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RWANDA

RWANDA INTEGRATED HEALTH SYSTEMS STRENGTHENING PROJECT:

Quarterly Project Report Narrative (April - June 2011)

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Table of Content

1. Executive Summary.....	5
2. Project Overview.....	6
3. Summary of progress made during the quarter.....	7
1. Result area 1: Improved utilization of data for decision making and policy formulation.....	7
Context and challenges:.....	7
Key achievements realized during the quarter.....	7
2. Result area 2: Strengthened financial systems for the rational use of available health resources.....	10
Context and challenges.....	10
Key achievements realized.....	11
PBF procedure manual development.....	16
3. Result area 3: Strengthened leadership and management and improved human resource productivity.....	16
Context and challenges.....	16
Key achievements realized.....	16
PERSPECTIVES FOR THE NEXT QUARTER.....	17
4. Result area 4: Quality improvement for results in access to and quality of services through standardized approach.....	18
Context and challenges.....	18
Key achievements realized.....	18
5. Result area 5: Effective decentralization of health and social services to improve access.....	19
Context and Challenges.....	19
Key achievements realized.....	19
Annex 1: Recommendations of the PBF system audits.....	21
Annex 2: Policy, procedures and guidelines review.....	23

ACRONYMS

AIDS/SIDA	Acquired Immunodeficiency Syndrome
BDD	Base de Données/Database
CA	Collaborating Agency
CAAC	Cellule d'Appui a l'Approche Contractuelle; performance-based financing Department of the Rwandan Ministry of Health
CBHI	Community Based Health Insurance (Mutuelle)
CDF	Community Development Fund
CHD	Community Health Desk (MOH)
CHW/ASC	Community Health Worker (Agent de Sante communautaire)
CTAMS	Cellule Technique d'Appui au Mutuelles de Sante; Mutuelle Technical Support Cell
CPD	Continuous Professional Development
CPN	Consultation Prenatale/Antenatal Consultation
DHIS	District Health Information System
DHS	Demographic and Health Survey
DH	District Hospital
DRG	Diagnosis Related Group
ET	Extended team
GOR	Government of Rwanda
HC	Health Center
HDP asdl	Health Development & Performance, a newly created Rwandan NGO from remnants of the Cordaid Rwanda team
HIV/VIH	Human Immunodeficiency Virus
H(M)IS	Health (Management) Information System
HR	Human Resources
HSS	Health Systems Strengthening
IHSSP	Integrated Health Systems Strengthening Project
ICT	Information, Communication and Technology
IT	Information Technology
JANS	Joint Assessment of National Strategy
LQAS	Lot Quality Assurance Sampling
M&E	Monitoring & Evaluation
MIS	Management Information System
MCH	Maternal and Child Health
MOH	Ministry of Health
MSH	Management Sciences for Health
MTR	Mid Term Review

NGO	Non-governmental Organization
PBF/PBC	Performance-based Financing/Performance-based Contracting
PEPFAR	President's Emergency Plan for AIDS Relief
PMA	Paquet Minimum des Activités; Rwandan basic package of health
PMTCT	Prevention of Mother-to-Child Transmission [of HIV]
PBP	Performance – based Financing
PRISM	Performance of Routine Information System Measurement tool
QA	Quality Assurance
RBF	Result-Based Financing
SIS	Système d'Information Sanitaire (Health Information System)
TA	Technical Assistance
TOT	Training of Trainers
TWG	Technical Working Group
USAID	United States Agency for International Development
USG	United States Government

1. Executive Summary

This report provides a snapshot of status of implementation of IHSS project for the period between April and June 2011.

In the area of HMIS, the IHSSP worked to establish an integrated roadmap for upgrade of HMIS and roll out of health indicator dashboard together with University of Oslo consultants.

The Project also worked with the MOH TB team to add denominators, modify the their routine data collection form, and create queries to calculate new indicators.

IHSSP staff provided support to MIGEPROF for costing of Integrated Child Protection Strategic plan. IHSSP staff also worked to incorporate the revised routinely collected indicators into the Health Center and the District Hospital monthly reporting formats. These will be the basis for the revised data entry screens to be developed in the DHIS-2 platform.

Building Capacity of data managers and M&E officers: IHSSP conducted 4 HMIS data use training sessions around the country with approximately 30 participants each time.

The PRISM (Performance of Routine Information Systems) assessment continued during the quarter: PRISM data analysis began with support from the IHSSP team and CDC's HMIS advisor. IHSSP HMIS Advisor helped to prepare the distribution plan for 33 generators for health facilities.

The main activities related to CBHI during the period from April 2011 to June 2011 are:

- The 2nd phase of Data entry for the UBUDEHE (Social Stratification) Data Base
- The social stratification data validation
- The CBHI Procedure Manuel
- The CBHI membership database design

The Costing of health services exercise continued during the quarter. A preliminary mini-report for the costs of health center services was produced before the availability of a full analysis report, comprising the results from health center, district hospital, and referral hospital level. The report describes the standard costs associated with the delivery of a particular health service, taking into account the staff time, drugs, medical supplies and tests required.

Clinical PBF counter evaluation and system Audit continued under the HDP sub contract. IHSSP supported the MoH/ PBF unit to conduct the PBF system audit and the community client survey.

IHSSP continued its involvement in the development of the PBF procedure manual document. This document will be the reference document for all PBF-related activities in Rwanda and will also be used during study tours and (inter)national trainings.

With regards to strengthening leadership, management and improved human resource productivity, during this quarter, the IHSSP/HRH team continued to support the MOH to operationalize the HRH strategic plan, to train the district hospital staff on the Workload Indicators for Staffing Need (WISN) and to support health professional bodies.

IHSSP/Quality Improvement team, in collaboration with the MoH and partners, DH continued the accreditation policy, procedure & guideline (PPG) review and development.

