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Table of Contents

Acronyms iii
Executive summary iv
Introduction 1
1. Improved utilization of data for decision making and policy formulation 2
1.1. Context and challenges 2
1.2. Key achievements 2
1.2.1. HMIS databases and web applications 2
1.2.2. HMIS plans, guidelines and SOPs 3
1.2.3. Capacity building 4
2. Strengthened financial systems for the rational use of available resources 5
2.1. Context and challenges 5
2.2. Key achievements 5
2.2.1. CBHI system 5
2.2.2. PBF system 8
2.2.3. Health services costing and financial studies 9
3. Strengthened leadership and management and improved human resource productivity 12
3.1. Context and challenges 12
3.2. Key achievements 12
3.2.1. HRH Strategic Policy and its operational plans 12
3.2.2. Operations and norms for Allied Health Professionals 12
3.2.3. Workload Indicators for Staffing Need (WISN) methodology 13
4. Quality improvement for results in access to and quality of services through standardized approach 15
4.1. Context and challenges 15
4.2. Key achievements 15
4.2.1. District hospitals operational accreditation policy 15
4.2.2. Clinical protocol/treatment guidelines 16
5. Effective decentralization of health and social services 18
5.1. Context and challenges 18
5.2. Key achievements 18
6. Other activities completed 19
6.1. Distribution of generators for health facilities 19
7. Activities scheduled for October –December 2011 20
Annexes 22
Annex 1. IHSS Project Results Framework 22
Annex 2. IHSSP Scheduled activities between October 2011 – December 2011 23

Table of Figures

Figure 1: Screen shot of the Rwanda Health Data Warehouse (DHIS-2) 3
Figure 2: Training of staff on iHRIS 4
Figure3: Total Population per Mutuelle Category 6
Figure 5: Health Services Costing Training for Master Trainers 11
Figure 6: CPD sensitization workshop for CPD providers 13
Figure 7: Example of the requirement calculation for doctors working in one district hospital 14
Figure 8: WISN training at district level 14
Figure 9: Development of clinical guidelines 17
Figure 10: Map for Health Facilities to receive generators 19

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)
CHD	Community Health Desk (Department of the Rwandan Ministry of Health)
CHIS	Community Health Information System
CHW	Community Health Worker
CSOs	Civil society Organizations
CTAMS	Cellule Technique d'Appui au Mutuelles de Sante (Mutuelle Technical Support Cell)
CPD	Continuous Professional Development
DH	District Hospital
DHIS	District Health Information System
DRG	Diagnosis Related Groups
GOR	Government of Rwanda
HC	Health Center
HIS	Health Information System
HMIS	Health Management Information System
HRH	Human Resources for Health
HSS	Health System Strengthening
iHRIS	Human Ressources Information System
IHSSP	Integrated Health Systems Strengthening Project
MCH	Maternal and Child Health (Department of the Rwandan Ministry of Health)
M&E	Monitoring & Evaluation
MIS	Management Information System
MOH	Ministry of Health
MSH	Management Sciences for Health
NGO	Non-governmental Organization
PBF	Performance-based Financing
PPG	Policy statements, procedures and guidelines
QI	Quality Improvement
RBC	Rwanda Biomedical Centre
SMS	Short Message Service
SPS	Strengthening Pharmaceutical System Project
TOT	Training of Trainers
TWG	Technical Working Group
USAID	United States Agency for International Development
USG	United States Government

Executive summary

During the reporting quarter, the IHSS project assisted the MoH in the completion of the following activities:

In the areas of HMIS, the IHSS project provided support for the upgrade of the national data warehouse and revised health facility reporting formats, the preparation of the new HMIS reporting system (DHIS-2), the update the Ministry of Health's e-Health Strategic plan, and trained in HMIS and data use.

About Health Finance, the project assisted the MoH in the realization of a CBHI procedure manual, in the data validation of the national social stratification process (UBUDEHE), for the update of the CBHI M&E database, the CBHI financial modeling and Data Audit, and the Community PBF system audit. Research related to health services costing study has also been done.

In the HRH field, the project continued ongoing support to the MoH HR team to implement the HRH strategic plan and its implementation framework, assisted the Rwanda Medical Council to establish the medical CPD governance structure, supported to finalize the draft law establishing the Rwanda Allied Health Professions Association and Rwanda Pharmacists Association and trained selected teams at district levels on the WISN methodology.

Regarding the QI component, the IHSS project assisted the MoH for the pre-test of accreditation required operational policies, procedure and guidelines at district hospitals. The project also assisted the MoH in the Review and Development of Clinical Protocol/Treatment Guidelines.

For the Decentralization unit, the IHSS project also produced the draft Decentralization Strategic Plan.

Introduction

The Government of Rwanda (GOR) has shown strong commitment to improve 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), aims to support 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.

The present report is the IHSSP quarterly narrative report for the activities covering the period of July 2011 to September 2011. It provides background, context and challenge of each of the IHSSP's five intermediate results and its results framework, and outlines key activities and results achieved during the said reporting quarter.

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

1.1. Context and challenges

The inappropriate data management and use has been found as challenge for decision making: 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.

1.2. Key achievements

1.2.1. HMIS databases and web applications

Preparation for national data warehouse and dashboard update

Consultants from, and paid for by, WHO/AFRO and WHO/Geneva made a visit to further develop the concept of Rwanda's Health Observatory. Two other WHO consultants came out to assist with this work, to customize the GIS module to meet Rwanda requirements and to develop the specifications for an extended metadata dictionary for data elements and indicators and defining data interchange formats between DHIS-2 and other systems – including TracNet, PBF, and GESIS). The system is now running on a cloud server while we are awaiting the completion of the MoH data center internet upgrade.

New HMIS reporting system (DHIS-2) upgrade

Consultants from HISP made two sets of visits to Rwanda to assist with the preparation for the new platform for the HMIS helping to finalize the HMIS monthly report formats and manage the DHIS-2 roll-out plans, cleaning up the MOH data center and assisting to transition the DHIS-2 web platform from Windows to Linux and working on data interoperability requirements, and continuing to train the HMIS team on creating data elements and data entry forms.

