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RWANDA INTEGRATED HEALTH SYSTEMS STRENGTHENING PROJECT:

Quarterly Report Narrative

July – Sept 2010

Rwanda IHSSP Project:

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Contract No. GHH-I-00-07-00058-02,

Task Order No. GHH-I-03-07-00058-00

Stronger health systems. Greater health impact.

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Acronyms

AIDS/SIDA	Acquired Immunodeficiency Syndrome
BDD	Base de Données/Database
BTC/CTB	Belgian Technical Cooperation/Coopération Technique Belge
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)
CHW/ASC	Community Health Worker (Agent de Sante communautaire)
CHAI	Clinton Health and Aids Initiative
CTAMS	Cellule Technique d'Appui au Mutuelles de Sante; Mutuelle Technical Support Cell
CNLS	Commission National de Lutte contre le Sida
CPD	Continuous Professional Development
CPN	Consultation Prenatale/Antenatal Consultation
DHS	Demographic and Health Survey
DH	District Hospital
DRG	Diagnosis Related Group
ET	Extended team
GOR	Government of Rwanda
HC	Health Center
HDP <i>asdl</i>	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
ILO/BIT	International Labor Organization
IT	Information Technology
ITG/IMT/ITM	Instituut voor Tropische Geneeskunde, Antwerp/ Institut de Médecine Tropicale d'Anvers/Institute for Tropical Medicine, Antwerp
M&E	Monitoring & Evaluation
MIS	Management Information System
MCH	Maternal and Child Health

MOH	Ministry of Health
MSH	Management Sciences for Health
NGO	Non-governmental Organization
PBF/PBC	Performance-based Financing/Performance-based Contracting
PEPFAR	President's Emergency Plan for AIDS Relief
PHP	Hypertext Preprocessor
PMA	Paquet Minimum des Activités; Rwandan basic package of health services
PMTCT	Prevention of Mother-to-Child Transmission [of HIV]
P4P	Pay-for-Performance
PRISM	Performance of Routine Information System Measurement tool
QA	Quality Assurance
RBF	Result-Based Financing
SIS	Système d'Information Sanitaire (Health Information System)
SWAP	Sector Wide Approach
TA	Technical Assistance
TOT	Training of Trainers
TWG	Technical Working Group
USAID	United States Agency for International Development
USG	United States Government
VCT	Voluntary Counseling and Testing
WB	World Bank

Executive Summary

During the last quarter of fiscal year 2010, IHSSP was very productive. Following is a summary of the main accomplishments and events of the quarter.

Overall project achievements (cross-cutting the 5 components): The national Health System Strengthening Strategic Framework and Consolidated Strategic Plan has been finalized and submitted to the Minister of Health for signature. 10,000 cell phones were turned over to the MOH and distributed to nearly 1,000 trainers (mostly data managers and CHW coordinators) for eventual distribution to CHWs for use in mUbuguzima and RapidSMS

As for the **HMIS component**: The SIScom database was updated and new rules were added to reduce data entry mistakes. The CBHI stratification database has been designed. A short term local consultant helped to prepare a functional review of the iHRIS HR information system. The MoH statistical booklet of 2009 was prepared.

Concerning the **Health Financing** component: After the revitalization of the reporting on Community health activities in the framework of community PBF, the completeness of reporting increased from 17% to 75% and is still improving. The information through this reporting system is now also used to inform the impact evaluation study on demand and supply side incentives. The first steps in a costing exercise for the different diseases and diagnoses were taken through a workshop in which diseases were prioritized for frequency and public health impact and associated with the level of the health system where they are treated. Districts have been instructed on use of the finalized PBF framework.

Four abstracts were accepted for panel presentation for the First Global Symposium on Health Systems Research conference in Montreux to be held in November 2010 The CBHI policy were approved and made publicly available.

The CBHI structures and functions were assessed at the decentralized level to identify gaps in administration, accounting management and functionality at the district (conseil d'administration) and sector (comites de gestion) levels. The CBHI stratification process was initiated, which will lead to a sliding scale of premiums for insurance according to economic calls, with the development and initial data entry of the members' database. Training sessions on community PBF to introduce the models were conducted and the revised PBF tools were introduced in the districts.

The **Human Resources for Health** team accomplished the following during the reporting period:

- Development of the strategic plan for Human Resources for Health
- Policy and strategy documents for Continuing Professional Development (CPD) for Rwanda Medical and Dental Council were completed and validated
- The first steering committee meeting with the MoH took place discussing the workload indicator of staffing needs (WISN) approach and two training of trainers sessions took place.
- A HRH situational analysis gathering data on institutional overview, stock, utilization, education and training, and governance including policy context.
- Co-facilitated the fourth workshop for the Leadership Development Program in Burundi.

- Consultative meetings with representatives of councils of Nursing and Midwifery were held to discuss the defining of norms and standards for licensing and with pharmacists and Allied Health Professionals to discuss further actions required to develop and/or finalize legal statutes governing their councils.

In the field of **Quality Improvement**, the District Hospital Strategic Accreditation Framework was developed and a draft will be shared before the end of October. During the preparatory phase for accreditation, a new initiative was launched, called the “Rapid Quality Improvement”, which will focus on reviewing and adapting the existing policies procedures and guidelines for the reference hospitals to the District level hospitals. A list of proposed required policies, procedures were identified and shared with DH teams to seek their input for adaptation.

The activities mentioned above that are implemented at district level have been supported by the **Decentralization** team. These include among others the Health PBF evaluation, Community PBF revitalization, CBHI situation analysis and M&E, training of health Steering committee at sector level on health data management, participation in District hospitals PBF evaluation activities and in PBF and CBHI extended team meetings.