The multidisciplinary facilitated by MSH continued to work on existing quality gaps, facilitating drafting of operational policies, procedure & guidelines (PPG) required for accreditation process of district hospitals. In all more than 25 sets of PPG were developed (Finance Services, Pediatrics, Surgery Theatre, Housekeeping, Infection Control, etc).

Also in the area of Quality Improvement, the IHSSP assisted the MOH in its bid to strengthen health systems while scaling up efficient, effective and sustainable provision of health services, reviewed its service delivery packages at all levels: Health Centers, District Hospitals and National Referral and University Teaching Hospitals, and proposed the new service package for the intermediate referral level 'Provincial Referral Hospitals.

In Rwanda, the National Decentralization Policy document was developed in 2001 but reference to the health sector with its technical specificities is limited in this document. The IHSSP Decentralization team is therefore focusing on the development of a strategic plan for the decentralization including aspects related to the health sector. IHSSP is supporting the MOH in this activity with the help of an international consultant. First steps in this process that started in June is review of existing documents and a series of consultative meetings with different stakeholders.

The Decentralization team also worked in the development of training modules in a number of areas this quarter. The different Training of Trainers (ToT)-modules under development developed are: health data management and data use for decision making at district level; and community health programs management for DH staff in charge of supervision of CHWs

2. Project Overview.

The Government of Rwanda (GOR) has shown strong commitment to improving delivery of health services through strengthening its Health System. The National Health Sector Strategic Plan (HSSP-II, 2009-2012) provides a strategic framework and specific reforms that will guide the Ministry of Health and partners in achieving the Government of Rwanda's vision of improving the health status of the population.

In support of these efforts, the Integrated Health System Strengthening Project (IHSSP), a 5-year USAID-funded project, managed by Management Sciences for Health (MSH) has the goal of supporting the Ministry of Health to strengthen health systems at central and

decentralized structures. The project is tailor-made to achieve the 5 intermediate results areas:- 1) Improved utilization of data for decision-making and policy formulation; 2) Strengthened health financing mechanisms and financial planning and management for sustainability; 3) Strengthened leadership and management and improved human resource productivity; 4) Quality improvement for results in access to and quality of services through standardized approach; and 5) Effective decentralization of health and social services to improve access.. This program of support has the main objective of strengthening the MoH's capacity to provide high quality, client-oriented health and social services to all Rwandans in a sustainable manner.

3. Summary of progress made during the quarter

1. Result area 1: Improved utilization of data for decision making and policy formulation.

Context and challenges:

At present too many data are collected and reported from health facilities and by the community health workers and too few are used. Access to data is difficult, due to lack of a national data sharing mechanisms and limited web infrastructure. The HMIS subsystems need to be built to be fully operational and data managers at the MOH-central level, at the districts and at the health facilities are either new or being hired. There is a perceived lack of data quality, particularly from the HMIS, calling for improved systematic internal data audit procedures in different structures of data flows.

Key achievements realized during the quarter.

Key accomplishments during this quarter for the health information systems component were

- ✓ **Establishment of an integrated roadmap for upgrade of HMIS and roll out of health indicator dashboard:** Signed a sub-contract with HISP/University of Oslo to support this effort. Provided initial orientation to DHIS-2 for HMIS team, supported 2 week training of 3 DHIS-2 implementors in Dar es Salaam (1 participant paid by IHSSP, the others funded by Rockefeller). Worked with HISP and MOH staff to develop a joint workplan with the HISP and WHO teams for roll out of the Dashboard.
- ✓ **Revision of TB PBF system:** Worked with the TB team to add denominators, modify the data collection form, and create queries to calculate new indicator (% of facilities achieving 50% of target).
- ✓ **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 is being validated next week.
- ✓ **Development and introduction of pharmacist licensing database for PTF:** This is a registration system for all pharmacists and pharmacy technicians. It is similar to the

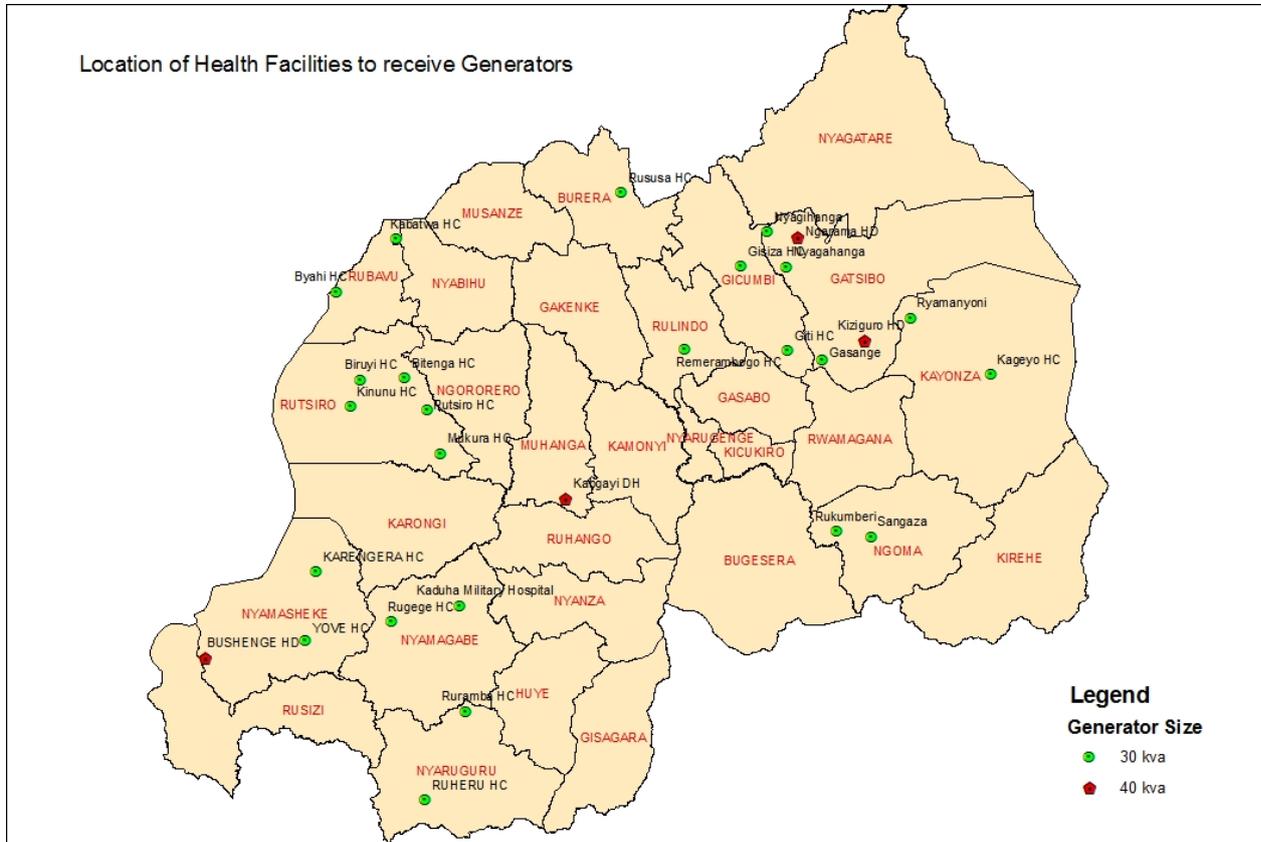
requirements of the Nursing and Medical councils, so the idea is to design a common platform that can be shared by all 3 organizations.

