

## **Annual Project Report**

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Rwanda IHSSP

October 2010 – September 2011

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INKUNGA Y'ABANYAMERIKA

RWANDA INTEGRATED HEALTH SYSTEMS STRENGTHENING PROJECT:

# Annual Project Report

## October 2010 – September 2011

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## ACRONYMS

CAAC	Cellule d'Appui à l'Approche Contractuelle (Performance-Based Financing Technical Support cell of the Rwandan Ministry of Health)
CAMERWA	Centrale d'Achat des Medicaments Essentiels au Rwanda (Rwanda Drug, Consumables and Equipment Central Procurement Agency)
CBHI	Community Based Health Insurance (Mutuelle)
CHD	Community Health Desk (Department of the Rwandan Ministry of Health)
CHIS	Community Health Information System
CHW	Community Health Worker
CSOs	Civil Society Organizations
CTAMS	Cellule Technique d'Appui aux Mutuelles de Santé (Mutuelle Technical Support Cell)
CPD	Continuous Professional Development
DH	District Hospital
DHIS	District Health Information System
DRG	Diagnosis Related Group
GESIS	Gestion du Système d'Information Sanitaire (Management of Health Information System)
GIS	Geographic Information System
GOR	Government of Rwanda
HC	Health Centers
HDP	Health, Development and Performance
HIS	Health Information System
HISP	Health Information Systems Programme
HMIS	Health Management Information System
HRH	Human Resources for Health
HSS	Health System Strengthening
iHRIS	Human Ressources Information System
IHSSP	Integrated Health Systems Strengthening Project

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ICD-10	International Classification of Diseases, 10 <sup>th</sup> edition
LMIS	Laboratory Management Information System
MCH	Maternal and Child Health (Department of the Rwandan Ministry of Health)
M&E	Monitoring & Evaluation
MIGEPROF	Ministry of Gender and Promotion of Child and Family rights
MIS	Management Information System
MINALOC	Ministry of Local Administration
MOH	Ministry of Health
MSH	Management Sciences for Health
NGO	Non-governmental Organization
OpenMRS	Open Medical Record Software
PBF	Performance-Based Financing
PPG	Policy statements, Procedures and guidelines
PRISM	Performance of Routine Information System Measurement
PTF	Pharmaceutical Task Force
QI	Quality Improvement
RBC	Rwanda Biomedical Centre
SISCom	Community Health Information System
SMS	Short Message Service
SPS	Strengthening Pharmaceutical System Project
TB	Tuberculosis
TOT	Training of Trainers
TracNet	Treatment and Research AID Centre Net
TWG	Technical Working Group
USAID	United States Agency for International Development
USG	United States Government

## INTRODUCTION

### Project Overview

In 2009 Management Sciences for Health was awarded, by the United States Agency for International Development, the Integrated Health Systems Strengthening Project (IHSSP).

The Rwanda Integrated Health Systems Strengthening Project is a 5-year duration project which was officially started in November 2009 which overall vision is to strengthen the Government of Rwanda's capacity to provide high quality, client-oriented health and social services to the Rwandan population in a sustainable manner. The project builds upon several years of U.S. Government support to the GOR in health system strengthening.

The project focuses on 5 different components:

- 1) Data management and data use
- 2) Strengthened health financial mechanisms
- 3) Human Resources for Health
- 4) Quality improvement of health services
- 5) Decentralized health and social services

The **data management and data use component** objective is to improve the utilization of data for decision-making, resource allocation and policy formulation across all levels of the health sector.

The **health financing component** seeks to strengthen and harmonize the health financing system to obtain efficient and viable provider payment mechanisms while offering health services of high quality. It strives towards the efficiency in allocation and use of health financial resources and the achievement of an appropriate balance between purchasers, payers and stewards.

The **human resources for health component**' objective is to improve the management, quality and productivity of human resources for health and related social services.

The **quality improvement team** seeks to improve the quality of health services through the implementation of a standardized approach in every district hospital and the institutionalization of a continuous and self-sustaining process of quality improvement in every health facility.

The **decentralization component** goal is to assist in the building of a fully functional district able to implement health and social services to the district level and below.

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## Executive Summary

This report provides an overview of the second year of implementation of the IHSS project, from November 2010 to October 2011. During this period, the IHSSP supported to the Ministry of Health (MoH) in HMIS, Health Financing, Human Resources for Health, Quality Improvement and Decentralization of Health services.

Regarding the **utilization of health data for decision making and policy formulation**, the IHSSP provided assistance in the roll-out of the Community Health Information System, the upgrade of the HMIS, the elaboration of Performance Based Financing (PBF) data collection tools and the related web application, and the development of drug import & pharmacists licensing databases.

In the **Health Finance domain**, the project has enhanced both Community Based Health Insurances (CBHI) and PBF systems by developing the CBHI procedure manual, achieving the social stratification process and updating the CBHI web-based database. The project also provided support to the Ministry of Health for CBHI financial modeling and data audit. About the PBF system, the IHSSP helped to develop the PBF procedure manual, to audit the Clinical and Community PBF systems and to conduct a Community client survey. Other realizations are the Community PBF implementation review, the Community PBF' Standard Operative Procedures and the health services costing study.

For the **Human Resources for Health component**, the IHSSP assisted in the coordination of the HRH Strategic Policy and its Strategic Plan. It assisted too the Rwanda Medical Council in the development of the Continuing Personal Development (CPD) policy and its implementation. Norms and Standards for Health professional associations and the law related to the Health Professional Bodies have been created, and the district hospitals have been trained on the Workload Indicators for Staffing Needs (WISN) methodology.

The **Quality Improvement team** assisted in drafting Terms of References for Quality Improvement Technical Working Groups and district hospitals accreditation management advisory committees. Review and development of the district hospitals accreditation policies, procedures and clinical protocol/treatment guidelines have been done. Review of the existing health service packages and development of provincial referral hospitals health service packages have been completed.

Concerning the **Health Decentralization**, the IHSSP assisted in the development of the strategic plan, the District Health Survey Review and the establishment of the districts M&E structure.

The project also assisted the MoH in the provision of services related to the President's Malaria Initiative, IT infrastructure and equipments, and distribution of generators to the health facilities.

# 1. IMPROVED UTILIZATION OF DATA FOR DECISION MAKING AND POLICY FORMULATION

## 1.1. Context and challenges

The GOR considers the use of Information Systems and ICT as critical to achieve improved access to care. This implies having effective infrastructures, applications and information systems. The health sector has demonstrated the vital role of ICT in integrating health information systems Community-Based interventions. The Rwandan MoH took initiative to strengthen and harmonize the HMIS, from the community to the central level. A nationwide electronic medical record system will be rolled out next year.

At its beginning, the project was facing many challenges: the low score of data use and the lack of data quality were some of the major ones. There was a perception that health workers spent too much time recording and reporting data and too little time using them. The MoH had also been through major restructurings, relationships between HMIS key departments were unclear, and some staff functions were not defined. Another gap was that the existing Information Systems were not fully integrated, and the available data were not easily accessed. The Human Resources Information System, introduced and supported by another project through late 2009, was no more maintained, and the CBHI database has to be enhanced with better data quality controls and a membership module.

## 1.2. Brief of progress

A strategic plan for HIS has been drafted and integrated into the national e-Health Strategic plan. Guidelines and standard operating procedures have been developed for HIS sub-systems. The HMIS reporting format has also been updated.

Web-based applications have been developed and initiated: the cell phone based systems, the DHIS-2 and the Rwanda PBF web-based application.

Databases related to drug import, pharmacists licensing and CBHI have also been produced.

Others activities include data assessment and capacity building.

## 1.3. Main activities and results achieved

### 1.3.1. HMIS Plan, SOPs & Guidelines and format reporting

#### e-Health Strategic plan

The project staff facilitated a 3-day workshop in Gisenyi to update the Ministry of Health's e-Health Strategic plan. This included developing micro-projects to upgrade the HMIS and implementing the national data warehouse and dashboard.

#### Standard Operating Procedures and Guidelines

IHSSP supported the MoH in the development of SOPs for district hospitals and health centers in data management. The first draft is available. The HIS project supported as well the MoH to update the guidelines of the Community Health Information System.

#### HMIS health facility reporting formats

IHSSP assisted the MoH in the selection of the Rwanda Minimum Indicator set, which includes around 150 routinely collected indicators. These indicators have been incorporated into the monthly reporting forms of the health centers and district hospitals.

The Rwandan priority diseases list and the morbidity data have been mapped to the WHO's ICD-10 coding framework. Data available from other reporting systems (TracNet, LMIS) have been removed.

Through this process the size of the forms have been reduced **from 26 pages to 12** for the health centers and from **46 pages to 12** for the districts hospitals!

Separate reporting forms have been created for the CBHI and for the Community Health Information System (SISCom).

### 1.3.2. HMIS databases and web-based applications

#### 1.3.2.1. Mobile phone-based Community Health Information System

The project has supported the roll-out of the mobile phone-based Community Information System. 10,000 cell phones have been distributed to the Community Health Workers and provided trainings to data managers and CHW coordinators in the use of the new reporting system.

