

Quarterly Project Report

Rwanda IHSSP

January 2012 – March 2012

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Rwanda Integrated Health Systems Strengthening Project

Quarterly Project Report - Narrative

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ACRONYMS

CAAC	Cellule d'Appui a l'Approche Contractuelle (Performance-Based Financing Department of the Rwandan Ministry of Health)
CBHI	Community Based Health Insurance (Mutuelle)
CHWs	Community Health Workers
C-IMCI	Community Integrated Management of Child Illness
COAG	United States Centers for Disease Control and Prevention Cooperative Agreement
CTAMS	Cellule Technique d'Appui aux Mutuelles de Sante (Mutuelle Technical Support Cell)
CTB/BTC	Cooperation Technique Belge (Belgium Technical Cooperation)
CPD	Continuous Professional Development
DHIS	District Health Information System
FP	Family Planning
GOR	Government of Rwanda
HF	Health Facility
HIS	Health Information System
HISP	Health Information Systems Program (NGO)
HMIS	Health Management Information System
HPPP	Health Public Private Partnership
HR	Human Resources
HRH	Human Resources for Health
HSS	Health System Strengthening
iHRIS	Human Resources Information System
IMCI	Integrated Management of Child Illness
JCI	Junior Chamber International (NGO)
JEMBI	Jembi Health Systems (A South Africa based NGO)
MCH	Maternal & Child Health
M&E	Monitoring & Evaluation
MIS	Management Information System
MOH	Ministry of Health
NICD	National Income Categorization Database / Ubudehe database
NCNM	National Council of Nurses and Midwives
PBF	Performance-based Financing
PPG	Policy, Procedures and Guidelines
QI	Quality Improvement
RBC	Rwanda Biomedical Center
RFP	Request for Proposals
RHEA	Rwanda Health Enterprise Architecture
SIS Com	Community Health Information System
TWG	Technical Working Group
USAID	United States Agency for International Development
USG	United States Government

INTRODUCTION

Based on the priority gaps in the Rwandan Health System and launched in November 2009, the USAID-funded Integrated Health Systems Strengthening Project is a 5-year project which seeks to improve financial and geographical accessibility for all Rwandans to quality health services that are sustainable and efficiently managed by well trained health sector staff with clear functional responsibilities.

The project focuses on the following components contributing to this overall vision with the overriding result areas:

- Improved utilization of data for decision-making and policy formulation across all levels of the health sector.
- Strengthened health financing mechanisms and financial planning and management for sustainability.
- Improved management, quality and productivity of human resources for health and related social services.
- Improved quality of health services through implementation of a standardized approach to quality improvement.

The main expected results are:

- Improved capacity of program managers to use data for decision making.
- Strengthened financial systems for the rational use of available resources.
- Implemented long-term human resources for health strategic plan and community health worker policy.
- National supervision framework and quality improvement mechanisms implemented.

The present report describes the activities and main achievements realized during the reporting quarter (January to March 2012).

EXECUTIVE SUMMARY

Last quarter, main realizations of the **Health Management Information System component** included:

- **Upgrade of the PBF and CBHI web applications**

To adjust with the new CBHI policy, the PBF and CBHI web applications have been upgraded, and their interoperability with other systems expanded. The CBHI M&E user manual (version 3) has been finalized, and the first version of the CBHI membership database manual is in progress.

- **Upgrade of the HMIS**

Monthly report forms for health facilities have been updated and the family planning and integrated management of child illness (IMCI) registers and user guidelines have been revised. The district health information system-2 (DHIS-2) has also been upgraded, and the Health Sector Data Sharing Policy developed.

- **Support to the Rwanda Health Enterprise Architecture (RHEA)**

To establish the RHEA, the design of an electronic registry system for health facilities has been initiated.

- **Support to President Malaria Initiative (PMI) systems design and M&E**

A draft concept paper for the development of a cell phone-based active surveillance system for malaria is under development.

- **Support to the human resources for health information system (iHRIS)**

The iHRIS is in continuous upgrade, and HR records in the system have increased.

- **Support to the health professional council registration system**

Functional specifications have been revised; and the nursing and midwives registration database and website are under development.

- **Support to the Ministry of Health to manage the national income categorization database**

A request for proposal for the development of a cell phone-based CBHI membership module has been submitted to the Ministry's e-Health Unit and Procurement office for action.

- **Training of data managers to the use of DHIS-2 and the new HMIS reporting tools**

DHIS-2 implementers' workshops have been organized to provide trainings to data managers, M&E, and Community Health Information System supervisors from administrative districts and DHs.

- **Support for health sector strategic planning**

The M&E framework for HSSP III has been designed.

The **Health Financing unit**:

- **Supported the development and implementation of the CBHI**

The English version of the CBHI procedures manual has been produced and submitted to the MOH for approval. SOPs for the CBHI data audit manual have been elaborated; and a revised French version of the manual produced.

- **Carried out CBHI studies and system analysis**

Studies on Community Based Health Insurance in Rwanda have been initiated, with Rockefeller Foundation funding. The first draft of protocol has been produced, and analysis of CBHI data supported.

- **Assisted the MOH for the PBF program roll out and data analysis**

The SIS Com data analysis report has been produced, and the development of the Ndera hospital Performance Evaluation tool is in progress.

- **Helped district hospitals for the institutionalization of the costing exercise for health services**

Costing exercise is being conducted and costing reports from 3 districts (Musanze, Nemba, and Ngarama) have been produced.

Human Resources for Health (HRH) component's activities were focused on:

- **Assistance to the Ministry of Health to revise the HRH policy to address the current HRH needs**

The HRH policy was finalized and validated by the HRH TWG.

- **Support to the MOH to manage HR development through continuous professional development (CPD)**

The draft of M&E plan for CPD was finalized and shared with the CPD steering committee. It is pending for inputs and/or approval by the CPD steering committee.

- **Health professional licensing process**

The development of a database to manage registration, certification and licensing of nurses and midwives is in final stage. A printer was provided, and over 300 nurses received their certificates.

Main activities of the **Quality Improvement component** include:

- **Review and development of health service packages**

Surgical services packages were reviewed and validated by the TWG.

- **Development of clinical protocols and guidelines**

The draft of protocols and treatment guidelines was finalized and shared with professional societies for final input.

- **Development of district hospital policies and procedures**

Inputs from DHs were incorporated in the drafts; next step will be the formatting and presentation to the health systems strengthening (HSS) TWG and validation.

- **Review and harmonization of the patient file**

The patient file was reviewed and is being shared with all users for final inputs before validation.

I. IMPROVED UTILIZATION OF DATA FOR DECISION MAKING AND POLICY FORMULATION

1. Upgrade of the PBF and CBHI web-based applications

Last quarter, the servers for the PBF and CBHI web-based applications were upgraded and moved to the Ministry of Health’s data center.

To adjust with the new CBHI policy, a new tariff assignment module has been added to PBF, together with a new scoring method module for TB. Interoperability with other systems has been expanded, and the CBHI membership web application is now interacting with the national income categorization (Ubudehe) database.

The CBHI M&E user manual (version 3) has been updated, and the CBHI membership manual (version 1) is in progress.

2. Upgrade of the health and management information system (HMIS)

The Integrated Health Systems Strengthening Project is committed to assist the Ministry of Health with the enhancement of its HMIS. One of the main objectives has been to introduce the DHIS-2 software platform. In addition to serving as the new platform for on-line data entry, it has enabled the Ministry to create a national data warehouse and dashboard for data sharing across the health sector.