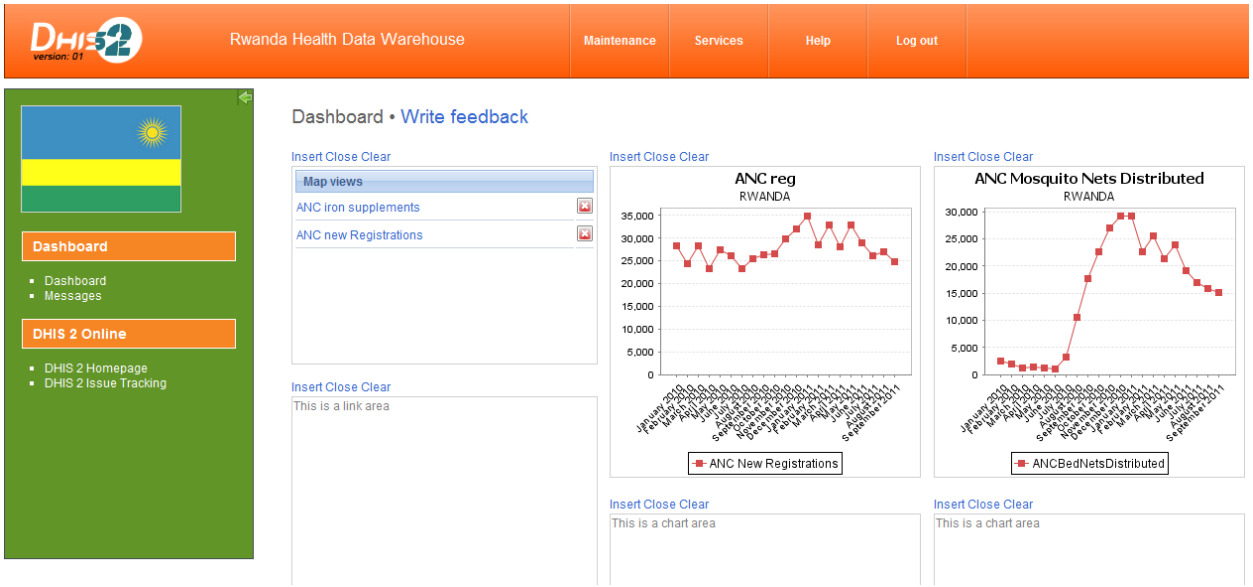


Figure 1: Screen shot of the Rwanda Health Data Warehouse (DHIS-2) which is a tool for collection, validation, analysis, and presentation of aggregate statistical data, tailored (but not limited) to integrated health information management activities1.

1.2.2. HMIS plans, guidelines and SOPs

e-Health Strategic plan

IHSP project staff helped to facilitate a 3-day workshop to update the Ministry of Health's e-Health Strategic plan. This included developing updated micro-projects for upgrading the HMIS and implementing the national data warehouse and dashboard.

Revision of Health Facility reporting formats

The project staff continued the process of getting consensus around the revised monthly reporting forms for the Health Center and the District Hospital. Through this process the size of the forms have been reduced from 26 pages to 12 for Health Centers and from 46 pages to 12 for District hospitals. The forms are awaiting final approval from the MoH senior management team before they can be incorporated into the DHIS-2 platform. Separate forms have been created for Mutuelle indicators reporting as well as for the Community Health Worker Information System (SISCom).

[1] DHIS-2 web site, http://dhis2.org/, accessed on November 3 2011

1.2.3. Capacity building

Preparations and training for the roll-out the new HMIS

The IHSSP worked with HISP and Futures group to identify the key areas of capacity building required to roll-out the new HMIS. This includes training in data collection (using the new reporting formats and recently harmonized registers), data management (including data entry using the new DHIS-platform) and data use (GIS, presentation graphics and feedback reporting using DHIS and other data sets). IHSSP organized trainings for the central level MoH HMIS team in using the DHIS-2 software. This included creating data elements, designing data entry screens and creating analytical feedback report formats installing and configuring Ubuntu Linux and DHIS-2.

Adaptation and trainings of iHRIS

The IHSSP worked with "Capacity Plus – IntraHealth" to adapt the iHRIS (Human Resources Information System) software in line with the functional requirements developed by WHO/CDC in June.

Figure 2: Training of staff on iHRIS

2. Strengthened financial systems for the rational use of available resources

2.1. Context and challenges

The 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, streamline financial procedures.

2.2. Key achievements

2.2.1. CBHI system

CBHI Procedure manual

A Community Based Health Insurance procedure manual has been developed. It describes operational policies, processes, and procedures for the implementation of CBHI following the introduction of the new policy.

During this quarter, the capacity building in CBHI Procedure Manual was conducted in 2 phases. The first one being the training of trainers (TOT) of CBHI district actors and the second one being the training of Section's staff (Managers & Accountants). The trainings of Sections staff were into two phases, 6 days for Managers, and 6 days for accountants in 4 different sites: Muhanga, Musanze, Huye and Rwamagana. The curriculum of the training covers:

- Overview of the new policy CBHI
- CBHI Administrative management
- Premiums management
- CBHI Accounting
- CBHI Financial Analysis
- Stock management
- CBHI Monitoring and Evaluation

The attendees were 776 out of 868 expected. The difference is due to the fact that some sections don't have yet accountants.

UBUDEHE / Social Stratification Process

In this quarter, the UBUDEHE process was at its data validation phase. The overall objective of the Social Stratification Project Database is to build a nation-wide flexible database covering nearly all household in Rwanda and recording certain socio-economic indicators. This will allow the population to contribute to the CBHI based on their revenues and their capacity to pay. The Government of Rwanda has defined 3 categories that will stratify the population based on their Socio-Economic Status, which will determine the premium per member of the household for the coming year of CBHI coverage. IHSSP supported the development of this web-based database with a CBHI membership interface that allows the mutuelle to pull information on family size and stratification information, while providing more details for MINALOC (Ministry of Local Government) and MoH.