### 1.3.2.2. New HMIS reporting system (DHIS-2)

A nationwide electronic medical record system will be rolled out next year. In order to operationalize the new HMIS reporting system (DHIS-2), the project supported the configuration of the system, provided initial orientation for HMIS team and training. The IHSSP and the MoH also developed a work plan for the roll-out of the system.

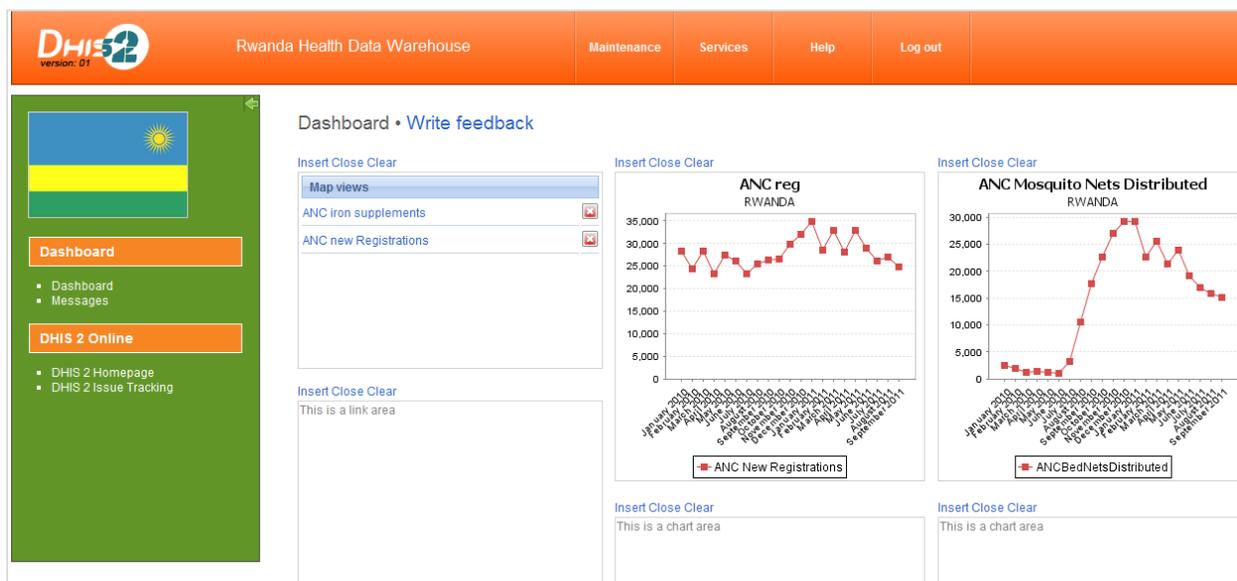


Figure 1: Screen shot of the Rwanda Health Data Warehouse (DHIS-2), which is a tool for collection, validation, analysis, and presentation of aggregate statistical data, tailored (but not limited) to integrated health information management activities<sup>1</sup>.

### 1.3.2.4. PBF data collection tools and PBF web application

The project provided assistance to the Performance-Based Financing Technical Support cell of the Rwandan Ministry of Health (CAAC) in order to enhance the PBF system. PBF data collection tools and its web application have been upgraded.

The IHSSP intervention was dominated by the following points:

#### PBF payments

The IHSP project assisted the MoH for the preparation of quarterly PBF payments and worked closely with the CAAC's to develop its capacity to prepare the payment vouchers.

<sup>1</sup> DHIS-2 web site, <http://dhis2.org/>, accessed on November 3 2011

## **Tuberculosis PBF System**

The project assisted the Ministry in developing a Tuberculosis PBF system for data collection and data-entry, which was transferred to the web-based PBF platform. The project team also helped for the update of the indicators and is in the process of designing an algorithm to calculate PBF bonuses.

### **1.3.2.5. Drug import & Pharmacists licensing databases**

The IHSSP, in collaboration with the Rwanda Strengthening Pharmaceutical Systems project and the MoH Community Health Desk, prepared the functional specifications for a system able to track the essential drugs and supplies needs of the Community Health Workers regarding the National Malaria Control Program. Two new databases requested by the MoH Pharmaceutical Task Force as a high priority have been developed:

A *drug import licensing system* designed to facilitate the licenses process and to track values and batch numbers of all imported drugs, and a *registration system* for all pharmacists and pharmacy technicians.

### **1.3.3. PRISM assessment**

The Performance of Routine Information Systems Management (PRISM) Assessment measures the data quality and the use of information in health information systems. This assessment will be the report that will form a baseline for evaluating progress.

The IHSSP supported the MoH to collect data from 20 selected health centers and community health worker cooperatives, 5 district hospitals, and 5 administrative districts.

The data-entry is now finished and the data analysis is in process.

### **1.3.4. Capacity building in HMIS**

#### **Data use & analysis**

The IHSS project conducted trainings on analysis and data use for the CBHI Technical Support Cell and the e-Health and HMIS departments. It also helped the MoH to develop curriculum and training materials for the HMIS team. A training plan has been developed and a series of training sessions were completed to show to the Community Health Desk data managers how to extract data from the current HIS (GESIS) and the Community Health Information System. The curriculum used for this training has also been adapted so that it will be the basis for the next training of the health center data managers.

## **PBF data management**

Trainings related to PBF data management have also been provided to the MOH's Community Health Desk, the CBHI Technical Support Cell and the TB units to train them in the use of the new web-based TB PBF module.

## **Roll-out of the new HMIS**

The project helped also to identify the key areas of capacity building required to roll-out the new HMIS. This includes training in Data collection (using the new reporting formats and recently harmonized registers), Data management (including data-entry using the new DHIS-platform), and data use (GIS, presentation graphics and feedback reporting, using DHIS and other data sets). A scope of work was established with Futures to support these efforts.

The IHSSP organized trainings for the MoH HMIS team in using the DHIS-2 software.

## **iHRIS**

The IHSS project has also worked with the IntraHealth Capacity Plus project to align the new Human Resources Information System (iHRIS) software with the functional requirements developed by the WHO in June. They then develop a 1 day orientation session for 90 district hospital staff on the system.



*Figure 2: Training of staff on iHRIS*

## 2. STRENGTHENED FINANCIAL SYSTEMS FOR THE RATIONAL USE OF AVAILABLE HEALTH RESOURCES

### 2.1. Context and challenges

#### 2.1.1. Background

Health financing is one of the pillars of an efficient health system. The Rwanda MoH objective is to ensure that essential health services, and particularly MDG-related interventions, are financially accessible to the whole population in an equitable, efficient and sustainable manner under a result-based financing framework.<sup>2</sup>

Rwanda is also considered as best practice country in Africa in implementation of Community Based Health Insurance (CBHI) and Performance-Based Financing (PBF) to improve access, quantity and quality of health care services.

Strengthening financial systems for the rational use of available health resources are an IHSSP priority area of support. The Community Based Health Insurance, the Clinical and Community PBF implementation are some of the project major realizations.

#### 2.1.2. Main Challenges in Health Financing

The National Health Insurance Policy from April 2010 highlights several challenges related to the sustainability of the CBHI system:

The financing of primary pools still relied mainly on the contributions of households who are relatively poor, and cross-subsidization from richer groups needed to be improved.

The national and district risk pools were under-funded as a result of weak contributions of potential sources and weak administrative capacity for resource mobilization.

The governance of the financing pools needed to be strengthened in order to improve oversight of the use of the funds.

The Clinical PBF needed strong assistance for operational planning, accountability mechanisms and streamlining financial procedures, and the Community PBF was at an embryonic of development.

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<sup>2</sup> Rwanda Health Financing Policy

### **2.1.3. Brief of progress**

During the reporting period, the project provided assistance for the realization of the CBHI procedure manual, the social stratification process and the update of the CBHI database. The project also provided support to the Ministry of Health for CBHI financial modeling and data audit. About the PBF system, the IHSSP helped to develop the PBF procedure manual, to audit the Clinical and Community PBF systems and to conduct a Community client survey. Other realizations are the Community PBF implementation review, the Community PBF' Standard Operative Procedures and the health services costing study.

## **2.2. Main activities and results achieved**

### **2.2.1. CBHI system**

#### **2.2.1.1. CBHI Procedure manual**

The IHSS project assisted the MoH in the development of the CBHI procedures manual. This document provides key information and guidelines following the introduction of the new CBHI policy.

#### **2.2.1.2. The Social Stratification Process (UBUDEHE)**

The Social Stratification Project overall objective is to build a nation-wide flexible database on social stratification. This will allow the population to contribute to the CBHI based on their revenues and their capacity to pay. A contribution system based on the household revenues will increase equity and strengthen the financing of the CBHI system in Rwanda.

The IHSS project contributed to this stratification process by developing a web-based database. This database allows the CBHI to retrieve stratification information, while providing more details for the MINALOC and the MoH. It is also accessible to key development partners in order to permit them to target more effectively vulnerable groups.

The first data-entry ended in January 2011. At the end of this process, information about a fraction of the population was still missing. The existing data were printed and sent to the villages for correction, and a second data-entry phase has been done during the third quarter of this year.