To provide harmonized and well documented recording and reporting formats, the HMIS monthly reporting forms have been updated, based on new inputs from health program staff and data managers during their training. Version 1.5 is now published; and forms are available on the MOH web site for referral and district hospitals, health centers, private clinics and dispensaries. IHSSP staff also assisted the MCH department to revise and prepare user documentation for the integrated management of child illness (IMCI) and family planning registers.

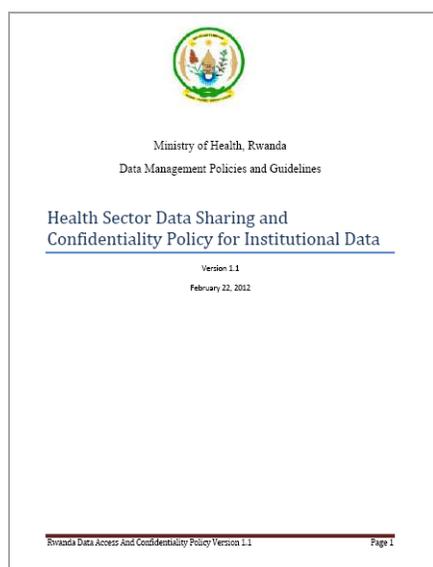


Figure 1: Health Sector Data sharing and Confidentiality policy for institutional data

To enhance the HMIS instance of DHIS-2, and to establish a more flexible web-based platform for HMIS data management, new security has been added, automatic backups have been scheduled and a synchronization tool to keep different DHIS-2 instances updated is being implemented.

The Ministry’s HMIS staff has been trained in DHIS system administration tasks.

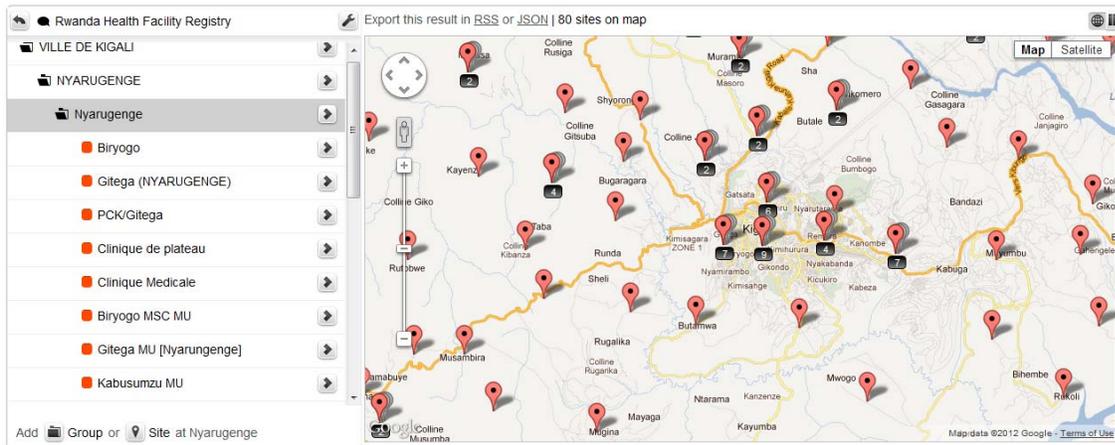
To enable better access to these tools, the project helped the eHealth team to finalize the health sector data sharing policy. This policy centralizes requests for data access within the HMIS department – for all health related information sub-systems - and defines procedures to request data access as well as the responsibilities of data users.

3. Support to the Rwanda Health Enterprise Architecture (RHEA)

The IHSS project assists the Ministry of Health with the design and implementation of the RHEA framework and its components. The objective is to put in place a health enterprise architecture framework to enhance health systems integration and interoperability.

Last quarter, the project assisted the MOH’s e-Health Unit and the team from JEMBI South Africa with the design and implementation of the health facility registry, and worked on tools to integrate the PBF system with the registry. The project’s team also participated in the RHEA conference from March 26-29, assisting with the design of other registries and discussions about infrastructure and support requirement.

Figure 2: Screen shot from Rwanda Health Facility Registry



Requirements for a Community Health Worker registry have also been defined and are likely to be integrated with the RapidSMS platform.

4. Support for PMI systems design and M&E

The IHSSP team has been providing continuing technical assistance to the Malaria Unit of the RBC to enhance their M&E system. A concept paper for the implementation of an active surveillance system for case-based reporting of malaria in low prevalence areas has been developed. The Malaria Unit staff has also been included in the data collection and use training for the new DHIS-2 platform (see point 8).

5. Support to the human resources for health information system (iHRHIS)

In collaboration with the Ministry and IntraHealth, the IHSS project supports the operationalization of the iHRIS (developed and initially introduced by the Capacity Project).

Last quarter, number of employee records increased in the system: from 15735 to 16465. New data elements, like posts and new departments, were added to reflect the changing structure and manpower needs of hospitals and Ministry-related institutions. The system is in continuous update (current version: Beta version).

6. Health professional council registration system

IHSSP is working with the health professional councils to set up an electronic registration system and to build a new database.

Last quarter, functional specifications for the registration system were redefined to respond to changes requested from the National Council of Nurses and Midwives (NCNM). The NCNM registration database and website development are in progress.

7. Support to the Ministry of Health to manage the national income categorization (Ubudehe) database

The national income categorization (Ubudehe) database contains over 9 million records classifying all households according to the Ministry of Local Government's income categorization scheme. These data are used in CBHI membership management process and other various Government programs.

During the reporting period, IHSSP used this database to conduct various data analyses at the request of the MOH, and finalized a request for proposals for the development of a mobile phone-based module for CBHI membership maintenance which will also enable Ubudehe authorities to update civil registration data (births, deaths and household moves).

Figure 3: Cell phone interface for the CBHI module to be developed.

CBHI Membership Management
1 Check membership status
2 Register membership payment
3 Register passive membership
0 Exit
Enter option above

8. Training of data managers in the use of DHIS-2 and the new HMIS reporting tools

The introduction of the new reporting forms and the new software to support routine health-related data reporting required an intensive capacity building program for the intended users: Data managers, M&E officers IT officers and SISCom supervisors from public health facilities. More sessions will be organized with funding from BTC's urban health program for staff from private clinics as the MOH is trying to bring them on board to collect comprehensive national wide data.

As a result of the training offered so far (beginning in November 2011), data managers from health centers, district and referral hospitals have been trained countrywide. All end users have access rights and virtually all have managed to enter data for the first quarter of 2012 into the system.

Reported data can now be accessed and used at any level of the health system any time and everywhere worldwide – assuming that users have requested and received authorization from the HMIS department.

Apart from the initial Training of Trainer sessions last November and December, and technical assistance from the IHSSP HMIS advisor and HMIS specialist the remaining training activities were funded by the United States Centers for Disease Control Prevention Cooperative Agreement and the Global Fund.