After the previous data entry exercise of all Rwandans population, the output from the database was:

- 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%

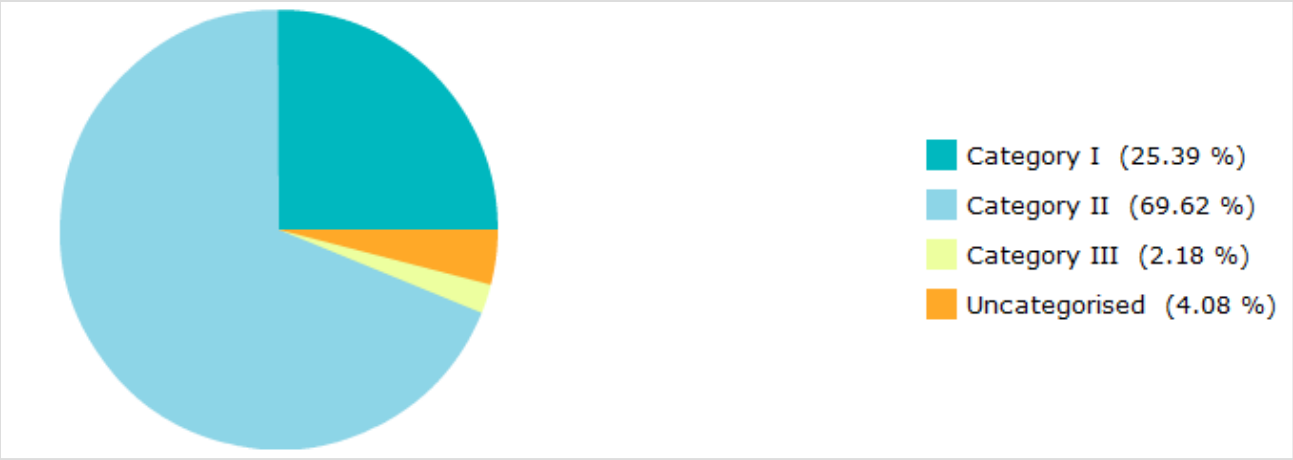


Figure3: Total Population per Mutuelle Category

After presenting results to the MoH and MINALOC (central and decentralized level included Permanent Secretaries from Ministries, governors and Mayors), a data validation process was proposed. The data validation, as decided by the Government, took place in all villages under direction of Steering Committees appointed by the local administration.

The committee at district level was in charge of overall coordination. They were also in charge of resolving any kind of problem, validating the data from villages before compiling them and send them to MINALOC. At the central level, the follow up was done by the existing Social Stratification Technical Committee in which IHSSP team is part. The results of this data validation will be available once the data entry phase III is finished, which began in late September and is supposed to take about one month.

Update of the CBHI M&E Database

From July 2011, the new CBHI policy is being implemented. Now, the M&E database and the reported indicators have to be reviewed and adapted to the new policy. The IHSS project supported the MoH to review and update the CBHI M&E indicators reported by sections. Proposed new indicators will need to be approved before updating them within the database. After the next steps will be the capacity transfer to District actors on the use of the database. The need to include districts reports within the database was identified as an issue to be addressed

CBHI financial modeling

With the CBHI new policy, premiums are collected from the lowest level of the scheme, which is the section level. For the year 2011, the expected amount to be collected is "31,494,964,763 RWF"[2], and must be used to cover Health care expenses at all levels of the Health Sector (Health centers, District Hospitals and Referral Hospitals). The current challenge is how this amount should be distributed efficiently to all levels of CBHI scheme (Section, district Pooling Risk and National Pooling Risk) without causing any risk to any level of the CBHI scheme.

[2] CBHI Policy, 2010

The project assisted the CTAMS to overcome this challenge, considering the projections from the new CBHI policy on expected total revenue and projected total expenses at each level.

The IHSS project will provide technical support for the conception and the design of this Financial/actuarial model to assist the MoH and individual "Mutuelles" to project their revenue and expenses based on elements such membership levels, premiums, administrative costs, expected utilization levels and facility reimbursement mechanisms levels. This model will be generic enough so that it can be used and modified easily. The expected outcome would be improvements in financial planning resulting in increased efficiency, access and sustainability.

CBHI Data Audit

The project is supporting the MoH in the management of CBHI database which help all levels to manage access and use data. This is done through a monthly reporting system of each section entered in the database, which is now functional, but the main issue is the data quality.

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

2.2.2. PBF system

Community PBF system audit

The IHSS project, in collaboration with the Community Health Desk, the School of Public Health and the PBF Unit at the MoH performed the first round of the system audit of the community PBF scheme. The aim of the audit was to assess that the system is implemented as designed. The audit tackled the issue of how well procedures and regulations are implemented according to the national community PBF-model. Actors from different structures (sector steering committee, district steering committee, health center, CHW cooperatives) were interviewed on varying issues like contract management, the evaluation visits, the payment cycles and the communication with higher levels.

Sampling was done as follows: 2 districts per province were picked randomly (excepted in Kigali City where one district was selected). In total, the system audit was conducted in 9 districts. In each selected district, 5 health centers (which correspond to the 5 CHW cooperatives) were also

picked randomly in the proportion of 2 cooperatives/Health centers implementing demand side model and 3 cooperatives/Health Centers applying supply side models. For the Kigali City selected district, only 3 CHW cooperatives were selected as all sites are implementing only the supply side model. Data are now being analyzed and an official report will be produced in coming weeks.

2.2.3. Health services costing and financial studies

Health services costing study

The project supported technically and financially the MoH in the implementation of a costing exercise of the packages of health services to determine the true cost of each type of health activity. A preliminary mini-report on the costs of health center services and a full analysis report, comprising the results from health center, district hospital, and referral hospital levels were produced. The report describes the standard costs associated with the delivery of health service, taking into account the staff time, drugs, medical supplies and tests required. It describes the unit cost for each service, which project costs under different scenarios that permit a comparison between actual utilization and projected (or target utilization) and between actual costs and standard costs.