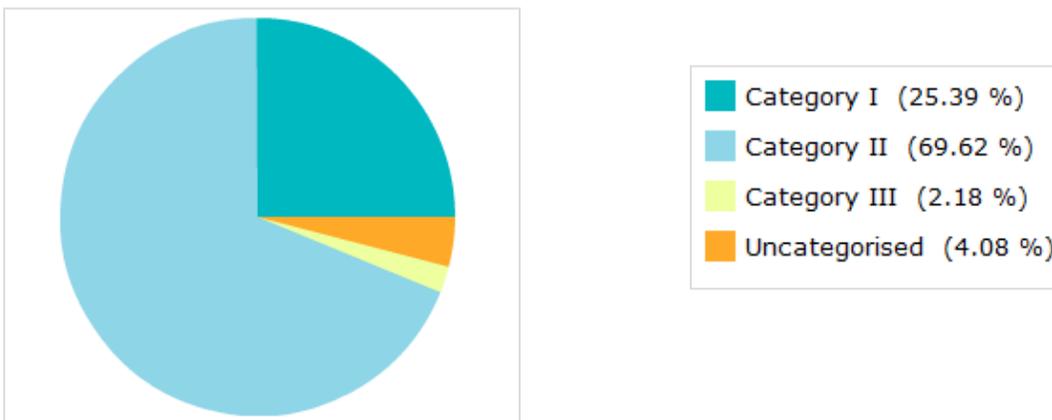
In addition to the development of the database, the project has conducted training to data-entry staff and supervisors. The project also co-financed salaries for the data-entry staff, and has provided technical and management supervision of this process.



*Figure 5. Second data-entry phase of the Social Stratification Process (Ubudehe) During this second phase, 600 data entry staff updated records based upon updated category information.*

The Socio-Economic Stratification Database will be a regularly updated to reflect the population, and the stratification will be updated each year.

**Results at the end of this process:** 91.2% of the population has been recorded, and is repartitioned as follows:



*Figure 4: Total Population per Mutuelle Category*

### 2.2.1.3. Update of the CBHI Database

From July 2011, the new CBHI policy is being implemented. The M&E database and the reported indicators had to be reviewed and adapted.

The IHSS project supported the MoH to review the CBHI M&E indicators reported by sections, and new indicators were elaborated. New reports and analysis requests have been produced and the Capacity transfer to District actors on the use of the database is still conducted to the central and district level actors.

By linking the CBHI interface to the Social Stratification one (UBUDEHE database), each level of the CBHI scheme will be able to record new members and to assign an accurate payment. This database will also help the CBHI managers to have a precise picture of enrollees and their categories.

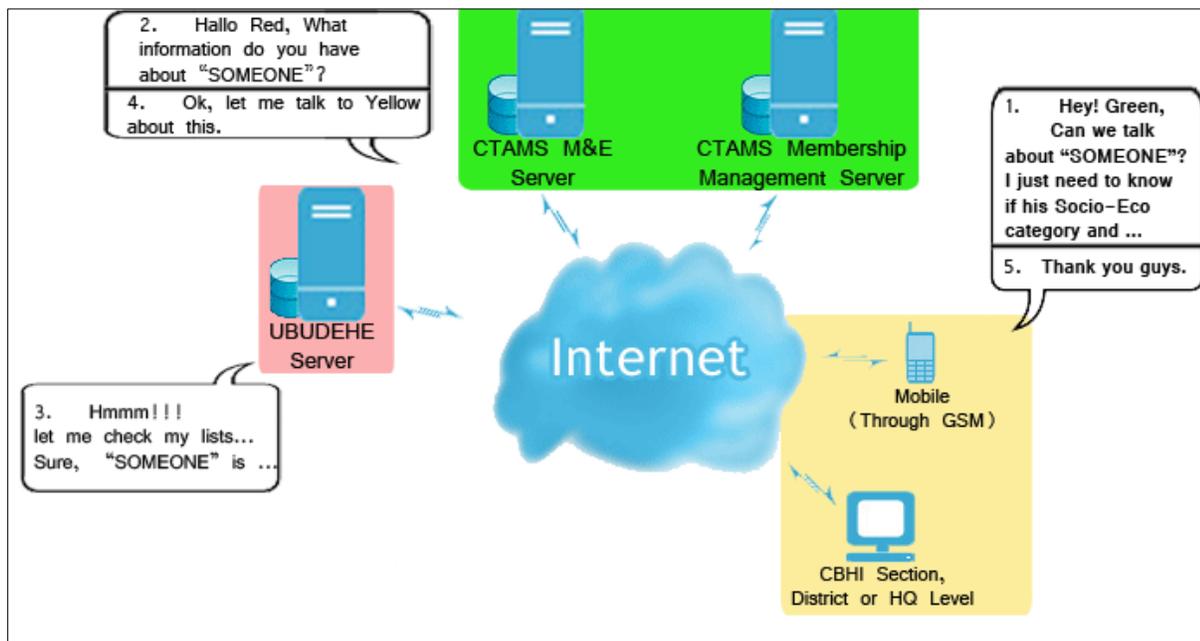


Figure3 : CBHI membership: Connectivity with Ubudehe

### 2.2.1.4. CBHI financial modeling

With the new CHBI policy, “31,494,964,763 RWF”<sup>3</sup> are expected to be collected for the year 2011, which must cover all health expenses, from health centers to district hospitals. The challenge is how to distribute this amount efficiently.

The IHSS project assisted the CBHI Technical Support Cell (CTAMS) for this financial modeling, considering the projections from the CBHI new policy on expected total revenue and projected total expenses, and following some principles (to prioritize the coverage of health centers invoices with mandatory transfer to central level for equalization).

This model would be generic enough so that it can be used easily. The expected outcome would be improvement in financial planning resulting in increased efficiency, access and sustainability.

For the next step, the project will continue to provide technical support for the conception and the design of this model and to assist the MoH and the individual “Mutuelles” to project their revenue and expenses based on elements such membership, premiums, administrative costs, expected utilization levels and facility reimbursement mechanisms.

#### **2.2.1.5. CBHI Data Audit**

The project is supporting the MoH in the management of the CBHI database which permits data access to all levels. A monthly reporting system is in place, where each section enters the information into the database, but the major issue remains the data quality.

The proposed intervention is to institutionalize a data quality audit which will help to identify the data quality problems, their origin, and to take action.

#### **2.2.2. PBF System**

##### **2.2.2.1. PBF procedure manual**

A PBF procedure manual has been developed for district hospitals and health centers. This document will be the reference for all PBF-related activities in Rwanda and will be used for study tours and (inter)national trainings.

A workshop held on June, gathering staff from the CAAC (Performance-Based Financing Technical Support cell of the Rwandan Ministry of Health), Directors and “titulaires” from 10 health facilities and PBF-experts from international NGO’s, demonstrated the ownership of the

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<sup>3</sup> CBHI Policy, 2010

Ministry on this important document which will outline the procedures used in the PBF-models for the different ministerial departments.

### **2.2.2.2. Design and development of new PBF schemes**

The project also supported the MoH to design a PBF manual framework for the Rwanda Drug, Consumables and Equipment Central Procurement Agency (CAMERWA), and was presented to the CAMERWA board and partners.

On request of the MoH, the IHSSP Health Financing team reviewed and refined the Rwanda TB PBF model in response to comments raised by the Global Fund. Indicators have been defined, and tariffs set. Data collection forms and an MS Access-based data-entry tool have been developed to capture third quarter data. These were integrated into the PBF web platform in January 2011.

### **2.2.2.3 Community PBF contracts review and SOPs development**

Due to new aspects introduced last year in the Community PBF scheme, especially on the CHW cooperative quality assessment, the project supported the MoH' Community Health Desk in the revision of two contracts, the CHW cooperative contract and the Sector PBF steering committee contract. The contracts are now in the process of being signed with decentralized stakeholders.

One of the main challenges noted in the evaluation of Community PBF conducted in January 2011 was the need to develop a clear role of supervisors placed at district hospital levels. A SOPs guide which detail all activities related to the PBF specific interventions was drafted. Those SOPs focused mainly in the coaching process of sector steering committees, the assessment activities and the data audit.

### **2.2.2.4 PBF System Audit**

#### **Clinical PBF**

During this year, the IHSS project, in collaboration with the MoH and other partners, conducted surprise district hospitals evaluations, assessing quantitative and qualitative status of delivery of health services to both hospitals and surrounding health centers.

The project designed the assessment methodology. The objectives were to evaluate the PBF-framework, its initial design and implementation, and to provide an independent audit/verification opinion.