Project Management: Project direction was ensured during the reporting period by the interim Chief of Party, Dr. Apolline Uwayitu, while MSH continued its search and selection process for a permanent COP. Newly recruited project staff during the quarter include: a Human Resources Manager; a Contracts Specialist; and several drivers.

About the Rwanda Integrated Health Systems Strengthening Project

The Government of Rwanda (GOR) has embarked on the next steps to strengthen its Health System and to reach its goals outlined in the Health Sector Strategic Plan II in order to accomplish the overall vision: “*Rwandan population* [will have] improved financial and geographic access to quality health services that are sustainable and efficiently managed by well trained *health sector staff* with clear functional responsibilities and of having *districts* becoming the hub for managing health service delivery supported by actively engaged community and civil society organizations.”

The Rwanda IHSSP is a 5-year contract awarded to Management Sciences for Health by USAID to support the Rwandan Ministry of Health in to achieve the following 5 intermediate results: 1) *Improved Utilization of Data for Decision-Making and Policy Formulation across All Levels of the Health Sector*, 2) *Strengthened Health Financing Mechanisms and Financial Planning and Management for Sustainability*, 3) *Improved Management, Quality, and Productivity of Human Resources for Health and Related Social Services*, 4) *Improved Quality of Health Services through Implementation of a Standardized Approach to Quality Improvement (QI)*, 5) *Extended Decentralized Health and Social Services to the District Level and below*.

Results Highlights

Highlights of the project’s activities during the quarter are reported below, beginning with cross-cutting work and then focusing on the project’s five intermediate results.

HSS Framework and Consolidated Strategic Plan development

IHSSP has assisted the MoH and USAID in the development of this document. Two workshops were organized since May 2010 in which input and feedback was gathered from pMOH staff and development partners on the content of the strategic plan. This plan will serve as an overall framework for the strengthening of Rwandan Health System as well as an advocacy document containing a concrete outline with specific interventions where a gap in funding remains. Final revisions, both cosmetic and content changes were made by MSH/Boston. The final document was submitted to the Minister for signature in August.

IR 1: Improved utilization of Data for decision making and Policy formulation across all levels of the health sector

This quarter has seen significant changes in the HMIS team at the MOH. Dr. Charles Ntare has taken over as HMIS coordinator from Dr. Emilien Nkusi, the counterpart of MSH’s HMIS technical advisor since 2008. A considerable amount of time of MSH’s staff has been devoted to orient Charles Ntare and his team on HMIS, prepare an annual operational plan and budget and review strategic plans in light of the HSS framework. A sub-set of this plan has been incorporated into the IHSSP workplan for FY2010-11.

IHSSP’s Health Information Systems team, did not grow as expected this quarter as the person identified for the Data Use Advisor did not end up taking the post and other candidates interviewed were not

selected. We did, however, begin work on the functional review of the iHRIS with the recruitment of a consultant for 3 months.

Key accomplishments during this quarter for the health information systems component included the following:

- **Roll-out of cell phone-based Community Health Information systems (mUbuguzima and RapidSMS).** The project has also completed the transfer and distribution of 10,000 cell phones. A total of nearly 1,000 trainers (mostly data managers and CHW coordinators from each of Rwanda's nearly 450 health centers) have been trained in all districts. The training of community health workers has not yet begun in earnest as the MOH works out with MINECOFIN how to transfer funds to each health center to fund the training.
- **Management and updating of the SIScom database:** during the information campaign for the explanation of the community PBF models, emphasis was also put on the completeness of reporting and data entry on CHW-activities. This quarter, bugs were discovered in the database that required to update 732 cooperative reports. This is currently ongoing. Despite this drawback, completeness of reporting for the year 2010 reaches close to 75% coming from a mere 17% in the previous quarters. To reduce data entry mistakes, logical checks were introduced in the database (red alerts when someone enters implausible data) and a whole new manual was elaborated on how to fill out reports in the SIScom database.
- **Design and implementation of Mutuelle Stratification Database:** This is complete now and data entry is scheduled to begin in mid-October. Nearly 150 data entry staff will be entering the data in 2 shifts over a 3 month period. This will help the Mutuelle with their cost stratification strategy and will also be useful for recalculating health facility catchment areas.
- **Technical Assistance to the MOH eHealth Unit:** With the staff changes in HMIS and considerable recruitment completed, the MSH team worked with the eHealth and HMIS unit to clarify the relationships between the units and develop an operational plan for 2010-11. We also worked out a seating plan for the team in the newly refurbished MOH offices. The HMIS advisor also assisted the new M&E advisor at the MCH desk with a broad range of analyses of HMIS data for the MCH annual report.
- **HR information system:** IHSSP hired a short term local consultant to help prepare a functional review of the iHRIS, the current web-based software that was implemented by the Capacity project. The server was non-functional for several months and has been re-enabled. The consultant is putting together functional specifications for new modules that were recommended by district and national level staff early last year including modules for: in-service training like the one MSH developed, leave management and employee performance management.
- **Preparation of the 2009 Health Statistics Booklet:** the IHSSP team organized a 1 day workshop for staff from key health programs to review HMIS data and develop analyses of key trends that will be included in the bulletin due to be completed at the end of October. This followed several days of intensive data analysis with the database manager at the MOH to prepare the draft analysis tables for each theme.