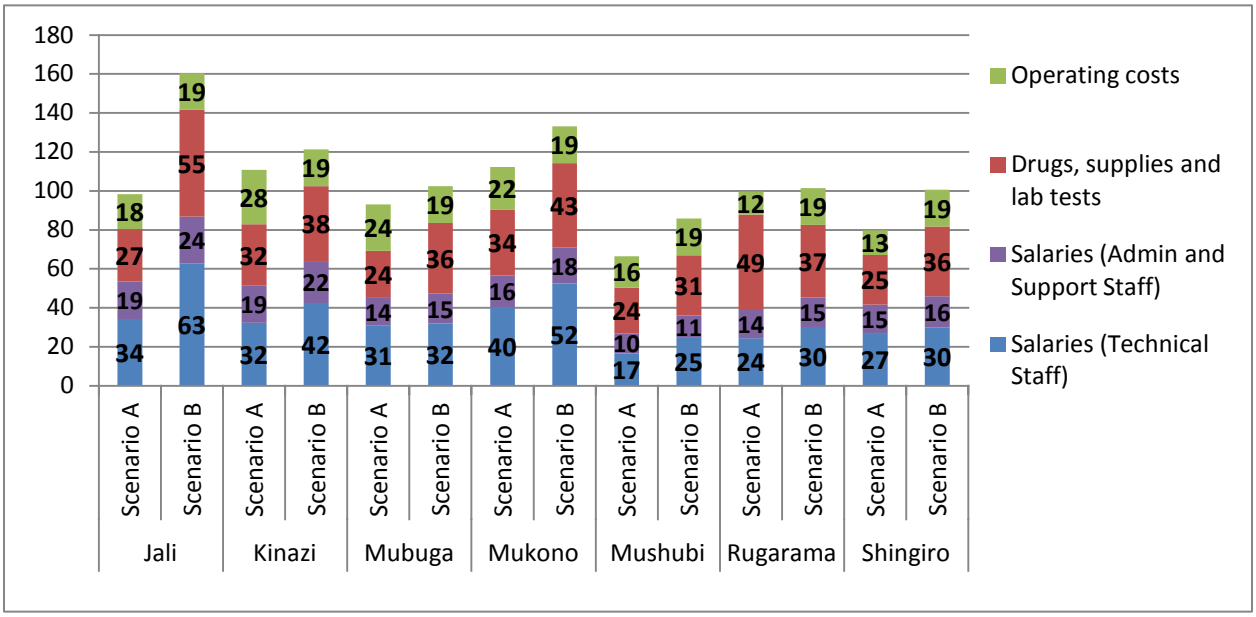


Figure 4: Total actual (scenario A) vs. standard (Scenario B) costs, broken down by input, for the sampled health centres in 2009 (RWF millions)

The project organized the following sessions for data dissemination:

- Data dissemination workshop for district level staff at MSH in which key personnel from all 40 district hospitals level were invited to review the results of the costing study at health center and district hospital level. The selected DRGs for district hospitals, along with their direct costs, were also presented.
- A validation meeting was held in which key personnel from the Senior MoH Management and Rwanda Biomedical Centre (RBC) were invited to review and comment on the results of the costing study at health center, district hospital and referral hospital level. DRGs were presented for district and referral hospital levels.
- Several meetings were held with CHUK staff to review pending issues with the data collected, while presenting the preliminary results from the DRG selection. Additional data requirements and clarifications were identified.

The IHSS project conducted a Health Services Costing Training for Master Trainers from September 5 to September 16. The proposed Master Trainers were appointed by the Ministry of Health and included staff from the MoH, the School of Public Health, District and Referral Hospital teams and IHSSP. The objectives were to:

- Teach a small group of local health practitioners, proficient with MS Excel (public health consultants, health services manager, health economists) to use the Rwanda Health Center and Hospital Costing Tools.
- Provide the Master Trainees with the skills to train Referral and District Hospital managers to use the costing tools for their own hospital and health centers.
- Teach the same group of local health practitioners on the Rwanda DRGs and provide them with sufficient skills to oversee the DRG implementation process and updating.

Figure 5: Health Services Costing Training for Master Trainers

Assessment of financial reporting and management

A financial specialist seconded to IHSS project by Futures Group conducted a field assessment of financial reporting and management. This assessment was conducted to understand the practices and plan interventions that can help health facilities and "Mutuelles" achieve standard financial reporting and management. 7 District Hospitals and 5 health Centers were visited.

Interviews were also held with the audit department at Rwanda Revenue Authority (RRA) to identify a list of financial accounting statements used for regular taxation audit and with Strengthening Pharmaceutical Systems (SPS) department. It was found that 5 financial statements are more important: the balance sheet, the income statement, the depreciation table, the list of creditors and the list of debtors. These documents (especially the balance sheet and the income statement) not only serve for fiscal audit, but also for standard financial management.

3. Strengthened leadership and management and improved human resource productivity

3.1. 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 HRIS 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.

3.2. Key achievements

3.2.1. HRH Strategic Policy and its operational plans

HRH strategic plan

During the quarter, the project continued ongoing support to the MoH HR team to follow up the implementation of the HRH Strategic Plan including its implementation framework and the medical postgraduate education review. The IHSSP supported the planning of capacity assessment exercise (following the guidelines of the Public Sector Capacity Building Secretariat, PSCBS) based on the quantitative needs of the HRH strategy.

3.2.2. Operations and norms for Allied Health Professionals

Structure to coordinate the CPD

The project assisted the Rwanda Medical Council to establish the medical CPD governance structure: the chief executive officer, an IT officer and an accountant are now at place. We assisted the council to hold a sensitization workshop for CPD providers and all medical associations and teaching hospitals were represented.

Figure 6: CPD sensitization for CPD providers

Law on Health Professions Association

The IHSS project supported to finalize the draft law establishing the Rwanda Allied Health Professions Association and Rwanda Pharmacists Association. The legal documents were discussed by the peers, translated and passed through legal advice. The document establishing those Professional Councils was finalized; it is now available in 3 languages and is under review by the MOH lawyers.

3.2.3. Workload Indicators for Staffing Need (WISN) methodology

The IHSSP team assisted the MoH to train selected teams at district level on the WISN methodology. Personnel from district hospitals and referral hospitals were trained as members of "district hospital WISN task forces". The WISN is a Human Resource planning and management tool that help health managers to analyze, calculate and determine the number of health workers and work time that are required to cope with actual workload in a given health facility.

Activity in the district hospital	Activity standard	Standard workload	WISN calculation
Direct patient care			
Inpatient consultation	15 min. / patient / day	6 496	6 919 / 6 496 = 1.07
Ward rounds	5 min. / patient / day	19 488	31 030 / 19 488 = 1.59
Outpatient consultation (new)	15 min. / patient	6 496	12 074 / 6 496 = 1.86
Outpatient consultation (reatt.)	5 min. / patient	19 488	19 / 19 488 = 0.001
Discharging inpatients	5 min. / patient	19 488	6 919 / 19 488 = 0.36
Referral of patients	5 min. / patient	19 488	0 / 19 488 = 0
Confirmation of death	5 min. / patient	19 488	9 / 19 488 = 0.0005
Writing a death certificate	5 min. / patient	19 488	9 / 19 488 = 0.0005
Major operations	120 min. / patient	812	54 / 812 = 0.07
Minor operations	30 min. / patient	3 248	660 / 3 248 = 0.2
Caesarean sections	60 min. / patient	1 624	74 / 1 624 = 0.05
Writing operation notes	30 min. / patient	3 248	(54+74) / 3 248 = 0.04
Other activities / meetings			
Meetings	90 min. / month		[90 / (160 x 60)] x 100 = 0.94%[21]
CME	60 min. / month		[60 /(160 x 60)] / 100 = 0.63%
Staff appraisal	60 min. / year		[60 / (1 624 x 60)] x100 = 0.06%
Tea break	30 min. / day		[30 / (8 x 60)] x100 = 6.25%

Figure 7: Example of the requirement calculation for doctors working in one district hospital
(from the manual, Applying the WISN method in practice)

Figure 8: WISN training at district level

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

4.1. 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.