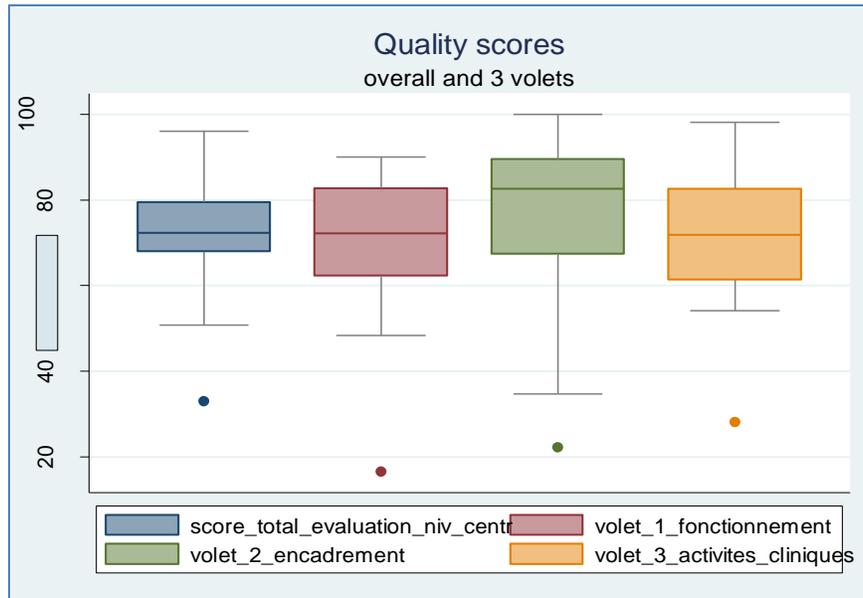


Figure 6: Overall score and scores per component for the 39 hospitals

The figure above shows the overall quality score and score per component for the 39 hospitals assessed during this exercise. We can see here that all quality scores were around 80%.

The graph below displays the results for the 6 health centers with all services aggregated (210 clients per health center) and indicates who responded to the interviewer with respect to existence of clients.

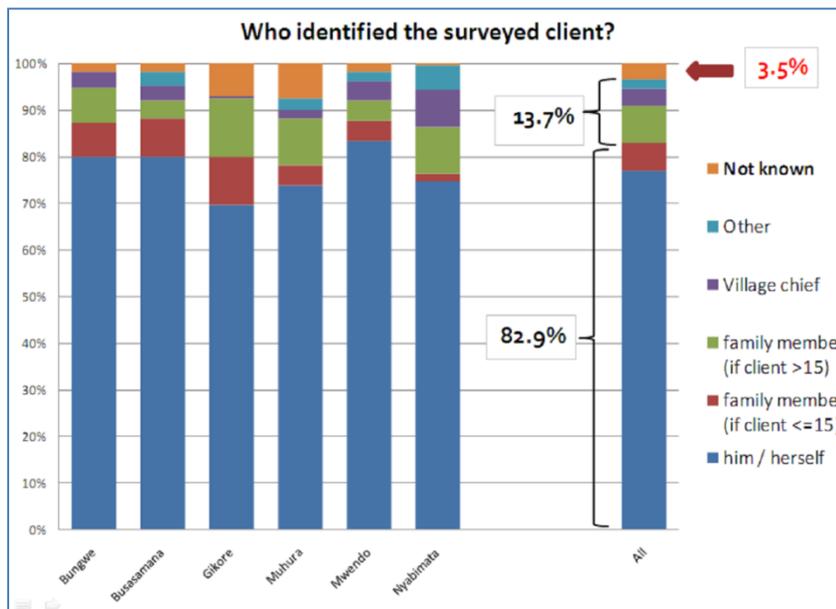


Figure 7: Confirmation of client existence client: results per health center

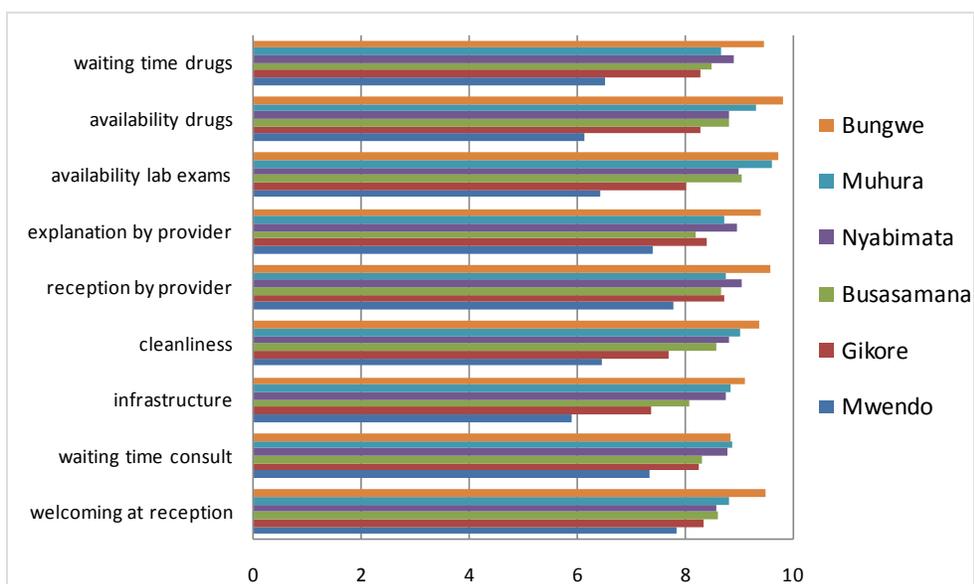
Confirmation of existence of client was primarily done by him/herself (range 69.5% to 83.3%) followed by family member for clients < 15 yrs of age (on average 6%). This leaves still on average 13.7% of clients whose existence was only confirmed by a proxy person. In previous surveys in 2008-2009, existence was confirmed for two thirds (65.3%) by client him/herself.

### Community PBF system audit

The IHSS project, in collaboration with the Community Health Desk, the School of Public Health and the MoH PBF Unit, performed the 1<sup>st</sup> round of the Community PBF system audit. This audit aimed to check if the procedures and regulations were implemented accordingly to the national Community PBF model. Actors from different structures (sector steering committee, district steering committee, health center, CHW cooperatives) were interviewed on varying issues like contract management, evaluation visits, payment cycles and communication with higher levels. The protocol for the community PBF audit has been developed by the project, and results will be available next quarter.

### Community client survey and counter verifications

The IHSS project also supported the MoH’ PBF Unit to conduct the PBF Community client survey. This survey’s component objective was to assess the client satisfaction for the health centers and the accuracy of quality of the health centers as evaluated by district hospitals team.<sup>4</sup>



*Figure 8: Mean scores for the 6 health centers for the 9 questions using a visual analogue scale (VAS)*

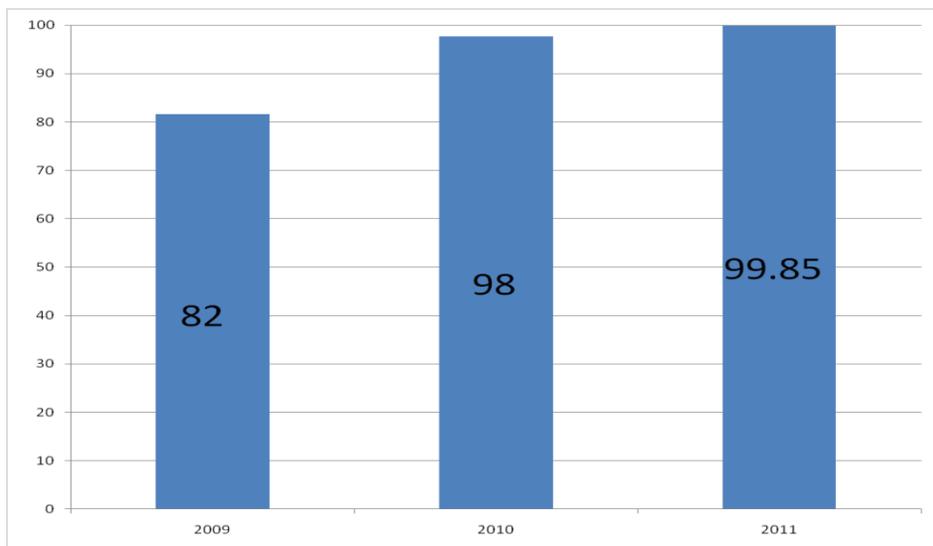
<sup>4</sup> Quantity verification and client satisfaction Quality counter verification and Performance Based Financing system & procedures, Period February – March 2011. Prepared by IHSSP/MSH in collaboration with HDP.

In total 1038 clients out of the 1044 identified (99.5% response rate) accepted to be interviewed and expressed their opinion of the different aspects of the functioning of the health center they visited. Each person gave a score between 1 and 10 for each of the 9 specific questions related to waiting times, availability of drugs and lab exams, infrastructure, communication by the health care provider and how they were received at the health center. Overall mean score of satisfaction ranged between 8.0 and 8.8 (standard deviation ranged from 1.6 to 2.0) but with significant difference between the health centers.

### Community PBF implementation review

The IHSSP supported the PBF Technical Support cell of the Rwandan Ministry of Health (CAAC) to revitalize the reporting on Community health activities. As a result, the completeness of reporting significantly increased.

The Community Health Workers (CHWs) reporting is becoming perfect: the overall completeness of reporting now varies between 95 to 100%.



*Figure 9: Evolution of the completeness rate in CHWs reporting*

#### 2.2.2.5. International Conferences and other fora

To share its experiences and practices, the IHSSP technical staff helped the MoH to draft abstract on the Rwanda PBF models. These abstracts have been selected for the first Annual Global Symposium on Health Systems Research, held in **Montreux** in November 2010, and were presented by both MoH and IHSSP staff.