- ✓ **Draft of Revised Health Facility Monthly reporting formats:** IHSSP staff worked to incorporate the revised routinely collected indicators into the Health Center and the District Hospital. These will be the basis for the revised data entry screens to be developed in the DHIS-2 platform. This involved working individually with many of the Ministry departments, such as laboratory, blood bank, MCH. Morbidity (outpatient and inpatient) data were aligned with WHO's ICD-10 coding framework. Other major changes included reducing the number of age categories and eliminating data that are available from other reporting systems (TracNet, LMIS).
- ✓ **Capacity Building:** During this quarter this focused mostly on training in data use for data managers at central and district levels:
 - **Data managers and M&E officers:** Conducted 4 HMIS data use training sessions around the country with approximately 30 participants each time. The session content focused on:
 - To enhance the target audience's understanding of the HMIS and its key data sources
 - To develop their capacity to analyze and use data from these data sources for M&E and Planning
 - The first of the sessions was for the benefit of the expanded HMIS team and some close partners at the central level (MCH, CHD, Blood Bank, CNLS, and data management advisors from USAID's ACCESS project). The curriculum and training materials were then adapted for use at the remaining training sessions held for M&E officers and data managers from all district hospitals. Those sessions were held in Butare, Gisenyi and Rwamagana. The training curriculum is being adapted now as the basis for data use training for all health center level data managers.
 - These courses included formal participant evaluations that were very positive and suggest that we continue similar sessions on a regular basis. See scores below on a scale of 1 to 10 from the HMIS unit training session.

Evaluation scores for Training in Use of HMIS and DHIS data, Gisenyi, 18-21 April 2011					
Question	Evaluation criteria	Average	Min	Max	range
Q1	Training as a whole	8.4	7	10	3.0
Q2a	Overall Course Content:	8.8	8	10	2.0
Q2b	Quality of Instruction:	8.6	7	10	3.0
Q2c	Overall Level of Satisfaction:	8.8	7	10	3.0
Q3	Overall Achievement of objectives:	8.4	7	10	3.0
Q4.1	Session rating: Overview of HMIS and related sub-systems	8.9	7	10	3.0
Q4.2	Session rating: Analysis of HMIS and SISCom data with excel pivot tables and charts	9.0	7	10	3.0
Q4.3	Session rating: DevInfo	8.0	5	10	5.0
Q4.4	Session rating: RapidSMS	8.7	6	10	4.0
Q4.5	Session rating: Use of DHIS-2 National health data warehouse	8.7	5	10	5.0
Q4.6	Session rating: Next steps for HMIS in Rwanda	9.1	7	10	3.0
Q5a	Methods: Presentations and use of relevant examples	9.2	8	10	2.0
Q5b	Methods: In-class discussions during training	9.0	6	10	4.0
Q5c	Methods: Group activities/discussions/ working in groups	9.1	6	10	4.0
Q5d	Methods: Participant/Group Presentations	9.0	8	10	2.0
Q6	How would you rate amount of information presented during the training	Just right	83%	Too much	17%
Q9	Would you recommend a training of this kind to your colleagues	9.3	7	10	3.0
Q10	how were the facilities at the Training Center	8.4	5	10	5.0
Q11	How were the training administration/organizational logistics	8.9	7	10	3.0