4.2. Key achievements

4.2.1. District hospitals operational accreditation policy

Pre-test of accreditation required operational policies, procedure and guidelines at DH

The pre-test of accreditation required policies, procedures and guideline drafts required for accreditation process was done in 40 district hospitals to check the applicability and seek input from DH teams. IHSSP supported the initiation and establishment of accreditation support structures as quality management advisory committees. The terms of references have been drafted for all committees and 23/40 District hospitals had appointed the required committees to Support accreditation process:

1. Ethical committee
2. Quality Improvement committee
3. Health and safety committee
4. Infection Prevention and Control committee
5. Resuscitation Committee
6. Disciplinary Committee
7. Recruitment Committee
8. Policy and procedure Committee

The relevant input from DH will be incorporated into the documents accordingly then proceed to the validation and dissemination.

4.2.2. Clinical protocol/treatment guidelines

The IHSS project assisted the MoH in the Review and Development of Clinical Protocol/Treatment Guidelines. The progress in development of Clinical Protocols/ Treatment guidelines is on track. The workshop was facilitated by IHSSP & SPS team. The main objectives of these clinical protocols / treatment guidelines are:

- Improve the quality of management of clinical conditions of high volume and high risk as part of QI package in the process of accreditation of health services.
- Improve, encourage and standardize the rational use of drugs thus contributing to the realization of MoH quality management vision.
- Provide guidance that will result in consistent and sufficient management of diseases/conditions
- Provide quality care by standardizing treatment, promote interventions of proven benefit, and discourage ineffective interventions
- Help ensure efficient use of resources, especially important in resource-constraint
- Enable standardized care and patient management for the same cases
- Harmonization of supply Chain System & contribute to the Streamlining of referral systems.
- To inform the next review of the essential drug list and drug formulary

A list of conditions was indentified in each specialty based on high volume and high risk conditions. A simplified template that indicates the following for protocols was adopted:

- *Definition / description of condition*
- *Causes*
- *Signs/symptoms*
- *Investigations*
- *Complications (if any)*
- *Management*
    - *Non Pharmaceutical*
    - *Pharmaceutical*
    - *Supportive treatment*

- *First choice of Treatment*
- *Alternative treatment*
- *Advice on discharge*
- *In case the patient is being managed at DH provide guidance on referral to Tertiary level or appropriate specialist*

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

Figure 9: Development of clinical guidelines

5. Effective decentralization of health and social services

5.1. Context and challenges

The MoH is keen to implement 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.

5.2. Key achievements

The IHSSP has drafted and submitted to the MoH a Decentralization Strategic Plan. We hope to facilitate the finalization of this document during the coming quarter.

6. Other activities completed

6.1. Distribution of generators for health facilities

The distribution plan for 33 generators for health facilities has been completed. IThe HSSP arranged for the vendor to make site visits to each of the proposed installation sites and create proforma invoices for each site. IHSSP held a meeting with the vendor and partners receiving the generators to discuss logistics for the final delivery and installation of the generators (see final map below).

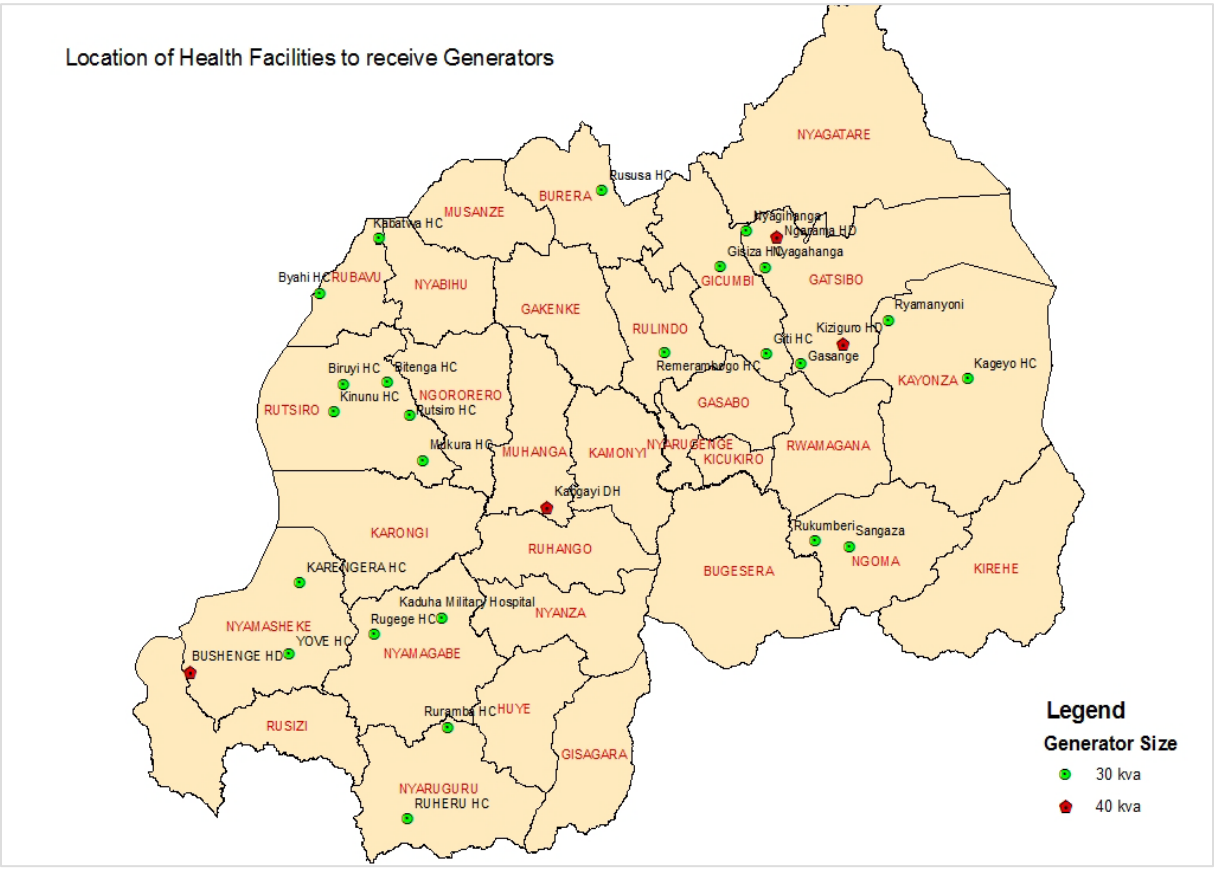


Figure 10: Map for Health Facilities to receive generators

7. Activities scheduled for October –December 2011

In the quarter following this reporting period (October – December 2011), the project will continue to provide support to the MoH in the completion of the following activities (see Annex 2):