- **Support to President's Malaria Initiative:** We completed the configuration and transfer of server for PNLN and worked regularly with the PMI team and technical working group that has been set up for Malaria-related M&E, Surveillance and Research, mostly to help with data analysis.
- **Support to CAAC:** Assisted with the preparation of Q2 payments which had to be reduced because of limited funds.
- **Support to Community Health Desk:** Thirty spreadsheets were consolidated into a database of community health worker with telephones in order to arrange logistics for the training and transfer of funds to health centers for mUbuguzima and RapidSMS training.

Other items to note:

- **Generator procurement:** The analysis is complete now. 40 generators are to be purchased pending approval from USAID.
- **IHSSP workplan and budget:** The HMIS team prepared their section of the IHSSP workplan, building on the HMIS and eHealth unit workplans.

IR 2: Strengthened Health Financing Mechanisms and Financial Planning and Management for Sustainability

- **CBHI stratification process with members' database development**

The CBHI new policy (with as main change the "stratification") has been approved and the first step of its implementation is the categorization of the population. The decision made by the MoH is to use the categorization done by the CDF based in the Ministry of Local Governance. The existing categorization data was collected in 2007 and needed to be updated in order to be relevant for stratification purposes. A technical committee has been put in place, with members from Minaloc, MoH and MoH partners (WHO, IHSSP & GTZ) who are overseeing and coordinating this activity:

In collaboration with Minaloc, MoH and other partners (GTZ, ILO, WHO), IHSSP has contributed technically in many ways in this quarter:

- ✓ Participation in the technical committee established by the 2 departments in the ministry to coordinate the stratification process (with the contribution of 2 members out of 6 members of this technical committee);
- ✓ The Database (Web Based) to keep all stratification related data (Names of members, Names of their dependants, their ages, their ID Numbers, addresses.....) has been developed with the support of IHSSP.
- ✓ IHSSP will contribute financially to the activity of Data Entry, which has a high budget. The IHSSP contribution will be the payment of the salaries of 300 Data entry Clerks for 17 days and the data entry supervisors for 34 days.

So far, the data have been collected in 23 districts. The activity of data entry is ongoing, recruitment of 300 staff for data entry has been done (most of the candidates are the ones who have done the same exercise with the ID card department). The activity of data entry is supposed to take about 4 months and the estimated total cost is 843,000 US\$. The main challenge faced is the financial gap which is around 404,000 US\$.

- **CBHI program assessment at decentralized level**

The objective of this activity was to identify the actual challenges faced by CBHI structures at decentralized level. IHSSP has conducted an assessment to identify gaps in administrative, financial and accounting management as well as in the functionality of organizational structures. The assessment has been conducted in 4 districts chosen by CTAMS (Ngoma, Karongi, Nyarugenge & Gisagara). The results of this assessment show that the main gaps in CBHI system are:

- ✓ No tools standardization
- ✓ There is no known accounting system
- ✓ The financial procedures are not well defined
- ✓ The bill verification is limited to physical existence of the patient (especially on section level)
- ✓ The main challenge is that the CBHI sections are not able to cover all expenses related to health services received by its members.

In regards to these challenges/gaps, IHSSP will focus its interventions to fill some of those gaps and will also support the elaboration of a procedure manual, and the standardization of tools (to be defined and inspired by the new policy).

- **Trainings on community PBF to introduce the 4 models**

IHSSP continues to support the roll out of the innovative approach of community Health Performance Based Financing with the introduction of the 4 models in all provinces:

- ✓ The supply side model will provide incentives to CHWs cooperative upon the completion and submission of a progress report (pay for reporting) as well as achievement of a set of indicators (pay for indicators). The pay for reporting will be assessing CHWs reports in term of Timeliness, Accuracy and Completeness (50%). In addition, it will assess CHW cooperatives through 9 prerequisites conditions (50%). This will be functional nationally within the 427 cooperatives of CHWs. The pay for indicators, which applies particularly to the supply side selected sectors, requires that incentives shall be offered to CHW cooperatives conditional on improvement in coverage of 5 maternal and child indicators.
- ✓ Unlike the Supply Side Model, the Demand Side aims at motivating health facilities users from selected sectors to increase the uptake of health care services which consequently will contribute to the reduction in maternal and child mortality rate.

Before implementing the new Community PBF model, an information campaign aimed at informing health officials on the changes has been organized by the Community Health Desk (CHD) at the MoH. It

is in this regard that the Ministry of Health in partnership with IHSSP organized trainings on Community PBF that took place from August 17th through September the 22nd in the whole country. Officials from 377 sectors of the 4 provinces and the city of Kigali were invited to these trainings. An attendance rate of 97% was recorded (1,416 participants with 19 workshops organized).

The main challenges noted in the implementation of the program are related to the design of the impact evaluation. The study focuses on implementation at sector level while cooperative and clinical work is linked to health centers. Some sectors contain more than 1 health center but this information was not correctly mapped leading to possible contamination in the introduction of the 4 models in the 200 sectors concerned by the impact evaluation. Currently, steps are being undertaken to update the training in the concerned sectors and health facilities.

The payment mechanism envisaged for community PBF has been updated but is not yet finalized. There has been a shift in payment for coverages to unit fees as long as the population sizes are not well defined for each target area and as long as complete data from the SIScom of the last 18 months is not available yet. The specific PBF-payment according to pay-for-indicators and pay-for-reporting still has to be made operational.