- ✓
 - **TB supervisors:** two separate sessions were completed with TB program supervisors to train them in the use of the new web-based TB PBF module and how to monitor trends and prepare quarterly PBF payments using Excel pivot tables.
 - **MCH and Community Health Desk Data Managers:** a training plan was developed and the first ½ day training session was completed to show them how to extract data from the GESIS and Community Health Information System.
- ✓ **Support to multiple MOH units for quarterly PBF payments:** Assisted with the preparation of Q4 payments for TB, Community Health and Clinical PBF. Worked with the community health desk to create complex queries to determine the % of CHW cooperatives that attained 50% of their targets. This process remains complicated by the fact that PBF targets were overly ambitious and that resulting budget execution is low. The ministry wants to increase incentive payments to align spending with budgets.
- ✓ **PRISM (Performance of Routine Information Systems) assessment:** PRISM data analysis began with support from the IHSSP team and CDC's HMIS advisor. The initial report should be available for review during a data analysis round table next quarter and will form a baseline for evaluating progress towards the end of the project.
- ✓ **Assisted with MOH data center move to new premises in Kicukiro:** Worked with Daniel Murenzi, MOH ICD director, and the helpdesk team to plan and implement the move of servers and IT infrastructure to the new MOH offices in Kicukiro. The move of the web and email servers has been delayed because of difficulties moving the RDB fiber optic cable to the new site, but other servers and network infrastructure are in place.
- ✓ **Supported PMI review by staff from Washington:** Discussed program strengths and weaknesses and made a presentation on eHealth in Rwanda for the visiting team – focusing on the dashboard and enhanced access to malaria data.

- ✓ **Helped prepare distribution plan for 33 generators for health facilities:**
 Extracted data on electricity availability in health centers and district hospitals, held a meeting with the vendor and partners receiving the generators to discuss logistics and created a map with the proposed distribution plan.



2. Result area 2: Strengthened financial systems for the rational use of available health resources

Context and challenges

MOH has made progress in mobilizing resources to finance delivery of health services, and, has been successful in obtaining basket funding for direct financing of funding gaps in its strategic plans. Rwanda is also considered as best practice country in Africa in implementation of Community Based Health Insurance (CBHI) and performance –base financing (PBF) to improve access, quantity and quality of health care services. These financing systems, however, need assistance to reinforce their operational planning, put in place accountability mechanisms and, streamlining financial procedures.

Key achievements realized

CBHI:

The main activities related to CBHI during the period from April 2011 to June 2011 are:

- The 2nd phase of Data entry for the UBUDEHE (Social Stratification) Data Base
- The social stratification data validation
- The CBHI Procedure Manuel
- The CBHI membership database design

As mentioned in our last quarter report, at the end of the 1st phase of the data entry for the **Social Stratification Database**, printed out copies of data per village that were so far recorded, were sent to villages and instructions were given on how to correct data and if necessary complete them. This exercise was finished the end of April, 2011.

The next step was to correct data in the data base and to complete the missing data. This constituted the second phase of data entry which was done from May 4th to June 14th, 2011.

At the end of this exercise, the result was as follows:

- Number of Districts with Data: **30/30 : 100%**
- Number of villages with recorded data: **14,747/14, 843 : 99.3%**
- Number of recorded population: **8,895,154/10, 330,770: 86.10%**

Subsequently a random sample of sectors was selected for which verification of data was conducted. One sector in each province was subject to this data validation process. The main objective of this activity was to see how accurate the data was and to evaluate how well the population agreed with their attributed categories in relation with the new policy of the CBHI payment scheme. This exercise served, as well, as preparation for how to deal with claims from the population during national roll out of the policy and as a lesson learnt in how to correct possible errors before launching the policy.

This validation will be conducted within every village in Rwanda. The results will be used to update the database.

The **CBHI Procedure manual** was edited and a Training of Trainers (ToT) was conducted in Musanze at the end of June. District CBHI directors received training and are now supposed to transfer capacity to other CBHI staff within their district. This procedure manual explains the Administrative and Financial management of the new CBHI Policy. Some issues are not agreed upon yet, more specifically the distribution of premiums at every level and the CBHI comfort package.

Another activity this quarter was the design of a **CBHI interface** which will link the Social Stratification Database with the CBHI membership database.

This CBHI interface will allow membership registration, give information on member's category, enable membership status search, and facilitate the management of patients roaming avoiding falsification of Membership cards.

The User Manual of this interface has been developed and after validation by the MoH, the CBHI district M&E teams will be trained.

Costing exercise:

A preliminary mini-report for the costs of health center services was produced before the availability of a full analysis report, comprising the results from health center, district hospital, and referral hospital level. The report describes the standard costs associated with the delivery of a particular health service, taking into account the staff time, drugs, medical supplies and tests required. The report describes the unit cost for each service, which project costs under different scenarios. These scenarios allow for a comparison between actual utilization and projected, or target utilization; and between actual costs and standard costs.

The report contains five different scenarios:

- Scenario A: actual services and actual costs;
- Scenario B: actual services and standard costs;
- Scenario C: needed services and standard costs;
- Scenario D: projected services and standard costs; and
- Scenario E: projected services and standard costs using shared or part time staff.¹

The standard costs were estimated by determining the quantities of resources (staff type and time, drugs and supplies, and tests) required to provide a good quality service. These quantities were then multiplied by the price of each resource to produce a total standard cost for each service. The portion of staff time related to the each service is treated as a direct cost and the balance of staff time used for non-patient tasks, such as health center management, is treated as an indirect staff cost. A separate cost is determined for the fixed facility operating costs (e.g., electricity) and that cost, together with the indirect staff cost, is allocated across the services in proportion with direct staff cost.

In order to estimate the cost of needed or projected numbers of services, incidence and prevalence rates together were used with catchment population figures to estimate the number of each type of service needed for full coverage of the community. The model can then be set to a percentage of the total need figures so that projections or targets can be used. The model then applies the standard costs to the needed or projected numbers of services to determine the total cost.

Figure 1 below displays the cost per service and cost per capita for the sampled health centers. Cost per service is calculated by dividing the total cost by the total number of

¹ Note that Scenario E was not used in this analysis, due to the fact that using shared or part-time staff is not generally feasible.

services. Cost per service can be used as a measure of quality for health services – a low cost per service may suggest lower quality for reasons such as drug stock-outs. Cost per capita is the total cost divided by the catchment population. The cost per capita is an important way to compare the costs across the sampled health centers. This is an equity measure, since, all things being equal, resources should be allocated equitably with regards to the population.

