data collected by IPs, the GOR, and other formal and informal sources. This enabled the ET to determine the trends and progress achieved.

Key Informant Interviews (KII): The KIs selected had the richest and most critical ideas and information relevant to the evaluation. The ET conducted a fairly large number of in-depth, face-to-face KIIs with people from key stakeholder groups who provided insights into the effectiveness of the SCHS Project's technical approaches, contributions, and gaps, with related interventions. Semi-structured interviews with a wide range of stakeholders in Kigali and the districts and follow-up sessions were also conducted with a few purposively selected KIs from the GIs and FGDs. To effectively conduct the interviews, the team developed a generic KII guide.

GIs: The ET also used GIs for data collection. These provided an opportunity for the team to meet with a more people from a range of SCHS stakeholders at central and decentralized levels, and to gain an in-depth understanding of their experiences with activity interventions and SCHS' current impact/status and future potential. To effectively conduct the GIs, the team developed a unified generic GI/FGD guide.

Categories of KIs: Using its own stakeholders' analysis and guidance from USAID/Rwanda, the GOR, and IPs, the ET conducted interviews with the following:

- USAID/Rwanda SCHS Project staff
- Other USAID/Rwanda HO staff
- USAID/Rwanda Program Office staff
- MOH, central level
- MOH, decentralized levels
- Rwanda Biomedical Center
- Other GOR central-level entities and line ministries
- Professional and umbrella bodies
- Development partners
- USAID/Rwanda IPs
- Academia

Site Selection and Visits: The ET selected 18 sites covering 21 entities, including Provincial Hospitals, District Hospitals, District Health Management Teams (DHMTs), Health Centers (HCs), Health Posts, and community health worker cooperatives, as well as one MCSP site and a District Health Management Team from the AIRS project. There were four selection criteria: implementation of key SCHS activities interventions; representation from high-, medium-, and low-performing districts/facilities/community health worker cooperatives based on assessments by IPs and the GOR; geographical coverage (all provinces and the City of Kigali); and logistics.

The ET was split into two sub-teams, Team 1 and Team 2, which conducted the site visits simultaneously. (See Annex VIII for the list and schedule of the visits.) The sites were selected during

close consultations with USAID/Rwanda, IPs, and the MOH. The MOH issued official letters of approval and notifications to the relevant local authorities, and the IPs (the Rwanda Health Systems Strengthening Activity and the AIRS Project) facilitated the overall logistics and organization of relevant people and meetings. It is to be noted that no IP staff participated in the discussions. The ET developed a Qualitative Capacity Assessment and Facility Observation Checklist (see Annex XI) for data collection and assessment from the sites and entities.

In total, the ET conducted 59 KIIs and GIs, meeting more than 250 people (see Annex X) *and visiting 18 field sites covering 21 entities; six in the City of Kigali, two in the Northern Province, four in the Southern Province, seven in the Eastern Province, and two in the Western Province.*

The mixed methodology approach involved the systematic integration of different types of data, using different methods that allowed the ET to compare data from different sources — a process known as "triangulation." This approach helped the ET glean objective insights into the performance of SCHS activities and their interventions (e.g., assess capacity impacts at the GOR level and capture the contribution of USAID's investments); their analysis of complementary quantitative and qualitative data led to findings, conclusions, and the formulation of recommendations based on facts and evidence.

DATA ANALYSIS METHODS

The ET used quantitative approaches and a range of qualitative analytical approaches, including fact-based content analysis, grounded theory approaches, trend analysis of reported results, and comparative analysis across IPs with similar or complementary objectives. The results were then triangulated to be compared and validated.

MECHANISMS FOR DATA VALIDATION

The ET used a variety of methods to ensure the validity of the collected data. In addition to systematic triangulation of sources and data collection methods and tools, the validation of data was also sought through regular exchanges with the USAID/Rwanda SCHS Project staff, the GOR, and IPs.

TOOLS AND INSTRUMENTS

The ET developed several data collection instruments and analysis tools (see Annex IX), including key generic KII and GI/FGD guides, the Qualitative Capacity Assessment and Facility Observation Checklist, and other data collection and analysis matrices focused on the evaluation questions. These tools helped the team analyze and identify key issues/gaps/challenges, their underlying barriers, and assets/opportunities; the key findings and conclusions from the evaluation as a whole; and subsequent formulation of prioritized, targeted, and actionable key recommendations.

ETHICAL CONSIDERATIONS AND CONFIDENTIALITY

As stated in the KII and GI guides, the ET obtained verbal consent from all KII and GI participants, according to USAID Evaluation Policy guidelines. Interviewees could opt out of individual questions or the whole interview, and were informed that the information they provided would remain confidential.

LIMITATIONS

The ET noted the following key limitations:

- Analysis was limited to SCHS Project activity areas and did not reflect the entire health sector or cover the full spectrum of service delivery. The analysis may therefore not definitively be able to establish attribution in certain areas.

- For some areas, baseline data were not available, and this limited the ET's ability to establish trends or change.
- As the SCHS Project is focused on the supply side and does not directly involve traditional patient beneficiaries, the evaluators in many cases had to rely mostly on the views and opinions of IPs, the GOR, and health service providers, as well as information and reports.
- There was limited time for data collection — just three weeks — to meet and engage with many stakeholders and different site locations.

V. KEY FINDINGS AND CONCLUSIONS

This section presents the main findings and conclusions of the Evaluation Team, organized by evaluation question.

EVALUATION QUESTION 1

To what extent has the design of the SCHS Project facilitated or hindered USAID's support to strengthen the capacity of the health sector to deliver high-quality services?

Introduction

The success of the SCHS Project to help strengthen the capacity of the Rwandan health sector to deliver high-quality services has and continues to be in the areas of design and effective implementation. However, the project design is the fundamental element and primary foundation that drives implementation, monitoring, and accountability to help strengthen the health sector's capacity to deliver high-quality services and achieve sustainability. Below are the ET's findings and conclusions from its examination of the SCHS Project interaction and dependences on stakeholders' activities in relation to the results framework. The findings and conclusions on the project's structure, coordination among IPs, and engagement of stakeholders in the health sector are also included.

Strengths and Key Achievements

SCHS Design, Structure, Internal Restructuring, and "Country Ownership"

SCHS design and results framework are strategically and closely aligned with broader USAID and Government of Rwanda strategies, and international standards and best practices.

The SCHS structure and design is tailored toward effective implementation of the health component of USAID/Rwanda's 2015-2019 CDCS. The CDCS goal is closely aligned with key GOR priorities for the next five years and mirrors the overarching goal of the EDPRS 2, "Accelerating progress to middle income status and better quality of life for all Rwandans through sustained growth of 11.5% and accelerated reduction of poverty to less than 30% of the population." The SCHS Project goal contributes to the achievement of the CDCS health-related Development Objective 3, "Health and nutritional status of Rwandans improved," and corresponds to its IR 3.1, "Strengthened capacity of health sector to deliver high-quality services." SCHS addresses the supply side of health services at both the central level (Sub-IR 3.1.1, "Central level health systems strengthened") and decentralized level (Sub-IR 3.1.2, "Decentralized health systems improved").

SCHS directly contributes to the goals of the HSSP III:

- Achieve universal and sustainable availability of quality drugs and consumables (SCHS resources and technical expertise are directed to MOH) and the Medical Production and Procurement Division [MPPD]/ RBC)
- Sustain at the current level and improve the access to high-quality health services. (This activity, among others, includes support to the decentralization of health management.)

Strengthen the institutional capacity of targeted health sector institutions by building strong systems for health care management, administrative leadership, and sound financial management (SCHS support MOH, RBC, MPPD, Ministry of Local Government [MINALOC], DHMTs/District Health Units [DHUs]).

Furthermore, all SCHS activity results frameworks are closely aligned with and directly contribute to achieving the overall SCHS results (e.g., the overall RHSSA goal, "Strengthened and expanded performance of the Rwandan health system at national, decentralized and community levels") and work

directly toward the achievement of the overall purpose of the SCHS PAD, "Strengthened capacity of the health sector to deliver affordable, responsive, high quality services", which directly mirrors IR3.1 in Rwanda's CDCS. The deputy director of the Mission's Health Office said, "This helps to avoid having personality-based programming instead of evidence-based programming."

The SCHS Project design and components address five of the World Health Organization's six health system strengthening components as sub-purposes, making the project technically viable to realize priority Rwandan health goals in line with global standards and guidelines.

Restructuring of the USAID/Rwanda SCHS team, driven by the project design, seems to have an early positive impact on internal coordination and overall focus on strategic results.

Based on the views of most USAID/Rwanda informants, the ET found that the project design and recent SCHS team restructuring gives a clearer overall sense of what USAID is supposed to help achieve. The design and restructuring ensure all project activities (i.e., RHSSA, AIRS, DELIVER/SCMS, and MCSP) have a collective, results-based approach and evidence-based programming.

The internal improved coordination, close monitoring, and weekly meetings have so far enabled the SCHS team and its management to have a continuous "bird's-eye" view of the collective progress of project activities. *Importantly, as the restructuring went into effect only in January 2017, the ET notes that it is too early to attribute any actual enhancement in the overall SCHS management capacity and effectiveness to it.*

SCHS has helped improve meaningful country ownership and build synergies.

The GOR's meaningful engagement in the actual design of project activities and joint work planning between IPs and associated government entities (e.g., MOH, RBC, MINALOC) capitalized on synergies and helped strengthen country ownership. According to multiple MOH leadership and key departmental staff, the ministry's close consultation and engagement during the RHSSA design phase has further strengthened GOR country ownership and led to more effective implementation of activities at all levels. One senior MOH official noted the USAID/Rwanda-supported Rwanda Health Private Sector Engagement (PSE) Assessment as a model of how MOH and USAID teams can effectively work together to strengthen country ownership. RHSSA worked closely with the MOH and the Health Financing (HF) Technical Working Group (TWG) to prepare the Joint Action Plan, which reflects all GOR priorities and aligns with the Health Financing Strategic Plan (HSFP). MOH, DHs, and AIRS also work together on IRS project planning and identifying stakeholders. For example, MOH identifies sites, and DHs and AIRS recruit the CHWs.

SCHS Planning, Management, and Coordination

USAID and IPs have effectively coordinated for improved focus on results, effective planning and monitoring, and achieving program efficiency.

Multiple findings revealed that there is effective and adequate coordination between USAID and its IPs. RHSSA, Management Sciences for Health (MSH), and the USAID team hold in-depth coordination and technical meetings every two or three weeks, and also engage through work planning processes and quarterly review meetings. The SCHS supply chain IP communicates and coordinates with the USAID/Rwanda management team on a weekly basis and with USAID/Washington every month. Also, all current (MSH, Abt) and previous (John Snow Inc.) IPs reiterated that quarterly meetings, updates, and reports occur between IPs and USAID.

There are pockets of effective coordination among the IPs at central and decentralized levels that have yielded important complementarity and efficiency gains in planning and implementation (including service delivery).

In this regard, IPs hold COP meetings every two months. Key examples of effective coordination that yielded results include biannual meetings of all relevant IPs and partners working on HIV; Abt Associates

and MSH coordinating to train and use CHWs on AIRS and RHSSA activities at lower levels, relying on MSH-supported Health Management Information System (HMIS) data; and MSH collaborating with eLMIS indicators.

The ET also found that there has been effective collaboration and coordination between MCSP and RHSSA, strengthening the bridge between HS and actual service delivery. For example, cooperation in developing components of standard operating procedures (SOPs), quality improvement (QI) guidelines, and Primary Healthcare Quality Standards (PHQS) led to efficiency gains, improved service delivery, and avoided duplication. RHSSA supports QI/accreditation/standards in all hospitals, including 12 MCSP hospitals, as it relates to maternal and child health (MCH); the overall principle is that RHSSA does higher level standards and MCSP gives technical assistance (TA) at the lower level. These contributed to the improvement in neonatal and post-neonatal mortality rates — 20 and 13 deaths per 1,000 live births, respectively (Rwanda Demographic and Health Survey 2015).

There has been effective coordination between USAID/Rwanda, GOR, IPs, and other development partners (DPs) in planning; strategy and policy formulation; and project development, implementation, and monitoring at both central and decentralized levels.

Through a large number of informants from key stakeholders groups (e.g., GOR, IPs, and DPs), the ET has confirmed generally effective coordination between GOR and other stakeholders, including USAID/Rwanda, IPs, and other DPs, in planning and implementation through the TWGs. Key examples include the development of the Joint Action Plan and the HSFSP and associated costing through the HF TWG, and implementation of RapidSMS application and the development of the Child Survival Development Project, both through the MCH TWG.

For the AIRS project, USAID/Rwanda and the United Nations International Children's Emergency Fund have worked with the GOR to develop health strategies and policies, and to map malaria-endemic districts They have also collaborated in the review of IRS activities. Additionally, RHSSA, in collaboration with DELIVER/SCMS, supported the development of the MPPD Strategic Plan.

Furthermore, SCHS IPs and DPs have coordinated with GOR entities at central and decentralized levels to plan and implement government strategies. RHSSA worked closely with the GOR, the private sector, and other DPs to support the revision and implementation of a more efficient tariff list for private sector service providers helping to increase their engagement in the Rwandan health sector. RHSSA also worked with the RSSB, MOH, and districts to effectively facilitate and support the transition of Community-Based Health Insurance schemes (CBHI, or *mutuelles*) management to RSSB by developing plans and supporting implementation of the transition with tools and training at the central and district levels, as well as in the nationwide CHW Cooperatives assessment.

Abt Associates (AIRS) is currently working with RBC to review the Malaria Strategic Plan 2018-2022, while John Snow Inc. (DELIVER/SCMS) worked with the MOH and others to develop the National Supply Chain Strategic Plan 2013-2018.

MCSP and RHSSA representatives regularly met and participated in the DHMT meetings (e.g., RHSSA and MCSP jointly facilitated the Integrated Planning Workshop of Huye District AAP 2016-2017) and central-level TWGs such as the Research and QI/accreditation TWG. Regular and effective engagement of RHSSA and MCSP representatives at district-level planning has fostered stronger collaboration and supported the effective preparation of District Annual Action Plans (DAAPs) in common districts.

RHSSA collaborates effectively with the GOR and academia at both central and decentralized levels. For example, RHSSA drafted terms of reference for TA support in health system strengthening activities with the MOH and the University of Rwanda School of Public Health. It was also reported that AIRS IP

worked well with the MOH and districts on IRS project planning and implementation: the MOH provided funds and identified sites and AIRS worked with DHs to recruit CHWs.

RHSSA has one person embedded in MINALOC and one provincial technical advisor (PTA) in each province and the City of Kigali to help improve coordination between the MOH and MINALOC, directly affecting implementation and capacity building, especially at the decentralized level. Top MOH officials hailed the inclusion and effectiveness of the PTAs.

It was also widely reported that IP programs that work at decentralized levels have improved coordination between local health providers/workers at the district and lower levels, and other IPs in program design, implementation, and capacity building. This has also supported local awareness, acceptance, and results. Specific findings include that, through RHSSA support, the Ruhango Provincial Hospital (PH) team started encouraging and working with the HCs to set up accreditation committees. The Ruhango PH team has also developed a capacity building plan for the staff that was shared with the Ministry of Public Services and Labor and Ruhango District as an input to the next district capacity building plan for health staff. Also, RHSSA developed training-of-trainers (ToT) programs at the District Hospital (DH) level in QI, which in some cases cascaded down and horizontally to other facilities (e.g., Kinazi and KIRWA HCs and Ruhango PH, which the ET visited).

Further coordination and collaboration was observed in the Belgian Technical Cooperation (BTC) project Ubuzima Burambye, which works at central and decentralized levels and has six result areas that are similar to RHSSA's. According to multiple KIs, RHSSA and BTC work closely, both bilaterally and through multiple TWGs, to avoid duplication and attain synergy in activity design and implementation.

Gaps and Challenges

Planning, Management, and Coordination: USAID/Rwanda and IPs, and Inter-IPs

SCHS IPs are not familiar with the high-level project design and associated management changes, possibly hindering a sense of inclusion.

The SCHS team did not broadly communicate the project concept and associated management changes to the relatively small number of IPs, as these have distinct technical areas and responsibilities with very limited overlap. As such, explaining these to the IPs may not have resulted in any greater productivity than simply asking them to coordinate/collaborate on areas where they do similar work (e.g., eLMIS, HMIS interoperability, and QI). The ET also noted that the activity-specific results frameworks are aligned very well with the overall SCHS results framework, so this situation did not have any adverse impact on the overall alignment and/or results. However, the ET noted that this may have hindered a sense of inclusion among the IPs.

There is inadequate coordination and collaboration among SCHS IPs in specific program activity planning and implementation, hindering overall efficiency (i.e., "value for money").

There has been inadequate coordination and collaboration among IPs in specific program activities, including data collection, analysis, monitoring and evaluation (M&E), Basic Laboratory Information System, and the involvement of CHWs in common districts and communities.

MCSP and RHSSA have areas of common monitoring and data collection needs; however, there is inadequate coordination between these two IPs regarding coverage of indicators, as well as development, integration, and use of associated tools. Both IPs support and require monitoring & evaluation (M&E) data from the same districts and facilities, programs, and services, but they work in parallel. MCSP uses its own QI matrix to set and analyze data and monitor indicators, while MSH uses District Health Information System (DHIS) dashboards, which is also critical to MCSP's work. These missed opportunities have led to duplications and inefficiencies in the M&E areas. One KI stated, "MSH

and MCSP should be having synergies on the ground, but currently they [do] not. It would be better if they were talking to each other more."

There has also been inadequate communication, planning, and coordination among MCSP, AIRS, and RHSSA for CHWs roles and responsibilities in implementing relevant program activities in common geographic areas. For example, in areas where MCSP trains and uses CHWs for RapidSMS and MCH services, including testing and treatment of child malaria, RHSSA and AIRS also use them for their activities. However, the three IPs do not effectively communicate, plan, and coordinate for the effective use of the CHWs to maximize values and program efficiency.

In general, the evaluation found that there has been limited and mostly only ad-hoc coordination and collaboration between the SCHS IPs on a large scale in specific areas. This is due to weak and ineffective communication and information sharing, which often results in missed opportunities, overlaps, and lack of efficiency gain, all of which adversely affect "results" and "value for money."

Planning, Management, and Coordination: USAID/Rwanda, IPs, GOR, and DPs

Inadequate advance notification of changes in U.S. government policy and resource allocation may create occasional planning and operational inefficiencies on the part of GOR entities.

This is associated with facts such as that the Rwandan fiscal year (July to June) does not align with the U.S. government's fiscal year (October to September), and that the U.S. government generally does not provide advance notification about changes in investment and policies, particularly changes in resource allocation (e.g., President's Emergency Plan for AIDS Relief commitment changes under Country Operational Plan 2017). This sometimes creates inefficiencies for planning and coordination on the part of the GOR and IPs (e.g., for purchasing commodities) at the central and decentralized levels. Similarly, DHs and DHMTs the ET visited reported that they were not informed in advance about their annual resource allocation from IPs.

Importantly, however, the ET noted that, despite having different planning cycles, IPs have ample information based on USAID guidance and their own work plans to estimate their projected contribution, especially at the decentralized level.

In recent months, some of the TWGs have not been effectively functional due to weak leadership, inadequate participation, and limited coordination among members.

Despite historically having strong leadership and ownership traits, the MOH in recent months has not been effectively leading some TWGs, affecting how they function. This has been exacerbated by a lack of participation from various TWGs members. In some cases, there has also been limited coordination among DPs and other TWG members on work planning, information sharing, and providing actual support, including TA, to the TWGs. This was exacerbated by a lack of clarity about the roles and responsibilities of some TWG members.

There were temporary communication gaps, slowness, and inefficiencies in supply chain management (SCM) and activities immediately after the closure of DELIVER/SCMS.

This occurred for a short period (about one month) during the transition phase, immediately after the closure of DELIVER/SCMS in country activities. The evaluation found that this was primarily caused by inadequate understanding and communication between RBC and the new USAID supply chain mechanism immediately after the closure of DELIVER/SCMS. Planning and execution were also ineffectively coordinated during the first month of the transition phase. *However, the ET noted that this situation, while unacceptable, was short-lived.*

GOR engagement in defining IPs' position descriptions of key professionals in line with the health sector needs was inadequate, and high-level advocacy and GOR resources to support embedded RHSSA and PTA positions in the longer run to ensure sustainability were insufficient.

Generally, the GOR (MOH, RBC, and others) does not get an opportunity to provide input to the position descriptions for IPs' key professionals in terms of background, qualifications, and relevant duties in line with the health sector needs. One high-level MOH official stated, "It would be very useful if MOH is involved to a certain degree in defining the criteria and qualifications of the positions in line with the HS needs … this will help to recruit the 'right people' to provide the 'right support.'" As effective as the RHSSA-supported embedded staff and PTAs have been, in the longer run, lack of GOR input poses a great challenge in terms of sustainability, as there are currently significant constraints on domestic resources for the GOR to take over these positions.

In summary, the design of SCHS is well-aligned with GOR and USAID strategic priorities and, to date, has facilitated USAID support to strengthen the capacity of the Rwandan health sector to deliver high-quality health services. There is substantial collaboration and coordination among stakeholders, particularly IPs and GOR entities at both central and decentralized levels. This has resulted in the development and implementation of effective policies and plans, and well-coordinated processes and effective implementation of activities and progress monitoring, as well as stronger country ownership. But challenges remain, including inadequate coordination and collaboration among IPs in specific program activities in planning and implementation, hindering overall efficiency.

EVALUATION QUESTION 2

To what extent has the SCHS Project strengthened the capacity of Rwandan health systems in relation to Sub-purposes 3, 4, and 5? What is the level of capacity of the GOR in these areas?

Sub-purpose 3: Essential medical products available and accessible at service delivery points

Introduction

A reliable and high-performing supply chain is an essential component of a robust HS. Rwanda's HSPP III identifies the maintenance of biomedical equipment, ensuring availability and quality control of medical commodities, drugs, and consumables, and improved SCM as key priorities.[12] Under the USAID portfolio, and for the coverage period of this evaluation, support for SCM was primarily provided by DELIVER and SCMS — SCHS activities that completed all their in-country operations in late 2016 — prior to the timeframe in which this evaluation took place. AIRS also conducted supply chain activities for IRS, some still ongoing, that procured insecticides and arranged for warehousing and distribution for its spraying districts. Working with the MOH, RBC, and DPs, these activities focused on developing and strengthening reliable and sustainable supply chains and management systems by implementing and supporting robust logistics solutions, promoting supportive commodity security environments, procuring health commodities, and building lasting central and local level capacity to ensure that the necessary medicine and other commodities were delivered to the service delivery points on a timely basis. This section outlines the key evaluation findings and conclusions in the supply chain area.

Institutional Strengthening

DELIVER/SCMS strengthened institutions at central and decentralized levels that significantly contributed to improved supply chain capacity and performance. Some challenges remain: Key GOR policies and strategies, to which DELIVER/SCMS contributed and which are needed to guide institutions in SCM, have not been approved. The MPPD is not yet semi-autonomous, which slows down key decisions and processes and adversely affects SCM's overall. The Logistics Management Office (LMO) remains institutionally weak and sub-optimally effective.

[12] HSSP III, July 2012-June 2018, MOH, December 2012.

Though AIRS has contributed to improving insecticide distribution systems and some aspects of warehousing, GOR procurement capacity for IRS remains limited.

Many KIs reported that DELIVER/SCMS support for building and supporting viable and durable SCM institutions was a key achievement of the USAID activity. They stated that DELIVER/SCMS provided ongoing capacity and coordination support to the Coordinated Procurement and Distribution System (CPDS), including seconding one staff member to the MOH for support. Strong support from DELIVER/SCMS provided the CPDS with the necessary technical capacity and stakeholder support to coordinate HIV commodity needs assessment and supply planning. Institutionally situated in the MOH under the LMO, chaired by the private sector, and encompassing key GOR and DP stakeholders, the CPDS developed into the driving force for quantification and resource management for procurement of HIV drugs and related commodities. By the time DELIVER/SCMS closed, the CPDS, its Technical Committee, and its Resource Management Committee constituted effective and nationally owned processes with robust institutional underpinnings.

According to KIs and DELIVER/SCMS final reports, these activities also supported institutional development in supply chain planning for family planning and for malaria commodities, including the establishment of logistics committees that operate in the same manner as the CPDS Technical Committee. These committees lack the decision-making power of the CPDS Resource Management Committee, but represent an important step forward by engaging key stakeholders in joint quantification and planning activities.

DELIVER/SCMS' contribution to strengthening the district pharmacies was also a notable achievement in institution building. With joint support from the BTC and USAID, the GOR, under the decentralization policy, started the initiative with eight district pharmacies, and DELIVER/SCMS provided both financial and TA. In 2008, when the Strengthening Pharmaceutical Systems (SPS) project (MSH) came to an end in Rwanda, SCMS took over and continued support to the eight pharmacies, and subsequently coordinated with the MOH to extend support to all 30 district pharmacies nationally.[13] DELIVER/SCMS strengthened the district pharmacies by helping them to develop business plans and by providing routine support in monitoring, training, and planning. Thirty district pharmacies were operating in Rwanda at the time of the evaluation, and had contributed to a significant improvement in the drug distribution system by relieving the MPPD of the responsibility for delivering drugs to all service delivery points and effectively devolving that responsibility to the district level.

Some institutional challenges remain, however. First, DELIVER/SCMS made important contributions to the development of key strategies, guidelines, and policies that were critical to optimal institutional functioning, but delays in GOR review and approval have hampered progress in strengthening SCM. Several key policies that DELIVER/SCMS supported were awaiting GOR approval at the time of the evaluation, including the Laboratory Harmonization Policy (awaiting approval for two years), the District Pharmacy Operational Manual (awaiting approval for one year), and the Continuous Professional Development (CPD) Governance (awaiting approval since July 2016). Others, such as a much-needed pharmaceutical plan at RBC, were yet to be developed.

Second, DELIVER/SCMS provided critical institutional strengthening support to MPPD, but challenges remain, notably limited success in supporting MPPD's prospective move to semi-autonomous status. DELIVER/SCMS supported the development of SOPs for warehouse management and procurement, and capacity building in procurement, warehousing, warehouse management information systems, transportation, and distribution. For example, SCMS supported the active distribution of health commodities from MPPD to district pharmacies, shortening the average delivery period from 35 days to seven days for a health facility.[14] According to HMIS, during fiscal year 2016, more than 94 percent of

[13] SCMS Final Legacy Document, 2016.
[14] SCMS Final Legacy Document, 2016.

health facilities had adequate supply of five key tracer drugs. However, the ET also found that MPPD's lack of semi-autonomous status might have been slowing key decision processes, including procurement, and adversely affecting overall efficiency, equity, and quality of SCM. The ET noted however, that at the time of the evaluation, the GOR was drafting laws to convert MPPD into a semi-autonomous body.

Third, DELIVER/SCMS played a critical role in the design of the LMO at the MOH and also supported the LMO to develop the National Supply Chain Strategic Plan (NSCSP) 2013-2018. However, the ET found that the LMO has remained weak and ineffective, and tools needed to monitor implementation of the plan have not been developed. The LMO has a broad mandate to provide oversight, guide, and coordinate SCM nationally, but lacks institutional integrity. Although it is housed in the MOH, it does not enjoy a formal position in the ministry's structure, and has just one dedicated staff member who sits under the Health Services Quality Assurance Unit. (See Annex XII for the MOH organizational structure). KIs described the LMO as having a "weak institutional profile" and being "almost virtual," and one KI said, "There is no leadership for supply chain at the MOH." Lack of clarity on the roles and responsibilities of RBC staff and the LMO has hampered communication and led to poor coordination, such as parallel scheduling of quantification meetings. The LMO has also not been able to provide effective oversight to the district pharmacies as they support SCM at the decentralized levels for program products and essential medicines.

Fourth, in the area of procurement for IRS, AIRS built GOR capacity for warehousing and distribution of insecticides at the district level, and government has taken over these functions in some districts. However, critical IRS SCM areas at the national level remain under-capacitated: AIRS conducts its own quantification for insecticide procurement for its IRS activities, and the activity itself is in charge of procurement (through a global mechanism) and responsible for securing and maintaining appropriate storage facilities at the national level.

Enabling Information Systems

DELIVER/SCMS strengthened SCM by supporting the introduction and institutionalization of eLMIS at central and district levels. However, critical gaps remain, notably inadequate utilization of eLMIS full functionalities (especially consumption) and persistent concurrent use of paper and electronic systems at decentralized levels, which has led to data recording errors that reduce SCM efficiency.

eLMIS is designed to facilitate commodity ordering at all levels; capture consumption data from health facilities and distribution data from MPPD, district pharmacies, and other distribution systems; and support effective planning and management of all activities involved in logistics management. Its introduction sought to address shortfalls in Rwanda's supply chain system (e.g., the high costs of inventory management associated with expiries, stockouts and emergency orders) and data availability and quality challenges (e.g., lack of real time data, lack of data visibility through the value chain, poor data quality, and lack of data validation and integrity checks).

DELIVER/SCMS supported the rollout of eLMIS starting in March 2014; by August 2014, the system had reached 99 percent of health facilities.[15] By April 2016, the LMO and MPPD were using it, and it was also operational in all 30 district pharmacies, 4 Referral Hospitals, 43 DHs, and 527 HCs.[16]

The ET found that introduction and use of eLMIS has led to significant strengthening of the supply chain, most notably with ordering. A survey of health facilities, conducted by DELIVER in 2015, found that use of eLMIS cut the time required to prepare an order from an average of four days to about 45 minutes, and decreased order processing level of effort from three people to one person. An analysis conducted by DELIVER in March 2016 found that 98 percent of facilities used eLMIS for ordering, and the latest

[15] SCMS Final Legacy Document, 2016.
[16] Review of the eLMIS in Rwanda: Costs and Potential Savings to Public Health Supply Chain Operations. Draft: June 24, 2016 USAID DELIVER Project.

data from Global Health Supply Chain found a figure of 95 percent. Furthermore, of the 13 facilities the ET visited, 11 (85 percent) reported using the eLMIS for ordering.

While excellent progress has been made, the ET noted critical gaps. First, gaps remain in eLMIS full utilization; notably, consumption data are under-utilized, resulting in inaccurate quantification and contributing to stockouts (see below for further discussion). Although Global Health Supply Chain's latest data showed that 82 percent of facilities used eLMIS to record consumption, of the 13 applicable entities the ET visited, just 69 percent used eLMIS for reporting consumption data, and KIs widely reported inadequate use of eLMIS for consumption reporting.

Second, the ET also found that concurrent use of paper and eLMIS systems for both ordering and consumption reporting has led to sub-optimal outcomes associated with data entry errors and inaccurate quantification. There is currently no system in place to assess the quality of data entered into eLMIS, and a 2016 quality check performed by the current USAID supply chain IP (Global Health Supply Chain) at 10 facilities — which examined eLMIS entries, paper records, and physically checked and counted stock — found multiple discrepancies in the numbers recorded in these forms.

Last, eLMIS is copyrighted and licensed, so the MOH must pay significant annual licensing fees. This limits ownership and customization by the GOR.

Building Human Resource Capacity

DELIVER/SCMS tools and training helped to build the human technical capacity needed to use eLMIS effectively. However, capacity gaps persist, especially at decentralized levels.

The ET found that the tools and training DELIVER/SCMS provided in conjunction with the introduction of the eLMIS strengthened SCM capacity. Notably, tools and training on use of the eLMIS and good practices in stock management and business planning, including quarterly training of district pharmacies on pharmacy management, were widely appreciated and utilized. As one district pharmacist reported to the ET, "Before I did not know how to quantify drugs and how the Rwanda supply chain worked. I now know how to quantify medical supplies, and I have the tools to use the system." In addition, DELIVER supported quantification training for MOH/RBC malaria and MCH staff, and pre-service training for university pharmacy students and university nurses and midwives.[17] AIRS also built human capacity in some districts to organize and conduct IRS, which has supported the GOR to take over these functions in districts previously covered by AIRS. (For more about the contribution AIRS has made, see the discussion of Sub-purpose 5).

Human capacity gaps remain, however. At decentralized levels, KIs reported that lack of ongoing mentoring and refresher training on financial management and use of eLMIS, coupled with high staff turnover, posed challenges to effectively managing supply chain activities. In particular, personnel in charge of entering data into eLMIS at the decentralized level reported that the training they had received was not sufficient to enable them to take advantage of the system's full functionalities, and that staff tasked with data entry have other responsibilities, including clinical work, and are unable to dedicate adequate time to eLMIS data entry. KIs reported that these account for under-utilization of eLMIS functionality and data quality issues.

[17] DELIVER/SCMS supported pre-service training for five classes of university pharmacy students and three classes of university nurses and midwives. USAID DELIVER Project Final Country Report, 2016.

Improving Warehousing and Optimizing Tendering

DELIVER/SCMS' introduction of the "warehouse in a box" improved storage capacity, supply chain operations, and inventory management, and its support in framework contracting improved GOR procurement capacity.

KIs reported that DELIVER/SCMS support for the innovative "warehouse in a box" was particularly appreciated, has increased MPPD-owned storage capacity by 30 percent, and significantly improved supply chain operations and inventory management at MPPD.

The ET found that SCMS' capacity building at MPPD in framework contracting strengthened procurement and resulted in a reduced lead time, from 12 months to 3-4 months.

Stockouts

Stockouts, primarily of essential medicine procured and managed by MPPD (and small instances of program commodities), remain a challenge, and are associated with complex rules and regulations at the Rwanda Public Procurement Authority (RPPA), lack of capacity at MPPD, gaps in the internal distribution system, delays in submission of payment requests from health facilities, and inconsistent use of eLMIS.

The ET found that stockouts at sites visited, including some stockouts of program commodities, were an ongoing challenge, particularly at decentralized levels. Of 13 applicable facilities, 31 percent reported recent stockouts of program commodities.[18] MPPD is responsible for procurement, management, and distribution of essential medicine without direct USAID support, and the ET found that the SCM system for essential medicines was sub-optimal and that stockouts of essential medicines were widely reported. Of these 13 facilities, 77 percent reported stockouts of five or more essential medicines.

At the central level, KIs associated stockouts with procurement delays due to complex rules, regulations, and slow processes at the RPPA, and noted that the MPPD had not made efficient use of a special waiver available for the procurement of health commodities that could considerably simplify its procurement process. For example, one KI stated, "Procurement takes a long time and is a process of negotiation." Another KI said, "MPPD should be able to work better within the RPPA confines, but currently they don't seem to know how."

At the decentralized level, issues with the internal distribution system were most frequently cited in discussions of stockouts, including insufficient use of eLMIS for recording consumption and associated challenges with accurate forecasting and ordering, and chronic and lengthy delays in the submission of requests for payment from health facilities that adversely affected eLMIS performance and central-level procurement, and led to ordering delays and stockouts.

At the most decentralized level, the ET found that CHWs sometimes faced challenges delivering drugs and commodities from HCs to Health Posts in a timely manner, due to lack of reliable and accessible transportation.

Conflicting Priorities in Supply Chain Goals

Based on needs on the ground and situational urgencies, DP and IP procurement sometimes takes precedence over national supply chain strengthening.

Building national capacity to support sustainable systems and national ownership is a key goal of USAID-support supply chain activities. Indeed, as one IP KI explained, "We work on the principle to empower, enable, and involve the government. Our goal is to work ourselves out of job by 2020." However, KIs also noted that the supply chain activity's priority is "to ensure the products are available," and,

[18] Three of the four facilities that reported stockouts of program commodities were in the Eastern Province. These reported stockouts of Tenofovir 300mg (December 2016), Unigold (HIV Rapid test, November 2016), Dapsone (January 2016), and Determine (November-December 2016).

therefore, despite the obvious linkages between the two goals, procuring program commodities must sometimes take precedence over efforts to support national systems. One KI reported that DPs' focus on meeting international standards, such as the World Health Organization 90-90-90 targets in HIV care and treatment, drives IP focus on procuring program commodities, at times to the detriment of strengthening national systems. One consequence of this has been periodic lapses in coordination between IPs and MPPD; one KI reported that IPs occasionally "overrode" the MPPD when making procurement decisions, or had convened strategy meetings on procurement of HIV drugs without inviting the MPPD.

In conclusion, DELIVER/SCMS made critical contributions to SCM systems, including providing ongoing support to the CPDS, supporting the District Pharmacy system nationally, introducing and supporting the rollout of eLMIS, and building human resource capacity. As a result, the CPDS is now firmly established, nationally owned, and institutionally solid, the ordering function of eLMIS is well-utilized, and human capacity for SCM has improved. Gaps and challenges remain, including a poorly developed LMO, weak and inconsistent use of eLMIS for consumption reporting and forecasting, persistent human capacity gaps at decentralized levels, frequent stockouts of essential medicine, and delayed government approval for critical policies and guidelines.

Sub-purpose 4: Increased domestic resources for the health sector used equitably and efficiently

Introduction

The Rwandan health sector remains heavily dependent on external funding. According to the latest Health Resource Tracking Tool report,[19] external assistance is estimated to be roughly 61 percent of total public spending on health. In view of the ongoing drawdown of DPs' contributions to the HS, increasing domestic resources for health and ensuring that those resources are used equitably and efficiently is critical to sustain the gains made, especially on the Millennium Development Goals, and to build on those gains. This section outlines the key evaluation findings and conclusions in the HF area under SCHS Sub-purpose 4.