Similarly, the project took active part by helping the MoH in the preparation of the **First International Conference on Community Health**, which took place in Kigali, in January 2011.

The project also participated in a **PBF Impact Evaluation Workshop**.

This workshop, organized by the MoH in collaboration with the World Bank, included the MoH Community Health Desk, district health representatives, community health focal points, and other implementers' partners.



*Figure 10: PBF Impact evaluation workshop*

This workshop aimed to disseminate evidence generated by PBF interventions in Rwanda, as well as to provide a forum for the MoH leadership to discuss challenges and opportunities in the Community Health program with district and health center level authorities.

The core objectives were to disseminate evidence generated by the 2006-2008 health center impact evaluation, and to present the achievements and challenges of the Community health program, with an emphasis on the community PBF program.

## 2.2.3. Health services costing and financial studies

### 2.2.3.1. Health services costing study

With support from USAID's Integrated Health Systems Strengthening Project (IHSSP), the Ministry of Health in Rwanda (MoH) has undertaken a **costing exercise** to determine the costs of providing the 'Paquet Minimum d'Activités' (PMA) and the 'Paquet Complémentaire d'Activités' (PCA).

The results of these costing exercises, together with a costing of Diagnosis Related Groups (DRGs), are to be used primarily to re-design reimbursement mechanisms and to revise premiums under the Community-Based Health Insurance (CBHI) schemes.

**The costing of the health centers** was performed using the Rwanda Health Center Costing Tool. This tool allows estimating a standard cost for each intervention, broken down by drugs, tests, medical supplies and staff.

Rwanda Health Center Costing Tool						
<p>The Rwanda Health Center Costing Tool, based on CORE Plus, Copyright Management Sciences for Health, Inc., 2010. Th without permission of MSH and credit must be given to MSH in any publication relating to its use. File : C:\Documents and Settings\zjarrah\My Documents\Synchronized Files\zjarrah\Projects\RWAND</p>						
<p><b>FACILITY:</b> Average Model <b>District:</b> <b>Start of Analysis:</b> 1-Jan-2009 <b>End of Analysis:</b> 31-Dec-2009</p>		<p>Go to Service List    Go to Incidence    Go to Needs Page Go to Facility Data    Go to Staff Assumptions    Go to Report Summary</p>			<p><b>SCENARIO:</b> Scenario E</p>	
	Run Scenario A	Run Scenario B	Run Scenario C	Run Scenario D	Run Scenario E	
	Scenario A = actual services and actual costs	Scenario B = actual services and normative costs	Scenario C = needed services and normative costs	Scenario D = projected services and normative costs	Scenario E = projected services and ideal number of staff	
<b>Costs: Total and Per Capita</b>						
Total cost of all services	103,973,457	115,597,306	164,113,380	120,288,076	114,480,529	
Total Cost at HC - primary	99,133,681	110,334,843	159,587,931	116,824,853	111,271,410	
Total Cost at HC - secondary	4,839,776	5,262,463	4,525,449	3,463,223	3,209,119	
Total Cost at Community	0	0	0	0	0	
Cost per service	2,108	2,343	2,751	3,035	2,888	
Cost per capita	5,198.67	5,779.87	8,205.67	6,014.40	5,724.03	
Total cost of curative services	55,807,587	64,209,301	99,661,022	70,613,054	68,333,338	
Average cost per curative service	2,772.75	3,190.18	4,094.00	4,365.75	4,224.80	
Total cost of preventive services	43,112,632	46,399,640	54,054,971	41,106,580	38,293,809	
Average cost per preventive service	1,497.94	1,612.15	1,575.97	1,803.74	1,680.32	
Total cost of other services (delivery, etc)	5,053,238	4,988,365	10,397,387	8,568,442	7,853,382	
Average cost per other service	12,047.91	11,893.24	10,314.87	12,793.59	11,725.93	
<b>Break-down of Total Costs</b>						
Salaries (Technical Staff)	28,549,902	33,988,972	38,115,163	26,559,747	21,644,266	
Technical Salaries as % of total	27.5%	29.4%	23.2%	22.1%	18.9%	
Salaries (Admin and Support Staff)	17,571,464	23,385,642	24,886,075	20,218,377	19,326,311	
Admin Salaries as % of Total	16.9%	20.2%	15.2%	16.8%	16.9%	
Drugs, supplies and lab tests	38,904,477	30,365,078	82,254,528	54,652,337	54,652,337	

Figure 11: Screen shot of the Rwanda Health Center Costing tool

This tool is contained in a Microsoft Excel workbook, which is a collection of individual worksheets linked together

Costing at the health center level was completed during the 4<sup>th</sup> quarter of this fiscal year and a draft report has been produced:

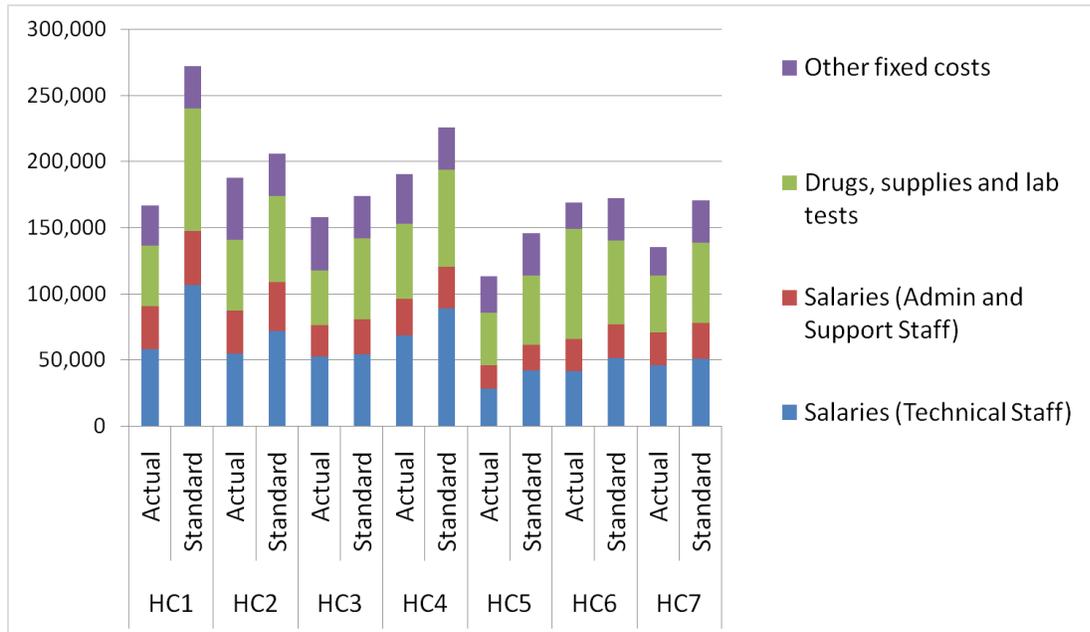


Figure 12: Health Centre Actual vs Standard Costs by Input, 2009 (USD)

Here above are the results for 7 health centers included in the costing exercise. In that example, we can see that the Actual costs are lower than the Standard ones, meaning that the quality of health care could be compromised by a lesser utilization of resources.

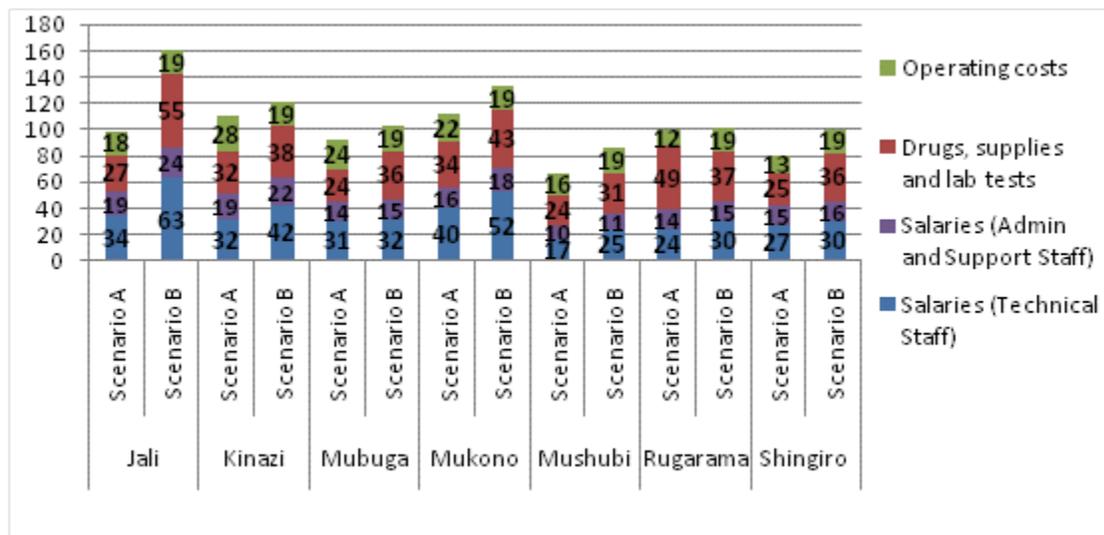


Figure 13: Total actual (scenario A) vs standard (Scenario B) costs, broken down by input, for the sampled health centres in 2009 (RWF millions).