The cost per service was around 2,000 RWF for all health centers, ranging from 1,287 in Jali to 2,313 in Mubuga. Cost per capita varied, with the highest figure in Mubuga (10,970 RWF), which may in part be due to its small catchment population size. Cost per capita in the remaining health centers varied from 4,806 in Kinazi to 1,999 in Jali, which had the largest catchment size in the sample.

Figure 1. Cost per service and Cost per capita for sampled health centers in 2009 (RWF)

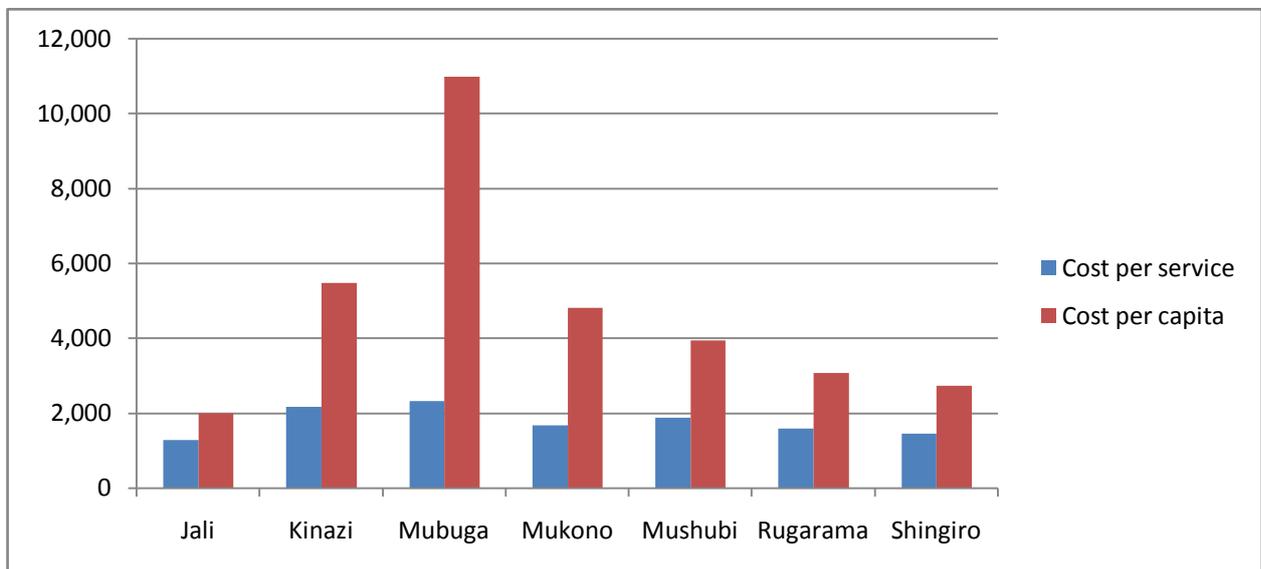
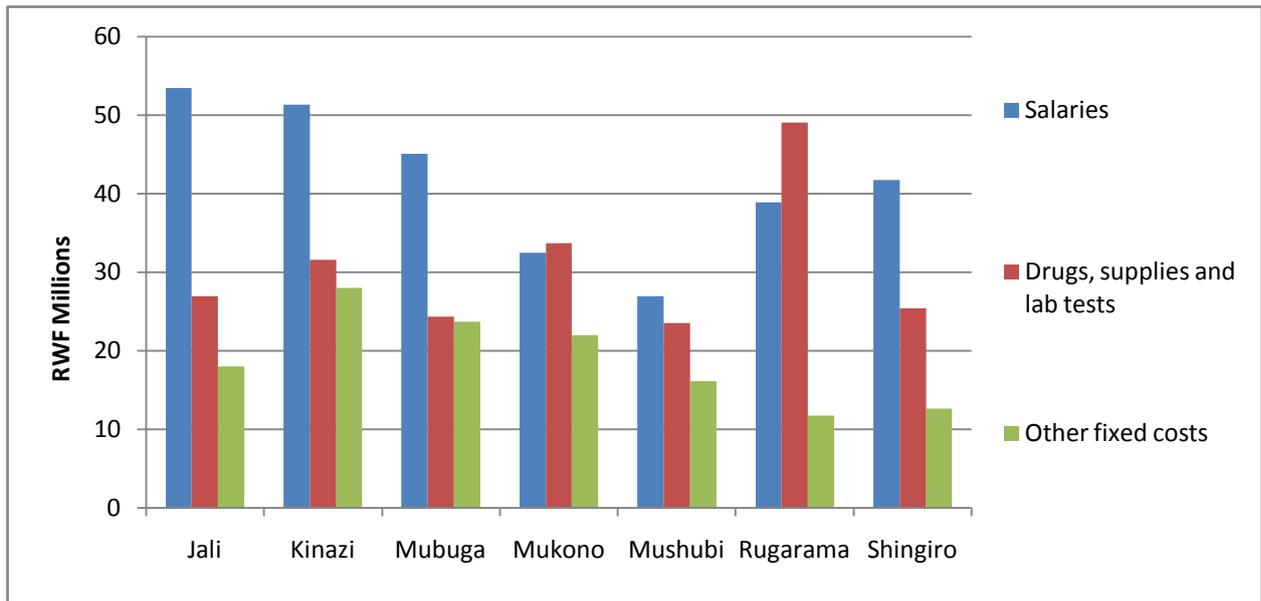


Figure 2 below shows the breakdown in costs between major inputs: salaries, drugs and medical supplies, and operating costs. In most health centers, salaries comprised the majority of the costs (an average of 45% of the total), with drugs and medical supplies consuming 34% of the total, and operating costs an average of 21%. However, both Mukono and Rugarama health centers showed higher drug costs than salaries, which could possibly be indicative of under-staffing.