Coordination for HF

RHSSA played a key role in supporting coordination for HF by co-leading and facilitating critical TWGs on HF and supporting other processes, such as the annual Joint Action Plan and the Joint HF Strategic Planning Exercise.

RHSSA has supported improved coordination for HF within the GOR and with DPs. With the MOH, it co-chaired the preparation of the Health Financing Strategic Plan (HFSP), an effort that included stakeholders ranging from the World Health Organization to BTC. RHSSA hired a consultant to provide the technical leadership for developing the HFSP, assumed primary responsibility for the technical aspects of coordinating its development, and supported the MOH to disseminate and advocate for it.

RHSSA also supported the annual Joint Action Plan process, which is aligned with the HFSP. The plan includes all MOH priority activities, and its process helps to avoid duplication across DPs.

GOR Fiscal Space and Resource Allocation to the Health Sector

RHSSA built the capacity of GOR financial systems in health by supporting the development of key policies and strategies, building MOH capacity to conduct costing, supporting key revisions to the tariff list, facilitating the rollout of the Integrated Financial Management Information System (IFMIS), and strengthening financial systems and capacity. Despite these efforts, critical challenges remain in HF, most notably that domestic resources for health are not increasing at the scale needed to sustain gains; the MOH lacks the technical and advocacy skills to conduct evidence-based negotiations to increase the domestic budget for health; and the absence of domestic

[19] Rwanda Health Resource Tracking Output Report: Expenditure FY 2013/14 and Budget FY 2014/15; published in September 2016

resources to support IRS in all 13 malaria-endemic districts has severely limited the impact of IRS on national malaria infection rates.

RHSSA has worked hard to increase domestic resources for health and support their equitable and efficient use. First, RHSSA has supported the development of key policies, plans, and SOPs, including supporting the development of the HFSP and the Health Financing Policy, in collaboration with the MOH General Directorate of Planning, Health Financing, and Information Systems and its TWG. RHSSA also supported the GOR to cost the health strategic plan and analyze the Health Resource Tracking Tool data. KIs reported that RHSSA support and training have helped improve business processes and overall M&E and evidence-based planning and decision-making at both central (e.g., HFSP) and decentralized levels (e.g., DAAP, financial management at the DH level). In particular, KIs noted RHSSA support for developing RBC units' SOPs.

Second, RHSSA built MOH central-level costing capacity by helping to revise the ministry's tariff list and supporting costing of community health care services provided by CHWs. Trained MOH staff now have the capacity to conduct costing of health care services. As a result of this support, the GOR officially updated and implemented the new private sector tariff list in December 2016, supporting increased PSE.

Third, RHSSA supported improved efficiency of financial systems in health through rollout of IFMIS to the 42 DHs and training in financial management systems. It supported initial IFMIS training of two people from each of these hospitals. In many places, this training had a ripple effect, as one hospital staff explained by saying, "Five staff were trained in IFMIS. We have also trained others, cashiers and finance managers. From what we learned, we came and disseminate to others. We now have nine people trained." RHSSA has begun to support coaching in IFMIS at these hospitals; at the time of the evaluation, it had already covered five hospitals. RHSSA training courses have resulted in the replacement of paper-based financial systems in all 42 hospitals, improving financial accountability and realizing increased efficiency.

As a result of RHSSA-supported strategies and training in financial management systems, some health facilities reported efficiencies and financial savings, including fewer medication expiries in the wards, fewer rejected insurance invoices, fewer medication errors, fewer client complaints about drugs that were paid for but unconsumed, and increasingly effective and accurate requisition of medications for the wards. One PH (Ruhango) reported that overall drug income from September 2013 to August 2014 rose by 11,163,297 Rwandan francs, while the difference in losses from expired drugs/medicines dropped by 60,890 francs. Some KIs also reported that RHSSA training, particularly in IFMIS, had been key to improving hospital budget practices. Ruhango PH reported that the skills acquired though RHSSA training had made budget planning and controlling easier, that budget limits for activities were now respected, and that the training supported compliance with financial management and administrative manuals, as well as QI in general.

The ET also noted, however, that gains in financial management capacity were unevenly distributed at the decentralized level, and that despite deployment and training in IFMIS, financial management technical capacity at decentralized levels was sub-optimal, resulting in weak financial accountability and reporting. KIs reported this was in part associated with structural issues: Although districts are now budget entities, they are not in control of their budget spending; health funds are generally channeled from the central level directly to health facilities (e.g., DHs and HCs), and do not go through the DHMT/DHU. In addition, the ET noted that eLMIS, is not being used for other business functions relevant to SCM, such as financial management.

Despite impressive advances toward optimizing fiscal space, the ET found that there has been no significant progress on addressing the national gap in resources for health. Between fiscal years 2013/4 and 2015/6, the absolute GOR domestic budget contribution to the health sector increased by 24.5 percent; however, as a percentage of total government domestic budget, the GOR health budget

remained essentially flat, falling slightly from 16.9 percent to 16.5 percent.[20] KIs reported that the Ministry of Finance and Economic Planning is not increasing the fiscal space for health and that the MOH lacks the requisite business, technical, and negotiation skills to effectively conduct the evidence-based negotiation and high-level advocacy needed to increased GOR resources for health. At the time of the evaluation, the GOR had no surplus tax specifically earmarked for health. Similarly, the ET found little evidence of increasing domestic resources for health under the AIRS activity. AIRS efforts to generate domestic resources to support IRS have not been extensive and, according to multiple KIs, advocacy efforts have not been adequate to successfully generate the resources needed to cover all 13 malaria-endemic districts. This means that, at the national level, IRS impact on malaria incidence rates is sub-optimal.

Community-Based Health Insurance

RHSSA provided support to the CBHI system by supporting the transition of its management from MOH to RSSB, helping the latter to develop the integrated CBHI membership and management system, and supporting CBHI implementation at all levels. However, CBHI enrollment fell significantly between fiscal years 2011/12 and 2015-16, and faces several entrenched challenges to expansion. Furthermore, improving CBHI membership rates cannot increase domestic resources for health and would aggravate the national resource gap.

RHSSA took several steps to support the CBHI system. First, it conducted studies, including the CBHI Sustainability Study, and developed plans and tools to support the transition of CBHI management from the MOH to RSSB. Second, it provided training at the central and district levels, and facilitated a national social mobilization awareness campaign carried out by RSSB and MINALOC. Third, it partnered with Jembi (a company based in South Africa), to support the development of an integrated CBHI membership and management system for the RSSB. RHSSA supported the rollout of the CBHI membership management system countrywide, including providing training on implementation at HCs and for district CBHI staff. According to RHSSA performance monitoring plans (PMPs), between 2014 and 2016, was a 30 percent increase in the number of CBHI structures fully implementing the membership management system. RHSSA also supported the RSSB to advocate for an increase in health insurance premiums, although this effort ultimately proved untenable.

RHSSA's strong support to transition the CBHI from the MOH to RSSB resulted in integration of 30 district CBHI management structures and pools into one national pool and system, realizing institutional, management, and operational efficiencies. One top RSSB official reported that RHSSA's support was one of the "most critical" elements of this successful transition. RSSB has now placed a dedicated person in charge of CBHI management at the health facilities, including at most HCs. Work, however, remains to be done: Despite integration, CBHI pooling continues to be inefficient and, due to GOR regulations, operates as a separate entity, not combined with other schemes such as Rwanda's Medical Insurance Agency (RAMA).

Despite these efforts and accomplishments, and improved efficiencies at RSSB, CBHI capacity to distribute national resources equitably remains sub-optimal; indeed, it has deteriorated over the course of this RHSSA. The transition of CBHI from the MOH to RSSB — which was intended to increase efficiency and improve enrollment — corresponded with a drop in CBHI enrollment. According to RSSB, as of April 2016, 81.3 percent of the population was covered by CBHI, a significant decrease from fiscal year 2011/12, when coverage was 91 percent.[21] Even if CBHI enrollment were to increase, the ET noted that, according to a recent RHSSA study, an increase in CBHI membership would actually widen the financial gap. (This study investigated the financial gap commonly associated with sub-optimal CBHI enrollment, and was intended for MOH advocacy purposes vis-à-vis the Ministry of Finance.)

[20] HSSP III Midterm Review, December 2015.
[21] The MOH CBHI Annual Report 2014/15 stated that CBHI coverage in fiscal year 2011/12 was 91 percent.

The ET found a number of challenges that have hampered growth in CBHI coverage. Some categories of CBHI customers reported that their premiums were too high to afford. Health facilities similarly noted that CBHI categorization, which determines premiums according to income, has been a point of contention for some customers. The CBHI system has recently been linked to the larger *Ubudehe* system, which is used to identify people who require full subsidization (Category I) and those who must pay a premium. According to some facility-level KIs, some customers, particularly those in *Ubudehe* Categories 2 and 3, report that they have been incorrectly categorized and that their premiums are not affordable. One DH KI in the Western Province stated, "some people in *Ubudehe* categories, especially Category 3, that require a payment do not have enough money to pay for CHBI." DHs, in particular, reported that patients such as these, especially those who require hospitalization and thus incur higher fees than out-patients, are unable to pay their hospital bills.

Other reported challenges to affording CBHI benefits included the RSSB requirement that clients pay full premiums up front, between January and June each year, for all family members, before benefits can take effect. Another noted challenge is that there is a 30-day waiting rule for new members to receive benefits after they pay the premium. This waiting period also applies to existing CBHI members, if the complete payment (for the following year) is not made before June 30. Some facilities the ET visited (e.g., the Kirwa HC) have found innovative ways to address these issues, such as supporting communities to organize into community groups and pool resources to make CBHI payments.

A community "mindset" that insurance is not necessary was cited as another challenge to increasing CBHI enrollment. This corresponds to a lack of community mobilization to raise awareness about the need for health insurance. The ET also found that the CBHI benefits package did not adequately cover the population's evolving health needs, such as the rising burden of non-communicable diseases, and that this deters some potential customers from enrolling.

In addition to the challenges in improving enrollment rates, some health facilities reported systemic problems in collecting and processing CBHI payments. Several HCs reported that absence of electronic medical records and e-billing systems at DH and HC levels affected facilities' capacity to collect fees, resulting in sub-optimal collection of premiums and fees. Some facilities also reported that these administrative delays in processing CBHI payments occasionally led to stockouts due to their inability to purchase medicine or get supplies from the District Pharmacy on loan. However, some of the HCs the ET visited did report a high capacity to manage the CBHI fees, due in part to the presence of a dedicated RSSB staff person on site. The Kinazi HC reported that it had increased CBHI enrollment from 68 percent in 2015 to 72 percent in 2016.

Business Capacity, PSE, and Income Generation

RHSSA supported income generation activities by helping to develop strategies, business case frameworks, and tools, supporting the CHW cooperatives, and contributing to evaluations of the cooperatives and community HSs. However, PSE in health remains minimal, plans for PPPs have yet to be implemented, and there is weak business capacity at all levels. The majority of CHW cooperatives are not generating profits and lack the support and capacity to be financially viable.

To build capacity for income generation in the health sector, RHSSA helped strengthen the RBC Business Unit, developed a strategy and roadmap for private wings at health facilities, and developed a pre-feasibility framework, business case framework, and other tools to support PSE and additional revenue-generating activities at central and decentralized levels. In fiscal year 2016, RHSSA developed or supported eight private sector initiatives (RHSSA PMP, December 2016).

The ET found that, despite these efforts, no innovative or attractive health-specific incentive system has been put in place for the private sector, and HF-level income generation schemes (e.g., private wings, co-location models, and hybrid models) have not started. Of the eight health facilities the ET visited,

only one had an income generation activity — renting one of its hospital buildings. Most hospitals reported very limited or no success in income generation, apart from patient fees and CBHI payments. The PPP policy and regulations have not been effectively disseminated at the decentralized level; as a result, health facility managers have not been sensitized to PPPs, and some DHMTs said they did not know much, if anything, about PPP policies and regulations, and have not had access to relevant training. Some PPP Health Posts run by One Family Health (OFH) are functional, and though processing and payment for CBHI claims has improved, the system is still manual and paper-based up to the district level, which delays payments.

Business capacity of MOH staff at both central and decentralized levels remains very limited, including in economic analysis and evidence-based planning, research, and business development, including revenue-generating activities. At the MOH central level, staff lack adequate high-level capacity to advocate for and promote PSE in health, and health facility managers lack technical capacity for business analysis. As a result, PSE has been limited in health sector policy dialogues and formulation, and there is inadequate communication and coordination between the private sector and the GOR. Some KIs referred to this as a "trust deficit."

One area in which RSHHA invested considerable effort was the CHW cooperatives. At the time of the evaluation, there were 475 cooperatives across the country serving 45,000 CHWs. RSHHA helped the cooperatives develop business plans and supported the establishment of a cooperative umbrella organization, led by the MOH.

The ET did note some progress. Indatwa, a CHW cooperative in Gikondo, invested in a 2-hectare farm in Muyumbu to grow bananas. Though it has managed to earn additional income, it was not generating a profit. Another cooperative, the Farming Cooperative of Community Health Workers of Rurenge Sector (Koarunge), hired staff, including a manager with veterinary training laborers, and had a poultry and maize growing business. Koarunge reported that the district supported it financially every quarter for service delivery, and noted good working relationships between CHWs and HCs, as did the Tabara cooperative. According to a 2016 CHW cooperative assessment conducted by the Centre for Policy Research and Capacity Development and supported by a costing study conducted by RHSSA, 23 percent of cooperatives had developed business plans and were generating revenues.

Overall, however, the results of the CHW cooperatives have been disappointing. They were envisioned as a mechanism to generate income and help sustain the HS at the community level, but the ET found they had generally weak capacity to conduct business, generate profits or manage finances. This aligns with the findings of the 2016 assessment, which found that in 2014, only 33 percent of cooperatives made a profit and were able to pay dividends to their members. Furthermore, it found that even if all cooperative profits were allocated to support the community health program, [22] they would cover less than 3 percent of the program's annual costs. The study also projected a number of scenarios investigating the potential long-term impact of the cooperatives on HF in Rwanda. According to the most optimistic of these scenarios, under which 100 percent of the cooperatives generate income, the profit would be able to support approximately 20 percent of the total cost of the community health program. The study concluded that the challenges to sustaining the program would persist "unless a mix of funding sources is identified to address the financial sustainability issue." The Performance-Based Financing (PBF) mechanism could provide one way to generate additional funds: Each CHW cooperative currently receives a quarterly PBF payment, about 70 percent of which is earmarked for investment in income-generating activities, with the remaining 30 percent shared among members. However, the cooperatives the ET visited reported that PBF payments were miserly, even for well-performing CHWs.

[22] Under new draft CHW guidelines on business dividends, 20 percent of yearly net benefits should be set aside for reinvestment, 30 percent should be shared among cooperative members, and 50 percent should be pooled in a reserve fund managed by the MOH to sustain the community health initiative.

Interviews at CHW cooperatives identified a variety of ongoing challenges. Cooperative management committee members lacked technical, business, and marketing skills, and most had inadequate resources and weak access to TA. Few received adequate and effective on-site mentorship and supportive supervision, and few could afford to hire a business manager. Many lacked a well-defined formal support structure for cooperative strengthening, and only one of the three cooperatives the ET visited had a business plan — and it was outdated. Cooperatives suffered from inadequate market linkages and high variable costs, such as transportation for business ventures, and lacked basic equipment such as computers for recordkeeping and documentation.

To summarize, by supporting the CBHI system and the CHW cooperatives, RHSSA has made important contributions to increasing domestic resources for health and ensuring those resources are used equitably and efficiently. The CBHI system now covers more than 80 percent of the population. Remaining challenges include the national budget for health, which as a percentage of total government budget, remains flat; unsuccessful advocacy for the resources needed to cover all malaria-endemic districts with IRS limits the impact of IRS on Rwanda's escalating malaria incidence rate; and CBHI coverage has fallen — and even if membership did expand, this would exacerbate the financial gap. Furthermore, PSE in heath is low, income-generating activities have yet to begin in a substantive manner, and most CHW cooperatives are not financially viable and lack the capacity to become viable or sustainable.

Sub-purpose 5: Leadership and governance (L&G) of HS at central and local levels strengthened

Introduction

Strong L&G structures are critical to a functioning HS; they are particularly important in Rwanda's ongoing decentralization process. Good governance and strong leadership skills are required at central and decentralized levels, and solid coordination across all levels is critical to ensure systems are functional, high-quality services are delivered, monitoring and reporting are conducted, and evaluations take place. For the SCHS Project, RHSSA is primarily supporting capacity building in L&G, but AIRS is also making important contributions. This section outlines the key evaluation findings and conclusions in L&G.

District and DHMT Planning, Reporting, and M&E Frameworks

Strong RHSSA support for facilitating and building management and planning capacity at district and provincial levels has resulted in DHMTs gradually becoming more effective and functional, and having increasingly integrated planning and decision-making processes and improved human resource management at decentralized levels. However, capacity for data use and evidence-based planning at decentralized levels is underdeveloped.

At the decentralized levels, RHSSA has trained 1,839 staff mangers (704 females and 1,135 males) in leadership and management skills. The activity has also helped improve human resource management in district health facilities through leadership training and mentorship, as well as development and training in the use of the Integrated Human Resource System and the Integrated Public Payroll System. As one senior MOH official stated, "RHSSA has been very instrumental in strengthening the DHMTs, especially in planning areas. Due to this support, they now see much improved DAAP and budget from the districts."

Table 2. Training Provided by RHSSA for Leadership & Management, HF, and QI

Performance Indicator	Fiscal Year 2015 Achievement			Fiscal Year 2016 Target	Fiscal Year 2016 Achievement		
	M	F	T		M	F	T
Number of staff/managers trained in leadership and management skills (short-term training/workshops and mentorship)	N/A	N/A	N/A	1,823	1,135	704	1,839
Number of staff/managers trained in HF skills	35	39	74	---	42	44	86
Number of staff/managers trained in QI, infection prevention and control, and accreditation surveys and facilitation/ supervision	17	14	31	200	154	69	223

Source: MSH progress reports.

The ET found that, as a result of RHSSA training courses, all DHMTs, including the four that the ET met, were able to produce M&E plans and DAAPs, and conduct midterm reviews of District Health Strategies. The ET also found that district health planning was broadly aligned with district and overall national priorities; that planning, implementation, and evaluation engaged key stakeholders; and that DHMTs were conducting overall monitoring and reporting using the RHSSA-supported DHIS2.

Despite this progress, the ET found that technical, planning, and business managerial skills among DHMTs and DHUs were sub-optimal, including relatively weak capacity for effective evidence-based strategy development, planning, and decision-making. A KI from one DHMT reported, "There is need to build the capacity of DHMT members … and DHMT members should also be trained in leadership, management, and governance."

In addition, although DHMTs have increased their use of data and information in planning processes, there are still gaps in capacity, particularly to analyze data. Furthermore, the culture and capacity for data analysis and use at decentralized levels remains weak. KIs provided several explanations for this, including that some district-level administrative units reported insufficient training on M&E and analysis tools needed to use data effectively. Indeed, only 63 percent of the DHMT and health facilities interviewed for this evaluation reported that they had ever attended a training on management and leadership development. KIs also reported that, in conjunction with the decentralization process, the number of technical staff at the district administrative level (DHUs) is sometimes insufficient, so trained staff may not be in place — and even if they are, there may not be enough to conduct the required data analysis. KIs also pointed out that key district-level decision-makers are not always health specialists. For example, DHMTs are often headed by the vice mayor of social affairs, who is a political appointee and not necessarily a health specialist, which can sometimes lead to a lack of understanding and adequate support for health-specific needs and evidence-based planning data requirements.

HS Capacity for IRS

AIRS has contributed to building HSs and human capacity for IRS. However, the timing of IRS in some districts detracts from its effectiveness, and the practice of engaging CHWs in spraying activities is undermining their ability to carry out their primary health care responsibilities.

Building HS and human capacity to conduct IRS is critical because national malaria incidence in Rwanda has risen dramatically. According to the MOH, the number of malaria cases nearly quadrupled between 2014 and 2015, from 514,173 to 1,957,000.[23] AIRS effectively built IRS capacity in the districts in which IRS took place, and beyond. In 2016, AIRS successfully implemented five spray rounds in two districts

[23] Deaths from malaria in the same period dropped from 499 to 424, suggesting that treatment is working well.

with a coverage rate of 99.2 percent. The DHMT reported that Kirehe district now has adequate capacity to plan, implement, and monitor AIRS activities, including providing district-level warehousing, and recruiting and training staff for IRS. Beyond the districts participating in the President's Malaria Initiative (PMI), AIRS supported a wide range of capacity development for GOR staff, including providing operational support, training, equipment, and entomological know-how. Effective IRS capacity transfer from AIRS to the Malaria and Other Parasitic Diseases Division, districts, and CHWs has resulted in the successful handover of districts to the GOR for IRS, as was the case with Bugesera.

KIs in Kirehe reported that residual resistance to IRS persists, due to social and cultural stigma and intolerance for the smell of insecticide. KIs also reported that the timing of spraying exercises in some districts, primarily during rainy periods, detracted from the effectiveness of IRS because more structures tended to be missed. For example, one KI explained that "sometimes the spraying exercise is conducted during [the] rainy season, and for this reason, people were reluctant to remove their belongings from their homes to allow for spraying because their belongings would get wet."

The ET found that AIRS' engagement of CHWs to carry out IRS — an effective approach for transferring IRS skills — appears to be overburdening the CHW system. Engagement in IRS activities can disrupt CHWs' regular community responsibilities and affect the efficiency and continuity of primary health care service delivery at the community level. Further contributing to the workload, CHWs' responsibilities have recently expanded to include malaria testing with the malaria rapid test kit and treatment.

Facility- and Institutional-Level Planning and Monitoring

At the facility level, RHSSA has effectively supported the development, deployment, customization, and associated training for a number of information systems and M&E and analytical tools (e.g., HMIS/DHIS2, Quantum Geographic Information System [QGIS], IFMIS, and Health Resource Tracking Tool), thereby strengthening planning, implementation, and monitoring capacity at facilities, in some cases directly resulting in efficiency gains. However, weak interoperable capacity, the inflexibility of existing information systems, and the absence of new systems are causing management and operational inefficiencies at decentralized levels.

The ET found that with RHSSA support, DH and PH planning and M&E capacity was improving. The Rutongo DH in particular reported that its work plan development took the activities of other partners into account. Ruhango PH reported using HMIS data for planning, M&E, decision-making, and setting supervision plans based on the trends identified through data analysis.

The ET also noted improvement in health facility QI/accreditation program implementation at the district level. The Masaka DH reported that its QI baseline in five risk areas had increased from 47 percent (2014) to 81 percent (2016), and the post C-section infection rate dropped from 9 percent (2015) to 3 percent (2016). At the Ngoma DH, neonatal infections dropped from 21 percent (2013) to 9 percent (2016). At the Kinazi HC, the ET found that the HC was following the QI plan and conducting quarterly evaluations. DHMTs and DHs were also conducting regular supervision activities and providing feedback to HCs. Overall, in fiscal year 2016, 67 percent of health facilities and districts created dynamic data dashboards for the key indicators in DHIS2, and 71 percent of facilities had data accuracy within 5 percent.[24] Soon to be introduced PHQS for the HCs were also developed with RHSSA support; these promise to further improve the quality of care at the HCs.

The ET noted that most of the systems are plagued by limited data integration and interoperability. For example, there is a lack of interoperability between HMIS and QGIS and between HMIS and eLMIS, and accreditation data and IRS data are not reported in HMIS. This reduces efficiency in data collection, reporting, and analysis, and consequently impedes effective planning and implementation. In addition, the

[24] RHSSA PMP, December 2016.

lack of electronic medical records and e-billing systems at DH and HC levels, noted under Sub-purpose 4, limit operational and financial efficiency gains.

Cascade Training

Cascade training is not being effectively implemented, resulting in uneven and weak transfer of know-how and skills, especially to the decentralized levels.

The RHSSA training model is based on ToT and predicated on effective skills transfer from ToT graduates across the HS. However, that transfer of skills is uneven and generally weak. The ET did note a few cases in which RHSSA DH and PH-level training had translated into cascade training for HCs. The Kibungo PH, for example, reported conducting cascade training in QI and action plan development, M&E, and leadership for HC staff in Kinazi. This, however, was not the norm. RHSSA-trained trainers at the district level were not always adequately transferring acquired knowledge and skills to other relevant staff in their own institutions, and in most cases, skills transfer was not effectively reaching the lower levels (i.e., HC and below) due to district-level inefficiencies and lack of resources to support or organize cascade training. ToT graduates also clearly lacked the practical logistical know-how to initiate, organize, and run additional ToT and training courses at lower levels. The ET also noted inadequate ongoing mentoring, refresher training, and knowledge and skills transfer in eLMIS, HMIS, QGIS, IFMIS, and database capacity for licensing and accreditation of health professionals. Many ToT graduates reported a lack of confidence and inadequate institutional recognition to conduct cascade training, due to a lack of official recognition and certification of their trainer status.

Coordination between Central and Decentralized Levels

Mechanisms for stakeholder coordination at all levels and for coordination between central and decentralized levels are in place and are reasonably functional. However, lack of clarity about roles and responsibilities and insufficient coordination among government organizations in the process of decentralization is adversely affecting district-level planning and decentralized health service delivery.

The ET noted that the mechanisms for intra-governmental coordination at both the central level (e.g., TWGs) and decentralized levels (e.g., DHMTs and Joint Action Development Forums) are in place, and that quarterly meetings are held between MOH, RBC (MCCH) and district M&E officers and data managers (MCSP Kigali). Additionally, DHMT records indicate and reported that RHSSA has effectively supported and strengthened DHMTs' capacity to facilitate dialogue among district health actors (district, health facilities, and DPs) for better coordination and monitoring of health interventions.

The ET also found, however, that the ongoing decentralization process has not yet adequately defined and delineated the roles and responsibilities of MINALOC and MOH at both central and local levels, and that this has resulted in insufficient coordination and communication between the ministries at decentralized levels. KIs reported that a lack of adequate coordination between the two has led to ineffective planning in some districts and resulted in inadequate coverage and quality of health service delivery at the decentralized levels.

Staff Turnover

High staff turnover at both central and decentralized levels affects delivery of high-quality health services, undercuts HS gains from capacity building, and undermines sustainability.

The ET found that high staff turnover was affecting health facilities' capacity to effectively absorb the information from capacity building and strengthen institutional processes. The Rutongo DH, for example, reported a 20 percent annual staff turnover concentrated in doctors and nurses, and noted that this had caused its accreditation rating to fall from 97 percent in 2013 to 63 percent in 2016.

Similarly, the Ruhango PH reported that its accreditation score dropped from 81 percent in 2015 to 74 percent in 2016 as a result of staff losses, a change that had pushed it down to Level 1 from Level 2.

KIs offered several explanations for high staff turnover, including the absence of an effective national staff retention strategic plan; an inadequate incentive system (including financial incentives) for health professionals working at central and decentralized levels; frequent institutional restructuring (MPPD) and changes in leadership (Ruhango PH); inadequate and inconvenient housing for health professionals, including doctors, especially in rural areas; and inconvenient modes of transportation to and from health facilities, particularly in rural areas. Table 3 shows staffing gaps at the Ruhango PH.

Table 3. Illustrative Staffing Gaps: Ruhango PH

Type of Staff	Actual Number of Staff	Number of Positions Officially Allocated by the GOR	Gap
General practitioners	7	14	50%
Nurses	41	80	48.75%
Specialists	4	10	60%
Midwives	12	12	0%
Total	64	116	44.83%

Source: ET data collected during site visits.

In summary, SCHS activities have meaningfully contributed to building L&G capacity in health at both central and decentralized levels. Effectively supported by RHSSA, the increasingly functional DHMTs are especially noteworthy. Gaps remain, however, particularly in the capacity for data analysis and its use in planning remains weak at the decentralized levels. Coordination between MOH and MINALOC in the decentralization process is also sub-optimal, and affects planning and health service delivery. Furthermore, RHSSA-supported ToT has only minimally translated into cascade training across the decentralized levels, and high staff turnover undermines efforts to sustainably build HSs and staff capacity.

EVALUATION QUESTION 3

Does SCHS target the most important and changeable factors that contribute to the GOR's capacity to sustain a strong system that will provide high-quality services? Are there other more important and changeable areas (in relation to SCHS Sub-purposes 3-5)?

Most "Important" and "Changeable" Factors for a Sustained HS: the Conceptual Framework

Almost two decades after the genocide, thanks to dynamic, bold, and visionary national leadership, as well as effective implementation of policies and strategies, Rwanda has made extraordinary progress in health, including attaining core Millennium Development Goal targets. So, it is now absolutely critical the country ensure that the results achieved are sustained, and further progress is made to build forward. As President Kagame said at the 68th UN General Assembly, "for us the [Millennium Development Goals] are a floor, not a ceiling." To strive along that path and make that a reality — and given the slowdown in external financing/aid, the increase in secondary and tertiary care facilities, and the training needed for medical specialists — a sustainable approach to strengthen Rwanda's HS is absolutely critical.

In relation to SCHS Sub-purposes 3-5, Evaluation Question 3 required the ET to investigate the factors that are critical to a well-capacitated and strong HS toward the path of sustainability. The box below presents a summary of the "important" and "changeable" factors that stakeholder groups identified as critical to a well-capacitated and strong Rwandan HS for ultimate sustainability.

GOR Central Level (MOH, MINALOC, RBC, RSSB): Leadership; advocacy; coordination; communication; management and implementation; governance, policy & planning; capacity building (including TA, supervision, mentorship); resources; institutional effectiveness and profile; resources; financial/resource management; innovation

GOR Decentralized Level (PHs, DHs, DPs, DHMTs, HCs): Leadership; governance, policy, and planning (staff retention); financial and resource management; resources; capacity building (including business skills, eLMIS training, refresher training, mentorship, QI/Assurance, financial management)

USAID/Rwanda: Leadership; advocacy; governance, policy, and planning; capacity building (DHMT, hospital management, financial, technical skills); coordination; ownership; resources; resource mobilization and management; institution effectiveness; capacity building; change management; innovation

IPs: Resources; leadership; advocacy; governance, policy, and planning; change management; institutional effectiveness; coordination; communication; capacity building (including business/financial skills and resource management); resources; institutional effectiveness; innovation

DPs: Governance, policy, and planning; capacity building (including DHMTs' management skills); coordination (TWGs, HSWG); communication; GOR resources

Professional and Umbrella Bodies: Governance, policy, and planning; capacity building (including TA support, skills, knowledge); coordination and communication; resources

Academia: Capacity building (training); resource generation; resource management

In relation to Sub-purposes 3-5, considering stakeholders' views and the key factors of the Rwanda-specific health system strengthening components and associated services, the ET identified the following elements and their components as the most "important" and "changeable" factors underpinning a well-capacitated and strong HS toward the path of sustainability: leadership and advocacy; governance, policy, and planning; management, coordination, and implementation; and learning and innovation, as illustrated in the conceptual framework in Figure 1.

Annex XII provides the basic principles and further details on each of these elements, including the key sub-question the ET had considered.

Figure 1. Most "Important" and "Changeable" Factors for a Sustained HS

Most "Important" and "Changeable" Factors for a Sustained HS: The Matrix

The USAID/Rwanda Health Team provided the ET with a matrix to frame the most "important" and "changeable" factors identified in the conceptual framework, underpinning a well-capacitated, strong, and sustainable HS. The ET, however, further segmented Quadrant (QR)1 into three parts:

	More Important	Less Important
More Changeable	**QR 1** • Part 1: Targeted Well • Part 2: Targeted, but not very well • Part 3: Should be targeted	**QR 3**
Less Changeable	**QR 2**	**QR 4**

1. Currently targeted well
2. Currently targeted, but not very well — needs improvement
3. Currently not targeted, but should be targeted moving forward, particularly in light of the recommendations made under Evaluation Question 2 (see Section V).

Key Findings and Conclusions

The final matrix on the following pages presents the key findings and conclusions in terms of the "important" and "changeable" factors associated with the quadrants in the matrix, in relation to Sub-purposes 3-5. It is important to note two points:

1. The more "important" and "changeable" factors are variables, and associated within the context and/or activities/IRs under Sub-purposes 3-5.

2. Although there are references to some of the main areas/evidence, specific evidence supporting the findings/conclusions and categorization of the more "important" and "changeable" factors is detailed in relevant parts of Evaluation Question 2.

The matrix highlights and focuses on the critical factors that contribute to a strong and sustainable HS, are "important" and "changeable" in relation to Sub-purposes 3-5, and fall within the quadrants of the matrix.

Sub-purpose 3: Supply Chain Management	Sub-purpose 4: Health Financing	Sub-purpose 5: Leadership & Governance
QR1, Part1: More Important and Changeable Factors — Targeted and Well-Addressed		
Governance: According to RBC, RHSSA has effectively supported the development, validation, and implementation of key institutional SOPs for RBC and its units, including but not limited to the MPPD. DELIVER/SCMS supported the MOH LMO to develop the National Pharmaceutical Supply Chain Strategic Plan (2013-2015) and other policy/planning documents, including the District Pharmacy Operational Manual, the Laboratory Harmonization Policy, and the Continuous Professional Development Governance. ***Coordination and Communication:*** DELIVER/SCMS has effectively supported and facilitated the CPDS for unified quantification, procurement, and resource management of HIV commodities — a major coordination success resulting into significant efficiency gain. RHSSA and DELIVER/SCMS also coordinated to help develop the MPPD strategic plan. ***Capacity Building:*** DELIVER/SCMS supported expanding MPPD's capacity by providing tools and training on good practices of stock management, business planning, and enabling eLMIS. It also helped the functioning of the district pharmacies by training the pharmacists on pharmacy management on a quarterly basis, and trained staff at health service delivery points. DELIVER also supported and facilitated the incorporation of supply chain curriculum into all pharmacy programs nationwide (2009), and nursing and midwifery programs (2013). ***Innovation:*** DELIVER/SCMS introduced "warehouse in a box" increasing efficiency and MPPD's storage capacity by 30 percent.	***Governance:*** RHSSA bolstered policy planning, strategy development, and implementation in the HF area. Examples include the HF Strategy and policy development, and costing of strategic plans such as the HF, Human Resources for Health, e-Health, and the CHW service package. ***Institutional Effectiveness and Capacity Building:*** RHSSA has strengthened RSSB's overall institutional capacity for CBHI transition and management by developing tools and SOPs, building systems, and providing training.	***Governance:*** RHSSA supported development of policies, strategies, and standards for the health sector as a whole, including the newly developed PHQS, QI, HFSP, and health financing policy (HFP). ***Coordination:*** RHSSA strengthened multi-stakeholder coordination and communication for effective planning at the district level through the DHMT and Joint Action Development Forum, although this was limited. ***Capacity Building:*** Overall, RHSSA strengthened leadership, management, M&E, planning, and QI capacity of both health facilities and administrative bodies (DHMT/DHU) at the provincial and district levels. RHSSA supported the DAAP production capacity at all districts and midterm review of the District Health Strategies. It has built training capacity at DHs, which in turn trained many HC staff in QI, M&E, and planning. ***Institutional Effectiveness:*** RHSSA effectively supported RSSB's institutional capacity for CBHI transition and management.

Sub-purpose 3: Supply Chain Management	Sub-purpose 4: Health Financing	Sub-purpose 5: Leadership & Governance
QR1, Part2: More Important and Changeable Factors — Targeted, but Not Well-Addressed		
Leadership & Ownership: Currently, there is inadequate leadership and ownership to move the management and procurement of essential medicine under the CPDS. The LMO has limited clout and profile for the same reasons. ***Governance:*** Enforcement of the previous MOH directive (March 31, 2014 & January 30, 2015) decommissioning the paper-based system for commodities and SCM was weak and inadequate. As a result, the paper-based system and eLMIS run in parallel. ***Coordination:*** Although there is good coordination in certain areas, it must be improved in others. Examples include inadequate coordination and communication between the supply chain IP and RBC during the early transition phase and that IPs lack focus on coordinated results (strategic level) to improve the supply chain by sharing work programs and identifying areas of collaboration. ***Capacity Building:*** MPPD is still not semi-autonomous and needs further capacity building to be fully self-sufficient. The LMO does not have the necessary technical capacities, and there is a clear lack of ongoing eLMIS refresher training and mentorship at the decentralized levels.	***Leadership & Advocacy:*** There is insufficient increase of and inadequate domestic resources in the health sector. ***Governance:*** Governance and management of the enabling environment for income generation is weak. For example: slow approvals of concepts; poor dissemination of the PPP policy; weak CHW cooperative business planning; lack of a study to support effective premium alignment with *Ubudehe* classification; and failure to capitalize on operational efficiency gains (e.g., electronic medical records, eBilling, SOPs for CBHI, and sub-optimal collection of CBHI premium/fees). ***Institutional Effectiveness:*** There is inadequate CBHI management capacity at many decentralized health facilities, including missing RSSB personnel. CHWs cooperatives lack ongoing mentorship and supportive supervision, and effective follow-up and support to address gaps identified in the cooperatives' capacity does not occur. ***Capacity building:*** Shortcomings include a lack of domestic resource generation capacity, concepts, and implementation; weak staff capacity for business thinking and development, economic analysis, and evidence-based advocacy for increased resources; lack of ongoing mentorship and refresher training on IFMIS; and inadequate analytical, business, and resource management skills for managers at the decentralized levels.	***Leadership:*** Upcoming dissemination and implementation of PHQS; high staff turnover at all levels undermining capacity gains and sustainability; current insufficient MOH leadership for active and functional TWGs; continued lack of clarity on the roles and responsibilities of RBC and MOH; inadequate coordination between MINALOC and MOH hinders ownership and implementation; and lack of official recognition and printed certificates for district-level trainers in all areas of health system strengthening. ***Governance:*** Absence of an approved human resource retention strategy with associated action plans and incentive schemes; inadequate PSE engagement: PPP frameworks and policy have not been disseminated, there is a lack of health-specific private sector incentives, and continued lack of clarity on roles and responsibilities between RBC and MOH in different areas. ***Coordination:*** Recent lack of effective coordination among TWG members in most cases. ***Capacity building:*** ToT graduates do not have the know-how to initiate, organize, and implement the cascading model to HCs and below. At the district level, M&E, decision-making, and PPP capacity need further development.