- **Costing exercise for the health services**

IHSSP continues to carry out the costing exercise which aimed to determine the costs of providing the Paquet Minimum d'Activités (PMA) and the Paquet Complémentaire d'Activités (PCA). The service package costing exercise is planned and overseen by the MOH's Costing Steering Committee. A 3 days workshop was organized in Rubavu from 19th to 21st August with the objectives to select among the ICD-10-classification diseases which are prevalent and of public health importance to Rwanda, and to develop from there a prioritized list of services to be costed using ICD-10 nomenclature. An expert group of 25 medical doctors coming from district and University teaching hospitals participated in this process with officials from MoH (including the Permanent Secretary). The output of this workshop was the production of a MS Excel work book containing the international disease codes showing which of those diseases are treated in Rwandan government health centers, district hospitals and government hospitals; and also a prioritized list of diseases has been established, grouping of the diseases currently treated in Rwanda into medical and surgical cases, and adult and pediatric groups.

A second step has been data collection on costs of procedures (e.g. administrative, clinical,...) in the health facilities. Well performing health facilities (based on the overall PBF quality Assessment, the financial management scores and scores from the district health system strengthening tool from the MoH) were chosen for this data collection. The following 9 health centers are involved: Jali Health Center (HC), Mukono HC, Mubuga HC, Gahanga HC, Shingiro HC, Mushubi HC, Rugarama HC, Kinazi HC, and Rukomo HC. Selected district hospitals are Nyamata, Ruhengeri, Rwinkwavu, Kibagabaga, Kibogora, and Ngarama. The two national teaching university hospitals (CHUK and CHUB) will also be part of the costing exercise.

At each level, a list of data to be collected has been established (see annex for more details).

Also a possible long term strategic uses of the Diagnosis Related Groups (DRG) costing work in Rwanda was proposed by the IHSSP to the USAID. The DRG costing can be an important entrée to many different aspects of the health financing framework in Rwanda: financing structure, reporting and analysis, quality, efficiency and cost effectiveness. See annex 2 for more details on the long term strategic uses of the costing exercise.

- **Abstract development with the MoH to be submitted for the Global Health Metrics and Evaluation conference 2011 in Seattle, Washington, USA**

The IHSSP team worked with MOH to prepare on costing of health services. The conference will highlight innovative methods, the latest debates in measurement, and the transformation of data into effective policy for improved population health. Sessions will be organized to promote debate, discussion, and an open exchange of ideas. Given the above announcement, the paper should probably focus on the measuring of costs and the use of the data to change the financing and efficiency of services which are expected to result in improved health services in Rwanda (See ANNEX).

- **Introduction of revised PBF tools in the districts**

The PBF revision framework ended in the beginning on the third quarter and IHSSP in collaboration with the PBF Extended team platform started the introduction on these changes through trainings in all 30 districts. Those trainings targeted supervisors and PBF evaluators at district level, health center staff (2 by each health center) at facility level. The objectives of the trainings were the introduction of the main changes introduced in the PBF administrative structure and tools, and health facilities, the development of the performance target for this 2010 and 2011 years through the business plan indicators, and at the end of the trainings health facilities renew and signed their PBF contracts.

- **Development of PBF procedure manual**

In the optic of harmonizing the implementation of PBF at national level, IHSSP support the MOH in the development of the PBF procedure manual, a reference tool for PBF to all implementers. A first draft was developed and submitted by the PBF technical unit CAAC to the MoH SMM for the first review. As next step, a workshop with partners to review contents of the draft document and identify necessary inputs will be conducted at the end the October.

- **Development of additional PBF models**

As requested by the MoH, IHSSP is supporting now the development of additional PBF mechanisms especially for the TB program and CAMERWA. Choice of indicators to improve functioning and certain key activities within the TB-program are currently under development and will be finalized next quarter.

- **Capacity building transfer to MoH and IHSSP staff**

Training on the data use and analysis for the MoH staff (CTAMS, e-health and HMIS departments) was organized by IHSSP. The main objectives of the training were the transfer of the CBHI Database

management capacity to MoH staff (Especially user's management) and the capacity transfer related to data entry & analysis done through the database. This was a 2 days training and 22 people participated in the training. The next step is the training of District CBHI staff, as many of them have a lack of sufficient knowledge on data analysis.

An African flagship workshop on health systems strengthening was held in Kigali, Rwanda, from June 21 to July 2, 2010. The workshop was organized by the World Bank in partnership with the Ministry of Health and the National University of Rwanda's (NUR's) School of Public Health. IHSSP staff in charge of CBHI together with the health financial specialist participated in the flagship. The main objectives of the Flagship course were: First, developing skills to develop the capacity to define the problems in the country, and second, to provide participants with vivid examples of innovations, financing, and planning. These skills gained by IHSSP staff will be very useful for the technical assistance to MoH.

Another Seminar for Francophone African Countries was organized by USAID, WHO, HSO Financing and Health System 2020; the main objective of the seminar was "how to make operational the health insurance in Africa"; Rwanda and Ghana were the country models. IHSSP participated, helping in facilitation (as Rwanda was chosen as the model), but also gaining from other country's experience.

IR 3: Improved Management, Quality and Productivity of Human Resources for Health and Related Social Services

- **Development of the strategic plan for Human Resources for Health**

As recommended by the roadmap of the HRH development plan and under auspices of the Ministry of Health, the IHSSP team was requested to partner with several partners including the Clinton Health Access Initiative (CHAI), CDC, Tulane University, University of Western Ontario, WHO, World Bank, SDC, GTZ and other development partners to develop the strategic plan on HRH for the upcoming five year (2010-2014). Several ongoing studies will provide the evidence basis for the strategy, which will be finalized by end 2010.