Figure 2. Total costs broken down by salaries, drug and medical supplies, and operating costs for the sampled health centers in 2009 (RWF millions)



Comparison of Actual vs. Standard costs

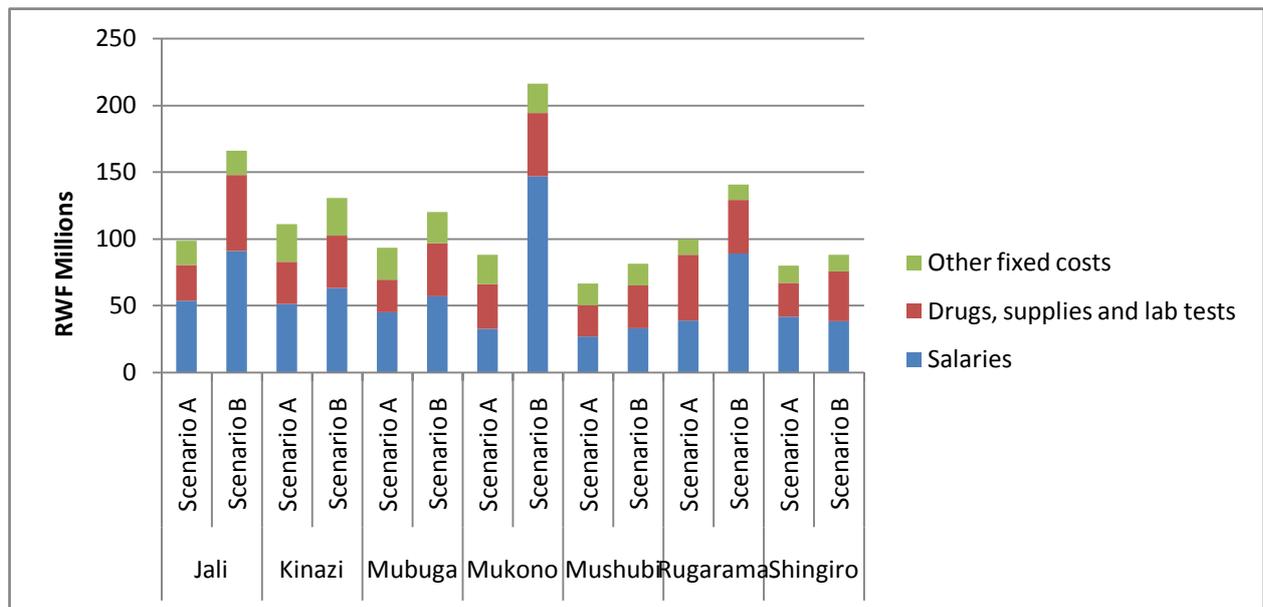
The CORE Plus model was used to provide a comparison of actual vs. standard costs for the sampled health centers. The actual costs are determined by the real expenditures made by the health center in 2009, whereas the standard cost is calculated by taking the actual utilization figures for 2009 and multiplying these figures by the standard costs per service.

Figure 3 below shows a comparison between actual and standard costs, at the same actual level of utilization. Scenario A denotes the scenario with actual health center costs and actual utilization for 2009; Scenario B uses the same utilization for 2009, with standard costs. Thus, comparing the two scenarios shows any disparities between the actual situation and the ideal, or standard, situation. For most of the sampled health centers, the actual amount spent on salaries was less than the amount predicted by the standard; suggesting they are understaffed. Only Shingiro paid slightly more in salaries than was predicted by the standard calculation. The largest difference between actual and standard salaries was at Mukono, where the model predicts the need for a high number of Assistant Sociales. This is due to the fact that, at Mukono, this position has a very small percentage of time available for service delivery, spending the majority of time on community supervision.

For drugs, all health centers were under spent in 2009. Note that the actual drug costs for the health centers include both purchased and donated drugs. In some cases, the difference was rather large (almost double the amount should have been spent on drugs in Jali).

Operating costs were equal in both scenarios, due to the fact that standards have not been developed for these costs, and therefore the model assumes equal costs in both scenarios.

Figure 3. Actual vs. Standard costs, broken down by input, for the sampled health centers in 2009 (RWF millions)



Scenario A = Actual utilization, actual costs. Scenario B = Actual utilization, standard costs

Clinical PBF counter evaluation and system Audit

Under the HDP sub contract, IHSSP supported the MoH/ PBF unit to conduct the PBF system audit and the community client survey.

PBF is implemented in Rwanda at national level since 2008 at health center (HC) and hospital level. Productivity of HC-activities is verified and validated by district teams (combination of administrative and hospital staff). It is recommended to perform regularly a counter verification process by an independent unit (HDP) for the following aspects of the PBF-model:

1. Accuracy of quantity as reported in the central PBF database
2. Verification of existence of phantom patients and of existence of service rendered
3. Client satisfaction for the health centers
4. Accuracy of quality of HCs as evaluated by district hospital team
5. Audit of the PBF-system and procedures

Background information and preliminary results were provided in the previous quarterly report. During a secondary analysis some extra crucial info became available. In one of the surveyed health centers, fraud was detected with regards to the number of “old” (current users) family planning users. Numbers were inflated and this was discovered during the detailed review of the FP-register and the matching with the FP medical files.

The other results (see previous quarterly report) were confirmed with stakeholders but corrective measures (i.e. reduction of PBF-revenues) were not yet implemented. This was a first exercise for the new members of the CAAC and the objectives of this audit were not yet widely communicated. After feedback to the concerned health facilities, it was decided that this type of audits should be conducted at regular intervals and that “sanctions” will be applied.

Recommendations given by the independent agency can be found in annex.