Sub-purpose 3: Supply Chain Management	Sub-purpose 4: Health Financing	Sub-purpose 5: Leadership & Governance
QR1, Part3: More Important and Changeable Factors — Not Targeted, but Should Be Targeted Well Moving Forward		
Advocacy: There is a lack of effective advocacy at the highest levels to integrate the planning, quantification, resource management, and procurement of essential medicine, and participation of program units such as malaria, TB, and family planning for better coordination and information sharing under the CPDS umbrella; need for increased procurement responsibilities for the MPPD; lack of timely approval of key policies, strategies, and guidance (e.g., the National Pharmaceutical Strategic Plan, the District Pharmacy Operational Manual, the Laboratory Harmonization Policy, and Continued Professional Development Governance). ***Governance:*** Planning, quantification, resource management, and procurement of essential medicine is not under the CPDS. RBC program units such as malaria, TB, and family planning are not represented in the CPDS consortium for better coordination and information sharing. ***Change Management:*** An effective and practical change management plan needs to be in place for the planned MPPD transition to a semi-autonomous body. **Resource:** There is not a plan for additional resource needs and mobilization to support an effectively functioning MPPD once it becomes semi-autonomous. ***Innovation:*** Inadequate innovative oversight and payment mechanisms (e.g., trust fund) for supplier payments, granting MPPD a bigger role in procurement and leaving oversight and payments to IPs.	***Advocacy:*** To spread out CBHI premiums on a monthly basis throughout the coverage year; foster PSE through creation of a forum for regular dialogue and provision of health-specific business incentives; and foster high-level evidence-based advocacy for increased GOR resources in the health sector. ***Governance:*** CBHI benefit packages are not always aligned with current and changing health needs (e.g., rising burden of non-communicable diseases). ***Capacity Building:*** Insufficient technical and business skills (e.g., bookkeeping and managerial, business thinking) among CHW cooperative executive committee members; insufficient business thinking among health facility mangers. ***Innovation:*** Community awareness campaign to increase CBHI enrollment (e.g., innovative multi-sector behavior change communications, and information, education, and communication); innovative savings and lending schemes to facilitate timely and full payment for CBHI premiums at the decentralized levels; and innovative health-specific private sector incentives.	***Advocacy:*** Upcoming promotion and sensitization of PHQS; staff retention and incentive schemes; TA and collaboration for better functioning of the TWGs; health-specific private sector incentives to foster PSE. ***Resource:*** Lack of an effective plan to mobilize resources to support the cascading ToT model at the lower levels; lack of resources for IRS in all malaria-endemic districts. ***Innovation:*** Need for innovative incentive schemes (financial and non-financial) for staff retention. ***Change Management:*** There is a need for capacity building support to health facilities to manage institutional changes with high staff turnover. ***Focus on Results:*** There is a need for support to strengthen coordination among key GOR entities to increase the focus on strategic results; insufficient awareness and understanding of key stakeholders, including high-level GOR staff, of the USAID/Rwanda support contributing/driving toward broader health sector strategic results.

Sub-purpose 3: Supply Chain Management	Sub-purpose 4: Health Financing	Sub-purpose 5: Leadership & Governance
QR2 — More Important and Less Changeable Factors		
Governance: Complex and slow RPPA procurement rules and regulations.	***Advocacy:*** Integration of CBHI into other RSSB insurance schemes (e.g., Rwanda's Medical Insurance Agency) for greater pool and management efficiencies (GOR regulations). ***Governance:*** Review of *Ubudehe* classification for CBHI premium alignment. ***Capacity Building:*** Basic equipment for Health Posts and CHW cooperatives (e.g., computers, running water, solar panels, and suitable restroom facilities).	***Resource, Capacity Building, and Innovation:*** High annual cost of eLMIS licensing and subscription.
QR3 — Less Important and More Changeable Factors		
Sub-purpose 4: Health Financing (HF) – Governance and Innovation: Build on current model of One Family Health (OFH) Health Posts (HPs) and scale up in line with the changes in government policy (e.g., community, public, and private partnership).		
QR4 — Less Important and Less Changeable Factors		
Sub-purpose 3: Commodity and Supply Chain Management (SCM) – Governance: U.S. government global procurement mechanisms for certain programs such as the President's Malaria Initiative (AIRS); U.S. government regulations regarding budget support and direct funding of government organizations.		

VI. RECOMMENDATIONS

This section presents the Evaluation Team's main recommendations, which are grouped by the evaluation questions and based on key findings and conclusions.

EVALUATION QUESTION 1: HEALTH SECTOR STRENGTHENING

- USAID/Rwanda should continue with the current design, structure, and management practices of SCHS for overall management and implementation for the remaining life of the project, including continuing to regularly communicate and coordinate with IPs to enhance the relationship between USAID/Rwanda and IPs, and coordination among SCHS IPs. *Priority level: High. Timeline: Now and ongoing.*

- USAID/Rwanda should replicate the RHSSA design model to engage the GOR in the design phase of all future SCHS activities, keeping an eye on and in line with USAID procurement restrictions. The Mission should also make joint work planning of IPs and GOR at both central and decentralized levels (through TWGs, DHMTs, and Joint Action Development Forums) a standard practice for all SCHS activities. *Priority level: High. Timeline: During future program design phases and ongoing.*

- The Mission should strengthen and ensure effective meaningful coordination and communication among the IPs to improve the focus on results and collaboration, and to attain "value for money" through efficiency gains in common areas of work. It should formally hold IPs accountable and ensure that sharing and collaboration take place through meaningful coordination and communication (e.g., work plans, review by chiefs of party, and coordination meetings), ensuring that each IP clearly identifies and shares activities and areas of collaboration with other IPs. IPs should report on actual progress in these areas through quarterly and annual reports. USAID/Rwanda should monitor progress and provide necessary guidance on an ongoing basis. *Priority level: High. Timeline: Now and ongoing.*

- IPs should continue current practices of embedding staff in the GOR at central and provincial levels for effective implementation and capacity building for now and in the medium term. At the same time, they should support high-level advocacy and explore and analyze strategies for increased GOR commitment and resources to take over these embedded and PTA positions in the longer run, thus ensuring sustainability. *Priority level: High. Timeline: Now and ongoing, and medium to longer term.*

- All IPs should heighten efforts to follow current good practices (such as by the RHSSA) of providing estimated support/contribution to both central and decentralized levels ahead of the GOR planning cycle, based on their own work plans and USAID/Rwanda's guidance. *Priority level: Medium. Timeline: Prior to next fiscal year planning period.*

- All IPs should actively participate, support, and facilitate Technical Working Groups while ensuring improved GOR leadership and ownership of the groups. They should also meaningfully engage the government in defining or getting input to the suitable qualifications and roles and responsibilities (terms of reference) of key IP professionals in line with the health sector context and needs. *Priority: High. Timeline: Now and ongoing.*

EVALUATION QUESTION 2: HEALTH SYSTEM STRENGTHENING

Sub-purpose 3: Recommendations for the Next Supply Chain Activity

1. **Build on past successes and lessons learned to further strengthen institutional capacity in procurement and distribution systems**

- Conduct an impact and risk assessment for potential decrease in USAID funding for critical commodities in the areas of HIV, malaria, and family planning. *Priority level: High. Timeline: Now.*

- Conduct high level advocacy and provide TA support to build the institutional profile and capacity of the Logistics Management Office. *Priority level: High. Timeline: Now and ongoing.*

- Conduct high-level advocacy and provide TA support for enabling laws to convert the MPPD into a semi-autonomous body with adequate startup resources. Once it is semi-autonomous, USAID/Rwanda and MPPD should explore options for transitioning more procurement responsibility of U.S. government commodities to MPPD, while leaving payment responsibilities and oversight functions with USAID IPs, in compliance with U.S. government regulations, including the Federal Acquisition Regulation.

- AIRS IPs should coordinate with supply chain IPs to strengthen MPPD's capacity to procure and store insecticides for IRS for efficiency gain (i.e., better "value for money"). *Priority level: Medium. Timeline: Now and medium term.*

2. Continue supporting and strengthening the Coordinated Procurement and Distribution System (CPDS)

- Conduct advocacy for integration of quantification and procurement of essential medicines under the CPDS umbrella and for the Rwanda Biomedical Center's malaria, TB, and family planning units' participation in the CPDS umbrella. *Priority: High. Timeline: Now and medium term.*

- Conduct a district-level warehousing assessment and develop creative/innovative warehousing solutions, such as putting additional units in the existing District Pharmacy space, establishing concepts such as "warehouse in a box." *Priority level: High. Timeline: Medium term.*

3. Strengthen the Use of the eLMIS to Reduce Stockouts and Gain Efficiencies

- Conduct a review of eLMIS data quality and use for consumption reporting and other relevant business processes, and devise and implement an action plan to improve data quality and increase use of the system for key business functions, including consumption reporting.

- Provide customized refresher training and ongoing mentoring and supportive supervision for eLMIS at the decentralized level.

- Advocate for and provide TA to implement the MOH directive to decommission the paper system and use eLMIS exclusively at all levels. *Priority level: High. Timeline: Now and ongoing.*

- Advocate for the approval of key supply chain-relevant policies, strategies, and guidelines, by the GOR (National Pharmaceutical Supply Chain Strategic Plan 2013-2018; District Pharmacy Operational Manual; Laboratory Harmonization Policy; and Continuous Professional Development Governance). *Priority level: Medium. Timeline: Now and medium term.*

Sub-purpose 4: Recommendations for RHSSA

1. Further strengthen business skills at all levels

- Provide training and refresher training in evidence-based planning and financial and business management skills to MOH and facility and administrative managers at the decentralized levels. *Priority level: High. Timeline: Now and ongoing.*

2. Strengthen CHWs cooperatives toward financial viability and sustainability

- Scale up TA in business plan development and business skills, and accelerate ongoing mentorship and supportive supervision for cooperatives on overall effective management and operation. *Priority level: High. Timeline: Now and ongoing.*

3. Strengthen Community-Based Health Insurance schemes (CBHI, or *mutuelles*) to increase enrollment

- Advocate for effective follow-up on the GOR plan to place a dedicated RSSB staff member at all HCs to effectively manage CBHI.
- Conduct a study to assess the feasibility of and identify the changes needed in administrative and financial systems to distribute CBHI premium payments on a monthly basis.
- Develop SOPs covering all aspects of CBHI management and distribute to all health facilities.
- Develop an innovative community-level advocacy and awareness campaign on CBHI benefits.
- Provide training to RSSB staff on business processes, including computerized bill verification and approval and payment systems. *Priority level: High. Timeline: Now and ongoing.*
- Conduct a study to determine if *Ubudehe* categorization is properly aligned with premiums, and recommend changes to the MOH and RSSB accordingly.
- Review the CBHI benefit packages to determine which critical health needs are not covered and recommend changes to the MOH and RSSB accordingly. *Priority level: Medium. Timeline: Medium and longer term.*

4. Strengthen income generation capacity among health professionals and support increased private sector engagement in health

- Conduct high-level advocacy for increased private sector engagement in the health sector.
- Disseminate the PPP policy and regulations, and provide training on PPP, business analysis and development, and innovative revenue generation for the MOH PPP Unit and for health facility managers at the decentralized levels. *Priority level: High. Timeline: Now and ongoing.*
- Develop service standards, quality improvement, and business skills, and provide associated training for Health Posts, building on the current PPP/community, public, and private partnership Health Post (e.g., One Family Health) model. *Priority level: Medium. Timeline: Now and ongoing.*

Sub-purpose 5: Recommendations for RHSSA and AIRS

1. Continue strengthening District Health Units/DHMTs/District Hospitals/Provincial Hospitals

- Provide refresher training on planning and financial management, including the Integrated Financial Management Information System for DHMTs, District Hospitals, and Provincial Hospitals. *Priority level: High. Timeline: Now and ongoing.*

2. Support data systems and their interoperability

- Develop modules in key existing systems such as the HMIS and eLMIS to facilitate data integration/exchange and interoperability across and with other systems. *Priority level: High. Timeline: Now and medium term.*

- Investigate alternative options for non-proprietary software for SCM, electronic medical records, and e-billing. *Priority level: Medium. Timeline: Medium and longer term.*

- Conduct a cost-benefit analysis and return on investment study of eLMIS and develop mechanisms for the health facilities to potentially cover all or part of the licensing fees. *Priority level: Medium. Timeline: Medium term.*

3. Strengthen training and mentorship and support cascade training

- Integrate a module on the "nuts and bolts" practicalities of organizing cascade training into current district-level training to ensure ToT graduates have the know-how to initiate, organize, and run ToT. Develop a system to track the number of cascade training courses and people trained, and monitor the quality of the training.

- Provide ToT graduates with official paper certificates stating they are certified trainers.

- Provide ongoing mentorship and refresher training to ToT graduates.

- Provide training and ongoing mentorship for health facility personnel on quality improvement/accreditation and use of SOPs, and develop a tool to support facilities to monitor the use of the procedures on a daily basis.

  Priority level and timeline for all of the above: High; Now and ongoing.

4. Improve intra-governmental coordination

- Develop an action plan geared to the Ministry of Local Government and the MOH, at both central and decentralized levels. *Priority level: Medium. Timeline: Now and medium term.*

5. Continue IRS activities and capacity building and advocate for expanding IRS coverage to all malaria-endemic districts

- Conduct evidence-based, high-level advocacy to increase PMI funding and to mobilize domestic resources for IRS to cover all 13 or additional malaria-endemic districts, and provide TA on IRS once coverage expands.

- Conduct and support advocacy campaigns to raise awareness of IRS benefits in affected communities. *Priority level: Medium. Timeline: Now and medium term.*

6. *Develop and implement strategies to reduce staff turnover*

- Develop a practical and evidence-based staff retention strategy and action plan for health facilities, including an incentive system for health professionals working at decentralized levels. *Priority level: High. Timeline: Now and ongoing.*

EVALUATION QUESTION 3: FACTORS THAT CONTRIBUTE TO SUSTAINABILITY

Recommendations for IPs and USAID/Rwanda

- Continue current efforts and focus, and build on gains on the more "important" and "changeable" factors identified as currently "targeted and well-addressed" under QR 1, Part1, of Evaluation Question 3 (see matrix) in context of the recommendations for Evaluation Question 2 in relation to SCHS Sub-results 3-5. The critically "important" and "changeable" factors for which current focus need to be continued are:

  - *Sub-result 3 (SCM): governance; coordination and communication; capacity building; innovation*

- *Sub-result 4 (HF): governance; institutional effectiveness; capacity building*
- *Sub-result 5 (L&G): governance; coordination; capacity building; institutional effectiveness*

- Heighten current efforts and focus to better address the more "important" and "changeable" factors identified as currently "targeted, but not well-addressed" under QR, Part 2, of Evaluation Question 3 in the context of the recommendations for Evaluation Question 2 in relation to Sub-results 3-5. The critically "important" and "changeable" factors for which current focus needs to be better addressed and improved are:

  - *Sub-result 3 (SCM): leadership and ownership; governance; coordination; capacity building*
  - *Sub-result 4 (HF): leadership and advocacy; governance; institutional effectiveness; capacity building*
  - *Sub-result 5 (L&G): leadership; governance; coordination; capacity building*

- Effectively plan for and employ new efforts and focus to better address the more "important" and "changeable" factors identified as currently "not targeted, but should be targeted well moving forward" under QR1, Part 3, of Evaluation Question 3 in the context of the recommendations for Evaluation Question 2 in relation to Sub-results 3-5. The critically "important" and "changeable" factors that need to be newly focused on and addressed are:

  - *Sub-result 3 (SCM): advocacy; governance; change management; resource; innovation*
  - *Sub-result 4 (HF): advocacy; governance; capacity building; innovation*
  - *Sub-result 5 (L&G): advocacy; resource; change management; focus on results; innovation*

- In light of recommendations above, the SCHS management team should provide effective guidance and ensure that the relevant project activities focus on and effectively address the common critical factors that are more "important" and "changeable" under QR1 Parts 1-3, underpinning the sustainability of the health system, namely governance; leadership and advocacy; capacity building; coordination and communication; institutional effectiveness; change management; resource; focus on results; and innovation within the context and areas identified.

- Do not address the factors under QR2 "More Important and Less Changeable Factors," QR3 "Less Important and More Changeable Factors," and QR4 "Less Important and Less Changeable Factors."

ANNEX I. SCOPE OF WORK

Assignment #: 261 [*assigned by GH Pro*]

Global Health Program Cycle Improvement Project -- GH Pro
Contract No. AID-OAA-C-14-00067
EVALUATION OR ANALYTIC ACTIVITY STATEMENT OF WORK (SOW)
Date of Submission: 7-15-2016
Last Updated: 5-11-2017
Amendment #1

I. TITLE: Performance Evaluation of the USAID/RWANDA Strengthening the Capacity of the Health Sector to Deliver Quality Health Services Project

II. Requester / Client

■ USAID Country or Regional Mission
Mission/Division: Rwanda / Health Office

III. Funding Account Source(s): (Click on box(es) to indicate source of payment for this assignment)

☐ 3.1.1 HIV	☐ 3.1.4 PIOET	■ 3.1.7 FP/RH
☐ 3.1.2 TB	☐ 3.1.5 Other public health threats	☐ 3.1.8 WSSH
■ 3.1.3 Malaria	■ 3.1.6 MCH	☐ 3.1.9 Nutrition
		☐ 3.2.0 Other (specify):

IV. Cost Estimate: Note: GH Pro will provide a cost estimate based on this SOW

V. Performance Period

Expected Start Date (on or about): 10-3-2016
Anticipated End Date (on or about): 6-27-2017

VI. Location(s) of Assignment: (Indicate where work will be performed)

Rwanda

VII. Type of Analytic Activity (Check the box to indicate the type of analytic activity)

EVALUATION:

■ **Performance Evaluation** (*Check timing of data collection*)
■ Midterm ☐ Endline ☐ Other (specify): .

Performance evaluations focus on descriptive and normative questions: what a particular project or program has achieved (either at an intermediate point in execution or at the conclusion of an implementation period); how it is being implemented; how it is perceived and valued; whether expected results are occurring; and other questions that are pertinent to program design, management and operational decision making. Performance evaluations often incorporate before-after comparisons, but generally lack a rigorously defined counterfactual.

☐ **Impact Evaluation** (*Check timing(s) of data collection*)
☐ Baseline ☐ Midterm ☐ Endline ☐ Other (specify):

Impact evaluations measure the change in a development outcome that is attributable to a defined intervention; impact evaluations are based on models of cause and effect and require a credible and rigorously defined counterfactual to control for factors other than the intervention that might account for the observed change. Impact evaluations in which comparisons are made between beneficiaries that are randomly assigned to either a treatment or a control group provide the strongest evidence of a relationship between the intervention under study and the outcome measured.

OTHER ANALYTIC ACTIVITIES

☐ **Assessment**

Assessments are designed to examine country and/or sector context to inform project design, or as an informal review of projects.

☐ **Costing and/or Economic Analysis**

Costing and Economic Analysis can identify, measure, value and cost an intervention or program. It can be an assessment or evaluation, with or without a comparative intervention/program.

☐ **Other Analytic Activity** (Specify)

PEPFAR EVALUATIONS *(PEPFAR Evaluation Standards of Practice 2014)*

Note: If PEPFAR funded, check the box for type of evaluation

☐ **Process Evaluation** (*Check timing of data collection*)

☐ Midterm ☐ Endline ☐ Other (specify): _____

Process Evaluation focuses on program or intervention implementation, including, but not limited to access to services, whether services reach the intended population, how services are delivered, client satisfaction and perceptions about needs and services, management practices. In addition, a process evaluation might provide an understanding of cultural, socio-political, legal, and economic context that affect implementation of the program or intervention. For example: Are activities delivered as intended, and are the right participants being reached? (PEPFAR Evaluation Standards of Practice 2014)

☐ **Outcome Evaluation**

Outcome Evaluation determines if and by how much, intervention activities or services achieved their intended outcomes. It focuses on outputs and outcomes (including unintended effects) to judge program effectiveness, but may also assess program process to understand how outcomes are produced. It is possible to use statistical techniques in some instances when control or comparison groups are not available (e.g., for the evaluation of a national program). Example of question asked: To what extent are desired changes occurring due to the program, and who is benefiting? (PEPFAR Evaluation Standards of Practice 2014)

☐ **Impact Evaluation** (*Check timing(s) of data collection*)

☐ Baseline ☐ Midterm ☐ Endline ☐ Other (specify):

Impact evaluations measure the change in an outcome that is attributable to a defined intervention by comparing actual impact to what would have happened in the absence of the intervention (the counterfactual scenario). IEs are based on models of cause and effect and require a rigorously defined counterfactual to control for factors other than the intervention that might account for the observed change. There are a range of accepted approaches to applying a counterfactual analysis, though IEs in which comparisons are made between beneficiaries that are randomly assigned to either an intervention or a control group provide the strongest evidence of a relationship between the intervention under study and the outcome measured to demonstrate impact.

☐ **Economic Evaluation** (PEPFAR)

Economic Evaluations identifies, measures, values and compares the costs and outcomes of alternative interventions. Economic evaluation is a systematic and transparent framework for assessing efficiency focusing on the economic costs and outcomes of alternative programs or interventions. This framework is based on a comparative analysis of both the costs (resources consumed) and outcomes (health, clinical, economic) of programs or interventions. Main types of economic evaluation are cost-minimization analysis (CMA), cost-effectiveness analysis (CEA), cost-benefit analysis (CBA) and cost-utility analysis (CUA). Example of question asked: What is the cost-effectiveness of this intervention in improving patient outcomes as compared to other treatment models?

VIII. BACKGROUND

Background of project/program/intervention:

Introduction

USAID/Rwanda is committed to achieving its development objectives. The SCHS project contributes to the achievement of the Development Objective (DO) 3 "Health and nutritional status of Rwandans improved" of USAID/Rwanda's draft 2014-2019 Country Development Cooperation Strategy (CDCS), and corresponds to its Intermediate Result (IR) 3.1, "Strengthened capacity of health sector to deliver high quality services." The project addresses the capacity/supply side of health services both

at the central (sub-IR 3.1.1) and decentralized (sub-IR 3.1.2) levels. The SCHS project is complemented by a second USAID/Rwanda health project focused on the demand side (corresponding to the IR 3.2 "Strengthened capacity of households and communities to improve their own health"). Together, these two projects will contribute to the achievement of the DO 3.

As mentioned above, the Strengthening Capacity of Health Sector to Deliver Quality Health Services Project (SCHS) is a five-year, $294 million project to strengthen Rwanda's health system. Through this project, USAID/Rwanda will, along with other development partners in the sector, engage GOR in a health sector financing dialogue as a critical step in both medium and longer-term goals of the GOR and USAID to increase the efficiency of the health sector and, in line with the GOR Vision 2020, to gradually decrease the country's dependence on foreign aid.

The project is implemented in close collaboration with the Ministry of Health (MOH). It directly supports the MOH's Health Sector Strategic Plan III (HSSP III) and the Government of Rwanda's Economic Development and Poverty Reduction Strategy 2 (EDPRS 2). In collaboration with MOH and other GOR entities at central and decentralized levels, the project will maximize the financial envelope of domestic health resources through innovative financing mechanisms.

Since its inception, the SCHS project has implemented 4-6 activities simultaneously. These include one to three activities focus on commodity procurement and supply chain strengthening for family planning, HIV and malaria; one on indoor residual spraying to combat malaria; one on maternal and child health and family planning service delivery; and one covering health sector leadership and governance, health finance, and health information systems.

The activities being evaluated in this project-wide mid-term performance evaluation include DELIVER II Task Order 4, DELIVER II Task Order 7, Supply Chain Management Systems (SCMS), Africa Indoor Residual Spraying, and the Rwanda Health Systems Strengthening Activity. Table 1 shows these four and all other SCHS activities.

Table 1: SCHS Project Activities (DO 3, IR 3.1)

Activity Name	USAID Office	Implementer	Cooperative Agreement/ Contract #	SCHS TEC (in millions)	Activity Dates	Active Geographic Regions	AOR, COR and/or Activity Manager
IRS2 TO4	Washington	Abt Associates, Inc.	AID-GHN-I-00-09-00013	$29.9	2009-2014	2-3 Districts per spray round	Kaendi Munguti
Integrated Health Systems Strengthening Project	Rwanda	Management Sciences for Health	AID-GHS-I-00-07-00006	$24.9	2009-2014	National	Michael Karangwa
Family Health Project	Washington	Chemonics	AID-696-C-12-00001	$18.9	2012-2015	20 Districts	Judy Chang
DELIVER II TO 4 Family Planning	Washington	PFSCM	AID-GPO-I-00-06-00007	$1.9	2011-2017	National	Ashley Smith/Pangday Yonzone
DELIVER II TO 7 Malaria	Washington	PFSCM	AID-GPO-I-00-06-00007	$14.7	2011-2017	National	Ashley Smith/Pangday Yonzone
SCMS	Washington	PFSCM	GPO-I-03-05-00032	$45.5 (Rwanda)	2009-2017	National	Ashley Smith/Pangday Yonzone

Activity Name	USAID Office	Implementer	Cooperative Agreement/ Contract #	SCHS TEC (in millions)	Activity Dates	Active Geographic Regions	AOR, COR and/or Activity Manager
Central Contraceptive Procurement	Washington	PFSCM	Various	$9.5	Ongoing	National	Ashley Smith/Pangday Yonzone
Africa Indoor Residual Spraying	Washington	Abt Associates, Inc.	AID-GHN-I-00-09-00013	$25.3	2014-2017	1-3 Districts per spray round	Kaendi Munguti
Rwanda Health Systems Strengthening Activity	Rwanda	Management Sciences for Health	AID-696-A-15-00001	$24.9	2014-2019	National	Michael Karangwa
Maternal and Child Survival Program	Washington	Jhpiego	AID-OAA-A-14-00028	$43	2015-2018	20 Districts	Mary Kabanyana
Global Health Supply Chain	Washington	Various	TBD	TBD	2015-2020	National	Ashley Smith/Pangday Yonzone

Background

In Rwanda, a country that has exceeded expectations regarding its performance in the health sector, the accolades run deep. Few, if any, countries on the African continent have managed to improve mortality rates and other key indicators in such a short period. From 2005 to 2010 and 2015, infant mortality declined from 86 to 50 to 32 deaths per 1,000 live births and under-five mortality declined from 152 to 76 to 50 deaths per 1,000 live births[25,26,27]. Deaths due to malaria are declining steadily, despite recent increases in incidence. Almost all pregnant women attending antenatal care (ANC) are counseled and tested for HIV, with Prevention of Mother to Child Transmission (PMTCT) services reaching 94%. More than 100,000 patients are on Antiretroviral Treatment (ART), representing 94% of expected patients. Modern contraceptive use among married couples has increased dramatically to 47.5%[28]. Enrollment of the population in the innovative Community Based Health Insurance (CBHI) scheme, covering an essential package of services, reached 91% in 2012 and the latest indications are that it is hovering above 80%. Several new district hospitals and maternity wards have been constructed and rehabilitated, or are in the process. These accomplishments would be remarkable for many countries, but Rwanda stands out in large part due to its post-crisis history. Globally, Rwanda is recognized for its executive level commitment to health - a commitment that is paying dividends. These gains, among numerous others, reflect the high rate of adoption of effective health practices by Rwandans, and focused strategic investment by politically dedicated executive level government officials. Additionally, gender equality and women's empowerment have been taken into account as a cornerstone of the Government of Rwanda's development strategy and a proven source of development progress across all sectors.

To achieve many of the advances to date, donors (including USAID) have relied on high levels of international technical assistance and direct financing of recurrent costs (including staff salaries) to operate an expanded health system. The system is now stronger, and health status is improving. Both the donor community and the GOR agree that it is time to tackle the problem of sustainability by strengthening the institutional capacity of the sector and building financing mechanisms that can be

[25] DHS 2005 Key Findings. http://dhsprogram.com/pubs/pdf/SR118/SR118.pdf.

[26] DHS 2010 Key Findings. http://dhsprogram.com/pubs/pdf/SR187/SR187.pdf.

[27] DHS 2014-2015 Key Indicators. http://dhsprogram.com/pubs/pdf/PR65/PR65.pdf.

[28] DHS 2014-2015 Key Indicators. http://dhsprogram.com/pubs/pdf/PR65/PR65.pdf.

maintained into the future. The GOR has asked the USG, through USAID, to continue assistance in the further development of the country's health management systems.

USAID/Rwanda uses the SCHS Project to strengthen the Rwandan health system and promote host country ownership by increasing capacity to manage a variety of systems operations. This includes: assistance in procurement of health commodities; improvements in service delivery (including quality and availability); further development and integration of information systems; identifying and piloting innovative solutions for mobilizing additional domestic resources for health, supporting an enabling environment for private health care services; and, overall, strengthening the system in an integrated manner. In addition to standard implementing mechanisms that provide technical assistance, activities will focus on local capacity development (largely within the MOH and related entities).

The SCHS project embodies the principles and development objectives espoused in the draft Mission CDCS, with its emphasis on developing sustainable improvements in the management of health services and commodities. It contributes to USAID's draft 2015-2019 CDCS overall goal of "Accelerating Rwanda's progress to middle income status and better quality of life through sustained growth and reduction of poverty" and directly to DO3, "Health and nutritional status of Rwandans improved." Rwanda's future growth and development are heavily dependent on the health of its population. For the population to become and remain healthy and productive, they must first have access to and be able to use safe, high quality health services. A strong health system with uniformly articulated and implemented policy and a financial structure that ensures access to services is the foundation for its success.

As described above, the purpose of the SCHS project corresponds to the IR 3.1 of the CDCS. The sub-purposes of the project are formulated along five of the six World Health Organization (WHO) health systems building blocks. The building block absent from the SCHS Project is Human Resources for Health (HRH). The Rwandan Ministry of Health has taken the lead on HRH and welcomes donor support in the five areas to which SCHS contributes. WHO has shown that strengthening the six building blocks results in stronger health systems. Within each of the five sub-purposes, outputs and planned activities will be focused on both central and local levels in line with the CDCS Sub-IR 3.1.1: Central level health systems strengthened and Sub-IR 3.1.2: Decentralized health systems improved.

The DO to which the project will be contributing is to improve the health and nutritional status of Rwandans. The purpose of the project is to strengthen the capacity of the health sector in Rwanda to deliver affordable, responsive, and high-quality health services. SCHS activities support five sub-purposes that together will contribute to the achievement of the project purpose and goal:

Sub-purposes:

1. Delivery of health services improved
2. Accurate and timely data use for decision-making institutionalized
3. Essential medical products available and accessible at service delivery points
4. Increased domestic resources for the health sector used equitably and efficiently
5. Leadership and governance of health system at central and local levels strengthened

Description of the Problem, Development Hypothesis(es), and Theory of Change

The project logic is based on the following development hypothesis: by improving the availability of quality health services, ensuring that accurate and timely health data are available and used for decision making, guaranteeing access and availability of medical products at service delivery points, promoting rational use of medicines, supporting GOR in its aspiration to increase domestic resources for the health sector, sustaining access and affordability of essential health services, and strengthening

leadership and governance of the health sector, USAID expects to achieve the purpose of the project: to strengthen the capacity of the health sector in Rwanda to deliver affordable, responsive and high quality health services.

This, in turn, will significantly contribute to improvement of health status of Rwandans, as expressed by the following high-level targets (in line with GOR HSSP III):

- Reduced under-five mortality from 72 to 42 per 1000 live births, exceeding the MDG for child health (50 per 1000 live births);
- Reduced maternal mortality from 476 to 220 per 100,000 live births, exceeding the MDG for maternal health (227.5 per 100,000 live births);
- Sustain HIV prevalence at 3% or lower
- Reduced Total fertility rate (TFR) from 4.6 to 3.4

In May 2015, key results from the Rwanda Demographic and Health Survey 2014-2015 were released. Under-five mortality was found to be 50 per 1000 live births; maternal mortality 210 per 100,000 live births; and total fertility 4.3. The GOR has committed to updating some targets for HSSP III in light of the early achievement of several goals that had been set for 2018. When new targets are set, the SCHS Project will revise its targets and results framework.

Overall, one of the key anticipated results of the project will be that GOR health systems will improve, but most importantly sustain the achievements in the health sector. By the end of the project, district health and local government authorities will provide administrative support and oversight to decentralized health facilities according to the health sector decentralization policy. The Project will result in improved management and productivity of health care workers at facility level and sustained delivery of community based health interventions by cooperatives of community health workers. The project will also have improved the framework for private sector engagement in health, creating an attractive investment environment as GOR continues to graduate from external donor funding in its transition to a lower-middle-income country. This will enable the GOR to reduce donor dependency in delivering essential health services, partially covering the recurrent costs of the system currently paid through external financing. USAID expects that as a result of project interventions, out of pocket expenditures on health, which can be catastrophic, will be reduced and financial access to affordable and quality healthcare services will be increased.

Improved central and decentralized health planning and governance systems will result in an increased percent of births taking place in health facilities from 85% to 90%, increased family planning couple years protection in USG-supported programs from 803,268 to 819,332, increased percentage of pregnant women who attend at least four antenatal care visits from 35.4% to 50%, maintaining an increased percentage of HIV-positive pregnant women who received antiretrovirals to reduce mother-to-child transmission during pregnancy and delivery at 95%, and a reduced ratio of household out-of-pocket expenditure on health to total expenditure on health to 11% from 15%. In turn, the project will contribute to the following impact: maternal mortality will be reduced to 220 per 100,000 from the 2013 baseline of 477; under-five mortality will be reduced to 42 per 1,000 live births from the 2013 baseline of 76; HIV prevalence will remain stable at 3% of the general population; and the total fertility rate will be reduced to 3.4 from a 2013 baseline of 4.6. In addition, gender integration into the SCHS activities will result in enhanced gender sensitivity, knowledge and skills for planning in the health sector at central and decentralized levels and improved delivery and quality of health services for all by health professionals.

By the end of the project, the proportion of USG contribution to Rwanda's health commodities budget will also be reduced, as the country takes on greater responsibility by increasing its own investments in commodities. Approximately 51% of the investment through this project will support the procurement of commodities in support of Rwanda's health sector. Most of these commodities are essential to maintain programs and the entire health system.

Summary Activity/Project/Program to be evaluated

The SCHS Project was designed taking into account the existing health portfolio of USAID|Rwanda at the time of design, as was the CHAIN Project. The SCHS Project absorbed activities that focus on the supply side of health services--the systems that deliver prevention, care and treatment--while the Community Health and Improved Nutrition (CHAIN) Project incorporated community-demand-focused activities already active within the portfolio. As new activities are planned and designed, they are done so under the aegis of the Projects.

This evaluation will consider three implementing mechanisms: 1) the Rwanda Health Systems Strengthening Activity, 2) SCMS/DELIVER, and 3) Africa Indoor Residual Spraying. This section includes a brief description of each activity, the geographic locations in which each operates and the targeted beneficiaries or groups. Since the beginning of the project, there have been no substantive modifications made to the activities. Annex 1 shows the relationship of the SCHS' activities to the sub-purposes and outputs in the project's Results Framework.

1. Rwanda Health Systems Strengthening Activity

In recent years Rwanda has made remarkable progress in improving the health of its citizens, particularly as seen through indicators for infant mortality, child mortality, and maternal mortality. Access to health services has improved as well, and promising efforts in hospital accreditation and quality improvement speak to this progress. To maintain this progress, much still needs to be done to make sure Rwanda's health system can sustain itself into the future. USAID's Rwanda Health System Strengthening Activity will enhance the resiliency of the Rwandan health sector to address new challenges and build a sustainable health system, capable of leading and managing changes for the improved health of all Rwandans.