The above picture shows the actual and standard costs of the 7 seven costed health centers, broken down by operating costs, drugs and salaries.

In addition, the **hospital costing** was performed using the Rwanda Hospital Costing Tool, in which the total direct hospital costs, then indirect costs, are allocated across the major departments. The cost per bed-day for each clinical department can then be determined. A separate tool, the Rwanda DRG Costing Tool has also been developed for costing the Diagnosis Related Groups (**DRGs**).

The project has then conducted a **Health Services Costing Training**, which aimed to teach a small group of local health practitioners, proficient with MS Excel (public health consultants, health services manager, health economists) to use the Rwanda Health Center and Hospital Costing Tools. The objectives were to provide the trainees with the skills to train hospital and district managers to use the tools for their own hospitals and health centers; and to provide them with sufficient skills to oversee the DRG implementation process and updating.



*Figure 14: Health Services Costing Training*

#### **2.2.3.2. Costing of Integrated Child Protection Strategic plan:**

IHSSP provided support to MIGEPROF for costing of Integrated Child Protection Strategic plan. Trained ministry staff to adapt and use costing tool. A final costed strategic plan was also validated.

## **3. IMPROVED MANAGEMENT, QUALITY, AND PRODUCTIVITY OF HUMAN RESSOURCES FOR HEALTH AND RELATED SOCIAL SERVICES**

### **3.1. Context and challenges**

#### **3.1.1. Background**

HRH (Human Resources for Health) is a central health strengthening building block for managing and delivering quality health care. To have a well functioning health system, sufficient numbers of people have to be available, trained, and equipped. The GOR is committed to guaranteeing the availability and the quality of Human Resources for Health by strengthening the capacity of educational institutions for health professionals, improving management capacity, and supporting continuous professional development.

#### **3.1.2. Main Challenges in HRH**

The main challenge regarding the HRH was an inadequate staffing of well trained public sector health professionals. The staff at central level was also lacking to effectively support services in the field. Furthermore, the scope of work of many health professionals was not determined or needed some revisions. Another challenge was also the need for capacity building on leadership and management at all levels.

#### **3.1.3. Brief of progress**

The HRH Policy and its Strategic Plan are in development.

The Workload Indicators for Staffing Need (WISN) method has been introduced.

The project also participated in the elaboration of the ministerial order for the registration of pharmacists and allied health professionals.

### **3.2. Main activities and results achieved**

#### **3.2.1. HRH Policy and HRH Strategic plan 2010-2016**

##### **3.2.1.1. HRH Policy**

The project assisted to the coordination and the development of the HRH policy. This document has been drafted and is waiting the TWG approval.

### **3.2.1.2. HRH Strategic Plan**

The IHSSP provided technical assistance for updating the 2006-2009 HRH Strategic Plans. An institutional situational analysis was needed, and the IHSSP assisted the Ministry in it.

The project also supported the MoH in the design of the Human Resources for Health (HRH) component of Health Systems Strengthening (HSS) Strategic Framework. This concept paper is being examined by the MoH Human Resource team for further actions.

### **3.2.2. Health Professional Bodies**

#### **3.2.2.1. CPD Policy and its Strategic Plan for medical cadres**

The IHSS project assisted the Rwanda Medical Council in the development of the Continuing Professional Development Policy (CPD) and its Strategic Plan.

The project helped to establish the CPD governance structure, and assisted the council to hold a sensitization workshop for CPD providers where medical associations and teaching hospitals were represented.



*Figure 15: CPD sensitization workshop*

### **3.2.2.2. Operations and Norms for Allied Health professionals**

To improve the quality of the population's health, it is necessary to put in place the regulatory bodies through professional councils, with a licensure system to assure minimum standard qualifications and control of professional norms.

The project supported existing health professional bodies to elaborate legal documents to establish their regulatory bodies (for pharmacists and allied health professionals associations), and to elaborate professional regulations, norms and standards of practice (for nurses and midwives council).

### **3.2.2.3. Law on Health Professions Association**

The IHSS project helped to finalize the law establishing the Rwanda Allied Health Professions Association and Rwanda Pharmacists Association.

The legal documents have been discussed by peers, translated and reviewed through legal advice. The current document is now available in 3 languages and is under review by the MoH lawyers.

### **3.2.3. Workload Indicators for Staffing Need (WISN) methodology**

This method is HRH management tool that allows to determine how many health workers of a particular type are required to cope with the workload of a given health facility.

An orientation of senior directors and HR managers on the WISN method has been conducted. Teaching hospitals and the Kigali Health Institute have also been trained.

The project also assisted the MoH to train selected team at district levels on the WISN methodology.

AWT: 1512 hours				
Health service activities of all cadre members	Workload component	Annual workload	Standard workload	Required number of staff members
	Antenatal care	1124	4536	0.25
	Postnatal care	612	2268	0.36
	Deliveries	267	189	1.41
	Family planning	2254	3024	0.75
<b>A. Total required staff for health service activities</b>				<b>2.77</b>
Support activities of all cadre members	Workload component	CAS (Actual working time)		CAS (Percentage working time)
	Recording and reporting	30 minutes per day		6.9%
	Meetings	2 hours per month		1.6%
	Home visiting	3 hours per week		6.3%
<b>Total CAS percentage</b>				<b>16.8%</b>
<b>B. Category allowance factor: <math>\{1 / [1 - (\text{total CAS percentage} / 100)]\}</math></b>				<b>1.2</b>
Additional activities of certain cadre members	Workload component	Number of staff members performing the work	IAS (Actual working time per person)	Annual IAS (for all staff performing activity)
	Supervision of midwifery students	1	2 hours, 4 times a year	8 hours
	Continuing education	2	6 days per year each	66.4 hours
	General administration	1	2 hours per week	104 hours
<b>Total IAS in a year</b>				<b>196.4 hours</b>
<b>C. Individual allowance factor (Annual total IAS / AWT)</b>				<b>0.13</b>
<b>Total required number of staff based on WISN: (A x B + C)</b>				<b>3.45</b>

Figure 16: Example of determining staff requirements, based on WISN

(from the WISN, User Manual)



Figure 17: WISN training

## 4. QUALITY IMPROVEMENT FOR RESULTS IN ACCESS TO AND QUALITY OF SERVICES THROUGH STANDARDIZED APPROACH

### 4.1. Context and challenges

#### 4.1.1. Background

Health Service delivery must be optimally effective and efficient to boost the health system toward a responsive system.

GOR's vision is that every Rwandan will consistently use health services that are easily accessible, meet international standards of care and directly responds to both perceived and actual needs of the individual.

#### 4.1.2. Main Challenges regarding the quality of Health Services

The existing health services packages required to be reviewed and updated to include the recent task shifting and the new intermediate provincial referral hospitals.

87% of district hospitals had below than 20% of operational policies, procedures & guidelines to guide service delivery as required for the accreditation process; even the few that exist are not harmonized, standardized and up to date.

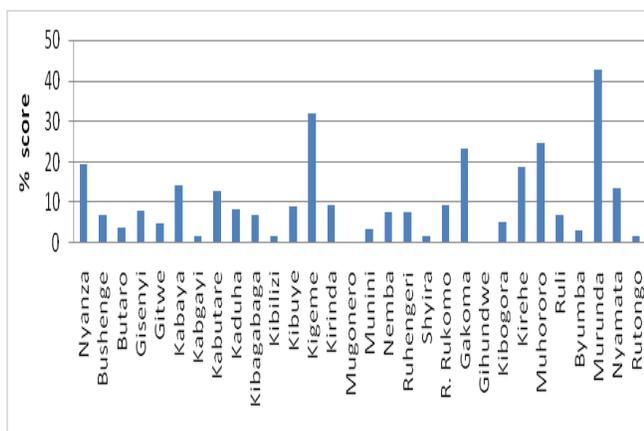


Figure 18: Existing policies and procedures, DH baseline assessment

Few clinical conditions had protocols and guidelines. For example: Malaria, HIV, TB, FP and MCH services.

Although there have been many different initiatives to improve quality, any comprehensive approach focusing on the holistic role and functions of the hospital at district level has been undertaken.

Other challenges were the low levels of institutionalizing Continuous Quality improvement, standard setting & monitoring.

There was also a need to establish a governing structure for quality improvement that is strong to ensure effective quality management leadership and support the implementation of quality management strategy and the accreditation process.

## **4.2. Main activities and results achieved**

### **4.2.1. Health services packages**

The IHSS project assisted the MoH in the review of its service packages at all levels: health centers, district hospitals, national referral, university teaching hospitals. The project also proposed a new service package for the intermediate referral level, ‘The five Provincial Referral Hospitals. Updated service packages will respond to the additional tasks given to health facilities at all levels.

The main objectives of reviewing the Rwandan service packages were to:

Promote and strengthen the health referral system;

Increase access to both primary and specialized health services for the Rwandan population;

Provide a standardized package of services at each level of health services;

Guide the upcoming accreditation process of district hospitals specifically the development of health care standards, operational policies, procedures and guidelines of district hospitals hence continuously improving the quality of service delivery;

Guide the MoH and public, private, and nongovernmental organizations and partners on how health facilities should be staffed and equipped with the basic required resources.