In the areas of **Health finance**, the IHSS project will assist the MoH to finalize the CBHI procedures manual (translation in English and editing) and to disseminate them, will continue to support the Ubudehe stratification process (Data validation, Database user manual update) and will provide support to the CBHI and PBF extended team platforms. The IHSSP will provide ongoing support to the enhancement of the CBHI stratification process, the design of a cell phone (SMS) interface for the CBHI Membership database update, and the design and development of a PBF model for district pharmacy. Quarterly CBHI M&E indicators data analysis, community PBF client survey and quarterly SIS-com data analysis will also be conducted. Others activities will include the finalization of the community PBF system audit (data analysis, report finalization and feedback), the design of a pricing method based on costing results and the support to the coordination mechanism on community PBF (Draft TOR, Quarterly meeting). Regarding the capacity building, the following activities will be conducted: training on costing for district actors, development of an updated training curriculum on community PBF for Sector steering committees and conduct TOT master trainers.

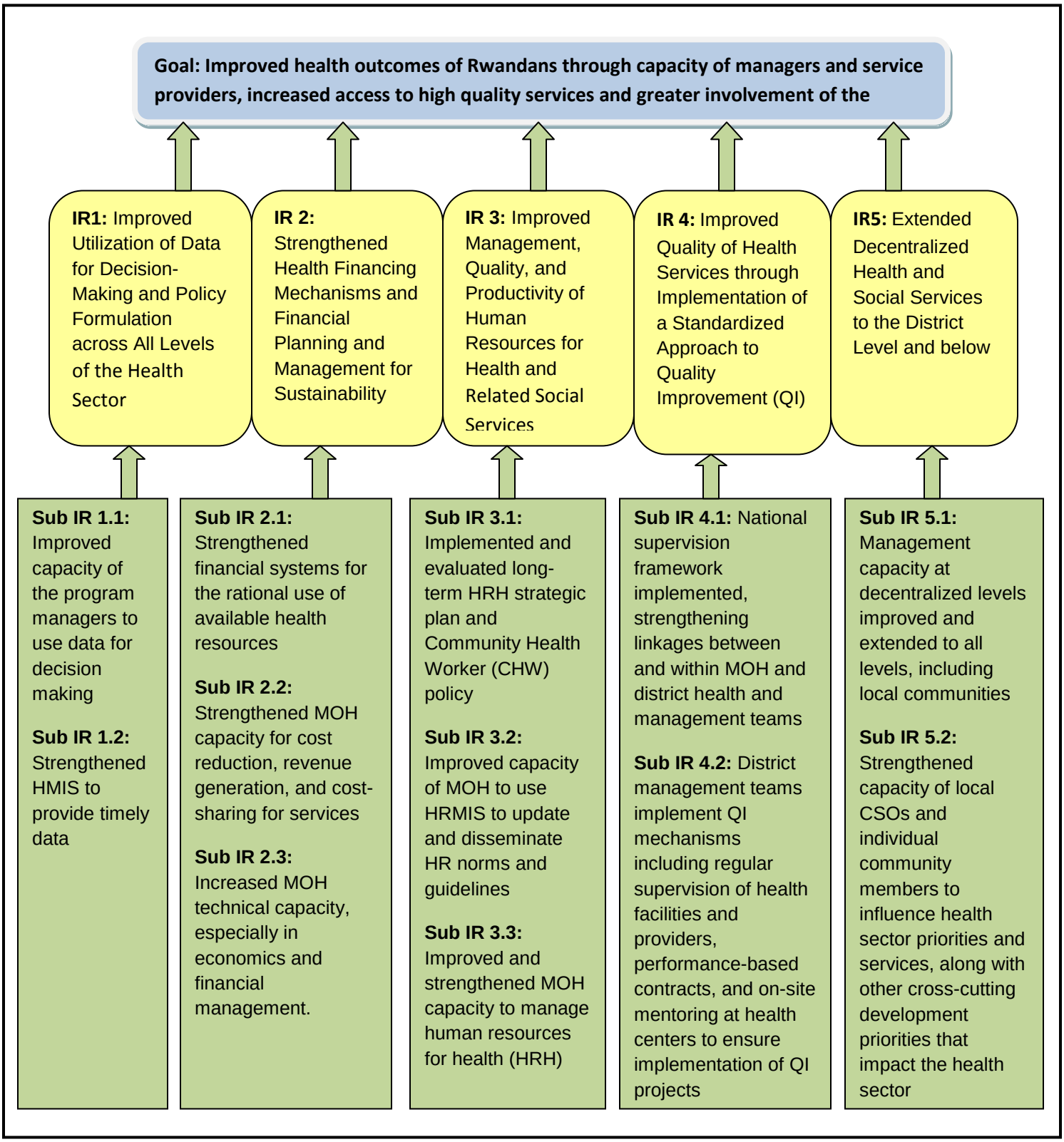
About the **HMIS**, the IHSS project will continue to work on the curriculum development for SOPs and new HMIS training, the enhancement of the CTAMS database, the customization of the new iHRIS system and the revision of HMIS data reporting. Others activities will include the standardization of disease and medical act coding, the configuration of MoH web servers and network for DHIS-2, the creation of a data entry system for the new reporting formats in the DHIS-2 platform , and operationalize national data warehouse and web-based dashboard portal to promote data sharing. Teachings will comprise the establishment and training of MoH team in managing the web presence to assure the availability of comprehensive and quality data, the conduct of ToTs in revised reporting instruments and registers and in using DHIS-2 for data entry of HMIS monthly reports.

The HRH component of the project will assist the MoH to review the HRH policy, develop the HRH operational plans, develop an M&E plan for HRH Strategic, will provide support to the health professional bodies in the elaboration and implementation of the Norms and standards of licensing document, and will assist the MoH to implement the WISN methodology.