The overall goal of RHSSA is to achieve strengthened and expanded performance of the Rwandan health system at national, decentralized and community levels by:

- Institutionalizing health systems thinking to increase advocacy, leadership and stewardship;
- Enhancing policy, planning and implementation at central and district levels;
- Increasing revenue mobilization for the health sector;
- Improving quality of health services and greater efficiency in resource use; and
- Strengthening M&E, health systems research, learning and knowledge-based practices.

Expected results:

- Advanced country ownership of strategies and meaningful partnership and participation among relevant national and local level leadership
- Upgraded capacity of central and local level healthcare managers for planning, policy and strategy implementation
- Increased revenues and efficient and equitable allocation of financial and human resources
- Expanded private sector engagement and investments in health facilities;
- Strengthened evidence base on accreditation schemes to support quality improvement in hospitals and other health facilities;

- Reliable and relevant data and information that is publicly accessible and used by health professionals for decision-making
- Increased use of research outcomes into policy, program, plans, and strategy dialogue and formulation

2. SCMS/DELIVER

Effective health commodities logistics management is a pillar supporting commodity security, and a component vital to the success of any public health program. Ensuring that clients have the right product at the right time is the main objective of a secure public health supply chain. The co-run DELIVER and SCMS projects work with the Ministry of Health to increase the availability of maternal and child health, family planning, malaria, HIV/AIDS, and related commodities. The projects encourage policymakers and donors to support logistics as a critical factor in the overall success of Rwandan health care mandates.

Objectives:

- The activities' main objectives are to increase access to essential medicines and support procurement of family planning, malaria, HIV/AIDS, and laboratory commodities by:
- Strengthening the national supply chain system for all essential medicines
- Building human capacity in logistics management
- Supporting Rwanda's Central Medical Stores with mentoring and by supplying operational equipment

Expected results:

- Reduce or eliminate stock outs
- Improve storage conditions
- Efficiently and effectively manage commodities according to clear logistics principles
- Liaise with national counterparts and build capacity to allow skills transfer
- Implement an eLMIS to enhance evidence-based decision-making for the supply chain at all levels.

3. Africa Indoor Residual Spraying

In Rwanda, approximately 11 of 30 districts contribute over 70% of the malaria disease burden. These districts are located in the eastern and Southern provinces. In order to prevent and control malaria in some of these districts, USAID employs Indoor Residual Spraying (IRS), which consists of the spraying of safe insecticides on the walls of structures – namely homes in target areas. IRS targets the mosquitoes before they are able to infect another person, thus disrupting the transmission of malaria. The Indoor Residual Spraying activities in Rwanda are supported under the Presidential Malaria Initiative (PMI). The IRS activity is implemented under the IRS 2 Task Order 6 by Abt Associates and is effective September 2014 to September 2016.

Prior to the current activity, Abt Associates implemented IRS Task Order 4 (TO4), also an IRS activity. The main objective of the three-year TO4 was to reduce the prevalence and incidence of malaria in Rwanda by:

- Supporting planning, operations and logistics for IRS implementation in Rwanda
- Supporting training, capacity building, and advocacy at national, regional, and district levels as a means of achieving IRS sustainability
- Ensuring safe and correct insecticide application, thus minimizing human and environmental exposure to insecticides

- Spray at least 85 percent of eligible structures in identified targeted
- Provide regular monitoring and evaluation for the IRS program
- Coordinate information, education and communication activities to raise awareness of IRS and its benefits

Some of the achievements of African Indoor Residual Spray (AIRS) IRS TO4:

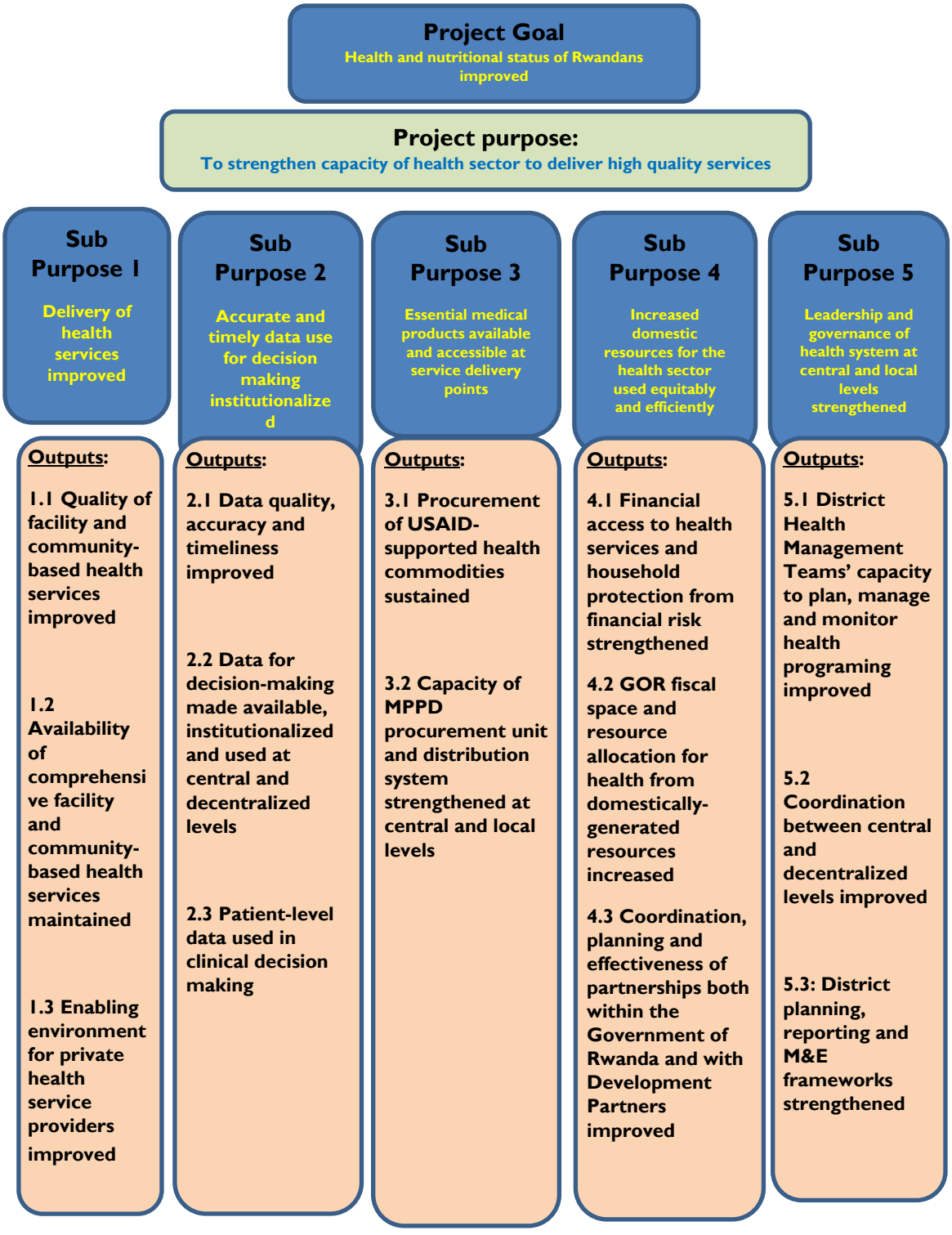
- 300,040 structures sprayed during the two spray rounds in 2014
- An estimated 1,217,837 people protected from malaria in Nyagatare, Bugesera and Gisagara
- 2,681 persons trained to deliver IRS in three districts
- Environmental and human safety measures from insecticide contamination enforced and IRS wastes disposed in accordance with the Rwanda Environmental Management Authority (REMA) safety regulations implemented.
- Due to increasing mosquito resistance to pyrethroids, in September 2013, PMI supported the use of a carbamate which has been shown to be more effective.
- Entomological studies have shown that the insecticide is effective in reducing vector-human contact.

The evaluation questions should consider TO4 and TO6. Both are important parts of SCHS.

Strategic or Results Framework for the project (*paste framework below*)

If project/program does not have a Strategic/Results Framework, describe the theory of change of the project/program/intervention.

Results Framework



What is the geographic coverage and/or the target groups for the project or program that is the subject of analysis?

National (see Activity table above)

IX. SCOPE OF WORK

A. Purpose: Why is this evaluation or analysis being conducted (purpose of analytic activity)? Provide the specific reason for this activity, linking it to future decisions to be made by USAID leadership, partner governments, and/or other key stakeholders.

The purpose of this evaluation is to provide specific learning and evidence for the design, planning, and management decisions by the SCHS Project Team going forward. The Strengthening Capacity of Health Sector to Deliver Quality Health Services (SCHS) Project is a five-year, $294 million project to strengthen Rwanda's health system that will mark 30 months of implementation in June, 2016. The SCHS Project is comprised of a number of activities (cooperative agreements and contracts as outlined in Table 1 above and Annex 2). With USAID support and the support of other donors to health service delivery and health systems strengthening, and the leadership of the Government of Rwanda (GOR), significant improvements have been made in the health sector and health outcomes over the last decade. However, the ability to sustain these significant health gains depends on increased capacity in community health, supply chain management, health financing, and in leadership and governance of the health sector to deliver an appropriate package of health services and commodities from the central level down to the local level. The Project began in 2013 under the title "Decentralized Health Systems Strengthening Project" and, in line with USAID's project definition guidance at the time, is the first supply-side health Project USAID/Rwanda has undertaken. In late 2014, the Project was given its current name as a result of a shift in planned implementation modality. Now, the SCHS Project Team would like to better understand how the Project structure and individual activities have contributed to results to date.

B. Audience: Who is the intended audience for this analysis? Who will use the results? If listing multiple audiences, indicate which are most important.

USAID/Rwanda Health Office and SCHS Project Team

C. Applications and use: How will the findings be used? What future decisions will be made based on these findings?

The USAID/Rwanda Health Office and specifically the Project Team will use results from this evaluation to inform management and planning for any required mid-course corrections and strategies to capitalize on efficiencies during the second half of project implementation.

D. Evaluation/Analytic Questions & Matrix:

a) Questions should be: a) aligned with the evaluation/analytic purpose and the expected use of findings; b) clearly defined to produce needed evidence and results; and c) answerable given the time and budget constraints. Include any disaggregation (e.g., sex, geographic locale, age, etc.), they must be incorporated into the evaluation/analytic questions. **USAID policy suggests 3 to 5 evaluation/analytic questions.**

b) List the recommended methods that will be used to collect data to be used to answer each question.

c) State the application or use of the data elements towards answering the evaluation questions; for example, i) ratings of quality of services, ii) magnitude of a problem, iii) number of events/occurrences, iv) gender differentiation, v) etc.

	Evaluation Question
1	To what extent has the design of the SCHS project facilitated or hindered USAID's support to strengthen the capacity of the health sector to deliver high quality services? In this context, design refers to the relationships between the elements of the SHCS project matrix (Annex 2) including the interactions and dependencies of stakeholders as well as activities implemented as they relate to the Results Framework. Consider elements such as structure, coordination among IPs, engagement of stakeholders among others.
The performance evaluation should answer questions 2 and 3 in relation to sub-purposes 3-5 (Medical products & Pharmaceuticals, Health Financing, Leadership & Governance)	
2	To what extent has the SCHS project strengthened the capacity of Rwandan health systems in relation to sub purposes 3, 4 & 5? a. What is the level of capacity of the GOR in these areas?
3	Does SCHS target the most important and changeable factors that contribute to the GOR's capacity to sustain a strong system that will provide high quality services? a. Are there other more important and changeable areas?
Note: Evaluation Matrix is located in Annex 1	

Other Questions *[OPTIONAL]*
(***Note***: Use this space only if necessary. Too many questions leads to an ineffective evaluation or analysis.)

E. Methods: Check and describe the recommended methods for this analytic activity. Selection of methods should be aligned with the evaluation/analytic questions and fit within the time and resources allotted for this analytic activity. Also, include the sample or sampling frame in the description of each method selected.

General Comments related to Methods:
The evaluation design should describe methodologies for the analysis of all qualitative and quantitative data that will be collected. This analysis should identify any barriers or constraints to answering the EQs and utilizing the data to realize the project as planned and describe how it adapted to changing circumstances (e.g., political or policy environment changes, etc.).

To address the evaluation questions about capacity, a Capacity Assessment should be incorporated into the methods listed below.

■ **Document and Data Review** (*list of documents and data recommended for review)*

This desk review will be used to provide background information on the project/program, and will also provide data for analysis for this evaluation. Review of the documents generated by the implementing partner for ongoing project monitoring and evaluation (M&E). These will include, but are not limited to:

- Rwanda CDCS 2015-2019
- USAID/Rwanda's annual Performance Plan and Report (PPR) and Performance Management Plan (PMP)
- Decentralized Health Systems Strengthening Project (later amended to SCHS) Approval Document
- USAID/Rwanda Strengthening the Capacity of the Health System Project Appraisal Document and Annexes (approximately 50 pages) with SCHS Monitoring, Evaluation, and Learning Plan (Annex 3)
- Rwanda Vision 2020

- Economic Development and Poverty Reduction Strategy II, 2013-2018
- Health Sector Strategic Plan III, 2013-2018
- Assessments and performance solution packages for all supported institutions and CSOs, among others.
- Implementing partners' annual work plans (approx. nine)
- Implementing partners' monitoring and evaluation plans (three)
- Implementing partners' quarterly and annual reports (six to nine)
- AIDTracker Plus reports on implementing partners performance
- Other health donors' reports readily available
- Other MOH readily relevant documents, M&E systems/reports
- Rwanda DHS & MIS (http://dhsprogram.com/Where-We-Work/Country-Main.cfm?ctry_id=35&c=Rwanda&Country=Rwanda&cn=&r=1)
- Other documents, as required

☐ **Secondary analysis of existing data** (*This is a re-analysis of existing data, beyond a review of data reports. List the data source and recommended analyses*)

Data Source (*existing dataset*)	Description of data	Recommended analysis

■ **Key Informant Interviews** (*list categories of key informants, and purpose of inquiry*)

Key informant interviews with a cross-section of SCHS project staff, sub-partner organization staff, national and local government officials, CSOs, and other program stakeholders. Key informant interviewees should include both men and women. The sample selected should be robust and include diverse stakeholders.

■ **Focus Group Discussions** (*list categories of groups, and purpose of inquiry*)

Focus group discussions will be conducted to help assess capacity, sustainability, and other more important and changeable areas that SCHS should address (see Annex 1). Focus group discussions with a cross-section of male and female beneficiaries of the SCHS project. If men and women participate in FGDs, the group discussion will be conducted separately for men and women, to adjust for the potential power differential between them, and to assure women's voice is heard equally to men. A comprehensive list of all focus groups with details such as gender and geography should be included as an annex to the Final Evaluation Report.

■ **Group Interviews** (*list categories of groups, and purpose of inquiry*)

Optional: Key informants can be grouped and interviewed together, as long as the respondents feel free to express their opinions openly.

☐ **Client/Participant Satisfaction or Exit Interviews** (*list who is to be interviewed, and purpose of inquiry*)

☐ **Facility or Service Assessment/Survey** (*list type of facility or service of interest, and purpose of inquiry*)

☐ **Cost Analysis** (*list costing factors of interest, and type of costing assessment, if known*)

☐ **Survey** (*describe content of the survey and target responders, and purpose of inquiry*)

Mini or rapid quantitative surveys with program beneficiaries

■ **Observations** (*list types of sites or activities to be observed, and purpose of inquiry*)

Semi-structured observations during site and health facility visits. The specifics of the sites to be visited will be finalized during the Team Planning Meeting in discussion with USAID, as it depends on the timeframe that the Team will be in the field and the IPs schedule of interventions/activities during this time.

☐ **Data Abstraction** (*list and describe files or documents that contain information of interest, and purpose of inquiry*)

☐ **Case Study** (*describe the case, and issue of interest to be explored*)

☐ **Verbal Autopsy** (*list the type of mortality being investigated (i.e., maternal deaths), any cause of death and the target population*)

☐ **Rapid Appraisal Methods** (ethnographic / participatory) (*list and describe methods, target participants, and purpose of inquiry*)

☐ **Other** (*list and describe other methods recommended for this evaluation/analytic, and purpose of inquiry*)

If **impact evaluation** –

Is technical assistance needed to develop full protocol and/or IRB submission?

☐ Yes ☐ No

List or describe case and counterfactual"

Case	Counterfactual

X. HUMAN SUBJECT PROTECTION

The Analytic Team must develop protocols to insure privacy and confidentiality prior to any data collection. Primary data collection must include a consent process that contains the purpose of the evaluation, the risk and benefits to the respondents and community, the right to refuse to answer any question, and the right to refuse participation in the evaluation at any time without consequences. Only adults can consent as part of this evaluation. Minors cannot be respondents to any interview or survey, and cannot participate in a focus group discussion without going through an IRB. The only time minors can be observed as part of this evaluation is as part of a large community-wide public event, when they are part of family and community in the public setting. During the process of this

evaluation, if data are abstracted from existing documents that include unique identifiers, data can only be abstracted without this identifying information.

An Informed Consent statement included in all data collection interactions must contain:

- Introduction of facilitator/note-taker
- Purpose of the evaluation/assessment
- Purpose of interview/discussion/survey
- Statement that all information provided is confidential and information provided will not be connected to the individual
- Right to refuse to answer questions or participate in interview/discussion/survey
- Request consent prior to initiating data collection (i.e., interview/discussion/survey)

XI. ANALYTIC PLAN

Describe how the quantitative and qualitative data will be analyzed. Include method or type of analyses, statistical tests, and what data it to be triangulated (if appropriate). For example, a thematic analysis of qualitative interview data, or a descriptive analysis of quantitative survey data.

Prior to the start of data collection, the evaluation team will develop and present, for USAID review and approval, a data analysis plan that includes how focus group interviews will be transcribed and analyzed; what procedures will be used to analyze qualitative data from key informant interviews; and how the evaluation will weigh and integrate qualitative data from these sources with quantitative data from existing performance monitoring data to reach conclusions about the program achievements. This analysis should identify any barriers or constraints to realizing the evaluation as planned and describe how it will adapt to changing circumstances (e.g., political or policy environment changes, etc.), and other corrective actions that will be taken.

All analyses will be geared to answer the evaluation questions. Additionally, the evaluation will review both qualitative and quantitative data related to the project/program's achievements against its objectives and/or targets.

Quantitative data will be analyzed primarily using descriptive statistics. Data will be stratified by demographic characteristics, such as sex, age, and location, whenever feasible. Other statistical test of association (i.e., odds ratio) and correlations will be run as appropriate.

Thematic review of qualitative data will be performed, connecting the data to the evaluation questions, seeking relationships, context, interpretation, nuances and homogeneity and outliers to better explain what is happening and the perception of those involved. Qualitative data will be used to substantiate quantitative findings, provide more insights than quantitative data can provide, and answer questions where other data do not exist.
Use of multiple methods that are quantitative and qualitative, as well as existing data (e.g., project/program performance indicator data, DHS, MIS, HMIS data, etc.) will allow the Team to triangulate findings to produce more robust evaluation results.

The Evaluation Report will describe analytic methods and statistical tests employed in this evaluation.

XIII. ACTIVITIES

List the expected activities, such as Team Planning Meeting (TPM), briefings, verification workshop with IPs and stakeholders, etc. Activities and Deliverables may overlap. Give as much detail as possible.

Background reading – Several documents are available for review for this analytic activity. These include the SCHS proposal, annual work plans, M&E plans, quarterly progress reports, and routine reports of project performance indicator data, as well as survey data reports (i.e., DHS and MICS).

This desk review will provide background information for the Evaluation Team, and will also be used as data input and evidence for the evaluation.

Team Planning Meeting (TPM) – A four-day team planning meeting (TPM) will be held at the initiation of this assignment and before the data collection begins. The TPM will:

- Review and clarify any questions on the evaluation SOW
- Clarify team members' roles and responsibilities
- Establish a team atmosphere, share individual working styles, and agree on procedures for resolving differences of opinion
- Review and finalize evaluation questions
- Review and finalize the assignment timeline
- Develop data collection methods, instruments, tools and guidelines
- Review and clarify any logistical and administrative procedures for the assignment
- Develop a data collection plan
- Draft the evaluation work plan for USAID's approval
- Develop a preliminary draft outline of the team's report
- Assign drafting/writing responsibilities for the final report

Briefing and Debriefing Meetings – Throughout the evaluation the Team Lead will provide briefings to USAID. The In-Brief and Debrief are likely to include the all Evaluation Team experts, but will be determined in consultation with the Mission. These briefings are:

- **Evaluation launch**, a call/meeting among the USAID, GH Pro and the Team Lead to initiate the evaluation activity and review expectations. USAID will review the purpose, expectations, and agenda of the assignment. GH Pro will introduce the Team Lead, and review the initial schedule and review other management issues.
- **In-brief with USAID**, as part of the TPM. At the beginning of the TPM, the Evaluation Team will meet with USAID to discuss expectations, review evaluation questions, and intended plans. The Team will also raise questions that they may have about the project/program and SOW resulting from their background document review. The time and place for this in-brief will be determined between the Team Lead and USAID prior to the TPM.
- **Workplan and methodology review briefing**. At the end of the TPM, the Evaluation Team will meet with USAID to present an outline of the methods/protocols, timeline and data collection tools. Also, the format and content of the Evaluation report(s) will be discussed. Along with this briefing the Team will submit a **workplan** and **evaluation protocol** that includes the following:
  - Evaluation questions
  - Evaluation methods with an evaluation matrix
  - Sampling Strategy per method, including criteria that will be used to select participants
  - Plan for data acquisition with draft questionnaires and other data collection instruments or their main features
  - Data analysis plan that describes procedures that will be used to analyze qualitative and quantitative data and how they will complement one another
  - Time frames and outputs/deliverables (including Gantt chart)
  - Known limitations to the evaluation design

  The Evaluation Team shall submit the workplan and evaluation protocol to the Activity Manager (AM) in Rwanda. USAID will review the work plan and suggest refinements on the proposed work within 1-2 working days.
  - **In-brief with SCHS in-country IPs** to review the evaluation plans and timeline, and for the project to give an overview of the project to the Evaluation Team.

- The Team Lead (TL) will brief the USAID **weekly** and at the **midpoint** to discuss progress on the evaluation, as well as challenges and emerging opportunities. As preliminary findings arise, the TL will share these during the routine briefing, and in an email.
- A **final debrief** between the Evaluation Team and **SCHS Team** in the Mission will be held at the end of the evaluation to present preliminary findings to USAID. During this meeting a summary of the data will be presented, along with high level findings and draft recommendations. For the debrief, the Evaluation Team will prepare a **PowerPoint Presentation** of the key findings, issues, and recommendations. The evaluation team shall incorporate comments received from USAID during the debrief in the evaluation report. This debrief will be followed by a debrief the USAID/Rwanda **Mission Director**. (***Note****: preliminary findings are not final and as more data sources are developed and analyzed these finding may change.*)
- **IP and Stakeholders' debrief/workshop** may be held with the project staff and other stakeholders identified by USAID. If USAID requests this during the TPM, it will occur following the final debrief with the Mission, and will not include any information that may be procurement deemed sensitive or not suitable by USAID.

Fieldwork, Site Visits and Data Collection – The evaluation team will conduct site visits to for data collection. Selection of sites to be visited will be finalized during TPM in consultation with USAID. The evaluation team will outline and schedule key meetings and site visits prior to departing to the field.

Evaluation/Analytic Report – The Evaluation/Analytic Team under the leadership of the Team Lead will develop a report with findings and recommendations (see Analytic Report below). Report writing and submission will include the following steps:

- Team Lead will submit draft evaluation report to GH Pro for review and formatting
- GH Pro will submit the draft report to USAID
- USAID will review the draft report in a timely manner, and send their comments and edits back to GH Pro
- GH Pro will share USAID's comments and edits with the Team Lead, who will then do final edits, as needed, and resubmit to GH Pro
- GH Pro will review and reformat the final Evaluation/Analytic Report, as needed, and resubmit to USAID for approval.
- Once Evaluation Report is approved, GH Pro will re-format it for 508 compliance and post it to the DEC.

The Evaluation Report **excludes** any **procurement-sensitive** and other sensitive but unclassified (**SBU**) information. This information will be submitted in a memo to USIAD separate from the Evaluation Report. Additionally, the SOW will be edited to remove information that should not be made public, per USAID/Rwanda's request, before inserting into the Annex of the Final Evaluation Report.

Data Submission: All quantitative data will be submitted to GH Pro in a machine-readable format (CSV or XML). The datasets created as part of this evaluation must be accompanied by a data dictionary that includes a codebook and any other information needed for others to use these data. It is essential that the datasets are stripped of all identifying information, as the data will be public once posted on USAID Development Data Library (DDL).

Where feasible, qualitative data that do not contain identifying information should also be submitted to GH Pro.

XIII. DELIVERABLES AND PRODUCTS

Select all deliverables and products required on this analytic activity. For those not listed, add rows as needed or enter them under "Other" in the table below.

Deliverable / Product	Timelines & Deadlines (estimated)
■ Launch briefing	September 28, 2016
■ In-brief with USAID	January 17, 2017
■ Workplan and methodology briefing	January 23, 2017
■ Workplan with timeline	January 24, 2017
■ Analytic protocol with data collection tools	January 24, 2017
■ In-brief with target IPs	January 24, 2017
■ Routine briefings	Weekly
■ Debrief with USAID with Power Point presentation	SCHS Team: February 21, 2017 Mission Director: February 22, 2017
■ Findings review workshop with SCHS IPs with Power Point presentation (*if requested by USAID*)	February 23, 2017
■ Draft report	Submit to GH Pro: March 27, 2017 GH Pro submits to USAID: April 4, 2017
■ Final report	Submit to GH Pro: May 18, 2017 GH Pro submits to USAID: May 23, 2017
■ Raw data (cleaned datasets in CSV or XML with data dictionary)	May 23, 2017
■ Report Posted to the DEC	June 27, 2017
□ Other (specify):	

Estimated USAID review time

Average number of business days USAID will need to review deliverables requiring USAID review and/or approval? _____10_____ Business days

XIV. TEAM COMPOSITION, SKILLS AND LEVEL OF EFFORT (LOE)

Evaluation/Analytic team: When planning this analytic activity, consider:

- Key staff should have methodological and/or technical expertise, regional or country experience, language skills, team lead experience and management skills, etc.
- Team leaders for evaluations/analytics must be an external expert with appropriate skills and experience.
- Additional team members can include research assistants, enumerators, translators, logisticians, etc.
- Teams should include a collective mix of appropriate methodological and subject matter expertise.
- Evaluations require an Evaluation Specialist, who should have evaluation methodological expertise needed for this activity. Similarly, other analytic activities should have a specialist with methodological expertise.
- Note that all team members will be required to provide a signed statement attesting that they have no conflict of interest, or describing the conflict of interest if applicable.

Team Qualifications: Please list technical areas of expertise required for this activities

- *List desired qualifications for the team as a whole*

- *List the key staff needed for this analytic activity and their roles.*
- *Sample position descriptions are posted on USAID/GH Pro webpage*
- *Edit as needed GH Pro provided position descriptions*

Overall Team requirements:
The evaluation team shall demonstrate familiarity with USAID's Evaluation Policy and guidance included in the USAID Automated Directive System (ADS) in Chapter 200.
It is expected that the Evaluation Team will be comprised of one internationally-hired Evaluation Team Leader. Other positions may be international, regional or locally-hired experts with skills defined below. Preference will be given to qualified local consultants. The Evaluation Team will work under the overall direction of the Team Leader.

Team Lead: This person will be selected from among the key staff, and will meet the requirements of both this and the other position. The team lead should have significant experience conducting project evaluations.
Roles & Responsibilities: The team leader will be responsible for (1) providing team leadership; (2) managing the team's activities, (3) ensuring that all deliverables are met in a timely manner, (4) serving as a liaison between the USAID and the evaluation/analytic team, and (5) leading briefings and presentations. The Evaluation Team Leader is responsible for clarifying the scope and timeline with USAID/Rwanda, compiling and distributing the background materials to the team members, team management and coordination, writing assignments, making transportation and logistics arrangements, field work preparation/scheduling, and briefings/debriefings. Working in conjunction with other team members, s/he will be responsible for data analysis, lessons learned, and recommendations

Qualifications:
- Minimum of 10 years of experience in public health, which included experience in implementation of health activities in developing countries
- Extensive experience in monitoring and evaluation
- Demonstrated experience leading health sector project/program evaluation/analytics, utilizing both quantitative and qualitative s methods
- Excellent skills in planning, facilitation, and consensus building
- Excellent interpersonal skills, including experience successfully interacting with host government officials, civil society partners, and other stakeholders
- Excellent skills in project management
- Excellent organizational skills and ability to keep to a timeline
- Good writing skills, with extensive report writing experience
- Proficient in written and spoken English; spoken French and/or Ikinyarwanda desirable
- Experience working in the region, and experience in Rwanda is desirable
- Familiarity with USAID health projects and program implementation
- Familiarity with USAID policies and practices
    - Evaluation policy
    - Results frameworks
    - Performance monitoring plans

Key Staff 1 Title: Health Systems Strengthening and Capacity and Organizational Development Specialist
Roles & Responsibilities: Serve as a member of the evaluation team, providing technical expertise on health systems strengthening (HSS), and to evaluate HSS capacity and

organizational strengthening activities. S/He will participate in all aspects of the evaluation, including planning, data collection, data analysis and report writing.

Qualifications:

- Expertise and knowledge in working with health system strengthening in developing countries, with a firm understanding of the six building blocks for HSS
    1. Service Delivery
    2. Health information systems
    3. Medical products & technologies
    4. Health care financing
    5. Leadership/governance
    6. Supply chain
- Experience and knowledge on the Rwandan health sector.
- Experience in individual and organizational capacity development related to health system strengthening
- Experience in stakeholder engagement
- Experience in conducting USAID evaluations of health programs/activities
- An advanced degree in public health, or related field
- Experience working in organizational capacity development/strengthening among governmental and non-governmental entities in developing country settings to strengthen health programs/activities
- Expertise in health financing, design and policy formulation in the health sector
- Good interpersonal communication skills
- Good writing skills, specifically technical and evaluation report writing experience
- Proficient in written and spoken English; spoken French and/or Ikinyarwanda desirable

Key Staff 2 Title: **Evaluation Specialist**

Roles & Responsibilities: Serve as a member of the evaluation team, providing quality assurance on evaluation issues, including methods, development of data collection instruments, protocols for data collection, data management and data analysis. S/He will oversee the training of all engaged in data collection, insuring highest level of reliability and validity of data being collected. S/He is the lead analyst, responsible for all data analysis, and will coordinate the analysis of all data, assuring all quantitative and qualitative data analyses are done to meet the needs for this evaluation. S/He will participate in all aspects of the evaluation, from planning, data collection, data analysis to report writing.

Qualifications:

- At least 10 years of experience in USAID M&E procedures and implementation
- At least 5 years managing M&E, including evaluations
- Experience in design and implementation of evaluations
- Strong knowledge, skills, and experience in qualitative and quantitative evaluation tools
- Experience implementing and coordinating other to implements surveys, key informant interviews, focus groups, observations and other evaluation methods that assure reliability and validity of the data.
- Experience in data management
- Able to analyze quantitative, which will be primarily descriptive statistics
- Able to analyze qualitative data
- Experience using analytic software
- Demonstrated experience using qualitative evaluation methodologies, and triangulating with quantitative data

- Able to review, interpret and reanalyze as needed existing data pertinent to the evaluation
- Strong data interpretation and presentation skills
- An advanced degree in public health, evaluation or research or related field
- Proficient in written and spoken English; spoken French and/or Ikinyarwanda desirable
- Good writing skills, including extensive report writing experience
- Familiarity with USAID health programs/projects, primary health care or health systems strengthening preferred
- Familiarity with USAID and PEPFAR M&E policies and practices
  - Evaluation policies
  - Results frameworks
  - Performance monitoring plans

Key Staff 3 Title**: Title: Public Health Specialist**
Roles & Responsibilities: Serve as a member of the Assessment Team, providing technical expertise on public health programming, including malaria, maternal and child health and nutrition among other health issues. S/He will participate in all aspects of the assessment, including planning, data collection, data analysis and report writing.
Qualifications:

- At least 8 years' experience in public health
- Familiarity with systems strengthening projects is desirable
- Experience implementing public health programs (malaria, maternal and child health, and/or nutrition) at the country level
- Excellent interpersonal skills, including experience successfully interacting with host government officials, civil society partners, and other stakeholders
- Experience in conducting USAID evaluations of health programs/activities
- Proficient in English and spoken French and/or Ikinyarwanda
- Good writing skills, with experience producing evaluation, assessment and/or technical reports

Other Staff Titles with Roles & Responsibilities (include number of individuals needed):

Local **Evaluation Logistics /Program Assistant** will support the Evaluation Team with all logistics and administration to allow them to carry out this evaluation. The Logistics/Program Assistant will have a good command of English and Ikinyarwanda. S/He will have knowledge of key actors in the health sector and their locations including MOH, donors and other stakeholders. To support the Team, s/he will be able to efficiently liaise with hotel staff, arrange in-country transportation (ground and air), arrange meeting and workspace as needed, and insure business center support, e.g. copying, internet, and printing. S/he will work under the guidance of the Team Leader to make preparations, arrange meetings and appointments. S/he will conduct programmatic administrative and support tasks as assigned and ensure the processes moves forward smoothly. S/He may also be asked to assist with data collection, as well as translation of data collection tools and transcripts, if needed.

Local Evaluators (2-3 local consultants) to assist the Evaluation Team with data collection, analysis and data interpretation. They will have basic familiarity with health topics, as well as experience conducting surveys interviews and focus group discussion, both facilitating and note taking. Furthermore, they will assist in translation of data collection tools and transcripts, as needed. The Local Evaluators will have a good command of English and Ikinyarwanda. They will also assist the Team and the Logistics Coordinator, as needed. They will report to the Team Lead.

Will USAID participate as an active team member or designate other key stakeholders to as an active team member? This will require full time commitment during the evaluation or analytic activity.

☐ Yes – If yes, specify who:

■ Significant Involvement anticipated – If yes, specify who: USAID/Rwanda Program Office staff, USAID/Washington staff, or other USAID staff may participate as part time observers.

☐ No

Staffing Level of Effort (LOE) Matrix (Optional):

This optional LOE Matrix will help you estimate the LOE needed to implement this analytic activity. If you are unsure, GH Pro can assist you to complete this table.

a) For each column, replace the label "Position Title" with the actual position title of staff needed for this analytic activity.
b) Immediately below each staff title enter the anticipated number of people for each titled position.
c) Enter Row labels for each activity, task and deliverable needed to implement this analytic activity.
d) Then enter the LOE (estimated number of days) for each activity/task/deliverable corresponding to each titled position.
e) At the bottom of the table total the LOE days for each consultant title in the 'Sub-Total' cell, then multiply the subtotals in each column by the number of individuals that will hold this title.

Level of Effort in **days** for each Evaluation/Analytic Team member
(*See Illustrative LOE Chart on USAID/GH Pro webpage.*)

Activity / Deliverable		Consultant LOE (days)						
		Team Lead / Key Staff 1	Key Staff 2	Key Staff 3	Local Evaluator	Local Evaluator	Local Evaluator	Logistics Coord / Evaluator
	Number of persons →	1	1	1	1	2		1
1	Launch Briefing	1			1			
2	Desk review	7	7	5	3	2		
3	Preparation for Team convening in-country	2	2		1			5
4	Travel to country	2	2	1				
5	Team Planning Meeting (Deliverable: Workplan & Protocol)	4	4	4		4		4
6	In-brief with Mission with prep	1	1	1		1		1
7	Workplan and methodology review briefing with USAID	0.5	0.5	0.5		0.5		0.5
8	USAID reviews workplan & protocol							
9	Revise Workplan & Protocol	1	1	1		1		1
10	In-brief with project with prep	0.5	0.5	0.5		0.5		0.5
11	Data Collection DQA Workshop (protocol orientation for all involved in data collection)	2	2	2		2		2
12	Prep / Logistics for Site Visits	1	1	1		1		13
13	Data collection / Site Visits (including travel to sites)	20	20	19		20	4	11

Activity / Deliverable		Consultant LOE (days)						
		Team Lead / Key Staff 1	Key Staff 2	Key Staff 3	Local Evaluator	Local Evaluator	Local Evaluator	Logistics Coord / Evaluator
	Number of persons →	1	1	1	1	2		1
14	Data analysis	7	7	6		10	14	10
15	Debrief with Mission with prep	1	1	1		1		1
16	Stakeholder debrief workshop with prep (if requested by USAID)	1	1	1		1		1
17	Depart country	2	2	2				
18	Draft report(s)	7	7	6		2		
19	GH Pro Report QC Review & Formatting							
20	Submission of draft report(s) to Mission							
21	USAID Report Review							
22	Revise report(s) per USAID comments	4	3	2		1		
23	Finalize and submit report to USAID							
24	USAID approves report							
25	Final copy editing and formatting							
26	508 Compliance editing							
	Upload Eval Report(s) to the DEC							
	Sub-Total LOE	64	62	54	5	47	18	50
	Total LOE	64	62	54	5	94	18	50

If overseas, is a 6-day workweek permitted ■ Yes ☐ No

Travel anticipated: List international and local travel anticipated by what team members.