Table 1: Summary of DHIS-2 Implementers Workshops' Participants

(DM: Data Manager, IT: IT officer, SIS Com: CHW supervisors, Others: Statistician, etc)

Period	Training location	Facilities	Participants				
			DM	M&E	IT	Sis Com	Others
28/11-02/12/11	Kayonza	Kirehe & Kiziguro DHs	22	3	2	1	0
	Rwamagana	Nyagatare& Ngarama DHs	31	2	1	1	1
	Gicumbi	Rutongo& Byumba DHs	41	3	2	1	0
19-23/12/11	Nyandungu	Kibagabaga,Muhima &Masaka DHs	39	5	3	2	1
23-27 Jan 12	Musanze	Butaro,Ruli,Nemba,Shyira & Ruhengeli DHs	69	6	2	2	0
30/1-03/02/12	Muhanga	Kabgayi,Remera Rukoma,Muhororo,& Gitwe GHs	50	7	2	2	0
06-10/02/12	Huye	Kabutare&Gakoma DHs	26	3	1	1	0
	Karongi	Murunda,Mugonero & Kibuye DHs	34	3	2	0	0
20-24/02/12	Kayonza	Rwamagana&Gahini DHs	34	4	2	2	0
	Rwamagana	Nyamata DH	16	2	1	0	1
	Ngoma	Kibungo& Rwinkwavu DHs	23	4	2	0	0

Period	Training location	Facilities	Participants				
			DM	M&E	IT	Sis Com	Others
27/2-3/3/12	Huye	Nyanza&Kibilizi DHs	26	3	2	2	0
		Kigeme&Kaduha DHs	19	3	2	2	0
		Munini DH	17	1	1	1	0
05-09/03/12	Rubavu	Gisenyi&Kabaya DHs	16	4	2	2	0
	Rusizi	Kibogora&Gihundwe	23	5	2	2	1
		Bushenge&Mibirizi	18	2	2	2	0

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

1. Support to the development and implementation of the CBHI

Last quarter, IHSSP developed SOPs for the CBHI data audit manual. Those SOPs are prepared in the context of the introduction of the CBHI data audit manual and process which will describe and clarify procedures to be followed by CBHI structures in the objective of conducting regularly CBHI data audit. Verification of medical invoices is part of the manual, and the project supported a technical working session with experts from national health insurance companies (RAMA, MMI), CBHI actors from the Ministry, and some in charge of bills verification at the facilities level. The process was followed by the edition of the manual and final French document was produced, and will be submit to the Ministry for approval after its translation in English.

2. CBHI studies and system analysis

a) CBHI STUDIES

Over the last decade, many efforts have been undertaken to support the expansion of the CBHI nationwide. Today, CBHI in Rwanda is widely recognized as one of the most successful in Africa. Rwanda has expanded its health insurance coverage from less than 7% of the population

in 2003¹ to 78% coverage of the population in 2010, and the CBHI scheme is covering the majority of insured population (98%)².

There is a lot to learn from such rapid expansion, and more evidence is needed as to whether the Rwandan model can be a replicable strategy to improve access to health care in low and middle income countries. The introduction of the new policy also created a need of financial management capacity.

MSH obtained some Rockefeller Foundation funding to help the Ministry of Health to carry out 4 CBHI studies:

1. Conduct an in-depth analysis of the access and equity of CBHI system;
2. Develop and implement a financial model to assist the MOH and individual mutuelles to project their revenue and expenses;
3. Develop an in-depth “best practices” and “lessons learned” publication to guide the design and implementation of CBHI programs elsewhere.
4. Conduct research on the role of CBHI in the overall health system, in particular in relationship to PBF.

The project provides technical assistance for the whole process, and studies will be conducted with the School of Public Health and the MOH’s Health Financing Unit during the coming 18 months. Planned tasks are desk reviews, house hold surveys, and interviews with CBHI actors.

This quarter was mainly the preparation phase. The main tasks conducted were:

- Negotiations of the contract with the School of Public Health which still ongoing;
- Contacts and information sharing with MoH involved units (Health Financing and research units), other key partners involved in the CBHI activities.
- Development of the protocols for the studies, specifying studies’ objectives, the methodology for each objective and the timeline.

A first draft of protocol has been produced which includes detailed conceptual approach and study design. Identified and established research questions and methods for each of the three objectives are also part of the protocol.

¹ World Bank, Rwanda Country Status Report, 2009.

² Republic of Rwanda, Ministry of Health. Measure DHS. Rwanda Demographic and Health Survey. 2010

b) CBHI DATA ANALYSIS

Last quarter, IHSSP worked on a CBHI M&E data analysis. This analysis focused on all data provided from 2008 to September 2011. Some key findings are presented below:

i) For **the compliance on data reporting**, 83% of CBHI sections ever reported in the data base. The report completeness varied along regions. At the districts level, there are many disparities on reports completeness. The Southern Province has the lowest completeness rate.

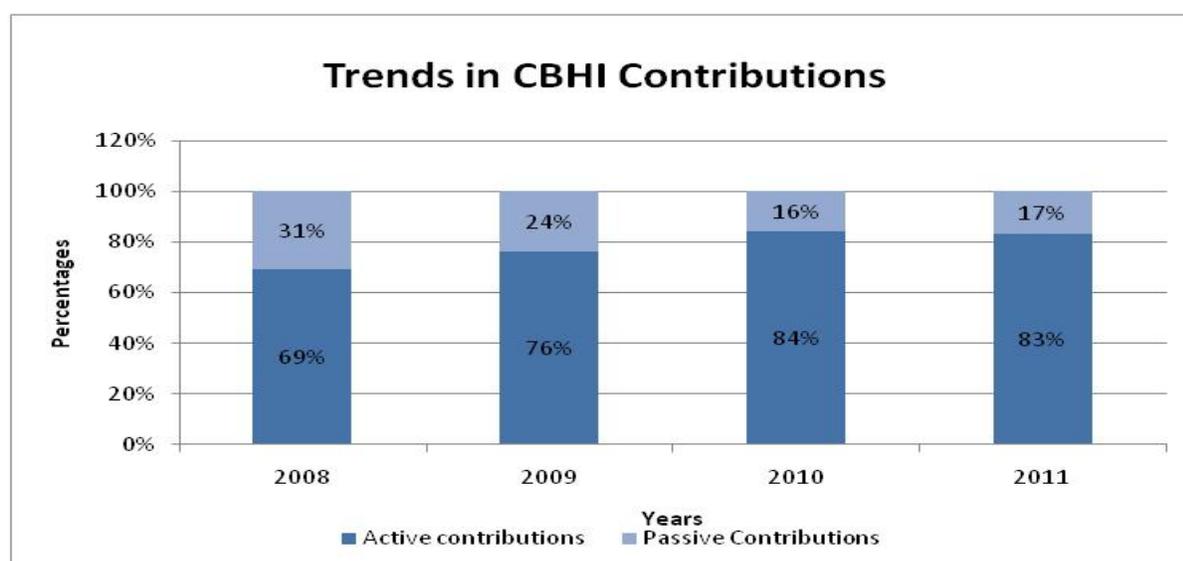
Table 2: CBHI completeness by province from 2008 to 2011

Province	# CBHI Sections	# CBHI Sections that reported	% CBHI Sections that reported
East	95	93	98%
North	81	79	98%
West	100	82	82%
South	99	55	56%
Kigali	27	23	85%
Tot	402	332	83%

ii) **Relevant findings on CBHI indicators:**

On average, each CBHI section spends around RWF 12 million per year to reimburse care provided to its members. An average total expenditure for a CBHI section, including its running cost, is about RWF 15 million per year. For the contributions, the trend in active CBHI contributions was increasing:

Figure 4: Proportions of CBHI active and passive contributions



Challenges: The CBHI data analysis shows that there are indicators reported with considerable errors, mainly the indicators of contributions (amount), and number of people / contributors. These errors should be eventually largely eliminated with the implementation of regular CBHI data audits.