PBF procedure manual development

IHSSP continued its involvement in the development of the PBF procedure manual document. This document will be the reference document for all PBF-related activities in Rwanda and will also be used during study tours and (inter)national trainings. A workshop was held at the end of June gathering staff from the CAAC (ministerial unit responsible for PBF), directors and titulaires from 10 health facilities and PBF-experts from international NGO’s (EGPAF, FHI, Intrahealth and MSH) demonstrating the ownership of the Ministry of this important document which will outline in detail the procedures used in the PBF-models for the different ministerial departments. The initial draft document was reviewed and updated and a final validated version is expected in the next quarter.

3. Result area 3: Strengthened leadership and management and improved human resource productivity

Context and challenges

The MOH in collaboration with the partners has devised human resources management and development strategies, including the PBF, to ensure staff retention and improve productivity. However, further refinement of procedures for individual staff and MOH department performance planning, assessment, and payment is needed. The massive scale of the CHW program presents significant challenges with respect to CHW capacity building, motivation, retention, QA, and data collection and use. The current HRMIS has laid a good foundation, but it has limited scope for supporting operational needs of district and health facility human resource (HR) managers, and the data are therefore not maintained routinely.

Key achievements realized

During this quarter, the IHSSP/HRH team continued to support the MOH to operationalize the HRH strategic plan, to train the district hospital staff on the Workload Indicators for Staffing Need (WISN) and to support health professional bodies.

HRH strategic plan

- Coordinated the development of the HRH policy that is still draft pending the comments and review of the HRH TWG;

- Led the development of the framework for the implementation of the HRH strategic plan – a concept paper is being examined by the MOH HR team for further actions.

Health professional bodies

- Supported the Rwanda Health Professions Councils and Ministry of Health on defining functional specifications to manage the registration, licensing, professional development and discipline of the registered practitioners;
- Assisted the Rwanda Medical Council to identify priority activities for the coming 6 months and recruitment process to be completed in July, 2011
- Assisted the Nursing and Midwives Council to design and produce license certificate and license identity card. Five thousand nurses and midwives are expected to obtain their certificates and license ID

Workload Indicators for Staffing Need (WISN) methodology

- The WISN methodology is a human resources management tool that determines how many health workers of a particular type are required to cope with the workload of a given facility. IHSSP team assisted in training a selected MOH team at central and district levels on the WISN methodology: 12 people from referral hospitals and health education institutions were trained as “national expert WISN team” and 30 people from 10 district hospitals were trained as members of the “district hospital WISN task forces”.

One staff of HRH component assisted the CAAC to carry out the quarterly PBF evaluation for district hospitals.

PERSPECTIVES FOR THE NEXT QUARTER

- Support the MOH to develop the M&E plan (Implementation framework) and operational plan for the HRH strategic plan
- Support the Rwanda Medical Council to develop the M&E plan for the CPD strategic plan
- Assist the Health professional bodies in the process of licensing and to develop their regulations
- Assist the MOH to establish the WISN methodology task forces in all district hospitals
- Finalize the recruitment of the CPD staff for Rwanda Medical Council
- Continue to assist health professions councils and MOH to design and implement a comprehensive information systems for registration, licensing and professional development of their registered members.

4. Result area 4: Quality improvement for results in access to and quality of services through standardized approach

Context and challenges

Quality improvement is central to health systems strengthening. The IHSSP intends to support the efforts of the MOH to implement a national supervision framework at the national, district, health center levels and community levels – to harmonize with the existing PBF mechanism. Other strategies to QI includes accreditation of District Hospitals, establishing a governing structure for quality improvements and, incorporating QI modules into pre-service training for appropriate cadres of health providers.

Key achievements realized.

DH operational accreditation policy, procedure & guideline (PPG) review and development:

The multidisciplinary team composed of District Hospital and MOH staff facilitated by MSH continued to work on existing quality gaps, facilitating drafting of operational policies, procedure & guidelines (PPG) required for accreditation process of district hospitals. In all more than 25 sets of PPG were developed (Finance Services, Pediatrics, Surgery Theatre, Housekeeping, Infection Control, etc). see Annex 2.

The developed PPG will provide guidance and increase consistence of services hence improving quality of services delivered by DH's. The developed PPG's are being pre-tested by District hospitals with an aim to seek input from DH's to facilitate finalization and validation of the developed PPG's.

Accreditation support structures (advisory committees) at facility level have been identified and terms of reference for each proposed to District Hospitals to facilitate their establishment.

Review of Health Service Packages at all Levels

The MOH in its bid to strengthen health systems while scaling up efficient, effective and sustainable provision of health services, reviewed its service delivery packages at all levels: Health Centers, District Hospitals and National Referral and University Teaching Hospitals, and proposed the new service package for the intermediate referral level 'Provincial Referral Hospitals.

The main objective of reviewing the Rwandan service packages was to:

- Promote and strengthen the health referral system;
- Increase access to 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;
- Update service packages to respond to the additional tasks given to health facilities at all levels.

5. Result area 5: Effective decentralization of health and social services to improve access

Context and Challenges

The MOH is keen to implementing initiatives to strengthen health governance through district health system development to ensure health system decentralization and citizen participation in health policy decisions and service delivery.

The key challenge remains working out operational modalities to strengthen the administrative decentralization structures, engaging partnerships approaches at district level, and improving capacities of decentralized structures.

The IHSS project has plans 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

Key achievements realized.

The activities of the decentralization component during this quarter have been centered on the development of the strategic plan for Decentralisation as well as on strengthening capacities of decentralized health structures.

Strategic plan for decentralization in health:

In Rwanda, the National Decentralization Policy document was developed in 2001 but reference to the health sector with its technical specificities is limited in this document. The team is therefore focusing on the development of a strategic plan for the decentralization including aspects related to the health sector.