Concerning the **quality improvement team**, the IHSSP will continue to support the MoH to review, develop and disseminate District hospitals required operational policies, procedures and Treatment Guideline / Clinical protocols for quality improvement.

Annexes

Annex 1. IHSS Project Results Framework



Annex 2. IHSSP Scheduled activities between October 2011 – December 2011

Next quarter activities in IHSSP – HMIS Component

Intervention	Activity/Task	Why it is important	Deliverable /Indicator	Start time	End time	Comments
Strengthen HMIS and eHealth management functions and structures, central MOH M&E coordination mechanism and M&E teams within departments and districts.	Curriculum development workshop for SOPs and new HMIS training	The MOH has recently been through major restructuring and relationships between key departments working with health information are unclear and certain staff functions are not defined.	Revised organizational chart and capacity building plan for eHealth/HMIS and staffing gaps filled	Oct-11	Oct-11	Curriculum development has focused on Reporting, Data Recording and Data Entry
Enhancement of CTAMS database to better track Mutuelle performance, and better data quality control	Refining performance indicators of mutuelle	The current indicator set needs refining to better track Mutuelle performance, the database needs to be enhanced with better data quality control and a membership module.	CBHI database and website updated,	Oct-11	Oct-11	
	Enhance Dbase quality control capacity			Sep-11	Oct-11	
	Develop and Integrate membership management module			Sep-11	Oct-11	
	ToT for central level CTAMS staff in use of new membership module and updated Mutuelle M&E indicators			Oct-11	Oct-11	
Customize the iHRIS system to meet the requirements	customize the iHRIS system to accommodate changes	The current software platform is missing some important HR management functions that would be useful to the Districts and central level MOH.	Functioning iHRIS system	Oct-11	Nov-11	Need Ministry to prioritize new features and negotiate funding with USG.
	iHRIS testing and dissemination			Nov-11	Dec-11	
Strengthened HMIS to provide reliable and timely data		Data quality remains a challenge even though reporting compliance has improved. Those data that are available are not easily accessed. These factors are challenges for evidence-based decision making	increased data quality score.			

	Revise existing data recording and reporting instruments of HMIS using minimum package of indicators and standard disease and medical act coding	Once a minimum indicator set is selected, data recording and reporting instruments should be simplified to streamline the system.	HMIS recording and reporting user manual and standard formats prepared.	Sep-11	Oct-11	
	Configure web servers and MOH network for DHIS-2 and Data Warehouse	MOH data center is being moved; need to reconfigure servers based on new location and applications for improved up-time.		Sep-11	Oct-11	
	Create data entry system for new reporting formats in DHIS-2 platform	Monthly reporting forms have been revised; health facilities will not be able to enter data from January without new data entry system.		Sep-11	Oct-11	
	Establish and train a team to manage MOH web presence to assure the availability of comprehensive, quality data	With increasing use of Internet as a medium for sharing data, it is crucial that the MOH have a strong team to develop and maintain its web presence.	MOH web site maintained and used to share HMIS analyses.	Sep-11	Dec-11	
	Conduct ToTs in revised reporting instruments and registers	To improve data quality, all health workers should be trained in the revised case definitions, registers and reporting formats.		Nov-11	Dec-11	
	Conduct ToT in using DHIS-2 for data entry of HMIS monthly reports	Data managers need to know how to use the new DHIS-2 platform to enter their Monthly reports. District and national level staff will subsequently train Health Center level data managers.		Oct-11	Nov-11	
Operationalize national data warehouse and web-based dashboard portal to promote data sharing	Operationalize national data warehouse	The data warehouse and web portal are key interventions to enhancing data access and use at both central and peripheral levels.	Data warehouse and web portal providing access to the minimum package of health indicators.	Sep-11	Dec-11	
	Web-based dashboard portal implementation			Nov-11	Dec-11	
Support to other components	Complete oversight of distribution and installation of generators			Oct-11	Dec-11	

	Support Professional councils with implementation of their licensing registries			Oct-11	Nov-11	
	Support eHealth team with implementation of National Health Facility Registry			Oct-11	Dec-11	

Next quarter activities in IHSSP – Health Finance Component

Intervention	Activity/Task	Why it is important	Deliverable/Indicator	Start time	End time
Increase capacity of policy makers related to CBHI and PBF	Finalize CBHI procedures manual: Translation in English and Editing	The implementation of the new Policy need assistance to reinforce the operational procedures, key information and comprehensive guidelines on how to implement the mutuelle intervention following the introduction of the new policy need to be developed.	English version of CBHI procedure manual developed	3-Oct-2011	15-Nov 2011
	Disseminate CBHI procedures manual document.	,,	% of district CBHI sections with the new procedures manual	15-Nov-2011	20-Dec 2011
	Support Ubudehe stratification process: Data validation, DB user manual update,	The web-based database with a CBHI membership interface will allows the mutuelle to pull information on family size and stratification information, while providing more details for MINALOC and MOH. In addition to providing information on Socio-economic stratification across the country	Web application functioning	1-Oct-2011	30-Nov-2011
	Support to the CBHI and PBF Extended team platforms	To bridge the gap between policy (CBHI or PBF) and implementation through the partners coordination activities nationwide, using participatory process in the Dev. of the mechanism and provide assistance to CTAMS, CAAC, districts CBHI structures activities and district PBF steering committee.	ToR for the platforms and editorials committees reviewed	1-Oct-2011	30-Sep-2012
Support the enhancement of CBHI stratification process	Design cell phone (SMS) interface for CBHI Membership DB update	Enable the CBHI sections (without internet connection, a web interface access) to use cell phones for routine data maintenance (Check on an individual's membership status and income category, Update payment information for membership renewals)	SMS interface developed	15-Nov-2011	15-Jan-2012
Strengthen the national PBF models and support the MoH to explore new	Design and development of a PBF model for district pharmacy	The Ministry of Health has decided to establish the PBF at all levels of the health system. The district pharmacies PBF model need to be also defined	Concept note district pharmacy developped	15-Dec-2011	15-Feb-2012