Table 3: Highlights of erroneous extreme values in active contributions reported by CBHI sections

CBHI Section	Actives contributions (2008)	Actives contributions (2009)	Actives contributions (2010)	Actives contributions (2011)
Birembo		3,066,000	5,801,000	55,563,000
Gisenyi	42,505,000	29,257,500	31,244,138	57,625,900
Karenge	60,796,090	21,100,000	11,496,000	19,158,889
Nemba	874,272	20,707,000	40,220,198	54,793,300
Ngange			991,402,000	13,266,530
Nyagasambu	85,353,179	21,963,165	6,927,264	6,455,791
Nyamirama		4,696,000	157,000	110,006,500
Nyarubuye (Kirehe)		106,388,000	8,696,000	9,355,000
Rukomo	20,737,000	20,451,000	22,672,000	88,850,000
Rwamagana	28,688,410	101,920,742	17,419,500	22,874,000
Tabagwe	89,590,899	15,359,000	14,098,000	15,989,000

3. Performance-based financing program roll-out and data analysis

a) NDERA TERTIARY HOSPITAL PBF EVALUATION TOOL

IHSSP supported the Ndera Hospital in the elaboration of their performance assessment tool which will focus on mental health specialized services. The grid will provide quarterly services score. Clinical activities evaluation will be expanded including patients' observations and interviews. A list of indicators is included in the tool, and the management team is very committed to introduce this grid as part of their daily management. The tool is designed in Excel like for district hospitals. At this stage, the tool will be considered by the hospital for continuous performance evaluation, and not for funding. It could be also applied to assess individual staff performance.

b) COMMUNITY PBF DATA ANALYSIS

The IHSSP team worked in collaboration with the MOH's CHD to analyze the data from SIS Com, looking at the performance trends of selected maternal and child health indicators.

A meeting with a larger team of the maternal and child health desk to share results is planned in April. Monitoring the SIS Com data should inform the MOH with respect to the success of current strategies.

Reporting completeness

Important information generated from this exercise based on the 2010 and 2011 indicators reported by CHWs is presented below.

The following table displays the number of reports of the community health workers available per quarter, for 2011.

Table 4: Completeness of reporting by cooperatives in 2011

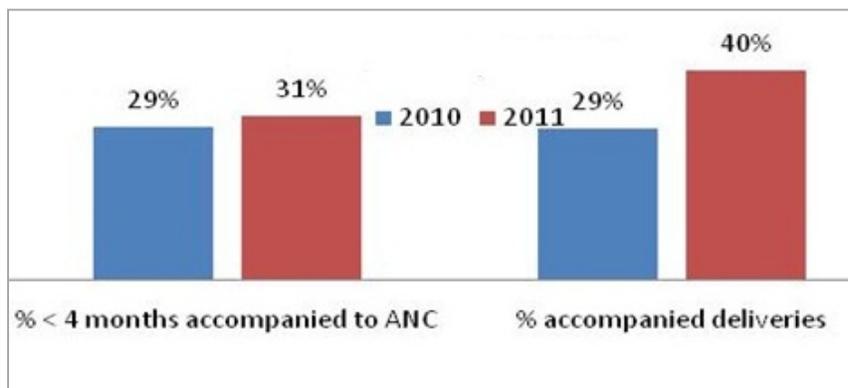
QUARTER	Reports received	Rapports expected	%
1	1337	1395	95.8
2	1342	1395	96.2
3	1363	1395	97.7
4	1362	1395	97.7
Total 2011	5404	5550	97%

The completeness rate in 2011 was in general highly favorable (97%).

Antenatal consultations and assisted deliveries (SIS Com data)

The figures below illustrate important increase in assisted deliveries, which passed from 29% in 2010 to 40% in 2011.

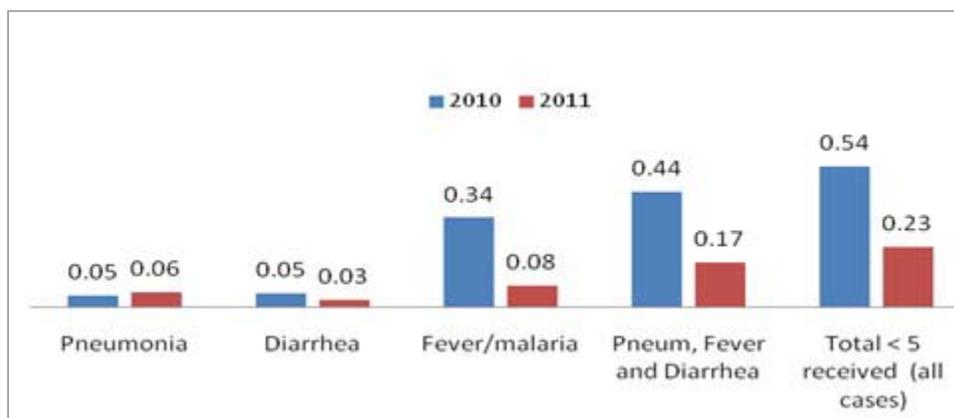
Figure 5: % of pregnant women accompanied for ANC and assisted deliveries



IMCI reported diseases (pneumonia, diarrhea and fever/malaria)

The following figure shows the per capita visits per year (managed by CHWs) for the under-5 population broken down by the 3 IMCI reported diseases (pneumonia, diarrhea and fever/malaria).

Figure 6: Per capita C-IMCI 2010-2011



Fever/malaria still remains the most important reason for consultation, followed by pneumonia and diarrhea. An overall decline of 57% of reported children received by CHWs was observed, except for pneumonia. For fever/malaria, the decline was 76%; followed by diarrhea, which declined of 40%. On the opposite, an increase of 20% was noted for pneumonia between 2010 and 2011.

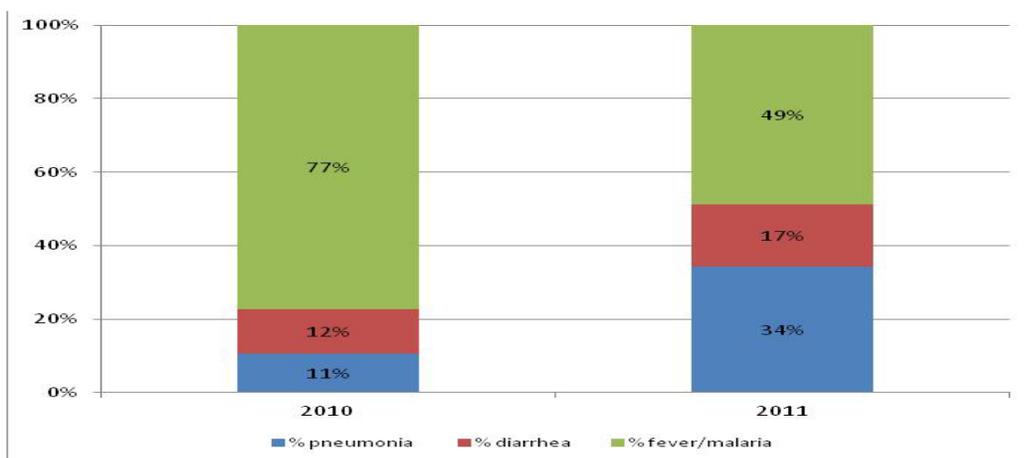
Several questions for this overall decline should be investigated. Three situations may explain that fact:

- 1) The decrease might due to the prevention activities, like mosquito nets and the use of the Rapid Diagnostic Test (RDT);
- 2) The changes in case definition, specifically for fever/malaria, may explain the decline in fever/malaria reported cases. Henceforth, registration is done only for cases confirmed by RDT. Cases not confirmed are automatically referred to the health facility.
- 3) Caretakers' behaviors changes should also be analyzed. The population could indeed search cares directly to health facilities rather than to consult CHWs.