XV. LOGISTICS

Visa Requirements

List any specific Visa requirements or considerations for entry to countries that will be visited by consultant(s):

If the team exceeds 30 days in Rwanda, they should apply for business visas. More information can be found at https://www.migration.gov.rw/index.php?id=79. If the consultants do not receive a business visa prior to arrival and stay for over 30 days and are traveling with ordinary/tourist passports, they will need to apply for a work permit after they arrive.

The following are the requirements:

1. Passport valid for at least six months
2. Application form and a passport photo
3. Copy of School Diploma/Certificate (the highest)
4. Police Clearance (from the country in which they lived the last six month before coming to Rwanda)
5. Résumé (CV)
6. Visa/work permit fee (100,000Frw)

For the diploma/certificate, they must be notarized and bring also the originals. The original will be taken to the Immigration to be compared to the copy and the original will be brought back (after check). The police clearance must me original.

For more information, you can also visit the Rwanda Directorate of Immigration website https://www.migration.gov.rw/index.php?id=79.

List recommended/required type of Visa for entry into counties where consultant(s) will work

Name of Country	Type of Visa		
Rwanda	☐ Tourist	■ Business	☐ No preference
	☐ Tourist	☐ Business	☐ No preference
	☐ Tourist	☐ Business	☐ No preference
	☐ Tourist	☐ Business	☐ No preference

Clearances & Other Requirements

Note: Most Evaluation/Analytic Teams arrange their own work space, often in their hotels. However, if Facility Access is preferred GH Pro can request it.

GH Pro does not provide Security Clearances, but can request **Facility Access**. Please note that Facility Access (FA) requests processed by USAID/GH (Washington, DC) can take 4-6 months to be granted. If you are in a Mission and the RSO can grant a temporary FA, this can expedite the process. If FA is granted through Washington, DC, the consultant must pick up his/her FA badge in person in Washington, DC, regardless of where the consultant resides or will work.

If **Electronic Country Clearance (eCC)** is required, the consultant is also required to complete the **High Threat Security Overseas Seminar (HTSOS).** HTSOS is an interactive e-Learning (online) course designed to provide participants with threat and situational awareness training against criminal and terrorist attacks while working in high threat regions. There is a small fee required to register for this course. [*Note: The course is not required for employees who have taken FACT training within the past five years or have taken HTSOS within the same calendar year.*]

If eCC is required, and the consultant is expected to work in country more than 45 consecutive days, the consultant must complete the one-week **Foreign Affairs Counter Threat (FACT) course** offered by FSI in West Virginia. This course provides participants with the knowledge and skills to better prepare themselves for living and working in critical and high threat overseas environments. Registration for this course is complicated by high demand (must register approximately 3-4 months in advance). Additionally, there will be the cost for one week's lodging and M&IE to take this course.

Check all that the consultant will need to perform this assignment, including USAID Facility Access, GH Pro workspace and travel (other than to and from post).

☐ USAID Facility Access (FA)
Specify who will require Facility Access: _____

☐ Electronic County Clearance (ECC) (International travelers only)
- ☐ High Threat Security Overseas Seminar (HTSOS) (required with ECC)
- ☐ Foreign Affairs Counter Threat (FACT) (for consultants working on country more than 45 consecutive days)

☐ GH Pro workspace
Specify who will require workspace at GH Pro: _____

■ Travel -other than posting (specify): GH Pro will arrange all international travel, while the GH Pro Logistics consultant will arrange in-country travel

☐ Other (specify): _____

XVI. GH PRO ROLES AND RESPONSIBILITIES

GH Pro will coordinate and manage the evaluation/analytic team and provide quality assurance oversight, including:

- Review SOW and recommend revisions as needed
- Provide technical assistance on methodology, as needed
- Develop budget for analytic activity
- Recruit and hire the evaluation/analytic team, with USAID POC approval
- Arrange international travel and lodging for international consultants
- Request for country clearance and/or facility access (if needed)
- Review methods, workplan, analytic instruments, reports and other deliverables as part of the quality assurance oversight
- Report production - If the report is public, then coordination of draft and finalization steps, editing/formatting, 508ing required in addition to and submission to the DEC and posting on GH Pro website. If the report is internal, then copy editing/formatting for internal distribution.

XVII. USAID ROLES AND RESPONSIBILITIES

Below is the standard list of USAID's roles and responsibilities. Add other roles and responsibilities as appropriate.

USAID Roles and Responsibilities

USAID will provide overall technical leadership and direction for the analytic team throughout the assignment and will provide assistance with the following tasks:

Before Field Work

- SOW.
  - Develop SOW.
  - Peer Review SOW
  - Respond to queries about the SOW and/or the assignment at large.
- Consultant Conflict of Interest (COI). To avoid conflicts of interest or the appearance of a COI, review previous employers listed on the CV's for proposed consultants and provide additional information regarding potential COI with the project contractors evaluated/assessed and information regarding their affiliates.
- Documents. Identify and prioritize background materials for the consultants and provide them to GH Pro, preferably in electronic form, at least one week prior to the inception of the assignment.
- Local Consultants. Assist with identification of potential local consultants, including contact information.
- Site Visit Preparations. Provide a list of site visit locations, key contacts, and suggested length of visit for use in planning in-country travel and accurate estimation of country travel line items costs.
- Lodgings and Travel. Provide guidance on recommended secure hotels and methods of in-country travel (i.e., car rental companies and other means of transportation).

During Field Work

- Mission Point of Contact. Throughout the in-country work, ensure constant availability of the Point of Contact person and provide technical leadership and direction for the team's work.

- Meeting Space. Provide guidance on the team's selection of a meeting space for interviews and/or focus group discussions (i.e. USAID space if available, or other known office/hotel meeting space).
- Meeting Arrangements. Assist the team in arranging and coordinating meetings with stakeholders.
- Facilitate Contact with Implementing Partners. Introduce the analytic team to implementing partners and other stakeholders, and where applicable and appropriate prepare and send out an introduction letter for team's arrival and/or anticipated meetings.

After Field Work

- Timely Reviews. Provide timely review of draft/final reports and approval of deliverables.

XVIII. ANALYTIC REPORT

Provide any desired guidance or specifications for Final Report. (See How-To Note: Preparing Evaluation Reports)

The **Evaluation/Analytic Final Report** must follow USAID's Criteria to Ensure the Quality of the Evaluation Report (found in Appendix I of the USAID Evaluation Policy).

a. The report should be no more than40 pages (excluding executive summary, table of contents, acronym list and annexes).
b. The structure of the report should follow the Evaluation Report template, including branding found here or here.
c. Draft reports must be provided electronically, in English, to GH Pro who will then submit it to USAID.
d. For additional Guidance, please see the Evaluation Reports to the How-To Note on preparing Evaluation Draft Reports found here.

Reporting Guidelines: The draft report should be a comprehensive analytical evidence-based evaluation/analytic report. It should detail and describe results, effects, constraints, and lessons learned, and provide recommendations and identify key questions for future consideration. The report shall follow USAID branding procedures. ***The report will be edited/formatted and made 508 compliant as required by USAID for public reports and will be posted to the USAID/DEC.***

The findings from the evaluation/analytic will be presented in a draft report at a full briefing with USAID and at a follow-up meeting with key stakeholders. The report should use the following format:

- Executive Summary: Summarizing the purpose, background of the project being evaluated, main evaluation questions, methods, with most salient findings, conclusions, and recommendations and lessons learned (if applicable) (3-4 pages)
- Table of Contents
- Acronyms
- Evaluation/Analytic Purpose and Evaluation/Analytic Questions (1-2 pages)
- Project [or Program] Background (1-3 pages)
- Evaluation/Analytic Methods and Limitations (1-3 pages): Evaluation methodology shall be explained in the report in detail. Limitations to the evaluation shall be disclosed in the report, with particular attention to the limitations associated with the evaluation methodology (e.g., selection bias, recall bias, unobservable differences between comparator groups, etc.)
- Findings (organized by Evaluation/Analytic Questions): All findings will be substantiated with sourced evidence within the report, but will maintain the confidentiality of all individual respondents
- Conclusions

- Recommendations (actionable)
- Annexes
  - Annex I: Evaluation/Analytic Statement of Work
  - Annex II: Evaluation/Analytic Methods and Limitations (additional details as needed to supplement the information in the report
  - Annex III: Data Collection Instruments
  - Annex IV: Sources of Information
    - List of Persons Interviews
    - Bibliography of Documents Reviewed
    - Databases
    - [etc]
  - Annex V: Disclosure of Any Conflicts of Interest
  - Annex VI: Statement of Differences (if applicable)

The evaluation methodology and report will be compliant with the USAID Evaluation Policy and Checklist for Assessing USAID Evaluation Reports

---

The Evaluation Report should **exclude** any **potentially procurement-sensitive information**. As needed, any procurement sensitive information or other sensitive but unclassified (SBU) information will be submitted in a memo to USIAD separate from the Evaluation Report.

All data instruments, data sets (if appropriate), presentations, meeting notes and report for this evaluation/analysis will be submitted electronically to the GH Pro Program Manager. All datasets developed as part of this evaluation will be submitted to GH Pro in an unlocked machine-readable format (CSV or XML). The datasets must not include any identifying or confidential information. The datasets must also be accompanied by a data dictionary that includes a codebook and any other information needed for others to use these data. Qualitative data included in this submission should not contain identifying or confidential information. Category of respondent is acceptable, but names, addresses and other confidential information that can easily lead to identifying the respondent should not be included in any quantitative or qualitative data submitted.

Additional Notes

Per the USAID Evaluation Policy and USAID ADS 203, draft and final evaluation reports will be evaluated against the following criteria to ensure the quality of the evaluation report.[29]

- The evaluation report should represent a thoughtful, well-researched, and well-organized effort to objectively evaluate what worked in the project, what did not, and why.
- Evaluation reports shall address all evaluation questions included in the SOW.
- The evaluation report should include the SOW as an annex. All modifications to the SOW—whether in technical requirements, evaluation questions, evaluation team composition, methodology, or timeline—need to be agreed upon in writing by the activity manager.
- The evaluation methodology shall be explained in detail. All tools used in conducting the evaluation—such as questionnaires, checklists, and discussion guides—will be included in an annex in the final report.
- Evaluation findings will assess outcomes and impact on males and females.
- Limitations to the evaluation shall be disclosed in the report, with particular attention to the limitations associated with the evaluation methodology (selection bias, recall bias, unobservable differences between comparator groups, etc.).

[29] See Appendix I of the Evaluation Policy and the Evaluation Report Review Checklist from the Evaluation Toolkit for additional guidance.

- Evaluation findings should be presented as analyzed facts, evidence, and data and not based on anecdotes, hearsay, or the compilation of people's opinions. Findings should be specific, concise, and supported by strong quantitative or qualitative evidence.
- Sources of information need to be properly identified and listed in an annex.
- Recommendations need to be supported by a specific set of findings.
- Recommendations should be action-oriented, practical, and specific, with defined responsibility for the action.

XIX. USAID CONTACTS

	Primary Contact	Alternate Contact 1	Alternate Contact 2	Alternate Contact 3
Name:	Jesse Joseph	Andrew Fourney	Michael Karangwa	Emmanuel Gasana
Title:	Health Systems Strengthening Team Lead	Senior M&E Advisor	Health Systems Strengthening Specialist	Senior Monitoring and Evaluation Specialist
USAID Mission:	Health Office, USAID/Rwanda	Health Office, USAID/Rwanda	Health Office, USAID/Rwanda	Program Office, USAID/Rwanda
Email:	jjoseph@usaid.gov	afourney@usaid.gov	mkarangwa@usaid.gov	egasana@usaid.gov
Phone:	+250 252 596 400 x2608	+250 252 596 400 x2838	(+250) 252 596 400 ext.2634	+250 252 596 400 x2459
Cell Phone:	+250 (0)788 316 614	+1 916-396-8660	(+250) 788 35 3198	+250 (0)78 838 5513

XX. LIST OF ANNEXES

1. Evaluation Matrix
2. Project Matrix Linking Activities to Sub-purposes and Outputs of the SCHS Results Framework
3. SCHS M&E Plan
4. Stakeholder Groups

SOW ANNEX 1: Evaluation Matrix

The illustrative design matrix in Table 2 links the EQs to data sources, collection methods, and analysis. USAID expects a detailed matrix in the work plan to summarize the evaluation design and methods section, and to supplement the narrative section.

Evaluation Design Matrix			
Evaluation Questions	**Suggested Data Sources**	**Suggested Data Collection Methods**	**Data Analysis Methods**
1. To what extent has the design of the SCHS project facilitated or hindered USAID's support to strengthen the capacity of the health sector to deliver high quality services?	- Project monitoring data - Project IP staff - USAID SCHS and USAID Program Office staff - Stakeholders	- KII - FGD	- Content Analysis - Grounded Theory
2. To what extent has SCHS project strengthened the capacity of Rwandan Health systems in relation to sub purposes 3, 4 & 5?	- USAID and IP Project Staff - GOR counterparts	- KII - FGD	- Content Analysis - Grounded Theory
2a. What is the level of capacity of the GOR in these areas?	- Project IP Staff - USAID SCHS Staff - GOR counterparts - Relevant stakeholders	- KII - FGD - Capacity Assessment (incorporated into other methods)	- Content Analysis - Grounded Theory
3. Does SCHS target the most important and changeable factors that contribute to the GOR's capacity to sustain a strong system that will provide high quality services.	- Project IP Staff - USAID SCHS Staff - GOR counterparts - Relevant stakeholders	- KII - FGD - Desk review	- Content Analysis - Grounded Theory
3a. Are there other more important and changeable areas?	- Project IP Staff - USAID SCHS Staff - GOR counterparts - Relevant stakeholders	- KII - FGD - Desk review	- Content Analysis - Grounded Theory

SOW ANNEX 2: Project Matrix Linking Activities to Sub-purposes and Outputs of the SCHS Results Framework

Notes: The term "design" in evaluation question 1 refers to the relationship of activities to sub-purposes and outputs of this matrix.

Sub-purposes	**1. Service Delivery**			**2. Health Information**			**3. Medical Products & Pharmaceuticals**		**4. Health Financing**			**5. Leadership & Governance**		
Outputs / Activities	**1.1: Quality of facility and community-based health services improved**	**1.2: Availability of comprehensive facility and community-based health services maintained services maintained**	**1.3: Enabling environment for growth of private health care services improved**	**2.1: Data quality, accuracy and timeliness improved**	**2.2: Data for decision-making made available, institutionalized and used**	**2.3: Patient level patient data used in clinical decision making**	**3.1: Procurement of USAID-supported health products sustained**	**3.2: Capacity of MPD procurement unit and distribution system strengthened at central and local levels**	**4.1: Financial access to health services and household protection from financial risk strengthened**	**4.2: GOR fiscal space and resource allocation for health from domestically generated resources increased**	**4.3: Coordination, planning and effectiveness of partnerships both within the Government of Rwanda and with Development Partners**	**5.1: District Health Management Team's capacity to plan and manage health programing**	**5.2: Coordination between central and decentralized levels improved**	**5.3: District Planning, Reporting and M&E frameworks strengthened**
Current activities:														
Rwanda Health Systems Strengthening Activity			■	■	■				■	■	■	■	■	■
DELIVER II							■	■						
DELIVER TO7 Malaria							■	■						
SCMS							■	■						
Central Contraceptive Procurement							■	■						
Indoor Residual Spraying							■	■						
Supply Chain Follow-On							■	■					■	■
Central Contraceptive Procurement							■	■						
Maternal and Child Survival Program	■	■		■	■	■						■		
Completed activities:														
IRS2 TO4							■	■						
Family Health Project	■	■		■	■	■						■		
Integrated Health Systems Strengthening Project				■	■				■	■	■	■	■	■

Evaluation questions 2 and 3 refer to the technical areas associated with sub-purposes 3-5

SOW ANNEX 3: Stakeholder Groups

Ministry of Health

1. Health Financing Unit
2. Planning, M& E unit
3. Health Information Systems Unit (HMIS)
4. Human Resources for Health Unit
5. Director General of Clinical Services
6. Director General of Planning, Health Financing and Information systems

Rwanda Biomedical Council

1. Director General
2. Meeting with Divisions: One meeting per division
3. Planning, M&E Division
4. Medical Production and Procurement (MPPD)
5. HIV Division
6. National Malaria Control Program (NMCP)
7. Maternal and Child Health department
8. Community Health Department
9. Corporate services department

Other Central Level

1. Rwanda Social Security Board: One general meeting
2. Rwanda Development Board: One meeting

Development Partners

1. USAID
2. Belgium Technology Cooperation
3. WHO
4. UNICEF
5. UNFPA
6. Swiss Cooperation
7. UNAIDS
8. Maternal Child Survival Project implemented by JPHIEGO
9. Rwanda Health Systems Strengthening activity implemented by MSH
10. Chemonics (supply chain project)
11. Abt Associates (malaria)

Decentralized Levels

1. District Health management teams (DHMT)
2. District Hospitals and 2 provincial hospitals
3. Health Centers
4. Cooperatives of community health workers

SOW ANNEX 4: SCHS Monitoring and Evaluation Plan

MONITORING

Monitoring information will be gathered through a variety of data collection mechanisms including regular implementing partner reporting, GOR reports, DHS, financial accounting systems; reviews of service records; registries and routine data from health information systems; qualitative assessments utilizing key informant interviews, focus group discussions, and direct observations; and quantitative population-based assessments and surveys when necessary. Regular joint-field visits will be made by members of the GOR's health sector and governance Technical Working Groups and will be scheduled to assess progress, but also as an opportunity for supporting supervision should it be needed.

For measuring progress in delivery of decentralized health services, changes in four dimensions will be looked at: authority, autonomy, accountability, and capacity building of local government in managing health systems that will result from the launch of interventions designed under the Rwanda Decentralization Strategic Plan.

Annual Implementation Reviews and Formulation of Work Plans:

Once awarded, implementing partners of each activity under this PAD will develop detailed monitoring plans at the start of the project for the full life of the project. These project monitoring plans will take the project design Logical Framework one step further and include more detailed activities. This life-of-project monitoring plan will be reviewed and feedback provided to the contractors. In addition to the life-of-project work plan, each implementing partner will complete an annual work plan at the commencement of each Fiscal Year of the project.

This annual work plan will include the detailed activities, timelines, indicators, and milestones which will be achieved for the upcoming year. The annual work plan will be submitted and reviewed by the Contracting Officer Representative/Agreement Officer Representative (COR/AOR) and other relevant technical staff and input/feedback will be provided to the implementing partners prior to final revisions and approval. The progress towards the implementation of activities in the work plan will be monitored closely by the COR/AOR through reviews of progress reports, site-visits, meetings, and regular communications. Furthermore, at the end of every fiscal year, around January; a review of progress will assess whether specific benchmarks have been met and whether to continue the activities as planned or modify the activities.

The core implementing partner and the cognizant COR/AOR will function as the secretariat for organizing these annual sessions on behalf of senior managers from the USAID/Rwanda Mission who will assess progress, discuss constraints and make decisions about the program for the following year. This process will allow for a maximum level of transparency about the responsibilities and commitments of each party and foster inclusive decision making about how to maximize outcomes for funds invested in certain areas.

In parallel to tracking the project progress, the monitoring plan will also incorporate contextual indicators that are beyond the influence of project indicators.

REPORTING

Quarterly reports

At the end of each quarter, the implementing partners under this PAD shall provide a quarterly report to the Mission providing updates and results on activities implemented and milestones achieved during the performance period. These reports should also include information on any challenges faced and what was done to address those challenges. These quarterly reports are critical for both the contractor to assess their own performance during the quarter and to determine whether the remaining quarters are adequate to achieve the annual M&E plans. They are also critical for the Mission to be able to assess the contractor's performance and to provide feedback on what was achieved and the way forward.

Semi-annual reports

At the end of the second quarter of each fiscal year, USAID/Rwanda and the project partner(s) will conduct a review of progress and challenges during the last 6-month period. The progress review will determine whether specific benchmarks have been met and whether to continue the activities as

planned or modify activities. During the fourth quarter of each fiscal year, the Mission and implementing partners will review progress and results of any corrective actions taken during the previous past 9-month period as the basis for developing the next annual work plan, which should be submitted to USAID/Rwanda prior to the end of the fiscal year.

Annual reports

At the end of each year, the implementing partners will be responsible for submitting an annual report, which will provide updates on the expected deliverables and achievements for the year. These annual reports will provide both the implementing partner and USAID/Rwanda with the opportunity to reflect upon the achievements of the year and to discuss what was achieved, what was not achieved, and any modifications that need to be made in the work plan for the following year and the life of the project.

Feedback

USAID/Rwanda will provide feedback to the implementing partners about their performance following each quarterly, semi-annual, and annual report, as well as any other time as the need arises. This feedback loop is essential to ensuring that both parties are in agreement about the achievements accomplished and plans moving forward. The implementing partner, in addition to being responsible for the submission of work plans, M&E plans and reports, will be required to integrate this feedback into future plans and activities as agreed upon.

EVALUATION

In order to evaluate the impact of the project, USAID/Rwanda will ensure that the baseline indicators in the performance measures are captured to ensure that post-project indicator results can be compared accordingly. The two types of formal external evaluations that will be conducted are:

a. An external mid-term performance review of the project will be conducted around January 2016. This assessment will be commissioned by USAID/Rwanda to an external agency. The evaluation, led by an external team leader, will involve USAID/Rwanda, USAID/Washington, GOR staff, and external consultants. The purpose will be to assess progress to date, determine whether any significant changes are needed and to define any adjustments necessary to improve implementation. Data for the assessment of progress will come from the MOH HMIS, district and project records, DHS V, as well as rapid surveys or other studies, if necessary.
b. An external final performance evaluation will be conducted in the final year of the project. This evaluation will also be commissioned to an external agency to assess overall project performance, determine whether targeted outputs and the purpose of the project have been met and provide USAID/Rwanda and the GOR with critical advice about lessons learned and future directions.
c. No impact evaluations are planned under this PAD.

As a project to strengthen the capacity of health system at the national level, influencing all areas of health planning, service delivery, leadership and governance, and health financing, it is not practical to identify impact evaluation questions which must, at the design stage, identify target and control groups for a counterfactual. Therefore, we do not anticipate commissioning an external impact evaluation for this project.

Some *illustrative* evaluation questions that may be considered include, but are not limited to:

1. Mid-term:
    a. Why has the project been successful or unsuccessful in achieving its annual targets?
    b. To what extent has the project succeeded in advancing the GOR's decentralization objectives?
2. Final:
    a. Why has the project been successful or not successful in achieving its objectives?
    b. To what extent have additional innovative sources of financing been identified to increase overall spending on health in Rwanda?
    c. How have District Health Management Teams been strengthened to identify district health needs, plan, budget and implement accordingly?

d. What is the capacity of GOR at all levels to forecast, procure, and distribute health commodities as a measurable change from the start of the project to the end of the project?

3. Additional questions that may be included in mid-term, final, or both evaluations, pending results of periodic monitoring:
   a. Can increases in GOR health expenditure be attributed (in part) to the project interventions?
   b. To what extent the dependence of GOR on donor funding in provision of health services to Rwandans decreased? In absolute terms and as a proportion.
   c. To what extent has the financial management capacity improved at all levels of the MOH system?
   d. To what extent is quality data available at the level of decision makers, shared and disseminated to all relevant stakeholders, and used to make programmatic and budgeting decisions?
   e. Have coordination efforts been strengthened and what systems level changes can be seen that can be linked to improved coordination?
   f. To what extent has the GOR's ability to engage the private sector in health improved?
   g. What additional, innovative sources of financing health care services been identified and implemented, and how have they been adopted or sustained?

LEARNING

USAID/Rwanda will utilize the information gleaned from monitoring, reporting, and evaluation as opportunities for learning and decision-making. Progress reports, quarterly, semi-annually, and annually will be used to assess the project's achievements and to chart the way forward. Collection of baseline data for the specific questions of evaluation interest, will serve as a starting point from which the project will expect to see changes made.

ANNEX II. CUSTOMIZED PROBING QUESTION SETS FOR DIFFERENT CATEGORIES OF STAKEHOLDERS

Questions for USAID/Rwanda Implementing Partners (IPs)

Evaluation Question 1: Design, Management, and Coordination

1. 1. Please explain your management structure and clarify the management relationship and support structure between your HQ and country office/team. What works well and what are the key challenges?
    a. If and how do you coordinate with GOR institutions?
    b. If and how do you coordinate with other development partners (DPs) and relevant projects?
    c. If and how do you coordinate/complement activities with other implementing partners (IPs) under the SCHS project?
    d. How do you coordinate and communicate with the USAID/Rwanda?
    e. What has worked well for a, b, c, and d above? What are the key challenges (NOT worked well) and how can they be addressed?
2. Explain the strategic approach, support and guidance (if any) provided by the management team ensuring a results driven implementation approach. How successful has the team been in focusing on overall results? Are your activities supporting/contributing toward the achievement of results? If so, please explain how. What have been the key challenges in this area? What can be done to improve the focus on results, i.e. to ensure better results based approach and implementation in the future?
3. How have your activity's management and coordination structures facilitated or hindered achievement of targeted results? What has worked well and what are the challenges in these areas, please explain.

Evaluation Question 2: Strengthened Capacity of Rwandan Health System (Sub-purpose 3, 4, and 5)

4. To what extent has your activity's interventions helped strengthen the capacity of the Rwandan health systems in relation to commodity and supply chain management?
5. Is there increasing GOR commitment and resources for health sector activities, particularly for areas relevant to your activity? Why or why not? Is there effective coordination for resource planning between GOR and DPs, and amongst the DPs. What are the key challenges in ensuring increased domestic resources generation and mobilization for the health sector? In ensuring that domestic health sector resources are used equitably and efficiently? How has this project worked to help address those challenges? What are some of the specific accomplishments by the project in this area, particularly addressing the challenges? What else needs to be done and how?
6. Has there been adequate leadership and effective governance in the health sector at both central and local levels? Please explain why and why not? What are the key challenges in strengthening leadership and governance of the health systems at the central, regional and local levels? What are some of the specific accomplishments by this project in these areas, particularly addressing the challenges? What else needs to be done?

7. In your opinion what is the level of capacity of the GOR in the above areas and what are the gaps/challenges?

Evaluation Question 3: Most Important and Changeable factors (e.g. leadership, advocacy, governance, institutional structure & effectiveness, resource (human, financial, material), management & coordination etc.) that contribute to the GOR's capacity to sustain a strong system (Sub-purpose 3, 4, and 5):

8. To what extent is the project meeting targets and expectations? Has the project design been translated into effective and innovative strategies and technical approaches? How can this be further improved?
9. In your opinion, currently what are the key changeable/variable factors for the effectiveness and success of your activity toward attainment of overall results and sustainability? Are there other important changeable/variable factors that need to be focused on to improve GOR's capacity toward having a sustainable health system?
10. Sustainability of the health system (sustaining current gains and building beyond) is a key focus of the USAID-supported work in Rwanda. What are the most important issues that need to be tackled in order to effectively achieve a sustainable health sector response in Rwanda?
11. How and in what priority areas/factors do you think the USAID investment in the remaining years of the SCHS project can do the most good, particularly in strengthening GOR capacity and further improving service quality?

Questions for USAID/Rwanda Staff

1. In your opinion, has the design of the SCHS project facilitated or hindered USAID's support to strengthen the capacity of the health sector to deliver high quality services?
2. Please explain the management and coordination mechanisms and practices that you follow for the SCHS Project. How do you coordinate and communicate with the USAID/W, IPs, GOR, DPs, and other stakeholders (if any) in relation to the SCHS Project? In your opinion, is there room for improvement to make the coordination and communication more effective with any of these partners? If so, how?
3. How effective do you think is the coordination among the IPs of the various SCHS Activities? Are they formally held accountable for coordination across activities, both in general and specific relevant components? How can this be improved further?
4. Please explain your USAID internal team structure for the SCHS Project management. Do you think there is any gap/lack of resources (human, financial, material) for the team to be more effective and efficient in managing the SCHS?
5. What aspects of the design have been particularly helpful at strengthening the capacity of the health sector?
6. What aspects of the design have been challenging in terms of strengthening the capacity of the health sector?
7. In your opinion, how has SCHS helped strengthen the capacity of the health sector to make essential medical products available and accessible at service delivery points (sub-purpose 3)? What have been the main successes and challenges? How would you describe the level of GOR capacity in this area? In your opinion, what are the main strengths and gaps in GOR capacity in these areas? How can the gaps/challenges be effectively addressed?
8. In your opinion, how has SCHS worked to help increase domestic resources for the health sector and ensure that they are used equitably and efficiently (sub-purpose 4)? What have been

the main successes and challenges? How would you describe the level of GOR capacity in this area? In your opinion, what are the main strengths and gaps in GOR capacity in these areas? How can the gaps/challenges be effectively addressed?

9. In your opinion, how has SCHS helped strengthen leadership and governance of the health system at both central and local levels (sub-purpose 5)? What have been the main successes and challenges? How would you describe the level of GOR capacity in this area? In your opinion, what are the main strengths and gaps in GOR capacity in these areas? How can the gaps/challenges be effectively addressed?
10. What are the main important and changeable factors does the SCHS Project targets? In your opinion, are these the most important and changeable factors that contribute to the GOR's capacity to sustain a strong system that will provide high quality services? Are there other factors that SCHS should focus on?

Questions for the GOR (Central)

1. In your opinion, has the design of the SCHS Activities (projects: RHSSA, DELIVER/SCMS/GHSC-PSM, AIRS) facilitated or hindered USAID's support to strengthen the capacity of the health sector to deliver high quality services?
2. How effective do you think is the coordination among the IPs of the various Projects? Do you think they are working together effectively toward strengthening the Rwanda health sector capacity in a consorted way in the targeted results areas?
3. How do you coordinate and communicate with the various Project IPs? Do you find the overall communication and coordination with the various IPs effective? How can these be improved further?
4. On the GOR end, how do you plan and coordinate with other DPs/stakeholders in order to effectively complement the various Projects' activities? Can this be improved further? If so, how?
5. In your experience, which aspects of the Projects' design have been particularly helpful at strengthening the capacity of the health sector?
6. In your experience, what aspects of the Projects' design have been challenging in terms of strengthening the capacity of the health sector?
7. In your opinion, how have the Projects helped strengthen the capacity of the health sector to make essential medical products available and accessible at service delivery points? What have been the main successes and challenges? How can the gaps/challenges be effectively addressed? Please respond with particular reference to the DELIVER II TO 4 and TO 7 and SCMS (all implemented by John Snow, Inc.); and also with reference to Africa Indoor Residual Spraying (implemented by Abt Associates, Inc. as relevant; and Rwanda Health Systems Strengthening (implemented by MSH) as relevant.
8. In your opinion, how have the Projects helped to increase domestic resources for the health sector and ensured that they are used equitably and efficiently? What have been the main successes and challenges? How can the gaps/challenges be effectively addressed? Please respond with reference to the DELIVER II TO 4 and TO 7 and SCMS (all implemented by John Snow, Inc.); Africa Indoor Residual Spraying (implemented by Abt Associates, Inc.); and Rwanda Health Systems Strengthening Activity (implemented by MSH).
9. In your opinion, how have the Projects worked to help strengthen leadership and governance of the health system at both central and local levels? What have been the main successes and challenges? How can the gaps/challenges be effectively addressed? Please respond with reference

to the DELIVER II TO 4 and TO 7 and SCMS (all implemented by John Snow, Inc.); Africa Indoor Residual Spraying (implemented by Abt Associates, Inc.); and Rwanda Health Systems Strengthening (implemented by MSH).

10. In your opinion, have the Projects focused on the most important and changeable factors that contribute to the GOR's capacity to sustain a strong system that will provide high quality services? Are there other important and changeable factors that the Projects should focus on?

Questions for MOH Decentralized Level (District and Provincial Hospitals)

1. How has USAID supported your hospital to deliver high quality services? Please respond with particular reference to these Projects (RHSSA, DELIVER/SCMS, AIRS), implanted by MSH, John Snow, Abt Associates, etc.
2. In your experience, which aspects of these Projects support (mentioned above) have been most helpful at strengthening the capacity of your hospital?
3. In your experience, what aspects of the support have been challenging and/or least helpful at strengthening the capacity of your hospital? How can these Projects help you further to address these gaps/challenges and be more helpful? What additional support would you need to improve health services at your hospital?
4. Are you able to obtain the essential medical products you need and can you distribute them efficiently as needed? What have been the main successes and challenges? How have these Projects (RHSSA, DELIVER/SCMS, AIRS) helped you and how can they help further to address these gaps/challenges?
5. How do you get your funding? In your opinion, how has USAID and these Projects (RHSSA, DELIVER/SCMS, AIRS) supported revenue generation (including capacity building) in your hospital? How do you ensure that these funds are used equitably and efficiently? Are patients using health insurance and if not, why not? What have been the main successes and challenges in resource generation and effective mobilization? How can the project help you further in terms of revenue generation and financial management?
6. In your opinion, how has USAID and these Projects (RHSSA, DELIVER/SCMS, AIRS) worked to help strengthen leadership and governance in your hospital? Is your hospital able to effectively plan, manage and monitor health programing? Are the necessary planning (evidence based) and M&E frameworks in place for your hospital (Please explain)? What have been the main successes and challenges in planning, managing and monitoring your hospital activities? How can USAID help you further to address these gaps/challenges?
7. In your opinion, have these Projects (RHSSA, DELIVER/SCMS, AIRS) focused on the most important and changeable factors that contribute to provide high quality services? Are there other important and changeable factors that these Projects should focus on?
8. In your opinion, what are the **three most important things** USAID should do to support your district to provide high quality health services?

Questions for MOH Decentralized Level (District Health Management Teams)

1. How have the USAID Projects (RHSSA, DELIVER/SCMS, AIRS) supported your district to deliver high quality health services? What have been the main successes and challenges, so far? How can they help further to address various gaps/challenges?
2. In your experience, which aspects of these Projects support (mentioned above) have been most helpful at strengthening the capacity of health services in your district?

3. In your experience, what aspects of these Projects support have been least helpful at strengthening the capacity of health services in your district?

What additional support would you need to further improve health services?

4. Are you able to obtain the essential medical products you need and can you distribute them efficiently as needed? What have been the main successes and challenges, so far? How can these Projects help further to address various gaps/challenges?
5. What are the sources of the district health budget?
6. In your opinion, how have the USAID Projects supported revenue generation activities (including capacity building) for health services in your district?
7. In your opinion are these funds mentioned above used equitably and efficiently? (please provide a support document)
8. Are patients using health insurance and if not, why not?
9. What have been the main successes and challenges in resource generation and effective mobilization?
10. How can USAID and these Projects help you further in terms of revenue generation and financial management?
11. In your opinion, how have these USAID Projects worked to help strengthen leadership and governance in your district?
12. In your opinion are planning, management and monitoring health systems working well in your district?
13. What have been the main successes and challenges in planning, managing and monitoring your district health activities?
14. How can USAID Projects help you further to address these gaps/challenges and help further build DHMT's capacity to effectively plan, manage, and monitor health programming?
15. How would you describe the coordination between the DHMT and the MOH central level? What are some of the challenges and areas of improvements? How can these Projects help support in that areas?
16. Do the USAID Project IPs communicate and coordinate with you as needed? Do you think this can be improved further, if so, how?
17. In your opinion, have these Projects (RHSSA, DELIVER/SCMS, AIRS) focused on the most important and changeable factors that contribute to having an effective DHMT to support the provision of high quality health services? Are there other important and changeable factors that these Projects should focus on?
18. In your opinion, what are the **three most important things** USAID should do to support your district to provide high quality health services?

Questions for MOH Decentralized Level (Health Center)

1. How has USAID Projects (RHSSA, DELIVER/SCMS, AIRS) supported your Health center to deliver high quality health services?
2. In your opinion, which aspects of the support have been most helpful/effective and why?
3. In your opinion, which aspects of the support have been least helpful/effective and why?

4. What additional support would your health center need to improve health services?
5. Can you obtain the essential medical products you need on time and how do you distribute them?
6. How has the USAID Projects helped your health center and what additional support would you need to further improve health services?
7. What are the sources of the health center budget?
8. Has the USAID Projects supported any revenue generation schemes/activities (including capacity building) for health services in your health center, if so how?
9. How do you use these funds?
10. Are patients enrolled on and using health insurance (CBHI) and if not, why not? What are the main barriers for increased number of people to enroll in the CBHI program?
11. What have been the main successes and challenges in resource mobilization?
12. How can USAID and its Projects help you further in terms of revenue generation and financial management?
13. Please explain how you plan, manage and monitor activities in your health center?
14. What have been the main successes and challenges in planning, managing and monitoring activities in your health center?
15. How can USAID help you further to address these gaps/challenges?
16. In your opinion, what are the **three most important things** USAID should do to support your health center to provide high quality health services?