PBF models					
Ensure PBF and CBHI data managemen t and audit	Conduct quarterly CBHI M&E indicators data analysis and reporting	More effective use and analysis of data should lead to more decisions and health impact	Data analysis report available	5-Oct-2011	30-Sep-2012
	Conduct Community PBF client survey	One of the layers of control of the reliability and accuracy of the reporting data in CBHI & PBF database is the verification at all levels. This serves as ultimate check to verify if data are complete and credible.	Report available	15-Dec-2011	28-Feb-2012
	Conduct quarterly SIS comm. data analysis and reporting	More effective use and analysis of data should lead to more decisions and health impact	Data analysis report available	15-Oct-2011	30-Sep-2012
Carry out studies and analyses with respect to efficiency of health financing mechanisms	Capacity building transfer on costing to district actors	The costing process requires the development of local capacity and capacity transfer is required so that MoH and facilities can carry out the updating without external technical assistance. The goal of long term and sustainable approach for building local capacity is to provide tools and methodologies that can be institutionalized by the MOH	Number of DH trained on costing	1-Oct-2011	30-Apr-2012
	Design pricing method based on costing results	The activity aimed to support the MOH in its financing structure by changing the reimbursement mechanism to a DRG basis which should shift some risk and should improve service provision efficiency.		15-Dec-2011	30-Jan-2012
Support the enhancemen t of community PBF roll out	Conduct community PBF system audit: Data analysis, Report Finalization and feedback	Evaluate the PBF-framework, its initial design, and implementation and provide an independent audit/verification opinion.	Report available	1-Oct-2011	30-Oct-2011
	Support the Coordination mechanism on community PBF: Draft ToR, Quarterly meeting	To bridge the gap between policy (on community health) and implementation through the partners coordination activities nationwide, using participatory process in the Dev. of the mechanism and provide assistance to CHD.	ToR available	21-Oct-2011	30-Sep-2012
	Develop refresher training curriculum on community PBF for Sector steering committees and conduct ToT master trainers	Transfer of capacity to new local actors involved in the community PBF scheme.	Curricula available	1-Oct-2011	14-Oct-2011

Next quarter activities in IHSSP - HRH Component

Intervention	Activity/Task	Why it is important	Deliverable/Indicator	Start time	End time
Support MOH in the review and production of the new HR Strategic Plan	Assist the MOH to review the HRH policy	To implement the HRH strategic plan Moh have to develop the operational plans and a M&E plan	HRH policy reviewd and validate	Oct, 2011	April, 2012
	Assist the MOH to develop the HRH operational plans		HRH operational plans developed	Oct, 2011	April, 2012
	Assists the MOH to develop an M&E plan for the HRH Strategic Plan		HRH M&E plan developed	Oct, 2011	April, 2012
	Assist the MOH to disseminate the HRH Strategic plan		Dissemination workshop report	Oct, 2011	April, 2012
Support professional bodies to elaborate, to validate and implement the document of norms and standards of licensing	Assist Rwanda Medical Council to develop a M&E plan for the CPD strategic plan	To improve the quality of health workers professional bodies have to put in place a licensing system and a Continuing Professional Development program	M&E plan for CPD program available	Dec, 2011	Janvier, 2012
	Assist Rwanda Medical Council to build capacity of CPD bureau		Report on CPD results and experiences	Oct, 2011	Sept, 2012
	Assist Rwanda Nursing and midwives council to finalize the licensing process		Licensing system is functional	Oct, 2011	Jan, 2012
	Assist Rwanda Pharmacists association and Rwanda Allied Health Professionals Association to establish a professional council		Allied Health Professional Council is established	Oct, 2011	Sept, 2012
	Assist Rwanda Pharmacists Association and Rwanda Allied Health Professionals Association for licensing process		Certificates and licensing ID are available		
	Assist Rwanda Pharmacists association and Rwanda Allied Health Professionals Association to develop their professional regulations		Common allied health professional regulations are developed	Oct, 11	April, 2012
Carry out regular analysis of staffing data and revise the staffing projections in the light of changing service needs	Assist MOH to implement the WISN methodology	Current HR decisions are not informed by any evidence base. HR managers need a comprehensive, reliable and timely HR information	WISN method is implemented a district level for nurses and midwives	Oct, 2011	Sept, 2012

Next quarter activities in IHSSP - QI Component

Intervention	Activity/Task	Why it is important	Deliverable/Indicator	Start time	End time
Review, develop and disseminate District hospitals required operational policies, procedures and Treatment Guideline / Clinical protocols for quality improvement.	Incorporating Field inputs of policies, procedures from District Hospitals	Document ownership and capturing ideas from DH teams	Policies and procedures within puts from DHs	1st Nov. 2011	30th Nov.2011
	Final review and validation of DH policies, procedures	Collective review and having a consensus on DH policies and procedures	Final documents validated	1st Dec. 2011	31th Dec.2011
	Organize finalization of drafting of National Clinical protocols/ Treatment guidelines	To finalize National Clinical protocols/ Treatment guidelines	National Clinical protocols/ Treatment guidelines drafts finalized	1st Oct.2011	30th Oct.2011
	Internal review of the document with development of the preamble , introduction, acknowledgement	Review and write introductory parts	Reviewed documents with introductory parts available	31st Oct.2011	4th Nov.2011
	Contact and share draft CPs/TGs with the editing team at MSH headquarter	Format and edit the document	Formatted document available	27th Oct.2011	20th Nov.2011
	Seek and incorporate inputs on clinical protocols / Treatment guidelines from professional bodies	Capture Professional bodies Ownership and contributions to the national CPs/TGs	National Clinical Protocols/Treatment Guidelines with inputs from professional bodies	21st Nov.2011	3rd Dec.2011
	Final review and validation of National clinical protocols / Treatment guidelines	Collective review and consensus on national CPs/TGs	Final national CPs/TGs validated	1st Dec.2011	31st Dec.2011
Institutionalization and sustainability of Quality Improvement	Establish and build capacity of accreditation support structures	To ensure structures that supports the accreditation process.	Accreditation management advisory committees available		
	Establish and build capacity of DH accreditation management advisory committees	Orient/train DH accreditation management advisory committees on managing accreditation program	Report on training/orientation of DH management accreditation advisory committees available	13th August 2011	30th Sept. 2012
	Continue to support MOH/ QI TWG to be fully functional	To strengthen QI support structures.	TWGs meeting minutes with recommendations available	1st July 2011	30th Sept. 2012
Develop new and update existing health services packages at all levels.	Finalization and validation of health services package for different levels	For collective review and finalization of service packages	Report on validation of service packages	24th October 2011	15th Nov. 2011
Support Health System Supervisions	Participate in the functional integrated joint supervisions	Support MOH to organize and participate in functional integrated joint supervisions	integrated joint supervision reports available	1st July 2011	30th Sept. 2012

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