- **Continuing Professional Development (CPD)**

The Rwanda Medical Council is committed to contribute to the national health systems strengthening particularly focusing on regulating the medical profession, Continuing Professional Development and the promotion of best practices in a bid to raise the standards of care. Medical practitioners have little access to continuing medical education (CME) and even less opportunity for continuing professional development (CPD) after graduation from the Faculty of Medicine. Given the rapid pace of new research and developments in all areas of medical care, it is imperative that professionals must continue to update their knowledge and skills regularly. During the reporting period, policy and strategy documents were completed and validated and a workshop to launch the program is scheduled early next quarter.

- **Workload Indicator of Staffing Need (WISN).**

Rwandan Ministry of Health wants to establish the workload indicators of staffing need (WISN) methodology. The WISN methodology calculates the required number of staff in a health facility based on the workload of that facility and accepted professional standards of service delivery. WISN is a very useful human resource management and planning tool, whose use can improve many staffing decisions. These include allocating and deploying staff, planning future staffing, and assessing professional performance and workload stress.

The long-term goal in Rwanda is for the WISN methodology to be accepted, implemented and regularly applied. Several things are essential for this to happen. First, the stakeholders and decision-makers must support the implementation of WISN and be committed to using the results for decision-making. Second, Rwanda must have a core group of individuals, who are competent in using the WISN methodology and able to train others in it. Third, select representatives of key professional cadres must take a lead in defining workload components and activity standards (two important steps in the WISN methodology). Fourth, the WISN methodology must eventually be integrated into the routine health management systems.

- In August, the first meeting of the WISN Steering Committee took place at the Ministry of Health. It included representatives of the Ministry of Health, Medical and Nursing Councils, professional associations, training institutions, and key donors. Dr. Karengera, the Advisor to the Minister of Health, who chaired the meeting, emphasized that the Ministry sees the development of a rational method for assessing staff needs and workloads as important. After explanation and understanding of the WISN methodology, the Steering Committee members approved the terms of reference and membership of the SC. They agreed that the development of health service standards, which are appropriate for Rwanda, is overdue and very important. It was also recognized that this meeting of the Steering Committee was only an initial step and much work is still necessary before the WISN methodology is fully established in Rwanda.
- In August, two TOT sessions on WISN were organized.
 - The first one for the two university teaching hospitals (Kigali and Butare) including a team of a doctor, nurse and HR manager; the Kigali Health Institute was also represented. This training took place at the IHSSP offices in Kigali from 11 to 13 August 2010.
 - The second TOT was organized on 17-19 August 2010 for teams from eleven district hospitals. As in the first TOT, each team consisted of a doctor, nurse and HR manager.
 - In total, 54 participants attended the trainings. Participants of both TOT were very keen to learn the methodology, and many commented on its usefulness for their work. The trainees acknowledged that Rwanda currently lacks locally-appropriate health service standards, and agreed that developing them was important.

- Next steps include to support and monitor the progress of practicing WISN development in the two teaching hospitals and the eleven district hospitals, convene a meeting or meetings between the teams after they finish the WISN development to share experience, reinforce learning and gather suggestions for next steps, review with USAID the PS's request for a full-time WISN person in the MOH. If approved, draft the terms of reference, hire the person and train him/her in WISN and finally prepare a step-by-step plan for establishing WISN in Rwanda in collaboration with the Ministry of Health and other relevant stakeholders and present it to the WISN Steering Committee for its approval.

- **HR and Decentralization**

The Rwandan government has well-defined terms of recruitment into the public service, and the labour law has recently been revised. The country also has a good reputation for its low level of corruption. All these will help Rwanda avoid many problems that other decentralized countries have encountered in transferring HR functions to lower levels, for example non-transparent hiring practices, nepotism and unfair dismissal. The main challenges for Rwanda are likely to be ensuring appropriate HR management of staff who are hired locally outside the public service, as well as the local management of pay-for-performance incentives. The Rwandan decentralization appears to have been characterized by frequent changes in management roles and structures at the district-level. This has resulted in a certain degree of organisational instability. The Ministry of Health Permanent Secretary has asked the IHSSP to place an additional staff member in the health team of all 30 districts. As part of planning for the placement of the additional staff members in several districts (though probably not all 30), the IHSSP has developed a special rider questionnaire to the PRISM assessment. The study will help the IHSSP define the 'minimum package' of health-related functions that districts should perform, and clarify the qualifications and experience of staff recruited for the district-level positions.

- **The fourth workshop for the Leadership Development Program in Burundi**

Since September 2009, Pathfinder, in collaboration with Management Sciences for Health (MSH), USAID/Burundi and the Burundi Ministry of Health has been organizing leadership development programs for the Ministry health managers. MSH/Rwanda was invited to co-facilitate the fourth workshop in September 2010 and build capacity for MSH staff in Burundi.

- **Development of specific statutes governing health professionals.**

The Government of Rwanda Ministry of Health authorized the formulation of specific statutes to govern health professionals. These statutes shall describe the entry point for health professionals, their career advancement and performance appraisals and management. The law governing the nursing profession needs revision and should be sent through all validation steps to be enacted. The Council of Pharmacists and other councils shall be encouraged. An overarching Health Professionals Council will be formed by members appointed from the various health professional bodies.

During this reporting quarter, the IHSSP team has held consultative meetings with representatives of councils of Nursing and Midwifery to discuss on defining norms and standards for licensing and with

pharmacists and Allied Health Professionals to discuss on further actions required to develop and/or finalize legal statutes governing their councils.

Further larger consultative meetings are planned next quarter.