CHWs were normally expected to report more cases than in 2010 due to good coverage of C-IMCI activities throughout the country (entire scaling up was done by the end of 2010).

As presented below, in 2011, fever/malaria was the main reason for consultation, with 49 %. Compared to 2010, a dramatic decrease in the fever/malaria proportion was observed, probably due to prevention strategies. This leads towards change in the disease profile, and pneumonia could become a major reason for consultation in the coming years.

Figure 7: Proportion of fever/malaria, pneumonia and diarrhea cases received by CHWs (Sis Com 2010-2011)



4. Institutionalization of health care costing

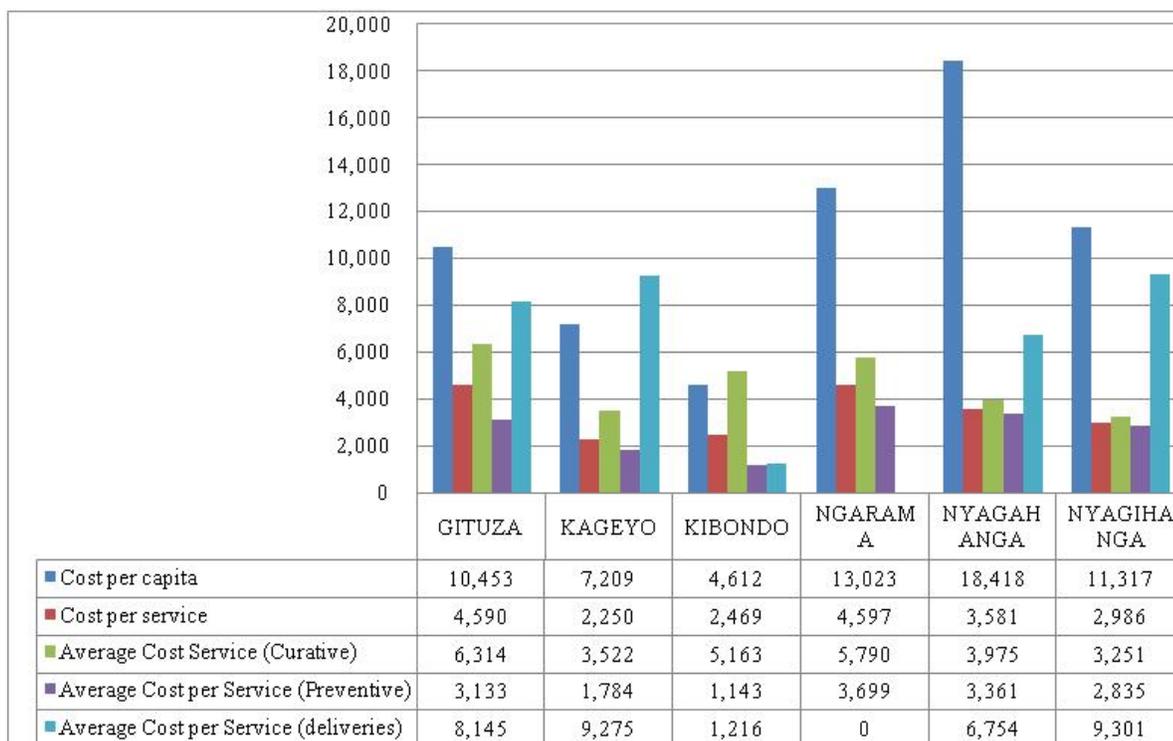
The objective of the institutionalization of the costing is to help the health facilities to determine the actual cost of services at the health center, the cost of a bed-day and outpatient visit at the hospital, and to ensure the ownership of the exercise, mainly for planning and budgeting.

DISTRICTS HEALTH FACILITIES RESULTS

Last quarter, the IHSS project provided support for an accurate data analysis of costing data collected to the health facilities.

The following figures show some results from one of the 5 districts participating in the costing exercise. It shows the comparison of the Ngarama health centers in terms of cost per service, cost per capita, and average costs of curative, preventive and deliveries.

Figure 8: Gatsibo district (Ngarama DH) health centers: Comparison of cost per service and cost per capita

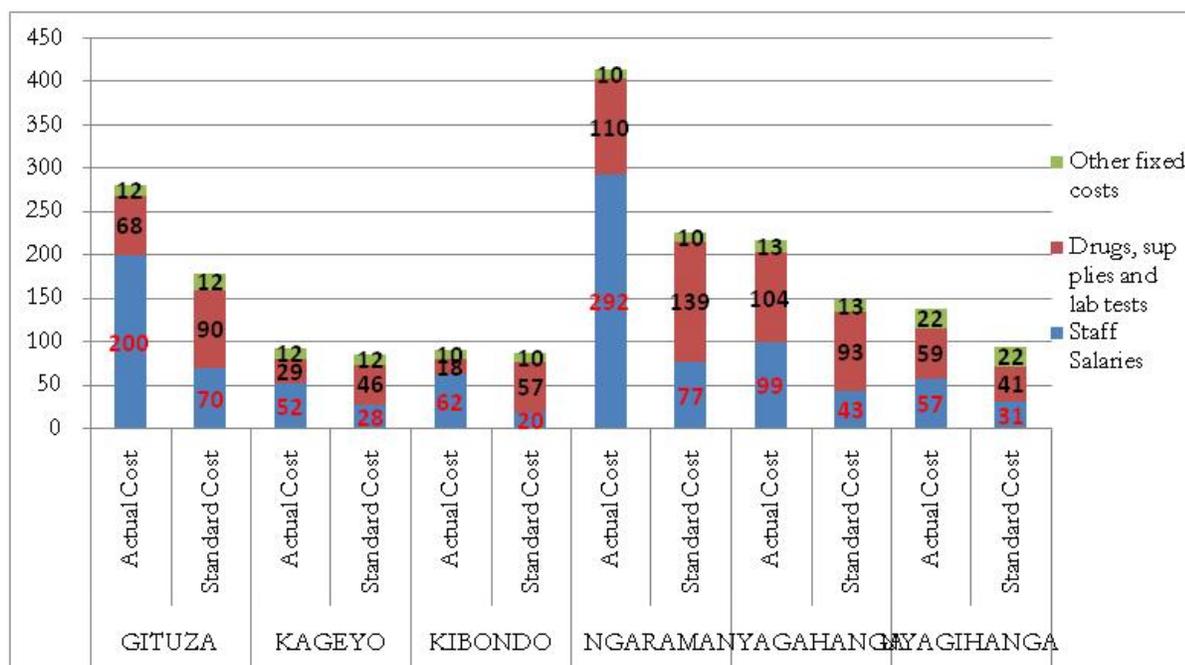


The preliminary results show that cost per service varies from RWF 2,250 in Kageyo to RWF 5,597 in Ngarama. There is also disparity in terms of cost per capita that varies from RWF 4,612 in Kibondo to RWF 18,418 in Nyagahanga. This is due to the catchment population covered by each health facility in the district. Nyagahanga provide health services to only 11,764 people

compared to those served by other health services in the district: Ngarama (31,704), Gituza (26,795), Kibondo (19,717) and Nyagihanga (12,147).