Questions for MOH Decentralized Level (CHWs Cooperatives)

1. Please explain what work you do and how you do it.
2. How has USAID Projects (RHSSA, DELIVER/SCMS, AIRS) supported your work and Cooperative? Please explain with example how the support has helped you.
3. Do you receive any incentives? Please explain.
4. How do you work with the health center? Do you face any difficulties dealing with the health center, or when you go there?
5. Can you always get the medicines and medical supplies that you need and on time? If not why not?
6. Can you tell us about any revenue generating activities you and your cooperative are involved in? How involved are you with the Cooperative? What can the Cooperative do more (and be helped with) to improve its income generation?
7. Please explain how you use ICT in your work?
8. Are the people in your community on CBHI? If not, why not?
9. What other support do you need to deliver improved and expanded health services?

Questions for Development Partners

1. Are you familiar with the SCHS Project and its Activities (DELIVER/SCMS, RHSSA, AIRS, PSM)?If so, in your opinion, has the design of the SCHS Project (or its activities) facilitated or hindered the support provided by USAID to strengthen the capacity of the health sector to deliver high quality services? How has the USAID SCHS Project Team and its implementing partners

coordinated with your office and relevant activities (including the ones implemented by your partners)?

2. In your experience, which aspects of the SCHS and/or its Activities (DELIVER/SCMS, RHSSA, AIRS, PSM) design have been particularly helpful at strengthening the capacity of the health sector?
3. In your experience, what aspects of the Projects' design have been challenging in terms of strengthening the capacity of the health sector?
4. In your opinion, how have these Projects strengthened the capacity of the health sector to make essential medical products available and accessible at service delivery points? What have been the main successes and challenges? In your opinion, what are the main strengths and gaps in GOR capacity in these areas? Please respond with particular reference to the DELIVER II TO 4 and TO 7 and SCMS (all implemented by John Snow, Inc.); and also with reference to Africa Indoor Residual Spraying (implemented by Abt Associates, Inc. as relevant; and Rwanda Health Systems Strengthening (implemented by MSH) as relevant.
5. In your opinion, how have these Projects supported to help increase domestic resources for the health sector and ensured that they are used equitably and efficiently? What have been the main successes and challenges? In your opinion, what are the main strengths and gaps in GOR capacity in these areas? How can the gaps/challenges be effectively addressed? Please respond with reference to the DELIVER II TO 4 and TO 7 and SCMS (all implemented by John Snow, Inc.); and also with reference to Africa Indoor Residual Spraying (implemented by Abt Associates, Inc. as relevant; and Rwanda Health Systems Strengthening (implemented by MSH) as relevant.
6. In your opinion, how have these Projects worked to help strengthen leadership and governance of the health system at both central and local levels? What have been the main successes and challenges? In your opinion, what are the main strengths and gaps in GOR capacity in these areas? How can the gaps/challenges be effectively addressed? Please respond with reference to the DELIVER II TO 4 and TO 7 and SCMS (all implemented by John Snow, Inc.); and also with reference to Africa Indoor Residual Spraying (implemented by Abt Associates, Inc. as relevant; and Rwanda Health Systems Strengthening (implemented by MSH) as relevant.
7. In your opinion, have these Projects focused on the most important and changeable factors that contribute to the GOR's capacity to sustain a strong system that will provide high quality services? Are there other factors that SCHS should focus on?

Questions for Professional Bodies and Academia

1. Are you familiar with the SCHS Project and its Activities (DELIVER/SCMS, RHSSA, AIRS, PSM)? If so, in your opinion, has the design of the SCHS project/its Activities facilitated or hindered the support provided by USAID to strengthen the capacity of the health sector to deliver high quality services? How has the SCHS project and its implementing partners coordinated with your organization?
2. In your experience, which aspects of the SCHS and/or its Activities (DELIVER/SCMS, RHSSA, AIRS, PSM) design have been particularly helpful at strengthening the capacity of the health sector?
3. In your experience, what aspects of the SCHS and/or its Activities (DELIVER/SCMS, RHSSA, AIRS, PSM) design have been challenging in terms of strengthening the capacity of the health sector?

4. In your opinion, how have these Projects strengthened the capacity of the health sector to make essential medical products available and accessible at service delivery points? What have been the main successes and challenges? In your opinion, what are the main strengths and gaps in GOR capacity in these areas? Please respond with particular reference to the DELIVER II TO 4 and TO 7 and SCMS (all implemented by John Snow, Inc.); and also with reference to Africa Indoor Residual Spraying (implemented by Abt Associates, Inc. as relevant; and Rwanda Health Systems Strengthening (implemented by MSH) as relevant.
5. In your opinion, how have these Projects supported an increase domestic resources for the health sector and ensured that they are used equitably and efficiently? What have been the main successes and challenges? In your opinion, what are the main strengths and gaps in GOR capacity in these areas? How can the gaps/challenges be effectively addressed? Please respond with reference to the DELIVER II TO 4 and TO 7 and SCMS (all implemented by John Snow, Inc.); and also with reference to Africa Indoor Residual Spraying (implemented by Abt Associates, Inc. as relevant; and Rwanda Health Systems Strengthening (implemented by MSH) as relevant.
6. In your opinion, how have these Projects worked to strengthen leadership and governance of the health system at both central and local levels? What have been the main successes and challenges? In your opinion, what are the main strengths and gaps in GOR capacity in these areas? How can the gaps/challenges be effectively addressed? Please respond with reference to the DELIVER II TO 4 and TO 7 and SCMS (all implemented by John Snow, Inc.); and also with reference to Africa Indoor Residual Spraying (implemented by Abt Associates, Inc. as relevant; and Rwanda Health Systems Strengthening (implemented by MSH) as relevant.
7. In your opinion, have these Projects focused on the most important and changeable factors that contribute to the GOR's capacity to sustain a strong system that will provide high quality services? Are there other factors that SCHS should focus on?

Questions for Private Sector

1. Are you familiar with the SCHS Project and its Activities (DELIVER/SCMS, RHSSA, AIRS, PSM)? If so, in your opinion, has the design of the SCHS project facilitated or hindered the support provided by USAID to strengthen the capacity of the health sector to deliver high quality services? How has the SCHS project and its implementing partners coordinated with your organization?
2. In your experience, which aspects of the SCHS and/or its Activities (DELIVER/SCMS, RHSSA, AIRS, PSM) design have been particularly helpful at strengthening the capacity of the health sector?
3. In your experience, what aspects of the SCHS and/or its Activities (DELIVER/SCMS, RHSSA, AIRS, PSM) design have been challenging in terms of strengthening the capacity of the health sector?
4. In your opinion, how have these Projects strengthened the capacity of the health sector to make essential medical products available and accessible at service delivery points? What have been the main successes and challenges? In your opinion, what are the main strengths and gaps in GOR capacity in these areas? How can the gaps/challenges be effectively addressed? Please respond with particular reference to the DELIVER II TO 4 and TO 7 and SCMS (all implemented by John Snow, Inc.); and also with reference to Africa Indoor Residual Spraying (implemented by Abt Associates, Inc. as relevant; and Rwanda Health Systems Strengthening (implemented by MSH) as relevant.

5. In your opinion, how have these Projects supported an increase domestic resources for the health sector and ensured that they are used equitably and efficiently? What have been the main successes and challenges? In your opinion, what are the main strengths and gaps in GOR capacity in these areas? How can the gaps/challenges be effectively addressed? Please respond with reference to the DELIVER II TO 4 and TO 7 and SCMS (all implemented by John Snow, Inc.); and also with reference to Africa Indoor Residual Spraying (implemented by Abt Associates, Inc. as relevant; and Rwanda Health Systems Strengthening (implemented by MSH) as relevant.
6. In your opinion, how have these Projects worked to strengthen leadership and governance of the health system at both central and local levels? What have been the main successes and challenges? In your opinion, what are the main strengths and gaps in GOR capacity in these areas? How can the gaps/challenges be effectively addressed? Please respond with reference to the DELIVER II TO 4 and TO 7 and SCMS (all implemented by John Snow, Inc.); and also with reference to Africa Indoor Residual Spraying (implemented by Abt Associates, Inc. as relevant; and Rwanda Health Systems Strengthening (implemented by MSH) as relevant.
7. In your opinion, have these Projects focused on the most important and changeable factors that contribute to the GOR's capacity to sustain a strong system that will provide high quality services? Are there other factors that SCHS should focus on?

ANNEX III. RELATIONSHIP BETWEEN SUB-PURPOSES, OUTPUTS, AND ACTIVITIES / IMPLEMENTING MECHANISMS

Sub-purposes	1. Service Delivery			2. Health information			3. Medical products & Pharmaceuticals		4. Health Financing			5. Leadership & Governance		
Outputs / Activities	1.1: Quality of facility and community-based health services improved	1.2: Availability of comprehensive facility and community-based health services maintained services maintained	1.3: Enabling environment for growth of private health care services improved	2.1: Data quality, accuracy and timeliness improved	2.2: Data for decision-making made available, institutionalized and used	2.3: Patient level patient data used in clinical decision making	3.1: Procurement of USAID-supported health products sustained	3.2: Capacity of MPD procurement unit and distribution system strengthened at central and local levels	4.1: Financial access to health services and household protection from financial risk strengthened	4.2: GOR fiscal space and resource allocation for health from domestically generated resources increased	4.3: Coordination, planning and effectiveness of partnerships both within the Government of Rwanda and with Development Partners improved	5.1: District Health Management Team's capacity to plan and manage health programing improved	5.2: Coordination between central and decentralized levels improved	5.3: District Planning, Reporting and M&E frameworks strengthened
Current projects:														
IRS2 TO4							■	■						
Family Health Project	■	■		■	■	■						■		
MCSP	■	■		■	■	■						■		
DELIVER II							■	■						
DELIVER TO7 Malaria														
SCMS														
Central Contraceptive Procurement														
Integrated Health Systems Strengthening Project									■	■	■	■	■	■
Planned activities:														
Rwanda Health Systems			■	■	■				■	■	■	■	■	■

Source: USAID/Rwanda, scope of work

ANNEX IV. BRIEF DESCRIPTION OF SCHS ACTIVITIES / IMPLEMENTING MECHANISMS COVERED IN THE MIDTERM PERFORMANCE EVALUATION

1. Rwanda Health Systems Strengthening Activity (RHSSA)

In recent years Rwanda has made remarkable progress in improving the health of its citizens, particularly as seen through indicators for infant mortality, child mortality, and maternal mortality. Access to health services has improved as well, and promising efforts in hospital accreditation and quality improvement speak to this progress. To maintain Rwanda's progress in health, much still needs to be done to make sure Rwanda's health system can sustain itself into the future. SCHS's Rwanda Health System Strengthening Activity (RHSSA), implemented by MSH, enhances the resiliency of the Rwandan health sector to address new challenges and builds a sustainable health system, capable of leading and managing changes for the improved health of all Rwandans. The overall goal of RHSSA is to *achieve strengthened and expanded performance of the Rwandan health system at national, decentralized and community levels by*:

- Institutionalizing health systems thinking to increase advocacy, leadership and stewardship;
- Enhancing policy, planning and implementation at central and district levels;
- Increasing revenue mobilization for the health sector;
- Improving quality of health services and greater efficiency in resource use; and
- Strengthening M&E, health systems research, learning and knowledge-based practices.

Expected results:

- Advanced country ownership of strategies and meaningful partnership and participation among relevant national and local level leadership
- Upgraded capacity of central and local level healthcare managers for planning, policy and strategy implementation
- Increased revenues and efficient and equitable allocation of financial and human resources
- Expanded private sector engagement and investments in health facilities;
- Strengthened evidence base on accreditation schemes to support quality improvement in hospitals and other health facilities;
- Reliable and relevant data and information that is publicly accessible and used by health professionals for decision-making
- Increased use of research outcomes into policy, program, plans, and strategy dialogue and formulation

2. DELIVER/SCMS

Effective health commodities logistics management is a pillar supporting commodity security, and a component vital to the success of any public health program. Ensuring that clients have the right product at the right time is the main objective of a secure public health supply chain. Implemented by PFSCM, the co-run DELIVER and SCMS projects (in-country activities completed in 2016) worked with the Ministry of Health to increase the availability of maternal and child health, family planning, malaria, HIV/AIDS, and related commodities. The projects encouraged policymakers and donors to support logistics as a critical factor in the overall success of Rwandan health care mandates.

Objectives:

- The activities' main objectives were to increase access to essential medicines and support procurement of family planning, malaria, HIV/AIDS, and laboratory commodities by:
    - Strengthening the national supply chain system for all essential medicines'
    - Building human capacity in logistics management, and
    - Supporting Rwanda's Central Medical Stores with mentoring and by supplying operational equipment

Expected results:

- Reduce or eliminate stock outs
- Improve storage conditions
- Efficiently and effectively manage commodities according to clear logistics principles
- Liaise with national counterparts and build capacity to allow skills transfer
- Implement an eLMIS to enhance evidence-based decision-making for the supply chain at all levels.

3. Africa Indoor Residual Spraying (AIRS):

In Rwanda, approximately 11 of 30 districts contribute over 70% of the malaria disease burden. These districts are located in the Eastern and Southern provinces. In order to prevent and control malaria in some of these districts, USAID employs Indoor Residual Spraying (IRS), which consists of the spraying of safe insecticides on the walls of structures – namely homes in target areas. IRS targets the mosquitoes before they are able to infect another person, thus disrupting the transmission of malaria. The Indoor Residual Spraying activities in Rwanda are supported under the Presidential Malaria Initiative (PMI). The IRS activity is implemented under the IRS 2 Task Order 6 by Abt Associates and is effective September 2014 to September 2016 (extended to 2018).

- Prior to the current activity, Abt Associates implemented IRS Task Order 4 (TO4), also an IRS activity. The main objective of the three-year TO4 was to reduce the prevalence and incidence of malaria in Rwanda by:
- Supporting planning, operations and logistics for IRS implementation in Rwanda
- Supporting training, capacity building, and advocacy at national, regional, and district levels as a means of achieving IRS sustainability
- Ensuring safe and correct insecticide application, thus minimizing human and environmental exposure to insecticides
- Spraying at least 85 percent of eligible structures in identified targeted
- Providing regular monitoring and evaluation for the IRS program
- Coordinating information, education and communication activities to raise awareness of IRS and its benefits

Source: USAID/Rwanda, scope of work and desk review

ANNEX V. THE EVALUATION PROCESS: AN EVIDENCE-BASED DRIVE

ANNEX VI. EVALUATION MATRIX

Evaluation Questions	Data Sources	Sampling Method	Data Collection Methods	Data Analysis Methods	Possible Limitations
1. To what extent has the design of the SCHS project facilitated or hindered USAID's support to strengthen the capacity of the health sector to deliver high quality services? In this context, design refers to the relationships between the elements of the SHCS project matrix including the interactions and dependencies of stakeholders as well as activities implemented as they relate to the Results Framework. Consider elements such as structure, coordination among IPs, engagement of stakeholders among others.	▪ Project/Activity monitoring data ▪ Project/Activity Quarterly/Annual Progress Reports ▪ Activity IP Staff ▪ USAID SCHS Project, and other USAID Health and Program Office Staff ▪ Stakeholders: ▪ GOR – MOH central level; MOH decentralized level; RBC; other central level entities/line ministries. ▪ Development partners; ▪ Professional/umbrella bodies; and ▪ Private health sector.	▪ Purposive – based on recommendations from USAID Rwanda and implementing partners, and Team's stakeholders analysis based on documents review ▪ Systematic – Team's analysis and relevancy	Qualitative: ▪ KIIs ▪ FGDs ▪ Documents Review	▪ Fact-based Content Analysis ▪ Grounded Theory ▪ Trend analysis on reported results on acceptable quality & performance standards ▪ Comparison: Assess efficiency of coordination mechanisms among IPs with similar or complementary objectives	▪ Analysis limited to SCHS project activity areas and does not reflect the entire health sector / cover full spectrum of service delivery. ▪ The analysis may therefore not definitively be able to establish attribution in certain specific areas.
2. To what extent has the SCHS project strengthened the capacity of Rwandan health systems in relation to sub purposes 3, 4 & 5?	▪ USAID SCHS Project and other Health Office Staff ▪ IP Project Staff ▪ Project/Activity monitoring data ▪ Project/Activity Quarterly/Annual Progress Reports ▪ GOR Counterparts ▪ Other Stakeholders:	▪ Purposive – based on recommendations from USAID Rwanda and implementing partners for KIIs, and Team's stakeholders analysis based on	Quantitative: ▪ Documents Review Qualitative: ▪ KIIs ▪ FGDs	▪ Trend Analysis (achievement compared to baseline & achievement compared to targets) ▪ Content Analysis ▪ Grounded Theory	▪ Trend analysis contingent on data availability. ▪ The analysis may not definitively be able to establish attribution on all aspects, as a number of factors external to the SCHS Project impact the capacity of the Rwandan health systems.

Evaluation Questions	Data Sources	Sampling Method	Data Collection Methods	Data Analysis Methods	Possible Limitations
	▪ GOR – MOH central level; MOH decentralized level; RBC; ▪ Professional/umbrella bodies; and ▪ Private health sector	documents review ▪ Random – for FGDs with service providers at central and decentralized levels			▪ Some findings will reflect only sites visited / SCHS project activity areas, and may not be generalizable to the whole country / non-project activity areas. ▪ Baseline data may not be available for all elements of sub-purposes 3, 4 and 5. ▪ As SCHS is focused on supply side, many cases, the evaluators will mostly have to rely on implementing partners' and health service providers' views, opinions, and information/reports. ▪ Limited available time to meet and engage with a relatively large number of stakeholders and different site locations (over 60 entities). ▪ Key informant(s) with informative past experience about certain SCHS Activity may not be available at the time of the evaluation
2a. What is the level of capacity of the GOR in these areas?	▪ Project IP Staff ▪ Project/Activity monitoring data ▪ Project/Activity Quarterly/Annual Progress Reports ▪ USAID SCHS and other Health Office Staff	▪ Purposive – based on recommendations from USAID Rwanda and implementing partners and Team's	Qualitative: ▪ KIIs ▪ FGDs ▪ Specific/limited Capacity Assessment based on	▪ Fact-based Content Analysis ▪ Grounded Theory ▪ Fact-based Trend Analysis	▪ Baseline data and progress reports may not be available for all elements of sub-purposes 3, 4 and 5. ▪ Absence of baseline capacity assessment. ▪ Capacity Assessment based on key variables only and

Evaluation Questions	Data Sources	Sampling Method	Data Collection Methods	Data Analysis Methods	Possible Limitations
	▪ GOR Counterparts ▪ Relevant Stakeholders - MOH central level; MOH decentralized level; RBC; other central level entities; development partners; academia; professional bodies; private health sector.	stakeholders analysis based on document review ▪ Random – for FGDs with service providers and other relevant professional at central and decentralized levels	checklist and KIIs. Quantitative: ▪ Documents review		contingent on data availability. ▪ Various Activities are at different levels of their implementation and life cycle.
3. Does SCHS target the most important and changeable factors that contribute to the GOR's capacity to sustain a strong system that will provide high quality services?	▪ Project IP Staff ▪ Project/Activity Workplan and Quarterly/Annual Progress Reports ▪ USAID SCHS and other Health Office Staff ▪ GOR Counterparts ▪ Relevant Stakeholders - MOH central level; MOH decentralized level; RBC; other central level entities; development partners; academia; professional bodies; private health sector.	▪ Purposive – based on recommendations from USAID Rwanda and implementing partners and Team's stakeholders analysis based on documents review ▪ Random – for FGDs with service providers at central and decentralized levels	Qualitative: ▪ KIIs ▪ FGDs ▪ Document Review	▪ Fact-based Content Analysis ▪ Grounded Theory	▪ Possible different understandings of "changeable" based on subjective views of interviewees.
3a. Are there other more important and changeable areas?	▪ Project IP Staff ▪ Project/Activity Workplan and Quarterly/Annual Progress Reports	▪ Purposive – based on recommendations from USAID Rwanda and implementing	Qualitative: ▪ KIIs ▪ FGDs ▪ Documents Review	▪ Fact based Content Analysis ▪ Grounded Theory	▪ Possible different understandings of "changeable" based on subjective views of interviewees.

Evaluation Questions	Data Sources	Sampling Method	Data Collection Methods	Data Analysis Methods	Possible Limitations
	▪ USAID SCHS and other Health Office Staff ▪ GOR Counterparts ▪ Relevant Stakeholders – MOH central level; MOH decentralized level; RBC; other central level entities; development partners; academia; professional bodies; private health sector.	partners and Team's stakeholders analysis based on document review ▪ Random – for FGDs with service providers at central and decentralized levels			

ANNEX VII. BIBLIOGRAPHY OF DOCUMENTS REVIEWED, USED, AND CONSULTED

1. AIRS Rwanda. (2013). *Capacity Building of the Ministry of Health.* Training Report.
2. AIRS Rwanda. (2013). *IRS Country Assessment Summary.* Kigali, Rwanda/Bethesda, MD. Africa Indoor Residual Spraying Project, Abt Associates Inc.
3. AIRS Rwanda. (2014). *IRS Country Capacity Building Plan.* Rwanda/Bethesda, MD. Africa Indoor Residual Spraying Project, Abt Associates Inc.
4. AIRS Rwanda. (2014). *PMI | Africa IRS (AIRS) Project Indoor Residual Spraying (IRS 2) Task Order Four. Rwanda End of Spray Report*, Bethesda, MD. Abt Associates Inc.
5. AIRS Rwanda. (2014). *The PMI Africa Indoor Residual Spraying Project (AIRS). Indoor Residual Spraying (IRS 2)*. Task Order Six Work Plan & Budget December 1, 2014 – December 31, 2015. Bethesda, MD. Abt Associates Inc.
6. AIRS Rwanda. (2015). *PMI | Africa IRS (AIRS) Project Indoor Residual Spraying (IRS 2). Task Order Six. Rwanda End of Spray Report,* Bethesda, MD. Abt Associates Inc.
7. AIRS Rwanda. (2015). *The PMI Africa Indoor Residual Spraying Project (AIRS) Indoor Residual Spraying (IRS 2) Task Order Six. Rwanda Work Plan & Budget January 1, 2016 – December 31, 2016*. Bethesda, MD. Abt Associates Inc.
8. AIRS Rwanda. (2017). *USAID SCHS Mid-term Performance Evaluation:* AIRS Rwanda in–Briefing PPP.
9. AIRS Rwanda. (2015). *People trained to deliver IRS September 2015.*
10. AIRS Rwanda. (n.d). *Capacity Building of the Ministry of Health*. Training Report.
11. AIRS. (2016). *Indoor Residual Spraying (IRS 2). Task Order Six. Rwanda End of Spray Report*. Spray campaign: February 15-March 09,2016.
12. AIRS. (n.d). *Monitoring and Evaluation Plan Matrix.*
13. Kicukiro District. (n.d). *Kicukiro DHU capacity building plan (CBP) 2016-2017.*
14. Masaka District Hospital. (2016). *Effect of accreditation in reduction of post cesarean section infections*, PPP.
15. Masaka District Hospital. (2017*). USAID SCHS Mid-term Performance Evaluation:* Masaka district hospital in–Briefing PPP.
16. Masaka Hospital. (2016). *Clinical care outcome and financial resources management situation in Masaka hospital 2014-2016*, PPP.
17. Masaka Hospital. (n.d). *Masaka hospital capacity building plan (CBP) 2016-2017.*
18. MCSP. (2017). *MCSP Rwanda program*. PPP, February 2017.
19. MINALOC. (2016). *Amabwiriza ya Minisitiri w'Ubutegetsi bw'Igihugu agenga gahunda igamije kunoza imitangire ya serivise,imikorere n'icungamutungo mu nzego z'ibanze hashingiwe ku kwigenzura no kwigiranaho.*
20. Ministry of Health. (2012). *Third Health Sector Strategic Plan* July 2012 – June 2018.
21. Ministry of Health. (2013). *Letter Mandatory use of the e-LMIS in pharmaceutical management.*
22. Ministry of Health. (2013*). Rwanda Malaria Control Strategic Plan July 2013- June 2018.*
23. Ministry of Health. (2014). *Adopted structure of MINISANTE 2014.*
24. Ministry of Health. (2015). *District Pharmacy Supply Chain Operations Manual. Volume One: Procurement.*
25. Ministry of Health. (2015). *Health Financing Sustainability Policy.*
26. Ministry of Health. (2015). *Mid-term Review of the Rwanda third Health Sector Strategic Plan (HSSP III, July 2012-June 2018).* Final Report. Kigali, 27 October 2015.

27. Ministry of Health. (2015). *Minutes of planning and health financing TWG meeting*. 15th October, 2015.
28. Ministry of Health. (2013). *Rwanda National Strategic Plan for Pharmaceutical Supply Chain.* October 2013 to September 2018. FINAL Draft – September 2013.
29. Ministry of Health. (2015). *The National eHealth Strategic Plan 2015-2020.*October 2016
30. Ministry of Health. (2016). *Agenda of planning, health financing and health information system TWG meeting as of February 23rd, 2016*
31. Ministry of Health. (2016). *M&E of JOINT ACTION PLAN of the Planning, Health Financing & Information Systems TWG*. July2015 – June 2016.
32. Ministry of Health. (2016). *Malaria Contingency Strategy.*
33. Ministry of Health. (2016). National Pharmacy Policy. April 2016.
34. Ministry of Health. (2016). *National Policy for Quality and Accreditation of Healthcare System in Rwanda*. March 2016.
35. Ministry of Health. (2016). *National Strategy for Quality and Accreditation of Healthcare System in Rwanda 2016 to 2018*. December 2016.
36. Ministry of Health. (2016). *Report of a Baseline Assessment on Public-Private Health Insurance.*
37. Ministry of Health. (2016). *Rwanda Health Financing Strategic Plan2016-2020.*
38. Ministry of Health. (2016). *Rwanda Health Resource Tracking Output Report*. Expenditure FY 2013/14 and Budget FY 2014/15.September 2016.
39. Ministry of Health. (n.d). *Human Resources for Health (HRH) Strategic Plan 2016-2021*.
40. Ministry of Health. (2014). *Health Sector Annual Report* - July 2013-June 2014.
41. MSH. (2014). *PBF sustainability study report.*
42. MSH. (2015). *Private Sector Engagement (PSE) Assessment Report*. Validation Workshop.
43. MSH. (2015). *Project Monitoring and Evaluation Plan*. November 2014 – November 2019.
44. MSH. (2015). *Rwanda Health Systems Strengthening Project*. Quarterly Report (April–June 2015).
45. MSH. (2015). *Rwanda Health Systems Strengthening Project*. Quarterly Report (January–March, 2015).
46. MSH. (2015). Southern Province's meeting Report on health system strengthening: "*Towards the development of health coordination of all actors involved in health to empowering district health system".* Huye District, 24-25 November 2015.
47. MSH. (2016). *A Comprehensive assessment of community health workers' (CHW) cooperatives in Rwanda.* Final report.
48. MSH. (2016). *Integrated planning approach for health systems at decentralized level*. Report of the District Health Integrated Annual Action Plans development for 2016-17 fiscal year.
49. MSH. (2016). *Nyanza DHMT meeting report as of 20/10/2016.*
50. MSH. (2016). *Report on the first district session of Integrated Planning Workshop Huye District AAP 2016-2017*. 21 March – 24March 2016 Muhanga Splendid Hotel, Rwanda.
51. MSH. (2016). *Rwanda Health Systems Strengthening Project*. Quarterly Report (April–June, 2016).
52. MSH. (2016). *Rwanda Health Systems Strengthening Project*. Quarterly Report (January–March, 2016).
53. MSH. (2016). *Rwanda Health Systems Strengthening Project*. Quarterly Report (October–December, 2015).
54. MSH. (2016). *Southern provincial Technical Adviser of MSH-RHSSA support report to JADF of districts.*
55. MSH. (2017). *Summary of MSH Participation in TWGs during RHSSA (since Nov 2014).*
56. MSH. (n.d). *Rwanda Health Systems Strengthening (RHSSA) Activity*. Quarterly Report (November–December 2014).
57. MSH. (n.d). *Strategic Plan for RHSSA: 2015-2019.*

58. Ngoma district. (2016). *Ngoma District Health Management Team meeting report as of 12/10/2016*
59. Ngoma district. (2016). *Raporo y'inama y'abayobozi b'inzego zibanze n'itsinda rishinzwe imicungire y'ubuzima mu karere ngoma (DHMT).* Ngoma 1st November 2016.
60. RBC. (2013). Letter from RBC: *Warehouse in a Box activity.*
61. Republic of Rwanda. (2016). *Rwanda Demographic and Health Survey 2014-15*. Final Report. http://dhsprogram.com/Where-We-Work/Country Main.cfm?ctry_id=35&c=Rwanda&Country=Rwanda&cn=&r=1
62. Republic of Rwanda. (n.d*). Economic Development and Poverty Reduction Strategy2013 – 2018*. Shaping our development.
63. Republic of Rwanda. (n.d). *Rwanda Vision 2020.*
64. RSSA. (2015). Annex III: *Performance Indicator Reference Sheets.*
65. RSSA. (2015). *Annual Report, Fiscal Year 2015* (with 4th quarter highlights). October 30,2015.
66. RSSA. (2015). *RHSS Baseline Assessment Report(Draft).* August 2015.
67. RSSA. (2015). *Second Year Work Plan FY 2016*. October 2015 – September 2016.
68. RSSA. (2016). *Activity driven implementation plan budget (2016-2017 updated 18 Oct 2016).*
69. RSSA. (2016). *Compilation of DHU Fully functional monitoring tool scores (September 2016).*
70. RSSA. (2016). *PMP Indicator progress review and updates*. Dec 2016.
71. RSSA. (2016). *Third Year Work Plan FY 2017*. (October 2016 – September 2017).
72. RSSA. (2017). *USAID evaluation overview RSSA*. In-brief PPP.
73. RSSA. (n.d). *Activity work plan final version updated 15 Oct 2015.*
74. RSSA. (n.d). *Annual Performance Report*. (October 2015 – September 2016).
75. RSSA. (n.d). *First Year Work Plan FY 2015*. November 2014 – September 2015.
76. RSSA. (n.d). *General HF conference recommendations.*
77. RSSA. (n.d). *Health Facilities' self-financing.* Final report.
78. RSSA. (n.d). *Health financing post conference report.*
79. RSSA. (n.d). *Program M&E Matrix (M&E Framework) Reporting Template*
80. RSSA. (n.d). *Work plan budget 2012-2015 version3 2-13-2015.*
81. RSSA. (n.d). *District Integrated Operational Planning*. Context of the planning workshop. Concept note.
82. RSSB. (2015). *A Study on the Community-based Health Insurance Deficit and Strategies for Sustainability.*
83. RSSB. (2016). *Community-Based Health Insurance Annual Report (DRAFT)*. Financial Year 2015/16.
84. Ruhango District. (2016). *Report of Ruhango district health strategic plan review.* Huye, 25th -29th July 2016.
85. Ruhango District. (n.d). *Ruhango district integrated planning 2016-2017*. Excel final version.
86. SCHS. (2014). Annex A: *Rwanda SCHS PAD Logical Framework.*
87. SCHS. (2014). Annex E: *Gender Analysis for USAID/Rwanda***.** Strengthening Capacity of Health Sector to Deliver Quality Health Services in Rwanda (SCHS) PAD July 2014.
88. SCHS. (n.d). Annex C: *USAID Forward and Health Systems Strengthening*.
89. SCHS. (n.d). Annex D: *Monitoring and Evaluation Plan and Learning Approach.*
90. SCSM. (2012). *Rwanda Lab System Design SOW*. Final.
91. SCSM. (2013). *Joint work plan. Project year 8.*
92. SCSM. (2013). *Laboratory harmonization and standardization workshop report*. Rubavu, July 17 – 25
93. SCSM. (2013). *National Supply Chain Assessment.* Rwanda Results.
94. SCSM. (2013). *PEPFAR narrative SCMS FY13***.** October 12 – September 13.
95. SCSM. (2013). *SCMS and USAID-Deliver Project work plan, FY2016*. SCSM/Deliver Task Order TO4 &TO7&TO3.
96. SCSM. (2014). *National Supply Chain Assessment. Report.* Rwanda September 2014.

97. SCSM. (2014). *Performance Management Plan for the Rwanda National Pharmaceutical Supply Chain Strategic Plan 2014 to 2019.* Draft Version 1.0 – as of March 18, 2014.
98. SCSM. (2014). *PMP-Implementation Plan*. Final, March 2014.
99. SCSM. (2014). *Rwanda National Pharmaceutical Supply Chain Strategic, Operational & Performance Management Plans.* PPP to MOH Senior Management Meeting. Kigali – March 2014.
100. SCSM. (2015*). Rwanda NSCA and Pharmaceutical Supply Chain Strategic Plan Technical Report.* Use of the NSCA to develop a National Supply Chain Strategic Plan. September 2013.
101. USAID/Deliver Project. (2014). *Task Order 4: Annual Report: October 2012–September 2013.*
102. USAID/Deliver Project. (2014). *Task Order 7: Semi-Annual Report: October 2013–March 2014.*
103. USAID/Deliver Project. (2016). *Final Country Report Rwanda.* Arlington, Va.: USAID/DELIVER PROJECT, Task Order 4 and Task Order 7.
104. USAID/Deliver Project. (n.d). *Rwanda Contraceptive Security Indicators Data Dashboard.*
105. USAID Rwanda. (n.d). *Rwanda Integrated Health Systems Strengthening Project*. Final Report. November 2009 – August 2014.
106. USAID/Deliver Project. (2013). *Rwanda Country Strategy and Work plan, 2013-2014***.**Final.
107. USAID/Deliver Project. (2013). Task Order 4. *Rwanda Country Strategy and Work plan, 2013-2014.*Final.
108. USAID/Deliver project. (2014). *Impact brief.*
109. USAID/Deliver Project. (2014). Task Order7. *Rwanda Country Narrative and Work plan, 2014-2015.*
110. USAID/Deliver Project. (2015). *Rwanda Medical Procurement and Production Division. Sage line 500 evaluation.* Report and recommendations. August 31, 2015.
111. USAID/Deliver Project. (2015). Task Order 4. *FY15 Rwanda Country Strategy and Work plan***.** Draft.
112. USAID/Deliver Project. (2015). *Work plan, FY15/Project Year 9*. Task Order 4.
113. USAID/Deliver Project. (2015). *Work plan, FY15/Project Year 9. Task Orders 4&7.*
114. USAID/Deliver Project. (2016). *Round one Report. Review of the Electronic Logistics Management Information System in Rwanda. Costs and Potential Savings to Public Health Supply Chain Operations.* Draft: June 24, 2016.
115. USAID/Deliver Project. (2016). *Work plan, FY2016. Task Orders 4&TO7 & TO3*.
116. USAID/Deliver Project. (n.d). *Draft Final SC Cost Report.*
117. USAID/Deliver Project. (n.d). *Rwanda Task Order 4 & 7*. October 2015 – September 2016. Updated Country Narrative.
118. USAID/Deliver Project. (n.d). *Work plan, Project year 8*. Task Order 4&7.
119. USAID/Rwanda. (2016). *Rwanda Health office indicators. Facts info 2015 data.*
120. USAID/Rwanda. (n.d). *Country Development Cooperation Strategy (2015-2019).*
121. USAID. (2012). *Rwanda: Costing of the Public Health Supply Chain*. Draft final report.
122. USAID. (2013). *Rwanda quarterly Mission reporting. Task order 4*.
123. USAID. (2013). *Rwanda quarterly report. Task order 7 Malaria*. Q1Oct-Dec 13 final.
124. USAID. (2014). *Strengthening the Capacity of the Health Sector to Deliver Quality Health Services.* Project Appraisal Document. December 2014**.**
125. USAID. (2014). *USAID/ Rwanda Performance Management Plan (2015-2019).* September 30, 2014
126. The World Bank. (2016). *World Development Indicators Databas*e, the World Bank Group

ANNEX VIII. FIELD VISIT SITES AND SCHEDULE

Region/ Province	Approximate Driving Time	Provincial Hospital	District Hospital	DHMT	Health Center	CHW Cooperative	Health Post	MCSP Site	AIRS District	No. of Interviews /sites	Covering Team/Sub-team	Date	Note
City of Kigali, Departure time from Serena - 7:30 AM	**0.5 Hour**	X	Masaka (High staff turnover site) - High (Visit 1st) **8:30 to 10:30 am**	Kicukiro (Masaka) - High (Visit 2nd) **11:00 to 12:30pm**	Gikondo (Kicukiro/Masaka) - High (Visit 4th) **2:30 to 3:30 pm**	Indatwaza Gikondo (Gikondo HC) - Matured (High) (Visit 5th) **3:45 to 4:45pm**	Kagarama (Kicukiro HC, Masaka DH) - Public - N/A (Visit 3rd) **1:30 to 2:15 pm**	X	X	**5**	**Team 1 (KB, DK, PN), Team 2 (LM, SM, TK)**	**2/2/2017**	
Eastern, Departure time from Serena - 7:30 AM	**2.5 Hours**	Kibungo - High **10:30 to 1pm / Team 1 & 2**	X	Ngoma (Kibungo) - Low **10:30 to 1pm / Team 1 & 2:**	Kirwa (Kibungo) - Medium **1pm to 2pm /Team 2**	Koaruge (Kirwa HC) - Expanding (Medium) **2.15 to 3.15pm/ Team 2**	X	Kibungo HC (Kibungo Sector, District: Ngoma) **1pm to 2pm /Team 1**	Kirehe (1 hour drive from Kibungo) **3 to 4pm/Team 1**	**6**	**Team 1, Team 2**	**2/7/2017**	Need to split/ DHMT &District hospital personel in One meeting Team 2 to leave this meeting earlier at 12:00 PM
Northern, , Departure time from Serena -	**1 Hour**	X	Rutongo (High staff turnover site) - Low **9 to 11am, Team 1**	Rulindo (Rutongo) - Medium High **12pm to 1pm, Team 1**	X	X	X	X	X	**2**	**Team 1**	**2/8/2017**	Team 1 covers this and travels to the Western Province
Southern, , Departure time from Serena -	**3 Hours**	Ruhango (High staff turnover site) - Low **10:30 am to 12:30pm, Team 2**	X		Kinazi (Ruhango) - Low **1:00pm to 2:00pm, Team 2**	Tabara/Kotaki (Kinazi HC) - Startup (Low) **2.15pm to 3.15pm, Team 2**	X	X	X	**3**	**Team 2**	**2/8/2017**	
Western, , Departure time from Serena - 7:30 AM	**3 Hours**	X	Gisenyi - Medium **9:00 am to 11am, Team 1**	X	X	X	Nyamyumba (Kigufi HC, Gisenyi DH) - Private - N/A; **11:30 an to 12:30 pm, Team 1**	X	X	**2**	**Team 1**	**2/9/2017**	
Provincial Technical Adviser's (PTA) Contact Info:									**Total Sites**	**18**			
COK: Mrs Edith Musabyimana, tel: 0788486960 ; email: emusabyimana@msh.org									**Total Entities**	**21**			
East: Dr Julius Kamwesiga, tel: 0788838991 ; email: jkamwesiga@msh.org													
South: Mr Jean-Marie SINARI, tel: 0738617912 ; email: jsinari@msh.org													
North: Dr John Kalach, tel: 0788437145 ; email: jkalach@msh.org													
Weest: Dr Louis Kitoko, tel: 0788384494 ; email: lkitoko@msh.org													

ANNEX IX. DATA COLLECTION INSTRUMENTS AND ANALYSIS TOOLS

Key Informant Interview (KII) Guide — Generic

USAID/Rwanda SCHS Mid-term Performance Evaluation Key Informant Interview (KII) Guide — Generic

1. Name and designation (Record interviewee(s) Name, organization, designation, email address, telephone number, and gender)

2. KII Respondents(s) _____

3. Date and Duration of KII _____

4. Gender # of male_____ # of female _____

(For details and key points notes instructions, see KII Summary Notes Template)

Key Reminders to the Facilitator/interviewer:

1. The key is to facilitate and lead rather than direct. It is not necessary to read the questions word for word. Rather, the questions serve as a guide to interview. Questions may be adapted according to the key informant, based on their level of involvement with the project and the information they have. If you realize that the interviewee is not well informed about a question, just move on to the following questions.
2. Begin the interview with a minute or two of general conversation. Introduce yourself and explain the purpose of the evaluation. Emphasize that this is an inward-looking evaluation of USAID's own support effectiveness and not an evaluation of the GOR.
3. The purpose is to get the person(s) involved in conversation and participate in the discussion.
4. Maintain a respectful and non-judgmental approach to the interviewee(s) and his/her/their viewpoints.
5. The purpose of the interview is to elicit information from the key informant. It is not to interject your own views or opinions or to get into a debate with the key informant. If you do not agree with the key informant's point of view, simply note it down in your notes. Under no circumstances should you get involved in a debate with the key informant.
6. Questions requiring opinions and judgments should follow factual questions, after some level of trust has been established and the atmosphere is more conducive to candid replies.
7. Questions should be simply worded, kept short, and phrased in the vernacular. Generally, they should be phrased to elicit detailed information, not just a simple 'yes' or 'no' answer.
8. When you probe for additional information, do not stray away from the guiding evaluation questions.
9. Although we will have interviewer questions lined up and in a certain order, let's not be afraid to deviate. It is entirely possible that a person may start talking and end up answering any number of questions without specifically being asked. It is also likely that someone may introduce a subject not included in the questions -- let him/her talk (within reason!). The whole point is to allow the person

to tell his/her story, including their particular knowledge, opinions, and experiences. Give them the space to say what they need to say. If the person deviates completely from the topic, then do pull them back by referring to the questions.