IR 4: Improved Quality of Health Services through Implementation of a standardized approach to quality

In the bid to reinforce efforts to quality of health care in Rwanda, Rwanda chose facility accreditation as one of the many strategies to improve quality of services. This is in line with institutionalizing the process of continuous quality improvement of health care services targeting a range of comprehensive services in facilities. The health facility accreditation program aims at creating the framework for a national health care facility accreditation program that would foster a sustainable culture of continuous quality improvement in health care even without partner support. It is on this note that the IHSSP/MSH Quality improvement team developed a District Hospital Strategic Accreditation Framework. Currently a draft is being developed and will be shared before the end of October.

While the MoH is trying to scale up the accreditation of health facilities from the National referral hospitals to the district hospital, given the experience of referral hospitals the biggest quality gap identified was lack of policies, procedures & clinical guidelines. Therefore, during the preparatory phase for accreditation 'The Rapid Quality Improvement' will focus on reviewing the existing policies procedures and guidelines and developing new ones, to provide guidance and direction on how best services should be offered hence bridging the existing quality gap in services delivery. A list of proposed required policies, procedures was identified and shared with DH teams to seek more input for finalization. Experience sharing of referral hospitals policies, procedure and clinical guidelines development will be done at a workshop next early quarter involving participants from 41 district hospitals. The intent of this is to sensitize DH teams to own the process and buy in of this heavy and crucial activity that is due to start. The next step will be to establish the existing gap with regard to quality improvement service operational policies, procedures and clinical guidelines.

Annual Activity Planning 2010-2011 for Quality Improvement has been developed as part of the IHSS Project plan for this year.

The QI team participated in the facilitation of district hospital PBF quality evaluation of the 2nd Quarter. Similarly the same team participated in the Workload Indicator Staffing Needs (WISN) training of trainers of both referral and district hospitals, aimed at teaching these institutions a methodology that will help them improve the current health personnel staffing situation and deployment of available health staff more effectively, as well as how to plan for future staff projections.

QI team participated in the development of the Continuous Professional Development (CPD) Strategic plan for the Rwanda Medical Council as it is committed to contributing to national health systems strengthening by focusing on regulating the medical and dental profession, Continuing Professional Development, and the promotion of best practices in a bid to raise the standards of care.

- The rationale behind CPD is that it will improve patient care and at the same time ensure that medical and dental professionals maintain and improve their competencies in their scope of practice. The program will foster the delivery of equitable, quality, services, and it is critical for the improvement of health outcomes and future technical sustainability.

A joint Quality Improvement plan for partners is being developed to be finalized at the end of October. This will help the clinical service unit coordinate all quality improvement initiatives and monitor implementation progress.

IR 5: Extended decentralized health and social services to the district level and below

- The decentralization team provided technical assistance to the Districts in understanding and use of HC PBF, Community PBF and CBHI-database: decentralization team assisted districts in organizing activities on PBF and CBHI reporting; and helped in updating reports for SIScom and CBHI BDD. For this, field visits have been conducted within the districts where problems were identified regarding reporting in BDD. Then, the new staff in districts was initiated on data entry, including Rulindo in the Northern Province.
- PRISM assessment: A questionnaire for administrative district chapter has been finalized and translated in Kinyarwanda. Data collection will started in the next quarter.
- Technical assistance was given to others components of IHSSP:
 - Training of Trainers (ToT) in mUbuguzima & RapidSMS: all new decentralization staff has been involved in-depth in training sessions. All districts across the country have been trained in how to conduct training at community level.
 - Training in Community PBF (4 models): this was carried-out in all districts.
 - Refresher sessions on business plan and PBF contract sessions: sessions well conducted by involvement of decentralization staff. Business plan have been developed at Health center, PBF contract signed by Comite de Pilotage and Health center.
- Annual planning 2010-2011: action plan for 2010-2011 has been developed.
- Participation in HSS framework workshop validation

Project Management

The IHSS Project direction was ensured during the reporting period by the interim Chief of Party, Dr. Apolline Uwayitu, while MSH continued its search and selection process for a permanent COP. The Senior Leadership Team, consisting of the COP, the Financial and Administrative Director and the Technical Director has commenced regular weekly meetings to review, decide and act on technical and management issues. The technical team leaders also meet with the COP and Technical Director at regular weekly intervals to reviews progress and upcoming activities.

Newly recruited project staff during the quarter include: a Human Resources Manager; a Contracts Specialist; and several drivers.

Red Flags for the Quarter July-Sept 2010

CHALLENGE	RESOLUTION
Urgent need to develop PBF-TB indicators due to approved grant from GF	Very frequent technical meetings to propose again a feasible adaptation of current PBF-model
Community PBF roll-out difficult to manage due to complex design	Proposal to simplify design and implement interventions at HC-level and not sector level
M&E department of different units of the MoH (among others MCH) require a lot of technical assistance	More physical presence at MCH department. Competent and available MoH staff needed.
Lack of permanent Chief of Party	Candidates were identified and interviewed during the quarter. Final selection will be early in next quarter
Lack of definition of what IHSSP's support to the districts should be	Discussions with MOH and USAID have begun to clarify this.

ANNEX 1: RWANDA DRG COSTING STUDY: Hospital Collection Tool

Steps to be followed and data to be collected.

Unless stated otherwise data are to be collected for the calendar year 2009 (January to December 2009).