### **4.2.2. District hospitals operational accreditation policies and procedures**

The IHSS project provided support to the MoH to identify the district hospitals operational accreditation required policies and procedures, and the existing gap. A multidisciplinary team composed by district and referral hospitals, MoH staff and facilitated by the IHSSP drafted

Policy statements, procedures and guidelines (PPGs) required for accreditation in 27 services areas:

Management & Leadership, Human Resource Management, Administrative Support, Ambulance management, Finance Management, Housekeeping services, Laundry service, Ethics, Health and Safety, Quality management, Infection prevention and control, Food Services, Clinical crosscutting, DTC/ Pharmacy, Procurement, Physiotherapy and Surgery, Obstetrics and gynecology, Pediatric services, Internal Medicine, Critical care, Emergency Care & Resuscitation Services, Operating theatre & Anesthesia ... Pharmacy services, Physiotherapy & Imaging. (See annex 2)

The developed PPG's have been pre-tested in 40 district hospitals to check the applicability and seek input from hospitals teams to facilitate finalization and validation of the developed PPG's.

### **Institutional capacity**

In its bid to contribute to strengthening the institutional capacity at the central MoH level, the project recruited two support staff seconded to MoH as part of the Quality Improvement (QI) Team and continued to support the new QI Technical Working Group (TWG) to provide technical support.

The IHSS project also supported the MoH to initiate and establish accreditation support structures as quality management advisory committees at district hospitals to have the ability to support the progressive accreditation process. All committees have got their TORs and 23/40 district hospitals have appointed the required committees to support accreditation process:

Ethical committee

Quality Improvement committee

Health and safety committee

Infection Prevention and Control committee

Resuscitation Committee

Disciplinary Committee

Recruitment Committee

Policy and procedure Committee

IHSSP assisted the MOH, through the support of the international consultant, to design a DH accreditation roadmap.

### 4.2.3. Clinical Protocol/Treatment guidelines

The project assisted the MoH in the Review and Development of Clinical Protocol/Treatment guidelines. The development of Clinical Protocols/ Treatment guidelines is at its final stage. The treatment protocols were developed by Rwandan clinical specialists in workshops that were facilitated by both IHSSP and SPS teams. **The main objectives of these Clinical Protocols /Treatment guidelines are:**

To improve the quality of management of clinical conditions of high volume and high risk as part of QI package in the process of accreditation of health services.

To improve, encourage and standardize the rational use of drugs thus contributing to the realization of MoH quality management vision.

To provide guidance that will result in consistent and sufficient management of diseases/conditions.

To provide quality care by standardizing treatment, promote interventions of proven benefit, and discourage ineffective interventions.

To help ensure efficient use of resources, especially important in resource-constraint.

To enable standardized care and patient management for the same cases.

To harmonize the supply Chain System & to contribute to the Streamlining of referral systems.

To inform the next review of the essential drug list and drug formulary.

Drafts will be shared with relevant stakeholders and professional bodies to seek more input as part of the validation process.



*Figure 19:  
Development of  
clinical guidelines*

## 5. EFFECTIVE DECENTRALIZATION OF HEALTH AND SOCIAL SERVICES

### 5.1. Context and challenges

#### 5.1.1. Background

The MoH's main objective for decentralization is to strengthen health systems for better health outcomes by bringing quality, timely health services closer to the communities and building the capacity of district and sector health managers to provide those services. Since 2005, the MoH has undertaken many steps to actively decentralize. Most notably, hospitals and health centers are expected to draft and implement budgets, receiving funds directly from the Government and health facilities can make decisions about service provision and health priorities for their own catchment populations as long as they are in line with national health objectives and strategies.<sup>5</sup>

#### 5.1.2. Main Challenges of Health Decentralization

In Rwanda, the National Decentralization Policy document was developed in 2001 but the reference to the health sector with its technical specificities was limited in the policy document, raising then a need for the strategic plan for the decentralization including aspects related to the health sector. There was a need to develop a Health Sector Decentralization Strategic Plan to guide the effective decentralization process. Although the MoH was identified among the two most decentralized structures (MoH and MINEDUC) during the review of the past phases of decentralization, many administrative functions that should be decentralized were still performed at the central level.

There was a need to facilitate the decentralization process through staffing & Capacity building of Districts' managers, steering committees and CSOs (civil society organizations) in Management, health data management, planning, M&E and data use for health interventions at decentralized levels.

#### 5.1.3. Brief of progress

The MoH had planned to improve the capacity of districts, sectors, and CHWs to manage and implement decentralized health service delivery, focus on role clarification, team building, and involvement of civil society organizations (CSOs) and other stakeholders. The development of

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<sup>5</sup> Health Decentralization strategic plan (draft).

the strategic plan for decentralization was in progress and the capacity strengthening of decentralized health structures was started.

## **5.2. Main activities and results achieved**

### **5.2.1. Strategic Plan for Decentralization**

The project assisted the MoH in the design of terms of reference for elaboration of a National Strategic Plan for Decentralization of Health Services.

The IHSSP staff also assisted the MoH in developing TOR for consultant. Finally IHSSP recruited short-term technical assistance who drafted the Strategic Plan. The draft plan has been submitted to the MOH for review.

### **5.2.2. District Health Services Review**

The IHSS project assisted the MoH to conduct a needs assessment and scope of technical assistance for the district health steering committee in establishing coordination mechanisms for a new integrated supervision approach.

### **5.2.3. Districts' M&E Structure**

The project supported the MoH to develop terms of reference for the districts M&E Officer positions. The TORs were approved by both MoH and MINALOC and the recruitment completed.

## 6. OTHER ACTIVITIES COMPLETED

### 6.1. Support to the President's Malaria Initiative (PMI)

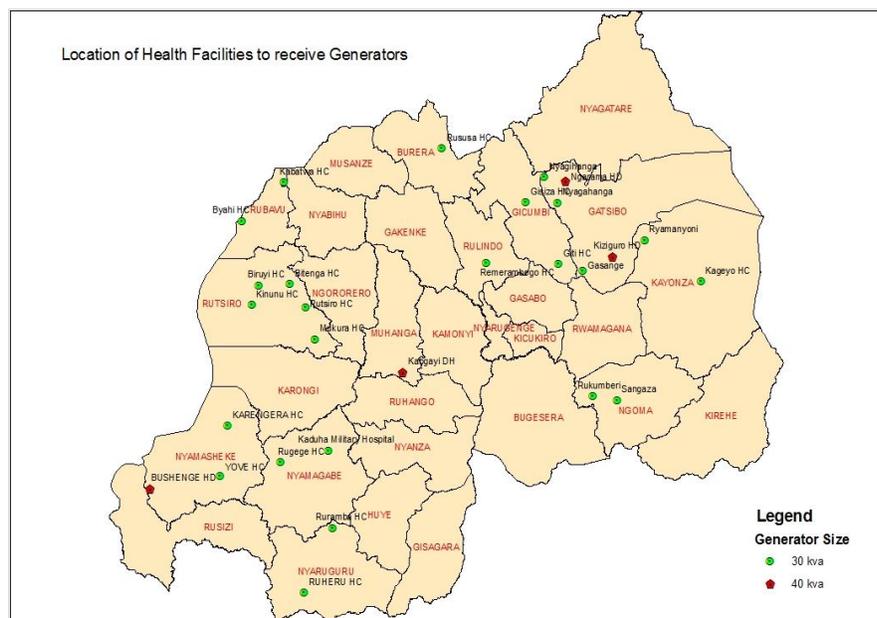
The project provided support to the President's Malaria Initiative through provision of access to additional data, support to routine analyses and continuous configuration of network with the new server (provided by the IHSSP). The project also worked with PNL P's M&E technical working group to help define their terms of reference and prepare an action plan. The IHSSP project also assisted the President's Malaria Initiative review and made presentation on e-Health in Rwanda for the visiting team from Washington. Program strengths and weaknesses have been discussed- focusing on the dashboard and enhanced access to malaria data.

### 6.2. Move of MOH servers and IT infrastructure

The IHSSP worked with the MOH ICD director and the help desk team to plan and implement the move of servers and IT infrastructure to the new MoH offices in Kicukiro.

### 6.3. Distribution of generators for health facilities

The project extracted data on electricity availability in health centers and district hospitals, arranged site visits and created "proforma invoices" for each site. The IHSSP held to prepare distribution plan for 33 generators for health facilities (see final map below).



*Figure 20. Map for Health Facilities to receive generators*

## CONCLUSION

The Government of Rwanda has set a health system strengthening framework coordinated by the Ministry of Health.