Interviewer's welcome, introduction and background to respondent(s)

Welcome and thank you for accepting the invitation to take part in this meeting. You have been asked to participate as your knowledge, experience, and point of view are important. We realize you are busy and very much appreciate your time.

Introduction: *Introduce ourselves.* As you are aware, we are conducting the USAID/Rwanda's SCHS Project Mid-term Performance Evaluation. We are very interested in learning about your perception and experience in this regard including what has and what has not worked well, key activities, results, sustainability issues, and future direction/plans/ideas/suggestions relevant to having a higher and impactful SCHS, thus improved services in the health sector. This discussion will take between one to two hours.

Please note that this evaluation is to examine some of USAID's own activities and approaches. This inward-looking evaluation is a standard practice within USAID and does not necessarily reflect any impact in actual programming, but rather part of a constant effort to improve USAID's support to the Government of Rwanda in more effective and efficient manner.

Ask respondent(s) to introduce themselves by stating their name and their background or relationship as it pertains to the health sector and the SCHS Project and its activities.

Consent/Anonymity: I would like to assure you that the discussion and release of information will be anonymous. The notes of this meeting will contain no information that would allow individual subjects to be linked to specific statements. You should be open, honest and try to answer and comment as accurately and truthfully as possible. You are also free to not respond to any of our questions or stop the interview at any time. Again, the purpose of this evaluation is to help USAID determine the extent to which the project is providing effective and efficient support to the GOR. The evaluation will identify successes, challenges and barriers to effective and efficient project planning and implementation. The results of the review will be used to formulate recommendations for project adjustments, if appropriate.

Also, as we speak to you and/or walk through your facility, we will take written notes and may also fill out a brief capacity assessment checklist.

Do I have your permission to begin?

Before we begin, do you have any questions about this interview?

Purpose and Questions

SCHS Mid-term Evaluation Purpose

The purpose of this mid-term performance evaluation is to better understand the effectiveness of the SCHS project activities toward the expected results so far, and provide specific learning and evidence for design, planning, implementation, and management decisions by the SCHS Project Team going forward.

SCHS Mid-term Evaluation SOW Questions

1. To what extent has the design of the SCHS project facilitated or hindered USAID's support to strengthen the capacity of the health sector to deliver high quality services? In this context, design refers to the relationships between the elements of the SHCS project matrix (Annex 2) including the interactions and dependencies of stakeholders as well as activities implemented as they relate to

the Results Framework. Consider elements such as structure, coordination among IPs, engagement of stakeholders among others.

2. To what extent has the SCHS project strengthened the capacity of Rwandan health systems in relation to sub purposes 3, 4 & 5?
   a. What is the level of capacity of the GOR in these areas?
3. Does SCHS target the most important and changeable factors that contribute to the GOR's capacity to sustain a strong system that will provide high quality services?
   a. Are there other more important and changeable areas?

Note: The performance evaluation should answer questions 2 and 3 in relation to sub-purposes 3-5 (Medical products & Pharmaceuticals, Health Financing, Leadership & Governance)

Key Probing Questions by categories of stakeholders

Please use the Customized Probing Question Sets for Different Categories of Stakeholders

(Annex 19) to seek important information to answer the evaluation questions above.

Conclusion

- Thank you for participating. This has been a very useful discussion
- Your opinions, knowledge, and insights will be a valuable asset to this Evaluation
- I would like to remind you that any comments featuring in this report will be anonymous
- Before we end, is there any question or anything else any of you would like to share, and make sure to thank all participants.
- THANK YOU and please make sure you have completed the attendance sheet.
- *Reminder to the team's final note writer: Please, write your summary notes based on the KII Summary Notes Template, and results of the KII.*

USAID/Rwanda SCHS Midterm Performance Evaluation: Group/Focus Group Discussion (FGD) Guide — Generic

1. Name and designation (Have an attendance list with Name, organization, designation, email address, telephone number, and gender)

2. FGD Group Name _____

3. Date and Duration of FGD _____

4. Gender # of male_____ # of female _____

(For details and key points notes instructions, see FGD Summary Notes Template)

Key Reminders to the Facilitator/interviewer:

1. The key is to facilitate and lead rather than direct. It is not necessary to read the questions word for word. Rather, the questions serve as a guide to interview. Questions may be adapted according to the key informant, based on their level of involvement with the project and the information they have. If you realize that the interviewee is not well informed about a question, just move on to the following questions.
2. The facilitator should make herself/himself familiar with the FGD guides in advance, so it is not necessary to continually check the guide.
3. Always, begin the interview with a minute or two of general conversation. Introduce yourself and explain the purpose of the evaluation. Emphasize that this is an inward-looking evaluation of USAID's own support effectiveness and not an evaluation of the GOR.
4. Obtain verbal consent from all participants, and emphasize that all participants should maintain confidentiality about the FGD.
5. Make sure the space for the FGD is comfortable, private and quiet.
6. Sometimes we have others (although not invited) who would like to observe the sessions--such as local officers, etc. In case we cannot avoid the situation, it is the facilitator's job to ensure that they only observe and do not interfere.
7. The purpose is to get EVERYONE involved in conversation and participate in the discussion.
8. Maintain a respectful and non-judgmental approach to participants and their viewpoints.
9. Try to solicit input from less vocal members (if some people just do not want to talk, that's okay). Do not allow a few people to dominate the discussion. Encourage others to participate by saying something like: "Can others share their opinion on this topic?" If a participant is not willing to share their opinion, do not push them to do so.
10. Questions requiring opinions and judgments should follow factual questions, after some level of trust has been established and the atmosphere is more conducive to candid replies.
11. Although we will have interviewer questions lined up and in a certain order, let's not be afraid to deviate. It is entirely possible that a person may start talking and end up answering any number of questions without specifically being asked. It is also likely that someone may introduce a subject not included in the questions -- let them talk (within reason!). The whole point is to allow the person to tell their story, including their particular knowledge, opinions,

and experiences. Give them the space to say what they need to say. If the person deviates completely from the topic, then do pull them back by referring to the questions.

12. At the end of the FGD, always ask whether there is anything else participants would like to share, and make sure to thank all participants.

13. Essential to create a safe environment! Before the meeting, list the following key ground rules on a flip chart:

a. Maintain confidentiality
b. Participate as much as possible
c. Ask questions as they come up
d. Turn off cell phones and pagers
e. Respect other opinions
f. Don't interrupt; let others finish speaking before you begin

Review these ground rules with the group and ask if there are any additional rules people would like to add.

Facilitator's welcome, introduction and instructions to participants

Welcome and thank you for accepting the invitation to take part in this focus group. You have been asked to participate as your knowledge, experience, and point of view are important. We realize you are busy and we appreciate your time.

Introduction: *Introduce ourselves.* As you are aware, we are conducting the USAID/Rwanda's SCHS Project Mid-term Performance Evaluation. We are very interested in learning about your perception and experience in this regard including what has and what has not worked well, key activities, results, sustainability issues, and future direction/plans/ideas/suggestions relevant to having a higher and impactful SCHS, thus ultimately improved services in the health sector. The focus group discussion will take no more than two hours.

Ask participants to introduce themselves by stating their name and their background or relationship as it pertains to the NHIS.

Consent/Anonymity: I would like to assure you that the discussion and release of information will be anonymous. The notes of the focus group will contain no information that would allow individual subjects to be linked to specific statements. You should try to answer and comment as accurately and truthfully as possible. You are also free to not respond to any of our questions or stop the interview at any time. Again, the purpose of this evaluation is to help USAID determine the extent to which the project is providing effective and efficient support to the GOR. The evaluation will identify successes, challenges and barriers to effective and efficient project planning and implementation. The results of the review will be used to formulate recommendations for project adjustments, if appropriate.

Also, as we speak to you and/or walk through your facility, we will take written notes and may also fill out a brief capacity assessment checklist.

Do I have your permission to begin?

Before we begin, do you have any questions about this interview?

Purpose and Questions

SCHS Mid-term Evaluation Purpose

The purpose of this mid-term performance evaluation is to better understand the effectiveness of the SCHS project activities toward the expected results so far, and provide specific learning and evidence for design, planning, implementation, and management decisions by the SCHS Project Team going forward.

SCHS Mid-term Evaluation SOW Questions

1. To what extent has the design of the SCHS project facilitated or hindered USAID's support to strengthen the capacity of the health sector to deliver high quality services? In this context, design refers to the relationships between the elements of the SHCS project matrix (Annex 2) including the interactions and dependencies of stakeholders as well as activities implemented as they relate to the Results Framework. Consider elements such as structure, coordination among IPs, engagement of stakeholders among others.

2. To what extent has the SCHS project strengthened the capacity of Rwandan health systems in relation to sub purposes 3, 4 & 5?
   a. What is the level of capacity of the GOR in these areas?

3. Does SCHS target the most important and changeable factors that contribute to the GOR's capacity to sustain a strong system that will provide high quality services?
   a. Are there other more important and changeable areas?

Note: The performance evaluation should answer questions 2 and 3 in relation to sub-purposes 3-5 (Medical products & Pharmaceuticals, Health Financing, Leadership & Governance)

Key Probing Questions by categories of stakeholders

Please use the Customized Probing Question Sets for Different Categories of Stakeholders

(Annex 19) to seek important information to answer the evaluation questions above.

Conclusion

- Thank you for participating. This has been a very useful discussion
- Your opinions will be a valuable asset to this evaluation
- I would like to remind you that any comments featuring in this report will be anonymous
- Before we end, is there any question or anything else any of you would like to share, and make sure to thank all participants.
- THANK YOU and please make sure you have completed the attendance sheet.
- *Reminder to the team's final note writer: Please, write your summary notes using the FGD Summary Notes Template, and based on the results of the FGD.*

Focus Group Discussion Attendance Form

USAID/Rwanda SCHS Project Midterm Performance Evaluation

January 17 – February 24

Focus Group Discussion Attendance Form

Date:

Time:

Group Name:

No.	Name	Title	Organization	Email/Phone	Gender
1.					
3.					
2.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					

Qualitative Capacity Assessment Checklist

Consent/Anonymity: As we speak to you and/or walk through your facility, we would like to take some written notes and may also fill out the following brief capacity assessment checklist. I would like to assure you that the discussion and release of information will be anonymous. The notes or checklist will contain no information that would allow individual subjects to be linked to specific statements/findings. You are also free to not respond to any of our questions or let us not fill the checklist. Again, the purpose of this evaluation is to help USAID determine the extent to which the project is providing effective and efficient support to the GOR. The evaluation will identify successes, challenges and barriers to effective and efficient project planning and implementation. The results of the review will be used to formulate recommendations for project adjustments, if appropriate.

Do I have your permission to begin?

Before we begin, do you have any questions about this interview and/or or walk through?

For Question 2a: What is the level of capacity of the GOR in relation to:

1. Sub-purpose 3 ***Essential medical products available and accessible at service delivery points***, outputs: 3.1 Procurement of USAID health commodities sustained; 3.2 Capacity of MPPD procurement unit and distribution system strengthened at central and local levels.
2. Sub-purpose 4 ***Increased domestic resources for the health sector used equitably and efficiently***, outputs: 4.1 Financial access to health services and household protection from financial risk strengthened; 4.2 GOR fiscal space and resource allocation for health from domestically- generated resources increased; 4.3 Coordination, planning and effectiveness of partnerships both within the Government of Rwanda and with Development Partners improved.
3. Sub-purpose 5 ***Leadership and governance of health system at central and local levels strengthened***, outputs 5.1 District Health Management Teams' capacity to plan, manage and monitor health programing improved; 5.2 Coordination between central and decentralized levels improved; 5.3 District planning, reporting and M&E frameworks strengthened.

Important note: *This checklist is subject to further changes(s) based on discussion with the IPs, USAID/Rwanda, GOR, and further investigation and analysis of reports by the team.*

Capacity Assessment Checklist	
Checklist Item	**Notes**
Sub-Purpose 3: Essential medical products available and accessible at service delivery points	
Staff at district pharmacies and service delivery points are using the supportive supervision tool	
MOH is conducting quantification and supply planning of HIV/AIDS, contraceptives and malaria commodities as well as conducting data driven quantification and supply planning exercises	
MOH health care workers are using the eLMIS system for ordering	
MOH health care workers are using the eLMIS system to record consumption data	
Stock-outs of essential medicine	
Stock-outs of program commodities/medicine	
LMO has developed and is using the tool to monitor the National Supply Chain Strategic Plan	
LMO is conducting data analysis, presentation and dissemination	
MOPDD and district staff trained in IRS logistics including warehouse and commodity management	
MOPDD staff involved in Logistics and procurement of AIRS related commodities	
Supply chain managers are using the unique identifier to standardize the drug coding system	

Capacity Assessment Checklist	
Checklist Item	**Notes**
Sub-Purpose 4 Increased domestic resources for the health sector used equitably and efficiently	
CHW cooperatives mobilizing resources through income generation activities	
CHW cooperatives with a business plan model reflecting geographic suitability and best practices	
CHW cooperatives with business plans developed and generating revenues	
CHWs coops capacity building plans in place and being implemented	
Community health worker (CHW) Cooperatives financially viable	
DHs Admins and chief accountants finance reporting using standard accounting systems, using IFMIS	
District Hospitals using standard financial management tools and procedures, i.e. using IFMIS	
Facilities having other income generating activities	
Health facilities have business plans in place with implementation action plans and the plans are being implemented	
CBHI data and financial management operations are computerized and operational	
Facility level supportive supervision reports exist and are followed up	
Health facility workers are effectively collecting and managing fees	
Facility CBHI Office shows increased enrollment	
All DAAP activities have financing sources	
District has alternative funds to conduct AIRS	
Local NGOs, community and business leaders are mobilized to ensure that government, the private sector, and communities are aware of the urgent need to sustain and lead future indoor residual spraying (IRS) and malaria control programs	
Local NGOs, community and business leaders are mobilized to ensure that government, the private sector, and communities are able to sustain and lead future indoor residual spraying (IRS) and malaria control programs	
Costing of CHW Service Packages in place	
MOH staff can analyze economic and financial feasibility of health system interventions	
Service and benefit packages are reevaluated, revised and costed by MOH	
Health sector resource streams mapped	
A resources allocation strategy including prioritization is in place and operationalized and being implemented	
Facility has engagement, partnerships and activities with private sector	
Facility is receiving increased resources and support from GOR	
Health facilities are adequately staffed	
Private sector initiatives developed or supported	
Service standards and quality checks are in place and being followed	
CBHI copayment and annual premiums reviewed and revised by RSSB and implemented for clients in different income categories	
Sub-Purpose 5 Leadership and governance of health system at central and local levels strengthened	
District hospital capacity building plans in place and being implemented	
AIRS incorporated in the district annual action plan (AAP)	
Broad-based stakeholders' (GOR and DPs/IPs) participate in District Annual Action Plan (DAAP) preparation	
DHMT fully functional- DHMT reports/Minutes of the DHMT meetings	

Capacity Assessment Checklist	
Checklist Item	**Notes**
DHMT is preparing the DAAP in alignment with national level plans & strategies, such as MTEF and MOH AAP	
District Annual Action Plan (DAAP) is prepared based on evidence and informed by district profile	
District Annual Action Plans (DAAP) are in place	
District assessments done and recommendations followed up and being implemented	
District level M&E framework and tools are in place and being used	
District M&E plans are in place	
IRS focal points at district and sector levels are trained in IRS implementation, supervision and management	
JADF Meetings and DHMT meetings regularly organized (recommendations taken up/advocacy)	
The District JADF Health Commission is functional	
DHMT members participating in management and leadership development trainings - Training attendance list/ report on the training sessions conducted	
District health managers are participating in local and national forums	
District health workers are part of district level data analysis	
District health facilities are using GIS for analysis of health data	
District Pharmacy (DP) business plan exists and being implemented	
Broad-based stakeholders' (GOR and DPs) participate in national health strategy and annual work plan preparation	
MOPDD staff involved in planning and implementation of IRS activities	
MOPDD trained staff in entomological monitoring	
Focal points at the MOPDD and districts are trained in IRS M&E with focus on data collection, management, analysis and storage	
Ministry of health (MOHs), and national malaria control programs (NMCPs) trained in AIRS planning and implementation	
Facilities have and use adequate monitoring tools	
HMIS at health facility is operational	
Timely and accurate HMIS reporting completed by facility – Progress reports (on both timeliness and data quality)	

Key Informant Interview (KII) Summary Notes Template

Not for Public Distribution - For USAID/Rwanda Internal Use Only

USAID/Rwanda SCHS Midterm Performance Evaluation

January 16 – February 25, 2017

Key Informant Interview (KII) Summary Notes

Agency/Department/Organization:

Type (GOR, DP, IP, NGO, CSO, FBO, PB, FI, PS-H, PS-NH, AC):

Level (National/Provincial/District /Community):

Date and Time:

Respondent(s):

Gender(s):

Interviewer:

Key Points in relation to the performance evaluation and associated questionnaire (overall role including institutional roles/Background/Key Facts, Progress Made/Assets/Opportunities, Gaps/Weaknesses/Not working well, Key Obstacles/Underlying Barriers, Capacity & Sustainability Issues, Needs/Wish List, Recommendations/Ideas/Comments) ***(Everything that is relevant to the questionnaire prepared for the respondent/organization)*****:**

Group/Focus Group Dissuasions (FGD) Summary Notes Template

Not for Public Distribution - For Internal Use Only

USAID/Rwanda SCHS Midterm Performance Evaluation

January 16 – February 25, 2017

Focus Group Dissuasions (FGD) Summary Notes

Agencies/Departments/Organizations and Participants:

No.	Name	Title	Organization	Email	Phone	Gender
Total No. Of Female: **Total No. Of Male:**						

Date and Time:

Key Points in relation to the performance evaluation and associated questionnaire (overall role including institutional roles/Background/Key Facts, Progress Made/Assets/Opportunities, Gaps/Weaknesses/Not working well, Key Obstacles/Underlying Barriers, Capacity & Sustainability Issues, Needs/Wish List, Recommendations/Ideas/Comments) ***(Everything that is relevant to the questionnaire prepared for the responding focus group)*****:**

Issues/Gaps/Challenges, Opportunities, and Barriers Matrix

Not for Public Distribution — For Internal Use Only

USAID/Rwanda SCHS Project Midterm Performance Evaluation

January - February 2017

(Compiled through Analysis of KIIs, FGDs, document reviews, and team's direct/indirect observations)

No.	Issues/ Gaps/ Challenges	Key Achievements/ Strengths/ Assets/ Opportunities	Associated Evaluation Question ID(s) – (1, 2)	Relevant to Q #3 (most important & changeable factors) – yes/no	Sub-Purpose/ Purposes	Source/ Sources	Level (e.g., National, Province, District, Commu-nity)	Underly-ing Barriers to Address Chal-lenge(s)
1								
2								
3								
4								
5								
6								
7								
8								
..								
..								

ANNEX X. PERSONS MET / INTERVIEWED

No	Name	Title	Organization	Meeting Type	Stakeholder Category
1	Jules Nahimana	Operation Manager	Abt Associates	GI	IP
2	Rodaly Muthoni	Chief of Party	Abt Associates	GI	IP
3	Rwangalinde Juste	M&E Manager	Abt Associates	GI	IP
4	Dr. Jan Borg	International Public Health Budget Support Expert	BTC	GI	DP
5	Kwizera Matabishi	Secretary	CHW Coop Indatwa	FGD	CHWs Coop
6	Mukamurigo Diane	Advisor	CHW Coop Indatwa	FGD	CHWs Coop
7	Uwanyirigira Beatrice	President	CHW Coop Indatwa	FGD	CHWs Coop
8	Uwitonze Innocent	Advisor	CHW Coop Indatwa	FGD	CHWs Coop
9	Bayingana Emmanuel	Vice Mayor, Social Affairs	DHMT-Kicukiro	FGD	District
10	Gatera Emerance	Director, Health	DHMT-Kicukiro	FGD	District
11	Kabera Jean Claude	Director of District Pharmacy	DHMT-Kicukiro	FGD	District
12	Kabisama Berndardine	CHW Representative	DHMT-Kicukiro	FGD	District
13	Mukamana M Claire	CBHI Officer	DHMT-Kicukiro	FGD	District
14	Munyaneza Deo	Communication Officer	DHMT-Kicukiro	FGD	District
15	Nyiramuzima Odette	RSSB-Kicukiro	DHMT-Kicukiro	FGD	District
16	Nyiramahoro Leonie	Health Promotion and Disease Prevention Officer	DHMT-Kicukiro	FGD	District
17	Saul Kiddo	Technical Director	GHSC-PSM	GI	IP
18	Kabatesi Beatrice	Verifier	Gikondo HC	FGD	HC
19	Mabano Fabiola	CHWs in Charge	Gikondo HC	FGD	HC
20	Marie Rose Kwitonda	Store Manager	Gikondo HC	FGD	HC
21	Musabyemariya Genevieve	QI in Charge	Gikondo HC	FGD	HC
22	Niyoyita Dieudonné	Data Manager	Gikondo HC	FGD	HC
23	Sr Dorothée	Head of HC	Gikondo HC	FGD	HC
24	Dr. Kyavulikira Benjamin	Chief Medical Staff	Gisenyi Hospital	GI	DH

No	Name	Title	Organization	Meeting Type	Stakeholder Category
25	Dusabimana Evariste	Administrator	Gisenyi Hospital	GI	DH
26	Gahongayire Jean Bosco	Supervisor	Gisenyi Hospital	GI	DH
27	Habanabakize Epa	QI Officer	Gisenyi Hospital	GI	DH
28	Habiyambere Jean Pierre	Pharmacist	Gisenyi Hospital	GI	DH
29	Ingabire Clementine	PBF Supervisor	Gisenyi Hospital	GI	DH
30	Karigirwa Grace	Data Manager	Gisenyi Hospital	GI	DH
31	Ngororano Bertin	Supervisor	Gisenyi Hospital	GI	DH
32	Nsengimana Thacien	CH Supervisor	Gisenyi Hospital	GI	DH
33	Siborurema Samuel	Data Manager	Gisenyi Hospital	GI	DH
34	Uwimana Claudine	HRM	Gisenyi Hospital	GI	DH
35	Baraka Jean	Head of HC Kigufi	HC Kigufi	KII	HC
36	Niyobigena Martine	Head of Health Post	Health post Muyange/Kicukiro	KII	HP
37	Mukakarara Odette	Nurse	HP Nyamyumba	KII	HP
38	Egide Nkunzwenimana	ENC Mentor	Kibungo Hospital	GI	PH
39	Evariste Uwingabire	ENC Mentor	Kibungo Hospital	GI	PH
40	Hakizimana J.Claude	Physiotherapist	Kibungo Hospital	FGD	PH
41	Hategekimana J.Baptiste	CH Supervisor	Kibungo Hospital	FGD	PH
42	Kamabera Epiphanie	FP Focal Point	Kibungo Hospital	GI	PH
43	Kayitesi Flaulatha	Mental Health Nurse	Kibungo Hospital	FGD	PH
44	Mushimiyimana Grace	In Charge of Pediatrics	Kibungo Hospital	FGD	PH
45	Niyonzima Donat	M&E	Kibungo Hospital	FGD	PH
46	Nkunzwenimana Egide	In Charge of Emergency	Kibungo Hospital	FGD	PH
47	Nkuruziza Justin	HR Manager	Kibungo Hospital	FGD	PH
48	Nsanzubuhoro Adeo	Director of Nursing	Kibungo Hospital	FGD	PH
49	Nsengimana J.Pierre	In Charge of Surgical Department	Kibungo Hospital	FGD	PH
50	Ntakinanirimana	Admin. Manager	Kibungo Hospital	FGD	PH
51	Nzahumunyurwa Thadée	Pharmacist	Kibungo Hospital	FGD	PH

No	Name	Title	Organization	Meeting Type	Stakeholder Category
52	Turatsinze Emmanuel	EHO&IPC FP	Kibungo Hospital	FGD	PH
53	Ukizentaburumwe J.M.V	QI/Accreditation Officer	Kibungo Hospital	FGD	PH
54	Uwurukwayo Olive	Lab Technician	Kibungo Hospital	FGD	PH
55	Mukaruberwa Jeanne D'arc	In Charge of Community Health	Kinazi HC	FGD	HC
56	Mukeshimana Jacqueline	RSSB-CBHI	Kinazi HC	FGD	HC
57	Nyiramitsindo Domina	Head of Pharmacy	Kinazi HC	FGD	HC
58	Umukunzi Francine	Head of Kinazi HC	Kinazi HC	FGD	HC
59	Umwali Jean Claude	Data Manager	Kinazi HC	FGD	HC
60	Uwimana Philomene	Accountant	Kinazi HC	FGD	HC
61	Samuel Niyitegeka	CHWs Supervisor	Kinihira PH	GI	DH
62	Bititi Fred	JADF Officer	Kirehe district	GI	DH
63	Bonny Niyibizi	M&E Health Officer	Kirehe district	GI	DH
64	Hitiyaremye Nathan	Director of Health	Kirehe district	GI	DH
65	Mukandalikanguye Geraldine	Vice Mayor, Social Affairs	Kirehe district	GI	DH
66	Muzungu Gerard	Mayor	Kirehe district	GI	DH
67	Ngirabakunzi Octavien	District Environment Officer	Kirehe district	GI	DH
68	Nsengiyumva J.Damascene	Vice Mayor, Economic Affairs	Kirehe district	GI	DH
69	Innocent Munyakabiga	Head of HC	Kirehe HC	GI	HC
70	Gashugi Augustin	Head of HC	Kirwa HC	FGD	HC
71	Iragena Olive	Data Manager	Kirwa HC	FGD	HC
72	Mahoromeza Rosette	Store Manager	Kirwa HC	FGD	HC
73	Mbaraga Vincent	RSBB Kirwa Section	Kirwa HC	FGD	HC
74	Musanabaganwa Pualine	Treasurer	Kirwa HC	FGD	HC
75	Turayisenga Janvier	IT & Secretary	Kirwa HC	FGD	HC
76	Muhayimana Vedaste	Manager/Veterinary	Koarunge-CHW	FGD	CHWs Coop
77	Mukampunga Janviere	Advisor	Koarunge-CHW	FGD	CHWs Coop
78	Mwubahamana Jeanette	Advisor	Koarunge-CHW	FGD	CHWs Coop

No	Name	Title	Organization	Meeting Type	Stakeholder Category
79	Ngarambe Augustin	Vice President	Koarunge-CHW	FGD	CHWs Coop
80	Niyotwizeye Evariste	Secretary	Koarunge-CHW	FGD	CHWs Coop
81	Ugiriwabo Bernadette	President	Koarunge-CHW	FGD	CHWs Coop
82	Hategekimana J Damascene	Vice President, Audit Committee	Kotaki-Coop CHW	FGD	CHWs Coop
83	Hategekimana Jean De Dieu	President, Audit Committee	Kotaki-Coop CHW	FGD	CHWs Coop
84	Mukakabera Beline	Advisor	Kotaki-Coop CHW	FGD	CHWs Coop
85	Mukamana Esperance	Secretary	Kotaki-Coop CHW	FGD	CHWs Coop
86	Mukaminega Pelagie	Secretary, Audit Committee	Kotaki-Coop CHW	FGD	CHWs Coop
87	Mushinzimana Eliazar	Advisor	Kotaki-Coop CHW	FGD	CHWs Coop
88	Mwikarago Albert	President	Kotaki-Coop CHW	FGD	CHWs Coop
89	Cyprien Ntakirutimana	QI Focal Person	Masaka DH	GI	DH
90	Dr. Marcel Uwizeye	Acting Director	Masaka DH	GI	DH
91	Hafashimana Syldio	Chief Accountant	Masaka DH	GI	DH
92	Magayane J Damascene	M&E Officer	Masaka DH	GI	DH
93	Nyirambonyinka M Christine	Acting Chief, Nursing	Masaka DH	GI	DH
94	Rubayiza Philomene	CHWs Supervisor	Masaka DH	GI	DH
95	Uwimana Valentine	Store Manager of Pharmacy	Masaka DH	GI	DH
96	Wellars Nsengiyumva	Accreditation Focal Person	Masaka DH	GI	DH
97	Dr. Mukarugwiro Beata	Technical Director	MCSP	GI	IP
98	Dr. Stephen Mutwiwa	Chief of Party	MCSP	KII	IP
99	Edwin Tayebwa	MER Director	MCSP	GI	IP
100	Khadia Naithani	Senior Program Manager	MCSP	GI	IP
101	Mukarugwiro Beata	Technical Director	MCSP	GI	IP
102	Nicholas Karugaba	QI Advisor	MCSP	GI	IP
103	Stephen Mutwiwa	Chief of Party	MCSP	Outbrief	IP
104	Nsabibaruta Maurice	M&E Specialist	MINALOC	KII	GOR
105	Ruhamyambuga Olivier	Corporate Planning Specialist	MINALOC	KII	GOR

No	Name	Title	Organization	Meeting Type	Stakeholder Category
106	Yves Bernard Ningabire	DG Planning M&E	MINALOC	KII	GOR
107	Patrick Karera	Sector Investment Officer	MINECOFIN	GI	GOR
108	Zachee Iyakaremye	Budget Management & Reporting Team Leader	MINECOFIN	GI	GOR
109	Baziga Gervais	Planning Specialist	MOH	GI	GOR
110	Birindabagabo Pascal	Health Insurance Policy	MOH	KII	GOR
111	Dr. Theophile Dushime	DG Clinical and Public Health Services	MOH	KII	GOR
112	Dr. Parfait Uwaliraye	DG Planning, M&E	MOH	KII	GOR
113	Eduard Munyangaju	Medical Supply Chain Coordination Officer	MOH	KII	GOR
114	J. Pierre Nyemazi	Permanent Secretary	MOH	KII	GOR
115	Kamuhangire Eduard	Director, HSQA	MOH	GI	GOR
116	Muhire Andrew	M&E Specialist	MOH	GI	GOR
117	Nkunda Denis	CHWs Cooperative Officer	MOH	GI	GOR
118	Shema Joseph	HRH Program Coordinator	MOH	GI	GOR
119	Dr. Aline	Director	MOPDD	KII	GOR
120	Dunia Munyakanage	Vector Control Supervisor	MOPDD	KII	GOR
121	Celsa Muzayire Gaju	Head of Medical Procurement and Production Division	MPPD	KII	GOR
122	Ahabwe Moses	Senior Technical Advisor	MSH	GI	IP
123	Baguma Athanase	Technical Advisor Health System-Decentralization	MSH	GI	IP
124	David Biseruka	Technical Advisor HRR-Leads	MSH	GI	IP
125	Denis Akishuri	Technical Advisor, QI	MSH	GI	IP
126	Dr. Kalachi John	Provincial Technical Advisor-North	MSH	GI	IP
127	Enrique Cabrera	Team Leader PSE/PPP	MSH	GI	IP
128	Francoise Kayirangwa	Technical Associate, Health Financing	MSH	GI	IP
129	Joy Atwine	Team Leader, QI	MSH	GI	IP

No	Name	Title	Organization	Meeting Type	Stakeholder Category
130	Kakana M Laetitia	Technical Advisor, QI	MSH	GI	IP
131	Kalinda Viateur	Technical Advisor, QI	MSH	GI	IP
132	Kamwesiga Jules	Provincial Technical Advisor-East	MSH	GI	IP
133	Kanyange Rose	Technical Advisor, PPP	MSH	GI	IP
134	Ken Heise	Acting Chief of Party, RHSSA	MSH	GI	IP
135	Kitoko Mbuguje Louis	Provincial Technical Advisor-West	MSH	GI	IP
136	Mukunzi J Louis	Technical Advisor, Financial Mgt.	MSH	GI	IP
137	Musabyimana Edith	Provincial Technical Advisor-Kigali City	MSH	GI	IP
138	Musabyimana Edith	Provincial Technical Advisor-Kigali City	MSH	GI	IP
139	Pierre Dongier	Principal Technical Advisor-RHSS	MSH	GI	IP
140	Randy Wilson	Team Leader, M&E	MSH	GI	IP
141	Richard Butare	Senior Technical Advisor	MSH	GI	IP
142	Sinari JM	Provincial Technical Advisor-South	MSH	GI	IP
143	Therese Kunda	Senior Technical Advisor	MSH	GI	IP
144	Munanira Emmanuel	President Asc	Nasho HC	GI	HC
145	Darius	Executive Secretary	National pharmacy council	KII	Professional body
146	Julie Kimonyo	Registrar	NCNM	KII	professional body
147	Daniel Habimana	MCSP District Coordinator	Ngoma District	GI	PH
148	Mujawimana Eduine	DPH	Ngoma District	FGD	PH
149	Nuwayo Derise	DH M&E Officer	Ngoma District	FGD	PH
150	Rutaganda Fiacre	Director, District Pharmacy	Ngoma District	FGD	District
151	Ines Buki	Country Director	PSM	GI	IP
152	Max Kabalisa	Senior HSS Advisor	PSM	GI	IP
153	Dr. Jeanine U. Condo	DG-SMT Member	RBC	GI	GOR
154	Dr. Jeanine Condo	Director General	RBC	KII	GOR
155	Eduard Niyonshuti	Head of Business Development Unit	RBC	KII	GOR