IHSSP is supporting the MOH in this activity with the help of an international consultant.

First steps in this process that started in June is review of existing documents and a series of consultative meetings with different stakeholders.

The strategic plan is supposed to be developed within the next quarter.

Training module for health data management and District Hospital community supervisors:

Development of training modules in a number of areas continued this quarter. The different fields wherefore Training of Trainers (ToT)-modules are developed are:

- health data management and data use for decision making at district level
- community health programs management for DH staff in charge of supervision of CHWs

Support to other components

Decentralization staff participated in many activities providing support to IHSSP's crosscutting activities. The Decentralization team assisted:

- the Health Financing component in the ToT on the procedure manual of CBHI and in the development of the PBF-procedure manual
- The decentralization team participated also in District Hospital PBF evaluation conducted in June 2011;
- The QI component in Development of the District Hospital Accreditation Strategy/Framework;
- The HRH component in CPD selection activity;
- Decentralization team participated also in:
 - ToT of module for RapidSms & mUbuguzima;
 - workshop on initiation of SOP for Health Financing activities

Challenges/problems

The main challenge faced is:

- Intervention mechanism at district level not yet clarified.
- The delay of the District M&E officer hiring process.

Perspectives for the next quarter

- Appointment of Health M&E officer in districts
- The Strategic plan for the Decentralization Health will be available
- Strengthening capacity of district team via trainings

Annex 1: Recommendations of the PBF system audits.

1. A couple of simple audit interventions (recounting the reported data and scrutinizing (medical files) revealed 1 case of fraud and some dysfunctionalities in the PBF-framework (mainly errors in reported data and lack of control). Currently the PBF-model incorporates data quality assurance (DQA) processes but these are not directly linked to payment. In addition to that supervisors responsible for the DQA are also the ones who are currently checking PBF-data and who did not identify the frequently recurring errors. Institutionalizing a more rigid data quality control system effectuated by the district will not remedy this since the leaner PBF-control system has not been implemented correctly on large scale. Independent random audit followed by financial sanctions would probably be more cost-effective and it is recommended that the PBF-audit at health center level is repeated at regular (quarterly) basis. Surveys in the community itself for a selection of patients is more time consuming and more expensive and could be done less frequently since the major errors have been detected already at an earlier stage. Feedback of the clients on the services and functioning of the health centers is much appreciated by the health centers and gives a good insight on areas needing improvement so these surveys should not be abandoned.
2. Some questions in the questionnaire need to be revised for the next round of surveys
3. It is recommended that in the next surveys, client verification for the “delivery service” will be included for all “counter-verified” health centers. Verification should also include services where fraud is perceived less likely but a high enough sample size is still required to be able to draw meaningful conclusions and to limit the possibility of a mere chance finding.
4. Data discrepancies between PBF and HMIS-data were often attributed to the use of “fiches de pointage journalies” whose data are not always transcribed to registers. One should consider omitting the use of these daily files if no additional benefit to the registers is seen.
5. The differences in data highlight that the role of district steering committees in controlling and verifying indicators and invoices is insufficient. It is recommended to link payment of the district steering committees directly to the reliability of the data which needs to be verified by independent audit mechanism.
6. It is recommended that the audit for the HC-quality evaluations effectuated by the DH will include also other services and will contain justification of the difference in the obtained scores in order to better understand why DH seem to consistently rate the HC higher. It is also recommended to examine further the reasons behind these discrepancies: is there subjectivity in the interpretation of the indicator? Are the evaluation grids relevant? Is it feasible and useful to visit each health center every quarter and verify indicators that might not change much over time? Is there too much of a conflict of interest when DH-evaluators often play the role as well of supervisors or at least represent the supervising and supporting unit?
7. The financial repercussions for the hospitals due to differences in evaluation scores have to be reviewed in light of the above findings. It is recommended to keep the element of reducing PBF-allocated funds but the calculation key might be altered.
8. Data of the audit on procedures should inspire the central level to improve communication with the lower levels and to demand better implementation of the PBF-guidelines. Evaluators need to have more skills for evaluation and need to understand the tools better. A system of certified (by national level) evaluators could be considered.

9. CAAC should reinforce the use of individual performance contracts for all staff members. In light of the feeble implementation the content of the evaluation should change and should probably be applied on semi-annual or annual basis. Evaluating ones performance in detail every quarter is not very realistic.
10. CAAC should reinforce the rule not to evaluate more than 5 services per day. Some health center staff even suggested < 3 since functioning of HC is disrupted and paralyzed if more services are visited. This rule should be more strictly imposed and PBF-adjustments should be introduced when not respected.
11. In view of the fact that quantity evaluations are almost always done on quarterly basis (it is time consuming and costly to perform a routine activity monthly), it seems logical to respect reality and accept quarterly evaluations. However more attention should go to independent random control of the reported quantity data with possible sanctions. A data quality assurance team is recently (beginning of 2011) put in place but procedures and exact sanctions are yet to be developed. The protocol of quantity verification could be used as guide.

Annex 2: Policy, procedures and guidelines review

District Hospitals Accreditation required policies, procedures and guidelines (Phase one)	
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
Ambulance management	Number of ambulances
	Status and maintenance of ambulances
	Allocation
	Triage of emergencies cases
	Time of call by health center
	Arrival of the ambulance transporting a patient
Finance	Billing and Invoicing
	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
Housekeeping services	Confidentiality and Access to data and information
	Appropriate cleaning methods and materials for various surfaces
	Safe storage of cleaning materials
	Hygienic storage of mops and brooms
	Cleaning at times which are least disruptive to the service
	Use of chemicals to the cleaning
	Supervision of cleaning staff
Laundry service	Handling of infected linen
	Loading of washing machines
	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	Outpatient admission to the hospital
	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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