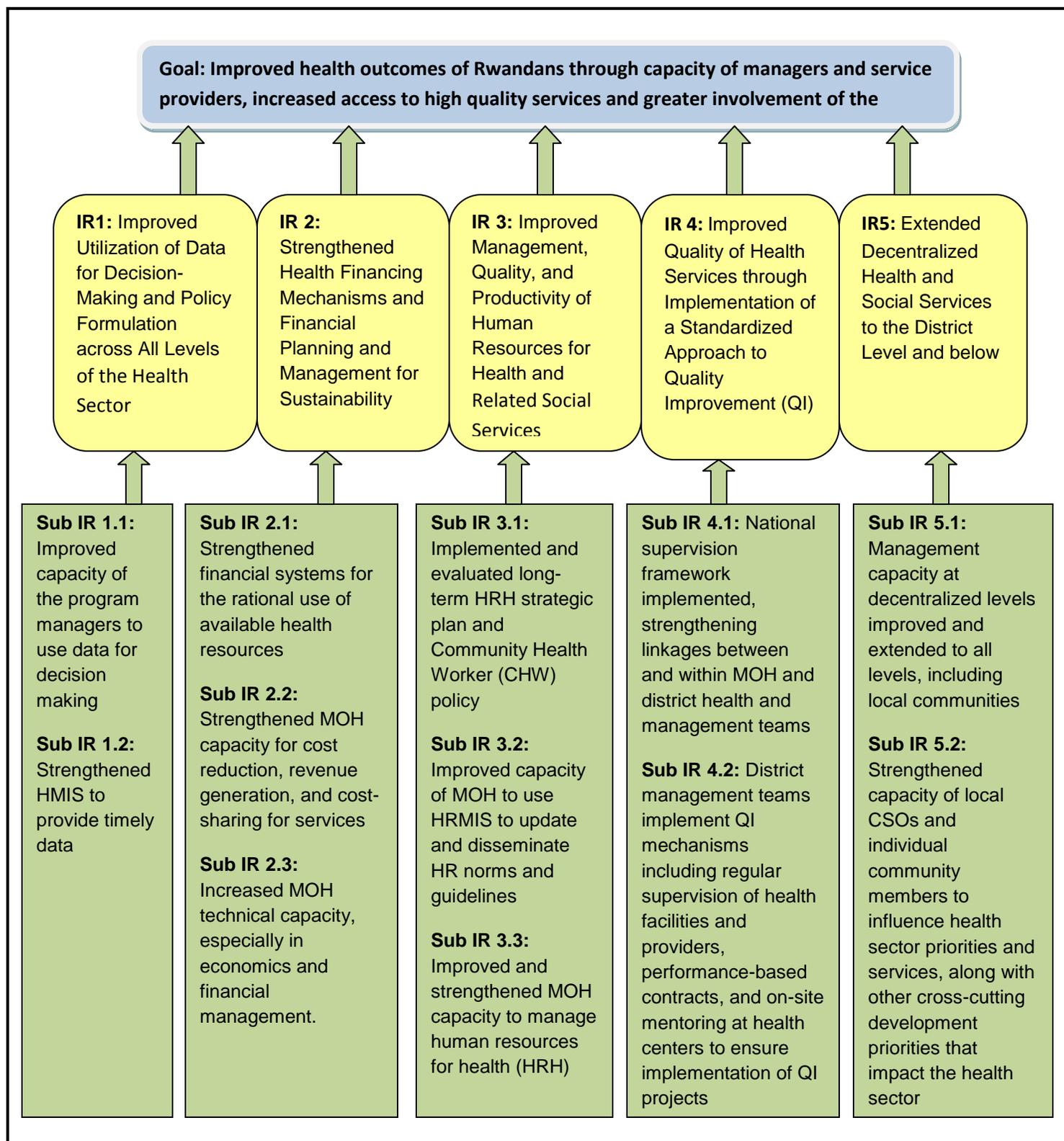
The Integrated Health System Strengthening Project assists the MoH through HMIS, health financial management, human resources for health, quality of health services and decentralization.

During the period of October 2010 to September 2011, the technical assistance of the project mainly focused on several aspects, as the upgrade of the HMIS indicators, dashboard and databases, the implementation of the new CBHI policy, the enhancement of the PBF systems mechanisms, and the health services costing analysis. Other realizations are the coordination of the HRH strategic orientation and the support to health professional associations, the assistance on districts health services accreditation standards development, the development of strategic plan for decentralization and establishment of districts M&E structure.

The project also provided technical support to the MOH regarding the President Malaria Initiative, IT infrastructure, and generators distribution to the health facilities.

The IHSS project will continue, through dialogue, collaboration and consensus with the MoH, to provide support to the Rwandan Health System Strengthening, to build a strong health system appropriately owned and mastered by Rwandans themselves.

*Annex 1. IHSS Project Results Framework*



**Annex 2: Policy, procedures and guidelines review**

District Hospitals Accreditation required policies, procedures and guidelines ( <i>Phase one</i> )	
Service areas	Required policies, procedures and guidelines
MGT& Leadership	Conduct of internal audit function
	Internal audit/Reporting of departmental audits
	Policies and procedures testing
	Legal opinion
	Phone usage
	Contract management
	Communication channels
	Hospital signage
	Use of notice boards in the hospital
	Patients' rights
	Disaster preparedness plan
	Mandatory administrative documents (Strategic plan, Action plan, Procurement plan, etc.)
	Collaboration between DH and central level
	Collaboration with NGOs
Human Resource Mgt	Staff orientation
	Sick leave management
	Dressing Code Uniforms and staff badges
	Ensuring current registration with professional bodies
	Disciplinary procedure
	Grievance and Dispute procedure
	Appeal
	Ensuring feedback report after course/seminars and workshops attended by hospital staffs
	Applying for attendance of seminars, workshops and short courses
	Applying for post graduate course
	Personnel files mgt
	Performance evaluation
	Internship management
	Recruitment
Dismissal	
Promotion	
Payroll	
Safeguarding of information in the medical record	
Admin Support	Records which are kept separately from the main record
	Release of medical records
	Destruction of medical records
	Visiting hours
	Protection of patients and staff from threats of violence

	Police enquiries
	Release of information to the media
	Provisional identification of unknown patients
	Requisitioning of goods and services
	Issuing of a buying order/contract
	Receiving of goods/supplies
	Handling of goods received
	Documents required from the supplier/vendor
	Custody of face-value documents
	Removal of fire arm from visitors
	Failure of the Telephone system
	Care and Management of social cases and indigents
	Fixed assets acquisition
Facility mgt& maintenance	Fixed assets movement/transfer
	Fixed assets loss/damages
	Disposal of redundant/obsolete assets
	Medical equipment safety and management
	Use of patient owned medical equipment
	Availability of operator and service manuals for medical equipment
	Condemning and decommissioning of medical equipment
	Medical equipment maintenance management program
	Acquisition of medical equipment
	Deployment of medical equipment
	Testing of devices brought in for demonstration or trial evaluation
	Training for safe & correct usage of medical equipment
	Cleaning and decontamination of medical equipment
	Biomedical engineering job requests system
	Maintenance of buildings
Number of ambulances	
Ambulance management	Status and maintenance of ambulances
	Allocation
	Triage of emergencies cases
	Time of call by health center
	Arrival of the ambulance transporting a patient
Billing and Invoicing	
Finance	Accounts payable
	Petty cash management
	Management of cheque payments/Payment orders
	Budgeting and Approval of budgets
	Financial operating procedures
	Collection and Distribution of hospital statistics
	Resource centre access and management
	Guarantee, security, integrity and validity of data
	Information plan development and implementation
	Usage of statistics by management
	Communication system management and usage
Confidentiality and Access to data and information	
Appropriate cleaning methods and materials for various surfaces	
Housekeeping	Safe storage of cleaning materials
	Hygienic storage of mops and brooms

services	Cleaning at times which are least disruptive to the service
	Use of chemicals to the cleaning
	Supervision of cleaning staff
	Handling of infected linen
	Loading of washing machines
Laundry service	Loading of dryer machines
	Laundry service/Finishing process and folding of clean linen
	Classification of work for processing
	Separation of staff who work in the clean and soiled areas
	Making of linen to identify ownership
	Use of chemicals in laundry
	Joint clinical services/ Delivery of clean linen from laundry to all wards
	Joint clinical services/ Availability of clean linen in case of emergency
	Limits to washing of patients' and staff's clothing
	Washing temperatures
	Searching used linen for sharps
	Registration of patients
	Ethics
Patients discharge	
Dealing with ethics-related problems	
Informed consent	
Dealing with patient's personal possessions	
Protection of personal possessions for patients in special circumstances	
Overcoming barriers to care	
Respect for cultural and religious needs of patients	
Patient and family health education	
Negative incident reporting	
Health and Safety	Incident investigation
	Reporting of accidents/injuries while on duty
	No smoking of tobacco products on hospital premises
	Manual handling(lifting of loads)
	Storage and labeling of flammable materials
	Storage of hazardous materials and dangerous goods
	Purchase of hazardous materials and dangerous goods
	Disposal of hazardous materials and dangerous goods
	Taking alcohol of patients and staffs and having alcohol in the hospital premises
	Drug or medication outside DR's description
	Radio and other noise making devices in hospital settings
	Use of Fire extinguishers
	Monitoring Data on incidents, injuries and other events that support planning and further risks reduction
	Handling storage and disposal of clinical and other waste
	Monitoring quality indicators
Quality Management	Documentation audits

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