No	Name	Title	Organization	Meeting Type	Stakeholder Category
156	James Kamanzi	DDG-SMT Member	RBC	GI	GOR
157	Jean Ntakarimara	Chief Legal Officer	RBC	GI	GOR
158	George Ntaganda	SMT Member	RBC/DDG's Office	GI	GOR
159	Coryse Gakuba	SMT Member	RBC/DG'S Office	GI	GOR
160	Juvenal Habiyambere	SMT Member	RBC/Internal Audit Unit	GI	GOR
161	John Wilson Niyigena	SMT Member	RBC/MPPD	GI	GOR
162	Dr. Jean Baptiste Mazarati	SMT Member	RBC-BIOS Dept.	GI	GOR
163	Nathalie Mutegaraba	SMT Member	RBC-CS Division	GI	GOR
164	Noella Bigirimana	SMT Member	RBC-DG's office	GI	GOR
165	Dr. Jose Nyamusore	SMT Member	RBC-ESR Division	GI	GOR
166	Dr. Innocent Turate	SMT Member	RBC-IHDPC Dept.	GI	GOR
167	Dr. Felix Sayinzoga	SMT Member	RBC-MCCH Division	GI	GOR
168	Claire Nancy Misago	SMT Member	RBC-MH Division	GI	GOR
169	Dr. Aimable Mbituyumuremyi	SMT Member	RBC-MOPD Division	GI	GOR
170	Lambert Kayishema	SMT Member	RBC-MPPD	GI	GOR
171	Ignace Ndekezi	SMT Member	RBC-MPPD Division	GI	GOR
172	Clarisse Musanabaganwa	SMT Member	RBC-MRC Unit	GI	GOR
173	Ir JMV BIRASA	SMT Member	RBC-MTI Division	GI	GOR
174	Dr. Swaibu Gatare	SMT Member	RBC-NCBT Division	GI	GOR
175	Dr. Marie Aimee Muhimpundu	SMT Member	RBC-NCDs Division	GI	GOR
176	Dr. Ivan Mwikarago	SMT Member	RBC-NRL Division	GI	GOR
177	Dr. Albert Tuyishime	SMT Member	RBC-PMEBS Division	GI	GOR
178	Malick Kayumba	SMT Member	RBC-RHCC Division	GI	GOR
179	Dr. Patrick Migambi	SMT Member	RBC-TB Division	GI	GOR
180	Dr. Solange Hakiba	Director General	RSSB	KII	GOR
181	Nyirishema Froduald	Director of Health	Ruhango district	FGD	PH
182	Bavuriki J.Claude	Accreditation Focal Person	Ruhango PH	FGD	PH

No	Name	Title	Organization	Meeting Type	Stakeholder Category
183	Dr. Mwilambwe Didier	Director	Ruhango PH	FGD	PH
184	Kazayire Adeline	Pharmacist RH	Ruhango PH	FGD	PH
185	Musabyimana Laurence	Chief of Nursing	Ruhango PH	FGD	PH
186	Ndayambaje Theogene	Director, District Pharmacy	Ruhango PH	FGD	PH
187	Ngezahimana J Baptiste	M&E	Ruhango PH	FGD	PH
188	Uwamahoro Martine	CHWs Supervisor	Ruhango PH	FGD	PH
189	Uzamukunda M Claire	Administration Manager	Ruhango PH	FGD	PH
190	Habimana Thatien	Director of Planning, M&E	Rulindo district	GI	DHMT
191	Kayombya N.Albert	District CBHI	Rulindo district	GI	DHMT
192	Manirafasha Jean D'amour	Director of Health	Rulindo district	GI	DHMT
193	Gasanganwa M Claire	Vice Mayor, Social Affairs	Rulindo district-DHMT	GI	DHMT
194	Rwagasore Felix	Head of HC	Rusumo HC	GI	HC
195	Aloys Niyomugabo	In Charge of Accreditation, QI, and PBF	Rutongo DH	GI	DH
196	Banganukuri JMV	Head of Surgery	Rutongo DH	GI	DH
197	Francois Ntihemuka	Head of Maternity	Rutongo DH	GI	DH
198	Gahimbaza Bernadette	Accountant	Rutongo DH	GI	DH
199	Gato Ishimwe	RN, Emergency	Rutongo DH	GI	DH
200	Hakizimana Alphonse	Logistics	Rutongo DH	GI	DH
201	Icyimpaye Bridgite	Social Assistant	Rutongo DH	GI	DH
202	Karanganwa Fabien	Hospital Administrator	Rutongo DH	GI	DHMT
203	Marie Claire Uwamahoro	CHWs Supervisor	Rutongo DH	GI	DH
204	Mugarura Philbert	Nurse	Rutongo DH	GI	DH
205	Mukeshimana Genevieve	TB Supervisor	Rutongo DH	GI	DH
206	Munyana Nelly Raissa	Head, Neonatology Department	Rutongo DH	GI	DH
207	Musabyimana Veronise	PF in Charge	Rutongo DH	GI	DH
208	Ndagijimana Seth	HR	Rutongo DH	GI	DH

No	Name	Title	Organization	Meeting Type	Stakeholder Category
209	Ndahayo Valens	RN	Rutongo DH	GI	DH
210	Ngabonziza Olivier	Radiographer	Rutongo DH	GI	DH
211	Nkundimana Osborn	Pharmacist	Rutongo DH	GI	DH
212	Nsangimana Aphrodis	Maintenance	Rutongo DH	GI	DH
213	Nteziryayo E.	IPC Team	Rutongo DH	GI	DH
214	Nyirabahunde Felicite	Clinical Services	Rutongo DH	GI	DH
215	Nyiraneza Beathe	Secretary	Rutongo DH	GI	DH
216	Rwaumbuguza Michel	Chief, Emergency	Rutongo DH	GI	DH
217	Sibomana James Gad	Data Manager	Rutongo DH	GI	DH
218	Theoneste Mutsindashyaka	M&E Officer	Rutongo DH	GI	DH
219	Usabuwera Jeannine	IT Manager	Rutongo DH	GI	DH
220	Yves Mulino	Medical Doctor	Rutongo DH	GI	DH
221	Dr. Thadee Vuguziga	Deputy Registrar	Rwanda Medical Council	KII	Professional body
222	Dr. Emmanuel Rudakemwa	Chairperson, RMDC	Rwanda Medical council	KII	Professional body
223	Atakilt Berhe	Health Specialist	UNICEF	GI	DP
224	Maharajan Muthu	Chief, Child Survival and Development	UNICEF	GI	DP
225	Manzi Emmanuel	Health Specialist	UNICEF	GI	DP
226	Aline Umubyeyi	Dean	UOR-SPH	KII	Academia
227	Collins Kamanzi	Researcher	UOR-SPH	KII	Academia
228	Habagusenga Jean D'amour	RCE-VIHSCM	UOR-SPH	KII	Academia
229	Andrew Fourney	M&E Advisor	USAID	GI	USAID
230	Jesse Joseph	Health Office Deputy Director	USAID	GI	USAID
231	John McKay	SCHS Team Lead	USAID	GI	USAID
232	Adriana Hayes	Director, Program Office	USAID/Rwanda	GI	USAID
233	Alice Mukaneza	M&E Specialist	USAID/Rwanda	GI	USAID
234	Elisabeth Uwanyiligira	FP/RH	USAID/Rwanda	GI	USAID
235	Emmanuel Gasana	M&E Specialist	USAID/Rwanda	GI	USAID

No	Name	Title	Organization	Meeting Type	Stakeholder Category
236	Gasana Emmanuel	M&E Specialist	USAID/Rwanda	GI	USAID
237	Janvier Mwitirehe	Finance Analyst	USAID/Rwanda	GI	USAID
238	Joshwa Okafor	GIS Follow	USAID/Rwanda	GI	USAID
239	Kaendi Munguti	Resident Advisor, PMI	USAID/Rwanda	KII	GOR
240	Lindsay Little	Health Management Advisor	USAID/Rwanda	GI	USAID
241	Lisa Godwin	Health Office Director	USAID/Rwanda	GI	USAID
242	Maria Kabanyana	SCHS Member	USAID/Rwanda	GI	USAID
243	Mary De Boer	CHAIN Team Lead	USAID/Rwanda	GI	USAID
244	Mukaneza Alice	M&E Specialist	USAID/Rwanda	GI	USAID
245	Munyaneza Richard	MCH Specialist	USAID/Rwanda	GI	USAID
246	Muturanyi Celestin	M&E Specialist	USAID/Rwanda	Outbrief	USAID
247	Nicole Mukunzi	HP & WASH Specialist	USAID/Rwanda	Outbrief	USAID
248	Pangday Yozone	SC Advisor	USAID/Rwanda	Outbrief	USAID
249	Tommy Harrold	Learning Advisor	USAID/Rwanda	Outbrief	USAID
250	Wivine Kabuto	Budget Program Assistant	USAID/Rwanda	GI	USAID
251	Kelly Wolfe	Senior Advisor for Africa	USAID/Washington	GI	USAID

ANNEX XI. QUALITATIVE CAPACITY ASSESSMENT CHECKLIST RESULTS FOR SITES / FACILITIES VISITED

1. Sub-purpose 3: Supply Chain

The following 11 items were in the checklist for Sub-Purpose 3. These items largely touched on supply chain management areas, including e-LMIS use, essential medicine and program commodity (stock-outs); planning; data collection and use; institutional capacity and capacity building.

	Supply Chain Checklist Items
1	Staff at district pharmacies and service delivery points are using the supportive supervision tool
2	MOH is conducting quantification and supply planning of HIV/AIDS, contraceptives and malaria commodities as well as conducting data driven quantification and supply planning exercises
3	MOH health care workers are using the eLMIS system for ordering
4	MOH health care workers are using the eLMIS system to record consumption data
5	Stock-outs of essential medicine
6	Stock-outs of program commodities/medicine
7	LMO has developed and is using the tool to monitor the National Supply Chain Strategic Plan
8	LMO is conducting data analysis, presentation and dissemination
9	MOPDD and district staff trained in IRS logistics including warehouse and commodity management
10	MOPDD staff involved in Logistics and procurement of AIRS related commodities
11	Supply chain managers are using the unique identifier to standardize the drug coding system

The existence of an item or its implementation as mentioned by the site was registered as a 'Yes' (Y), those that were not as 'No' (N), and those that were found to be not applicable as 'N/A', as highlighted in the table below.

		Entry and Summary Results for SCHS Sub-Purpose 3 (Supply Chain)			
Region	**Facility/Org./Inst./Admin Body Name**	**Type**	**Checklist Item(s) Answered 'Yes'**	**Checklist Item(s) Answered 'No'**	**Checklist Item Not Applicable (N/A)**
City of Kigali	Masaka	DH	1-5	6	7-11
	Kicukiro	DP	2-5	1,6	7-11
	Kicukiro (Masaka)	DHMT	3	1,4-6	2,7-11
	Gikondo (Kicukiro/Masaka)	HC	3	1,4-6	2,7-11
	Indatwa za Gikondo	CHWs Coop			1-11
	Kagarama (Kicukiro HC)	HP		1-6	7-11
Eastern Province	Kibungo	PH	1-4,6	5	7-11
	Ngoma (Kibungo)	DP			1-11
	Ngoma (Kibungo)	DHMT			1-11
	Kirwa (Kibungo)	HC	1,3-6		2,7-11
	Koaruge (Kirwa HC)	CHWs Coop			1-11
	Kibungo HC (Ngoma)	HC (MCSP Site)			1-11
	Kirehe	DHMT (AIRS)	9	10	1-8,11
Northern Province	Rutongo	DH	3,5	1,2,4-6	7-11
	Rulindo (Rutongo)	DHMT		1	2-11
Southern Province	Ruhango	PH	1-5	6	7-11
	Ruhango	DP	2-5	1,6	7-11
	Kinazi (Ruhango)	HC	1,3-6		2,7-11
	Tabara/Kotaki (Kinazi HC)	CHWs Coop			1-11
Western Province	Gisenyi	DH	1-5	6	7-11
	Nyamyumba (Kigufi HC)	HP	5	1,3,4,6	2,7-11
Central	Central MOH Planning, HF, CHW	MOH			1-11
	Central MOH LMO	MOH	8	7	1-11
	Malaria, Parasitic Diseases Division (MOPDD)	RBC	9,10		1-11
	Rwanda Social Security Board	RSSB			1-11

2. Sub-purpose 4: Health Financing

The following 28 items were in the checklist for Sub-Purpose 4. These items largely fell in seven broad themes including health financing initiatives that foster CHW Coop sustainability; Revenue generation; Effective CBHI management; Improved Financial Management (system use, reporting and fee collection); Private sector engagement (PSE), Improved resource allocation and financing; and Human resource management (HRH)

No.	Health Financing Checklist Items	Categories of Items
1	CHW cooperatives mobilizing resources through income generation activities	All CHW related items
2	CHW cooperatives with a business plan model reflecting geographic suitability and best practices	
3	CHW cooperatives with business plans developed and generating revenues	
4	CHWs coops capacity building plans in place and being implemented	
5	Community health worker (CHW) Cooperatives financially viable	
6	DHs Admins and chief accountants finance reporting using standard accounting systems, using IFMIS	Financial Management
7	District Hospitals using standard financial management tools and procedures, i.e. using IFMIS	Financial Management
8	Facilities having other income generating activities	Revenue Generation
9	Health facilities have business plans in place with implementation action plans and the plans are being implemented	Revenue Generation
10	CBHI data and financial management operations are computerized and operational	CBHI
11	Facility level supportive supervision reports exist and are followed up	Financial Management
12	Health facility workers are effectively collecting and managing fees	Financial Management
13	Facility CBHI Office shows increased enrollment	CBHI
14	All DAAP activities have financing sources	Resource allocation
15	District has alternative funds to conduct AIRS	AIRS
16	Local NGOs, community and business leaders are mobilized to ensure that government, the private sector, and communities are aware of the urgent need to sustain and lead future indoor residual spraying (IRS) and malaria control programs	
17	Local NGOs, community and business leaders are mobilized to ensure that government, the private sector, and communities are able to sustain and lead future indoor residual spraying (IRS) and malaria control programs	

No.	Health Financing Checklist Items	Categories of Items
18	Costing of CHW Service Packages in place	CHW
19	MOH staff can analyze economic and financial feasibility of health system interventions	Analysis
20	Service and benefit packages are reevaluated, revised and costed by MOH	HRH
21	Health sector resource streams mapped	Resource allocation
22	A resources allocation strategy including prioritization is in place and operationalized and being implemented	Resource allocation
23	Facility has engagement, partnerships and activities with private sector	PSE
24	Facility is receiving increased resources and support from GOR	Resource allocation
25	Health facilities are adequately staffed	HRH
26	Private sector initiatives developed or supported	PSE
27	Service standards and quality checks are in place and being followed	QI
28	CBHI copayment and annual premiums reviewed and revised by RSSB and implemented for clients in different income categories	CBHI

		Entry and Summary Results for SCHS Sub-Purpose 4 (Health Financing)			
Region	**Facility/Org./Inst./Admin Body Name**	**Type**	**Checklist Item(s) Answered 'Yes' (Y)**	**Checklist Item(s) Answered 'No' (N)**	**Checklist Item Not Applicable (N/A)**
City of Kigali	Masaka	DH	6,7,10-13,24,27	8,9,23,25,26	1-5,14-22,28
	Kicukiro	DP			1-28
	Kicukiro (Masaka)	DHMT	13,14,16,	15,17,24,25	1-12,18-23,26-28
	Gikondo (Kicukiro/Masaka)	HC	1,10-13,25,27	8,9,23,24,26	2-7,14-22,28
	Indatwa za Gikondo	CHWs Coop	1,3,5,	2,4,	6-28
	Kagarama (Kicukiro HC)	HP (Public)	11,12,25	10,24,26,27	1-9,13-23,28
Eastern Province	Kibungo	PH	6,7,10,11,12,27	8,9,13,22-26,	1-5,14-21,28
	Ngoma (Kibungo)	DP			1-28
	Ngoma (Kibungo)	DHMT	14,	15-17,22	1-13,18-21,23-28
	Kirwa (Kibungo)	HC	9,11-13,27	8,10,23-26	1-7,14-22,28
	Koaruge (Kirwa HC)	CHWs Coop	1,5,	2,3,4,	6-28

		Entry and Summary Results for SCHS Sub-Purpose 4 (Health Financing)			
Region	**Facility/Org./Inst./Admin Body Name**	**Type**	**Checklist Item(s) Answered 'Yes' (Y)**	**Checklist Item(s) Answered 'No' (N)**	**Checklist Item Not Applicable (N/A)**
	Kibungo HC (Ngoma)	HC (MCSP Site)			1-28
	Kirehe	DHMT (AIRS)	16,	15,17	1-14,18-28
Northern Province	Rutongo	DH	6,7,12,13,24,27	8-11,23,25,26	1-5, 14-22,28
	Rulindo (Rutongo)	DHMT	1,15	2,3,5,14,16,18	4,6-13,17,19-28
Southern Province	Ruhango	PH	6,7,10-12,27	8,9,13,23-26	1-5,14-22,28
	Ruhango	DP			1-28
	Kinazi (Ruhango)	HC	10-13,25,27	8,9,23,24,26	1-7, 14-22,28
	Tabara/Kotaki (Kinazi HC)	CHWs Coop		1-5	6-28
Western Province	Gisenyi	DH	6-8,12,13,23,24,26,27	9,10,25	1-5,11,14-22,28
	Nyamyumba (Kigufi HC)	HP (Private)	11-13,23,25-27	10,24,	14-22,28
Central	Central MOH Planning, HF, CHW	MOH	18	19,20,22	1-17,21,23-28
	Central MOH LMO	MOH			1-28
	Malaria, Parasitic Diseases Division (MOPDD)	RBC			1-28
	Rwanda Social Security Board (RSSB)	RSSB		28	1-27

3. Sub-purpose 5: Leadership & Governance

As regards the fifth SCHS sub-purpose, there were 26 items in the checklist. These items largely fell under four broad themes including initiatives that foster Improved Planning; Multi-stakeholder coordination and communication; Improved monitoring and evaluation processes (M&E); as well as Capacity building (primarily training).

No.	Leadership & Governance Checklist Items	Categories of Items
1	District hospital capacity building plans in place and being implemented	Capacity building
2	AIRS incorporated in the district annual action plan (AAP)	Planning
3	Broad-based stakeholders' (GOR and DPs/IPs) participate in District Annual Action Plan (DAAP) preparation	Coordination & Communication

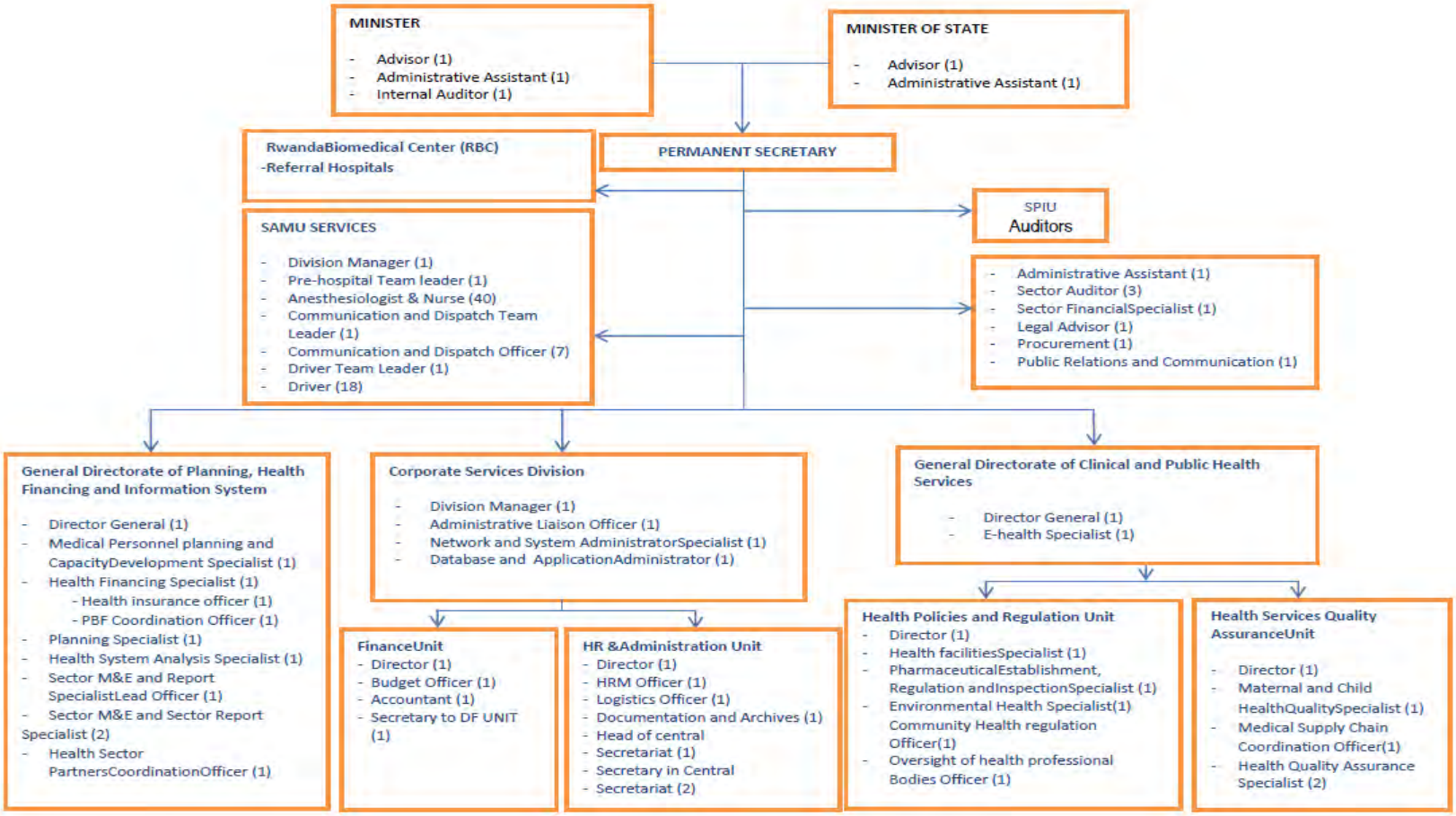
No.	Leadership & Governance Checklist Items	Categories of Items
4	DHMT fully functional- DHMT reports/Minutes of the DHMT meetings	Coordination & Communication
5	DHMT is preparing the DAAP in alignment with national level plans & strategies, such as MTEF and MOH AAP	Planning
6	District Annual Action Plan (DAAP) is prepared based on evidence and informed by district profile	Planning
7	District Annual Action Plans (DAAP) are in place	Planning
8	District assessments done and recommendations followed up and being implemented	M&E
9	District level M&E framework and tools are in place and being used	M&E
10	District M&E plans are in place	M&E
11	IRS focal points at district and sector levels are trained in IRS implementation, supervision and management	Capacity building
12	JADF Meetings and DHMT meetings regularly organized (recommendations taken up/advocacy)	Coordination & Communication
13	The District JADF Health Commission is functional	Coordination & Communication
14	DHMT members participating in management and leadership development trainings - Training attendance list/ report on the training sessions conducted	Capacity building
15	District health managers are participating in local and national forums	Planning
16	District health workers are part of district level data analysis	M&E
17	District health facilities are using GIS for analysis of health data	M&E
18	District Pharmacy (DP) business plan exists and being implemented	Planning
19	Broad-based stakeholders' (GOR and DPs) participate in national health strategy and annual work plan preparation	Coordination & Communication
20	MOPDD staff involved in planning and implementation of IRS activities	Planning
21	MOPDD trained staff in entomological monitoring	Capacity building

No.	Leadership & Governance Checklist Items	Categories of Items
22	Focal points at the MOPDD and districts are trained in IRS M&E with focus on data collection, management, analysis and storage	Capacity building
23	Ministry of health (MOHs), and national malaria control programs (NMCPs) trained in AIRS planning and implementation	Capacity building
24	Facilities have and use adequate monitoring tools	M&E
25	HMIS at health facility is operational	M&E
26	Timely and accurate HMIS reporting completed by facility – Progress reports (on both timeliness and data quality)	M&E

		Entry and Summary Results for SCHS Sub-Purpose 5 (Leadership & Governance)			
Region	**Facility/Org./Inst./Admin Body Name**	**Type**	**Checklist Item(s) Answered 'Yes' (Y)**	**Checklist Item(s) Answered 'No' (N)**	**Checklist Item Not Applicable (N/A)**
City of Kigali	Masaka	DH	1,14-16, 24,25	17	2-13,18-23,26
	Kicukiro	DP	18		1-17,19-26
	Kicukiro (Masaka)	DHMT	3-10,12-16,18	2,11,22,23	1,17,19-21,24-26
	Gikondo (Kicukiro/Masaka)	HC	24,25,26	17	1-16,18-23
	Indatwa za Gikondo	CHWs Coop			1-26
	Kagarama (Kicukiro HC)	HP (Public)		24-26	1-23
Eastern Province	Kibungo	PH	1,15,16,24-26	14,17	2-13,18-23
	Ngoma (Kibungo)	DP	18		1-17,19-26
	Ngoma (Kibungo)	DHMT	1,3-13,15,16	2,14,17,22	18-21,23-26
	Kirwa (Kibungo)	HC	24,25,26	17	1-16,18-23
	Koaruge (Kirwa HC)	CHWs Coop			1-26
	Kibungo HC (Ngoma)	HC (MCSP Site)			1-26
	Kirehe	DHMT (AIRS)	1-10,12-16	11,17,22	18-21,23-26
Northern Province	Rutongo	DH	1,14-17,24-26		2-13,18-23
	Rulindo (Rutongo)	DHMT	3-6,10,13,15-18	1,7-9,14	2,11,12,19-26

		Entry and Summary Results for SCHS Sub-Purpose 5 (Leadership & Governance)			
Region	**Facility/Org./Inst./Admin Body Name**	**Type**	**Checklist Item(s) Answered 'Yes' (Y)**	**Checklist Item(s) Answered 'No' (N)**	**Checklist Item Not Applicable (N/A)**
Southern Province	Ruhango	PH	1,14-16	17	2-13,18-26
	Ruhango	DP		18	1-17,19-26
	Kinazi (Ruhango)	HC	24-26	17	1-16,18-23
	Tabara/Kotaki (Kinazi HC)	CHWs Coop			1-26
Western Province	Gisenyi	DH	24-26	17	1-16,18-23
	Nyamyumba (Kigufi HC)	HP		24-26	1-23
Central	Central MOH Planning, HF, CHW	MOH	19		1-18,20-26
	Central MOH LMO	MOH			1-26
	Malaria, Parasitic Diseases Division (MOPDD)	RBC	20-23		1-19,24-26
	Rwanda Social Security Board	RSSB			1-26

ANNEX XII. ADOPTED STRUCTURE OF THE MINISTRY OF HEALTHS, 2014



ANNEX XIII. MOST "IMPORTANT" AND "CHANGEABLE" FACTORS FOR A SUSTAINED HEALTH SYSTEM: ELEMENTS OF THE CONCEPTUAL FRAMEWORK

The exact configuration of the HSS components and associated services vary from country to country, but for Rwanda, the most critical elements that have and continue to come together and interact and work effectively are: effective leadership, political will and advocacy, and policy; a robust financing mechanism; a well-trained and adequately paid workforce; reliable information on which to base decisions and policies; well-maintained facilities and logistics to deliver quality medicines and technologies; results-based Monitoring and Evaluation and a culture of knowledge-based learning and innovation. The core principle for improving all these components and associated services toward a strengthened and effective HS, ultimately leading to better health outcomes, is 'sustainability' – both financial and institutional, which would also lead to programmatic sustainability.

Taking the stakeholders views and the key important factors of the Rwanda specific HSS components and associated services into consideration, in relation to sub-purposes 3-5 of the SCHS Project, the ET identified the following elements and their components as the 'most important' and 'changeable' factors' underpinning a well capacitated and strong HS toward the path of 'sustainability':

1. Leadership and Advocacy: Leadership, including 'political will' and advocacy, is at the heart of ensuring a strong 'country owned' and 'country led' HS in Rwanda. Rwanda's strong recent success clearly and convincingly testifies for it. Effective leadership and advocacy constitute the primary foundation for all the other 'important' and 'changeable' factors and provide ongoing critical support and direction for the overall success of the HS. In looking at this element, the team reviewed key documents and asked a key set of overarching questions (see ***Annex II*** for the evaluation questions) to determine: i) the extent of effective leadership at various levels (national and district) of the HS, and ii) the extent of high level (including political) support and advocacy for strengthening the HS.

2. Governance, and Policy & Planning: In realizing a well-integrated, strengthened, and sustainable HS, effective leadership and broad advocacy must be supported by both effective health system governance and an enabling policy and planning environment that clearly sets out not only the strategic objectives and goals, but also a well-defined and prioritized results-oriented operational plan. Together, they formulate the legal and policy base and the critical underpinning toward successful implementation at all levels. Overall, in evaluating these factors, the team reviewed various documents and asked a key set of overarching questions to determine: i) how effective have the decentralization process and associated support been, especially at the district level, ii) to what extent the plans and strategies in place are used to guide the HS, and iii) whether the key institutions involved in strengthening the HS have the necessary mandate, profile and capacity to play their assigned roles.

3. Management, Coordination and Implementation: Successful implementation of even the most effective strategies and plans is always a critical challenge. The aspect of overcoming the political and organizational obstacles needed for effective implementation has many times not been adequately addressed across the development community. The plans and goals have to be connected to the actual implementation with effective management and coordination among all stakeholders. While many times the necessary policies and strategies may seem to be in place, the actual implementation of them may be absent due to weak and inefficient management, coordination and institutional effectiveness. As such, the team looked into this segment in the following key functional and organizational sub-components for the HS, again in relation to sub-purposes 3-5 of the SCHS Project:

Institutional Effectiveness
Capacity/Competency (skills – analytical, business, financial/resource management, etc.)
Resources (human and financial)
Focus on Results
Coordination, Communication & Collaboration
Change Management

The team reviewed various documents and asked a key set of overarching questions to determine: i) whether there were sufficient human and financial resources for effective implementation, ii) if the various individuals and institutions have the necessary capacity and roles and responsibilities were clearly assigned, iii) if there are well-maintained facilities and logistics to deliver quality medicines and technologies, iv) if there was effective coordination and collaboration, v) if there was adequate focus on the targeted broader strategic results, and vi) if there was a plan for effective management of the anticipated changes.

4. Management, Coordination and Implementation: With the ultimate goal of improving health outcomes in Rwanda, the Health Management Information System (HMIS) and overall learning agenda are the principal entry points to provide that crucial information and knowledge for planning and decision-making. The whole culture of information generation, knowledge capturing, and learning leading to 'innovations' at all levels of the HS is critical to improve program efficiencies and health outcomes. The team reviewed various documents and asked a key set of overarching questions to determine: i) are there adequate training and periodic retraining at facilities and programs for staff, ii) is there an incentive system to encourage the usage of knowledge based practices including 'what works' and 'what doesn't work' for implementation support at all level, and iii) is there 'innovation' and if it is prioritized and incentivized.

ANNEX XIV. DISCLOSURE OF ANY CONFLICTS OF INTEREST

GLOBAL HEALTH PROGRAM CYCLE IMPROVEMENT
PROJECT

USAID NON-DISCLOSURE AND CONFLICTS AGREEMENT

USAID Non-Disclosure and Conflicts Agreement- Global Health Program Cycle Improvement Project

As used in this Agreement, Sensitive Data is marked or unmarked, oral, written or in any other form, "sensitive but unclassified information," procurement sensitive and source selection information, and information such as medical, personnel, financial, investigatory, visa, law enforcement, or other information which, if released, could result in harm or unfair treatment to an individual or group, or could have a negative impact upon foreign policy or relations, or USAID's mission.

Intending to be legally bound, I hereby accept the obligations contained in this Agreement in consideration of my being granted access to Sensitive Data, and specifically I understand and acknowledge that:

1. I have been given access to USAID Sensitive Data to facilitate the performance of duties assigned to me for compensation, monetary or otherwise. By being granted access to such Sensitive Data, special confidence and trust has been placed in me by the United States Government, and as such it is my responsibility to safeguard Sensitive Data disclosed to me, and to refrain from disclosing Sensitive Data to persons not requiring access for performance of official USAID duties.
2. Before disclosing Sensitive Data, I must determine the recipient's "need to know" or "need to access" Sensitive Data for USAID purposes.
3. I agree to abide in all respects by 41, U.S.C. 2101 - 2107, The Procurement Integrity Act, and specifically agree not to disclose source selection information or contractor bid proposal information to any person or entity not authorized by agency regulations to receive such information.
4. I have reviewed my employment (past, present and under consideration) and financial interests, as well as those of my household family members, and certify that, to the best of my knowledge and belief, I have no actual or potential conflict of interest that could diminish my capacity to perform my assigned duties in an impartial and objective manner.
5. Any breach of this Agreement may result in the termination of my access to Sensitive Data, which, if such termination effectively negates my ability to perform my assigned duties, may lead to the termination of my employment or other relationships with the Departments or Agencies that granted my access.
6. I will not use Sensitive Data, while working at USAID or thereafter, for personal gain or detrimentally to USAID, or disclose or make available all or any part of the Sensitive Data to any person, firm, corporation, association, or any other entity for any reason or purpose whatsoever, directly or indirectly, except as may be required for the benefit USAID.
7. Misuse of government Sensitive Data could constitute a violation, or violations, of United States criminal law, and Federally-affiliated workers (including some contract employees) who violate privacy safeguards may be subject to disciplinary actions, a fine of up to $5,000, or both. In particular, U.S. criminal law (18 USC § 1905) protects confidential information from unauthorized disclosure by government employees. There is also an exemption from the Freedom of Information Act (FOIA) protecting such information from disclosure to the public. Finally, the ethical standards that bind each government employee also prohibit unauthorized disclosure (5 CFR 2635.703).
8. All Sensitive Data to which I have access or may obtain access by signing this Agreement is now and will remain the property of, or under the control of, the United States Government. I agree that I must return all Sensitive Data which has or may come into my possession (a) upon demand by an authorized representative of the United States Government; (b) upon the conclusion of my employment or other relationship with the Department or Agency that last granted me access to

Sensitive Data; or (c) upon the conclusion of my employment or other relationship that requires access to Sensitive Data.

9. Notwithstanding the foregoing, I shall not be restricted from disclosing or using Sensitive Data that: (i) is or becomes generally available to the public other than as a result of an unauthorized disclosure by me; (ii) becomes available to me in a manner that is not in contravention of applicable law; or (iii) is required to be disclosed by law, court order, or other legal process.

Please be advised that I was the design team lead for the RHSSA project, however my involvement was only in the design phase. I have never worked for or been involved and/or associated with the project in any capacity including its implementation.

ACCEPTANCE
The undersigned accepts the terms and conditions of this Agreement.

Signature Tariqul Khan Date 8/8/2016

Name Tariqul Khan Title

Sensitive Data; or (c) upon the conclusion of my employment or other relationship that requires access to Sensitive Data.

9. Notwithstanding the foregoing, I shall not be restricted from disclosing or using Sensitive Data that: (i) is or becomes generally available to the public other than as a result of an unauthorized disclosure by me; (ii) becomes available to me in a manner that is not in contravention of applicable law; or (iii) is required to be disclosed by law, court order, or other legal process.

Agreed.

ACCEPTANCE

The undersigned accepts the terms and conditions of this Agreement.

Signature: Katya Burns	Date: 09/15/2016
Name: Katya Burns	Title: consultant

Sensitive Data; or (c) upon the conclusion of my employment or other relationship that requires access to Sensitive Data.

9. Notwithstanding the foregoing, I shall not be restricted from disclosing or using Sensitive Data that:
(i) is or becomes generally available to the public other than as a result of an unauthorized disclosure by me; (ii) becomes available to me in a manner that is not in contravention of applicable law; or (iii) is required to be disclosed by law, court order, or other legal process.

ACCEPTANCE
The undersigned accepts the terms and conditions of this Agreement.

Signature 	Date: 8/03/2016
Name: Jennifer Kaahwa Katekaine	Title Team Leader, Evaluator HSS & CB

Sensitive Data; or (c) upon the conclusion of my employment or other relationship that requires access to Sensitive Data.

9. Notwithstanding the foregoing, I shall not be restricted from disclosing or using Sensitive Data that: (i) is or becomes generally available to the public other than as a result of an unauthorized disclosure by me; (ii) becomes available to me in a manner that is not in contravention of applicable law; or (iii) is required to be disclosed by law, court order, or other legal process.

ACCEPTANCE

The undersigned accepts the terms and conditions of this Agreement.

Signature  Date 08/05/2016

Name Richard Kibombo Title Evaluation Specialist

Global Health Project Cycle Improvement Project

1331 Pennsylvania Avenue NW, Suite 300

Washington, DC 20006

Phone: (202) 625-9444

Fax: (202) 517-9181

http://ghpro.dexisonline.com/reports-publications