1. Get a list of departments at December 2009 – clinical, ancillary and administrative.
2. Get a list of the wards and the number of official and unofficial beds in each ward for December 2009. Include list of private patient beds and how they are distributed.
3. Get a list of the types of treatment provided at the hospital grouped by clinical department (inpatient and outpatient) as at December 2009.
4. Get a list of the total staff of the hospital by type and level of staff for December 2009.
5. Get a list of staffing (doctors, nurses and midwives) for each clinical department (outpatient, emergency and inpatient) for December 2009. This can be expressed in terms of number of staff of each type and level that is on duty – day shift and night shift. For example 1 doctor and 3 level-one nurses on duty in the surgical ward during the 9 hour day shift.
6. Get a list of salaries and allowances for each staff member (or if that is not available, for each staff type and level). Get information on any contributions made on the employees behalf (eg to social security).
7. Get the full set of HIS data for each month from January 2009 through June 2010.
8. Get the actual expenditure data for calendar year 2009 the hospital as a whole broken down by line item to the greatest level of detail possible (eg transport, administrative supplies).
9. Get any information available on which of those costs directly relate to specific departments. EG fuel which may be for heating or transport.
10. Get the budget for calendar years 2009 and 2010.
11. Get information on any significant amounts of supplies and services provided free of charge to the hospital in 2009 – name of donor, type and quantity of goods or services, and cost (if available).
12. Visit each ancillary department and see what records they have for issues to, or services performed for, the clinical departments. (The ancillary departments are lab, pharmacy, radiology, operating theatre, rehabilitation and blood bank). For example, find out if the lab department has records which show the numbers and costs of tests carried out for each department (or ward). If so get the total number of tests and total cost for the tests performed for each department for 2009. Check that the total number of services for each clinical department adds up to the total number performed by the ancillary department. Collect these data for every ancillary department.
13. If the ancillary department does not have the services and cost data available, get the data from the registers. To do this, first get the total number of services for each month, calculate the average and see if there is any significant variation in those totals. Use that to select a month which has a total number of services that is close to the average. Then count the number of tests for each clinical department for that month and make sure that the totals add up to the grand total for the month.

14. Get a copy of the user fee schedules for insured patients, uninsured patients, indigent patients and private patients.
15. Get a copy of the PBF contract.
16. If the hospital is a teaching hospital describe the teaching functions, which staff are involved and how much time is spent teaching for each staff person.
17. Get 3 inpatient records for each category included in the DHHIS for which there are 12 or more cases in the year, on average. Get the doctors to say which one of those records reflects the best treatment and make a copy of that record. The copy needs to show the patient name, age, sex, diagnosis, details of each test and treatment, and whether the patient was discharged or died. Note that we do not need to do this for outpatients.
18. Take a photo or a photocopy of each inpatient clinical department or ward register for one recent month (June 2010) and produce a summary of the total number of each type of diagnosis treated in that department/ward in the month.

Possible long term strategic uses of the DRG costing work in Rwanda

Cost modeling description

The DRG cost modeling work in Rwanda will produce cost estimates of health service outputs. These may be expressed as the cost of a preventive or curative service at a health centre (e.g. family planning or treatment of pneumonia) or a hospital outpatient clinic, and as the cost of an inpatient course of diagnosis and treatment at a hospital.

The cost modeling includes several important features which will be useful for the MOH:

1. Costs are based on Rwandan standard treatment protocols and resource needs. This means that the costs represent the resources needed to provide good quality services.
2. Actual costs are also calculated for a sample of facilities. This means that we can compare what they actually spent with what they should have spent and thus measure efficiency levels and estimate resource gaps.
3. The health centre cost model includes incidence and prevalence rates and can show the cost of the resources needed to increase coverage levels.
4. The health centre model automatically produces a list of drugs needed for the actual or projected numbers of services.
5. The models include a revenue component which means that the mix of revenues can be modeled to reflect changes in numbers of services and modifications to fee and reimbursement levels.

Strategic health finance framework

The DRG costing can be an important entrée to many different aspects of the health financing framework in Rwanda. These can be summarized as follows:

1. Financing structure:

- a. Changing the insurance reimbursement mechanism to a DRG basis which should shift some risk from the mutuelles to the facilities and should improve service provision efficiency. At the same time changing the amounts paid to reflect real costs.
 - b. The changes in insurance reimbursements can lead to:
 - i. changes in premiums and co-payment levels,
 - ii. Changes in billing and payment systems.
 - c. Changing user fee mechanisms and levels,
 - d. Changing incentive payment mechanisms and levels.
 - e. Changing the way that government subsidies are calculated by providing more accurate information on costs.
 - f. Changing the ways donors contribute by providing service purchasing options.
2. Planning and budgeting
 - a. Setting feasible coverage and scale up targets based on available resources (the cost models show the cost of different target levels).
 - b. Aligning facility and district budgets with projected costs.
3. Reporting and analysis
 - a. Providing more precise costs to NHAs.
4. Quality, efficiency and cost effectiveness
 - a. Providing better information on the resources needed to meet quality standards.
 - b. Providing information that can be used to compare the efficiency of resource provision across facilities, which can lead to efficiency improvements.
 - c. Providing information on the cost of services at different levels and the savings that can be achieved by task shifting (e.g. from health centre to community).

Annex 2: Suggested abstract on the measuring of costs and the use of the data to change the financing and efficiency of services

Possible title: “Restructuring the funding of health services based on a better understanding of costs – the Rwanda experience”

Keywords: Costing, Health service packages, community-based health insurance, reimbursement mechanisms, Rwanda.

Presentation – panel preferred

Abstract

Objectives: By the end of the presentation, the participants will be able to understand how to measure costs and how to use them to restructure the funding and efficiency of health services.

Improving health service sustainability is an important goal in Rwanda. Challenges exist both in the financing of services and the efficiency and quality of provision. One major challenge is the way in which insurers reimburse service providers which puts all the financing risk on the insurers and which does not encourage the providers to be efficient in the use of scarce resources. Another challenge is the difficulty in making a successful case to the Ministry of Finance based on the need for services.