The costing exercise institutionalized at the district level was also used to provide a comparison of actual vs. standard costs for district health centers. The actual costs are determined by the real expenditures made by the health center in 2010 (scenario A), whereas the standard costs are calculated by multiplying the actual utilization figures for 2010 by the standard costs per service (Scenario B). The following figure shows a comparison between the actual and standard costs in the six Ngarama health centers, at the same actual level of utilization. Comparison of scenarios shows disparities between actual and ideal, or standard, situation.

Figure 9: Gatsibo district (Ngarama DH) health centers: comparison of actual and standard costs



For most of the six health centers, the actual amount spent on staff costs was higher than the amount predicted by the standard, suggesting the HCs are overstaffed. The largest difference between actual and standard staff costs was at Ngarama HC, where the model predicts an underutilization of the staff. This is because this health center is much closer to the hospital and most of its services (like deliveries) are referred to the hospital.

For drugs, the actual expenditure was lower than the standard cost at all the health centers: some donated drugs were not included because the health centers do not value them. In some cases, the

difference was large, the actual drug expenditure being at Gituza (68 million vs 90 millions), Kageyo (29 million vs 46 million), Kibondo (18 million vs 57 million) and Ngarama (110millions vs 139 millions).

Operating costs were equal in both scenarios, due to the fact that the actual costs were used as the standards.

Challenges

Although the selected district hospitals succeeded to conduct the costing exercise, the main challenge came from the data collection process, which took more time than any other step in the process. Indeed, most of the information about health services is recorded manually in book registers. There is a strong need for computerization and software for financial information management, especially in pharmacies and in different services to have exact information on allocation of costs.

Another major challenge concerns the availability of information on the real value of donated drugs used by health facilities, and salaries provided by donors.

Finally, as the costing process is a new exercise for hospital managers and staff, they have yet to use the results for hospital management - especially in planning and budgeting. With the costing information, hospitals can be made aware of the utilization of funds and the profitability of services.

III. STRENGTHENED LEADERSHIP AND MANAGEMENT AND IMPROVED HUMAN RESOURCE PRODUCTIVITY

1. Assistance to the Ministry of Health to revise the HRH policy to address the current HRH needs

The HRH policy addresses the current needs of HRH in the Ministry of Health. The update of HRH Policy document has been finalized and validated by the HRH-TWG. The MOH is reviewing the document in order to proceed to the cabinet for final approval.

2. Support the MOH capacity to manage HR development through continuous professional development (CPD)

The Ministry of Health seeks ensure the highest quality of medical care to the population of Rwanda through a variety of structured educational opportunities that incorporate the most current medical knowledge, skills, and ethical attitudes in all disciplines of medicine and dentistry with the support of the Rwanda Medical Council and other stakeholders.

During the quarter, the project continued to work with the CPD executive coordinator for the development of an M&E plan for CPD program through regular working sessions. The draft of M&E plan was finalized. CPD steering committee is reviewing the document for final approval.

3. Health professional licensing process

a) ASSISTANCE TO THE NATIONAL COUNCIL OF NURSES AND MIDWIFES (NCNM)FOR LICENSING

The registration process of nurses and midwives began in 2003. The objective was to ensure that all nurses and midwives practicing in the country were registered and authorized to work in Rwanda. Data registration was done on an Excel sheet. There was then a need for the National Nurses and Midwives Council (NNMC) to have an updated registration database to issue certificates and licensing identity.

During the reporting quarter, the project provided assistance to the NNMC in the development of a database to manage registration, certification and licensing of nurses and midwives. The development of the database is now at its final stage; and will undergo final tests in April 2012. The IHSSP also assisted the NNMC by providing a printer, and over 300 nurses received their certificates.

b) ASSITANCE TO THE PHARMACISTS AND ALLIED HEALTH PROFESSIONALS COUNCIL

In February, the ministerial order to register allied health professionals was published in official gazette and MOH appointed a staff in charge of that activity. The design of registration forms has been finalized. A detailed action plan and budget for the registration exercise have been elaborated.

Challenges

- ❖ The Ministry regularly changes the priorities which disrupts the project's plans.
- ❖ There is a shortage of staff at MOH to manage the tasks as urgently planned and prioritized.

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

1. Review and development of health service packages

The service packages of health care at national referral, university teaching, and district hospitals; health centers and health posts, specify the services that should be provided at each health facility level.

Last quarter, identification of Surgical and Obstetrics and Gynecology interventions to be done at each health facility level (health centers, district and provincial hospitals) was done with the Surgical and the Obstetrics & Gynecology societies. The aim was to guide referral of patients with conditions that require specialized skilled interventions and equipment. Similarly, the same list of interventions will guide allocation of resources at different facility levels, and will be part of health services packages.

2. Clinical protocols and treatment guidelines development

The primary objective of the treatment guidelines/clinical protocols development was to lead to accessible quality health care; and to improve and encourage the rational use of drugs.

Last quarter, the drafting of treatment guidelines / clinical protocols has been finalized, and drafts shared with professional societies to seek final input. The dermatology, ENT and Oral health teams have provided their inputs and incorporated them in the final document. Surgical, internal medicine, obstetrics & gynecology and ophthalmology inputs are still pending.

The identification of surgical, obstetrics and gynecology interventions to be done at each health facility level (health center, district, and provincial) was done with the surgical and the obstetrics & gynecology societies. The aim was to guide referral of patients with conditions that require

specialized skilled interventions and equipment. Similarly the same list of interventions will guide allocation of resources at different facility levels.

Challenges

In this process, the availability of health professionals in their societies has been a big challenge.

3. District hospital operational policies and procedures development

District hospital operational policies and procedures reflect the ideal performance of a health facility to provide quality care. Achieving compliance with these policies and procedures will assist in proactively putting the systems in place to avoid the most important risks to quality care. In the process to finalize DH operational policies and procedures, the QI team has incorporated inputs from district hospitals in the drafts.

4. Review and harmonization of patient file

The team which is reviewing the file reached a consensus of harmonizing the existing files to have same patient file across health facilities. Having the same patient file does not exclude the need for specialties having specific records for their patients. It was suggested that specific patient records in the process of care will be considered as additional to the mother file in different areas of specialty. The file is being shared with all users for final inputs, the next step will be to incorporate inputs accordingly and then proceed to validation.

V. CROSS-CUTTING TECHNICAL ASSISTANCE

1. Support for health sector strategic planning (HSSP III)

The MOH requested support of the HMIS advisor to participate on the core team of authors for the Health Sector Strategic Plan III (HSSP III. 2012 – 2017), focusing particularly on the Health Information building block and on the development of the M&E framework.