In both cases it is vital to know how much services should cost. The Ministry of Health has, therefore, recently embarked on a major exercise to determine the cost of each service included in the packages of health services at health centers and hospitals. Innovative methods were used to determine the costs, in particular the use of standard costs which reflect the resources needed to provide good quality services, and the use of cost modeling to estimate the cost of the packages at different coverage levels.

The cost information is being used to develop a payment system which is based on diagnosis-related groups and which will make it easier for the insurers to set premiums and to reduce their financial risk. At the same time it will encourage the providers to control costs. The cost information is also being used to justify budget proposals made to the Ministry of Finance by relating resource needs to the numbers of health services required. An additional benefit is that understanding the true cost of services will encourage the shifting of services to the most efficient level. These changes are all expected to result in service improvements.

Authors: TBD with the MoH

Annex 3: IHSSP Performance Management Plan Indicator Summary Table Quarter 2, 2010

Component	Indicator	Target	Achieved this quarter	Comment
Component 1: HIS and Data Use: (IR: Improved Utilization of Data for Decision-Making and Policy Formulation across All Levels of the Health Sector)				
1	# Annual HMIS, PBF, CBHI bulletins and data sets published and used increasingly	1 HMIS bulletin published annually; PBF data sets published quarterly, downloads increased quarterly	HMIS: 0 PBF: 2 data sets CBHI: 1 data set	
2	Data quality score, disaggregated by district hospital, health center and community levels	2011-80% ($\leq 10\%$ variance) ; 2012-90% ($< 10\%$ variance)	DH: HC:	Not yet available. To be collected with new PBF quality assessment form from Oct 2010 onwards
3	% of district health offices and facilities with internet connections	2010-10%; 2011- 50%; 2012-80%		Waiting for update figures with data from District Health Strengthening tool database
4	Data use score	Increase by 20% over BL by mid-term; 50% over BL by EOP		Baseline PRISM Assessment protocol and questionnaires completed, scheduled to take place in August
5	# of individuals trained in strategic information related topics <ul style="list-style-type: none"> • CHW cell-phone reporting systems Training of Trainers 	TBD	1000	Trainers from central level and all 8 districts in Southern Province have been trained.
Component 2: Health Financing (IR: Strengthened financial systems for the rational use of available health resources)				
6	% of CBHI structures (<i>sections de mutuelles</i>) that meet CBHI data audit standards	TBD		Audits have not yet begun.
7	% of CHW cooperatives that meet data accuracy standards (accuracy level target TBD)	2011- 50 % of cooperatives meet		Audits have not yet begun.

Component	Indicator	Target	Achieved this quarter	Comment
		standard; 2012-75% meet standard		
8	% of HC that achieve their business plan goals	2010-50%; 2011-70%		To be assessed at end of 2010
9	% of PBF indicators (reported cases) confirmed to exist at the community level	> 95%		Community client surveys not yet begun.
10	PBF quality score	X % increase from baseline	DH: 75.2% (down 16% from 89.3% Q4) HC: 86.2% (down 0.4% from 86.6% Q4)	District hospitals scores went down significantly because the PBF evaluation teams decided to make surprise visits during the 1 st Quarter. Health center scores did not change significantly.
11	Reporting rate for each listed database, disaggregated by database	Maintain \geq 95%	PBF: 99.1% (up from 97.2% Q4). CBHI: 80.1% Q1 (up from 75% Q4) SIS Comm: 86.8% (up from 80.8%) HMIS: 97.4% Q1 (up from 96.3% Q4) IHRIS: NA	Reporting rates are reported 1 quarter late, to allow data entry at district level. IHRIS is currently off-line.
12	# of individuals trained in PBF and financial management related topics	TBD		
Component 3: Human Resources (IR: Improved management, quality, and productivity of human resources for health and related social services)				
13	% of district and sector teams that completed the BLDP program (cumulative)	2011-100% of district teams; 2012-30% of sector teams; 2013-50% of sector teams; 2014-		Scheduled to begin in FY2011

Component	Indicator	Target	Achieved this quarter	Comment
		75% of sector teams		
14	Medical and nursing councils approved licensing norms and standards; doctors and nurses have registered in licensing program	2011-norms and standards introduced; 2012-20 % of all doctors and nurses have registered in licensing program		Scheduled to begin in FY2011
15	# of people trained in HR-related topics	TBD		HR team assisted with curriculum development and ToTs reported under the Information component
Component 4: Continuous Quality Improvement (IR: Improved quality of health services through implementation of a standardized approach to quality improvement (QI))				
16	New integrated formative supervisory tool is completed, validated and handed over to MOH for implementation	2010	DH level Supervisory tool pre-tested	
17	% of District Hospitals in the accreditation program (cumulative)	2011-20%; 2012-50%; 2013-75%		Activity to begin in FY2011
18	# of people trained in Quality Improvement-related topics	TBD	None this quarter	
Component 5: Decentralized Institutional Strengthening (IR: Extended decentralized health and social services systems to the community level)				
19	% of Districts who meet their Health Imihigo target	TBD		District strategy still being finalized, expect to report at end of 2010
20	# of individuals from District level administration trained by topic	TBD	None this quarter	
21	# of Districts where capacity building plan has been developed (cumulative)	2011-5; 2012-15; 2013-30		District strategy still being finalized, expect to report at end of 2010

Management Sciences for Health

784 Memorial Drive

Cambridge, MA 02139

Tel: (617) 250-9500

Fax: (617) 250-9090

www.msh.org