The objective was to assist with the preparation of the HSSP III and to gather baseline data for the HSSP III M&E framework from various data sources. The Health Information component log frame and narrative have been completed, the M&E framework for HSSP III designed, and an estimation of baseline values for all HSSP III indicators has been carried out.

IHSSP also provided a consultant to draft the following chapters of the HSSP III:

- Maternal and Child Health
- Disease Prevention and Control
- Health Promotion and Behavior Change
- Service Delivery Systems
- Governance and Sector Management

VI. ACTIVITIES SCHEDULED FOR THE NEXT QUARTER

Next quarter, the following activities have been scheduled: (See also annex 2)

The **HMIS component** will complete recommendations for strengthening M&E and HMIS coordination across all Ministry of Health institutions. The team will provide support for the development and integration of the mobile membership management module to the CBHI membership database, and provide training to the MOH's CBHI technical support Unit in the use of this new module. The HMIS team will also continue the development of the iHRIS, with support from Capacity Plus. Former GESIS data will be migrated to the new DHIS-2 platform; customization of data-entry system for new reporting formats in DHIS-2 platform will be completed; and a team to manage the MOH's web presence and to assure the availability of comprehensive and quality data will be established and trained. Newly designed reports, with inputs from the Musanze workshop, will be designed within the system; and documentation of existing HMIS recording and reporting instruments will be completed. The team will begin to work with the WHO on design of Rwanda country profile for Health Observatory, and support the Ministry's e-Health team with implementation of national Health Facility Registry.

The **Health Financing unit** will develop and implement a financial model to assist the MOH and individual CBHI sections to project their revenues and expenses; develop study questionnaires for the CBHI studies; and provide support for the CBHI extended team coordination mechanism. Other activities will include the design of PBF tool for the Ndera Hospital, the review and update of clinical PBF indicators, and the conduct data on the PBF, SIS Com and CBHI systems.

The **Human Resources for Health team** will assist the MOH on developing the HRH operational plans and an M&E plan for the HRH strategic plan. It will also assist the Rwanda Medical Council to build capacity of the CPD bureau; help the National Council of Nurses and Midwives in the licensing process; and assist the Pharmacists and Allied Health Professionals Association to establish a professional council, to begin a licensing process, and to develop their professional regulations.

The **Quality Improvement component** will finalize and format both service packages and operational procedures documents; conduct internal technical review of clinical protocols and guidelines related to surgery, obstetrics and gynecology, internal medicine, pediatric and ophthalmology. The status of provincial hospitals care will be assessed in relation to the accreditation program, and inputs will be incorporated to the Patient file, in a bid to finalize it.

ANNEXES

Annex 1: IHSSP Key Interventions (January- March 2012)

IHSSP INTERVENTIONS		PROGRESS / ACHIEVEMENTS
Improved data utilization for decision making and policy formulation		
Improvement of the mechanisms and structure for management and use of Health Information	Updating the HMIS monthly report forms	Version 1.5 available for RH, DH, HC, Private Clinics and Dispensaries.
	Health Facility registers	FP register, Client Card, Consultation form and user guidelines redesigned for integration into HMIS data collection manual. Tools approved by FP technical working group.
		IMCI registry and user guidelines for integration into HMIS data collection manual designed. Tools submitted to MCH team for approval.
	HMIS Policy documents, Guidelines & SOPs	Data sharing policy (Manual) developed.
		“e-Health/Health Information section and M&E Framework of HSSP III” developed.
Organizational structure for HMIS/e-health units	Rwanda Health Enterprise Architecture (RHEA): The design of Health Facility registry (electronic registry system) is under development. Discussions made for other registries and about hardware/infrastructure and support requirements for RHEA.	
Development of Databases and Web – Application for Information Management	CBHI Membership database	Data extraction from the database as requested by the MOH.
		CBHI Membership Manual (version 1) in progress. It will be completed after the

IHSSP INTERVENTIONS		PROGRESS / ACHIEVEMENTS
		specification of SOPs.
		RFP for development and maintenance of cell phone based CBHI membership maintenance module: Request for Proposals with software functional requirements submitted to e-Health unit and MOH Procurement office for action.
	CBHI M&E / Indicators database	CBHI M&E User Manual, version 3, finalized. To be approved by CTAMS.
	DHIS-2	System upgraded; trainings provided to data managers from HCs, DHs, and RHs. Reporting from end-users for January and February data initiated.
	HRH Information System (iHRIS)	Continued with support of HR records and system upgrade.
	Health Professional Council registration system	Functional specifications for health professional council registration revised. It will need integration with other councils and iHRIS. Nursing and Midwives registration database & website development in progress.
	Cell phone based active surveillance system for Malaria	Draft concept paper for the development of a cell phone-based active surveillance system for Malaria under development. There is still a need for further discussion with Malaria Unit staff.
Capacity building	DHIS2 implementers workshop	Training provided to Data Managers, M&E, SISCom Supervisors from administrative districts and DHs.
	DHIS-2 data demand and use workshop	Concept paper and Curriculum for “DHIS-2 data demand and use” workshop developed. Training to be organized in April 2012.
Strengthened Financial Systems for the Rational Use of available Health Resources		

IHSSP INTERVENTIONS		PROGRESS / ACHIEVEMENTS
Enhancement of Health insurance system reforms	SOPs and related tools developed for the new CBHI policy	CBHI procedures manual (English version) produced and submitted for approval.
		SOPs for CBHI data audit manual developed. Manual (revised French version) produced. English version to be translated before proceeding to the approval.
	CBHI Studies and Systems analysis carried out	First draft of Protocol for Studies on CBHI (Rockefeller funding) produced.
		CBHI Data Analysis carried out.
Performance Based Financing (PBF) Program roll out	PBF Studies and Systems analysis carried out	SIScom/Community PBF data analysis report produced.
		Development of the Ndera Performance Evaluation tool in progress.
Institutionalization of Costing Exercise for health services	Costing Exercise	Districts costing reports (Musanze, Nemba, Ngarama) produced.
Strengthened Leadership & Management and Improved HRH Productivity		
Streamlining the HRH policy framework	HRH Policy	Policy document finalized and validated by the HRH-TWG. Under review for approval by SMM/MOH, before further validations.
Licensing Process and Roll out of a Continuous Professional Program (CPD)	Operational plans for medical doctors –CPD Program	Draft of the M&E plan for medical CPD finalized, pending for inputs and approval
	Health Professional Licensing	National Nursing and Midwives' Council (NNMC): Development of a database to manage registration, certification and licensing of nurses and midwives in final stage. Printer provided to print out certificates; over 300 nurses received their certificates.
		Pharmacists and allied health professionals: Ministerial order for registering of allied health

IHSSP INTERVENTIONS		PROGRESS / ACHIEVEMENTS
		professionals published. Design of registration forms finalized. Action plan and budget developed for registration process.
QI for Results in Access to and Quality of Services through Standardized Approaches		
Accreditation Program	Health Service packages	Surgical Service packages reviewed and validated by TWG.
	Clinical protocols/treatment guidelines development	Draft of treatment guidelines/clinical protocol finalized and shared with professional societies for final input. Dermatology, ENT and Oral health teams' inputs incorporated. Surgical, internal medicine, Obstetrics & Gynecology and ophthalmology inputs still pending.
	DH operational policies and procedures	Inputs from DHs in the drafts of policies and procedures incorporated. Next step will be drafts formatting and presentation to the HSS-TWG and validation.
	Review and harmonization of the patient file	Patient file revised. Being shared with all users for final inputs before validation.

Annex 2: IHSSP- Activities scheduled for the next quarter (April- June 2012)

IHSSP INTERVENTIONS	PLANNED ACTIVITY/TASK	START TIME	END TIME	IHSSP INPUTS / RESOURCES	
Improved data utilization for decision making and policy formulation					
Improvement of Routine mechanisms for Health Information System	Organizational structure for HMIS/e-health units	Complete recommendations for strengthening M&E and HMIS coordination across all Ministry of Health institutions	Dec-11	Feb-12	TA-IHSSP Staff
		Establish and train a team to manage MOH web presence to assure the availability of comprehensive, quality data	Jun-12	Jun-12	Workshops Costs, TA-IHSSP Staff
		RHEA: Support e-Health team with implementation of National Health Facility Registry	Oct-11	May-12	TA-IHSSP Staff
		Begin work with WHO on design of Rwanda country profile for Health Observatory	May-12	Jun-12	TA-IHSSP Staff; (To be founded by WHO)
	Health Facility registers	Complete documentation of existing HMIS recording and reporting instruments.	Nov-11	May-12	TA-IHSSP Staff, Printing costs
Development & Operationalization of Databases and Web – Application for Information Management	CBHI Membership database	Select vendor for Mobile phone based membership system and complete development of phase I	Apr-12	May-12	TA-IHSSP Staff; (To be funded by Rockefeller)
		Develop and integrate mobile membership management module	May-12	Jul-12	Workshop costs
		ToT for central level CTAMS staff in use of new membership module	Jun-12	Aug-12	
	DHIS-2	Migrate former GESIS data to DHIS-2 platform	Mar-12	May-12	TA-IHSSP Staff
		Complete customization of data entry system for new reporting formats in DHIS-2 platform	Apr-12	Jun-12	TA-IHSSP Staff, Workshop costs, Consultancy costs (Future)
		Follow up on Musanze workshop to develop feedback reporting formats for new HMIS – implementing the newly designed report within the DHIS-2 framework.	Apr-12	Jun-12	TA-IHSSP Staff
	National data warehouse and web-based dashboard portal	Operationalize national data warehouse	Sep-11	Jun-12	TA-IHSSP Staff
HRH Information System (iHRIS)	Continue the development roadmap of iHRIS, negotiate with “Capacity Plus” to implement leave tracking and payroll connector.	May-12	Jun-12	TA-IHSSP Staff; (To be founded by “Capacity Plus”)	

IHSSP INTERVENTIONS		PLANNED ACTIVITY/TASK	START TIME	END TIME	IHSSP INPUTS / RESOURCES
Strengthened Financial Systems for the Rational Use of available Health Resources					
Enhancement of Health insurance system reforms	CBHI Studies and Systems analysis	Develop and implement a financial model to assist the MOH and individual CBHI to project their revenue and expenses	Apr-12	Jun-12	TA-IHSSP Staff
		Develop a study questionnaires (on the analysis of the access, equity and efficiency of CBHI system and applications for submission to scientific and ethic review committees	Apr-12	Jun-12	TA-IHSSP Staff
		Develop a study questionnaire for "Best-Practices" publication to guide the design and implementation of a CBHI program and applications for submission to scientific and ethic review committees	Feb-12	Apr-12	TA-IHSSP Staff
		Support the CBHI extended team coordination mechanism	Apr-12	Jun-12	TA-IHSSP Staff
	SOPs and related tools developed for new CBHI policy	Produce CBHI procedures manual	May-12	May-12	TA-IHSSP Staff
		Design CBHI data audit Manual	Apr-12	Jun-12	TA-IHSSP Staff
		Introduce and avail account software for CBHI sections	Apr-12	Jun-12	TA-IHSSP Staff
Performance Based Financing (PBF) Program roll out	SOPs and related tools developed for new CBHI policy	Design PBF tool for Ndera Hospital	Apr-12	May-12	TA-IHSSP Staff
	PBF Studies and Systems analysis	Review & update clinical PBF indicators	May-12	May-12	TA-IHSSP Staff, Workshop costs
		Conduct quarterly PBF, SIS Com & CBHI M&E indicators, data analysis and reporting	Jan-12	Mar-12	TA-IHSSP Staff
		Conduct PBF indicators counter verification	May-12	Jun-12	TA-IHSSP Staff
	PBF extended team coordination	Support the PBF extended team coordination mechanism	Apr-12	Jun-12	TA-IHSSP Staff, Workshop costs
Strengthened Leadership & Management and Improved HRH Productivity					
Streamlining the HRH policy framework	Operational plans for medical doctors	Assist the MOH to develop the HRH operational plans	Oct, 2011	April, 2012	TA-IHSSP Staff
		Assists the MOH to develop an M&E plan for the HRH Strategic Plan	Oct, 2011	April, 2012	TA-IHSSP Staff
Licensing Process and Roll out of a Continuous Professional	Rwanda Medical Council	Assist Rwanda Medical Council to build capacity of CPD bureau	Oct, 2011	Sept, 2012	TA-IHSSP Staff
	Rwanda Nursing and midwives council	Assist Rwanda Nursing and midwives council to finalize the licensing process	Oct, 2011	Jan, 2012	TA-IHSSP Staff

IHSSP INTERVENTIONS		PLANNED ACTIVITY/TASK	START TIME	END TIME	IHSSP INPUTS / RESOURCES	
Program (CPD)	Rwanda Pharmacists association and Rwanda Allied Health Professionals Association	Assist Rwanda Pharmacists association and Rwanda Allied Health Professionals Association to establish a professional council	Oct, 2011	Sept, 2012	TA-IHSSP Staff	
		Assist Rwanda Pharmacists Association and Rwanda Allied Health Professionals Association for licensing process			TA-IHSSP Staff	
		Assist Rwanda Pharmacists association and Rwanda Allied Health Professionals Association to develop their professional regulations	Oct, 11	April, 2012	TA-IHSSP Staff	
WISN methodology roll out	WISN methodology	Assist MOH to implement the WISN methodology	Oct, 2011	Sept, 2012	TA-IHSSP Staff	
QI for Results in Access to and Quality of Services through Standardized Approaches						
Accreditation Program	service package and operational procedures	Formatting of both service package and operational procedures documents	6 th April	18 th April	TA-IHSSP Staff, Printing costs	
	Clinical protocols/treatment guidelines development	Internal technical review of: <ul style="list-style-type: none"> • Surgical care • Obstetrics & Gynecology care • Internal Medicine care • Pediatric care • Ophthalmology 	15 th April	7 th May	TA-IHSSP Staff, Workshop costs	
	Situational Analysis and structure of accreditation program	Assess the status of provincial hospitals care in relation to the accreditation program	Assess the current licensing process and any other existing evaluation systems of health services	7 th May	30 th June	TA-IHSSP Staff, Consultancy costs (JCI)
		Propose structure of the Accreditation governing body: <ul style="list-style-type: none"> ✓ identifying key stakeholders, ✓ Determine composition of accreditation Board 				
harmonization of patient file		Incorporate of inputs to Patient file in a bid to finalize the file	15 th April	30 th April	TA-IHSSP Staff	

Rwanda Integrated Health Systems Strengthening Project (IHSSP)

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