



USAID | **RWANDA**
INKUNGA Y'ABANYAMERIKA

RWANDA INTEGRATED HEALTH SYSTEMS STRENGTHENING PROJECT:

THE PROJECT MANAGED BY MANAGEMENT SCIENCES FOR HEALTH (MSH)

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First Annual Project Report

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Acronyms

AIDS/SIDA	Acquired Immunodeficiency Syndrome
BDD	Base de Données/Database
CA	Collaborating Agency
CAAC	Cellule d'Appui a l'Approche Contractuelle; performance-based financing Department of the Rwandan Ministry of Health
CBHI	Community Based Health Insurance (Mutuelle)
CHW/ASC	Community Health Worker (Agent de Sante communautaire)
CTAMS	Cellule Technique d'Appui au Mutuelles de Sante; Mutuelle Technical Support Cell
CPD	Continuous Professional Development
CPN	Consultation Prenatale/Antenatal Consultation
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
IT	Information Technology
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
PMA	Paquet Minimum des Activités; Rwandan basic package of health services
PMTCT	Prevention of Mother-to-Child Transmission [of HIV]
PBP	Performance - based Financing
PRISM	Performance of Routine Information System Measurement tool

QA	Quality Assurance
RBF	Result-Based Financing
SIS	Système d'Information Sanitaire (Health Information System)
TA	Technical Assistance
TOT	Training of Trainers
TWG	Technical Working Group
USAID	United States Agency for International Development
USG	United States Government

I. Introduction

This first Project Annual Report for the Integrated Health System Strengthening Project, Task Order Number : GHS -1-006-07-00006, summarizes the key activities and results of the contract during the first year of implementation from November 2009 to September 2010 (corresponding to fiscal year 2010).

The report provides an overview of the IHSSP's five intermediate results, and its results framework, and outlines key activities and results achieved during the reporting period. The report also highlights programmatic challenges experienced during this period.

The implementation of the Rwanda Integrated Health System Strengthening Project (IHSSP), started officially in November 7th, 2009 as a 5-year USAID-funded project to support the Ministry of Health in strengthening its health system at central and decentralized level. The project is tailor-made to focus on 5 intermediate results areas:

- 1) For the data management and data use component, the goal is to improve utilization of data for decision-making, resource allocation and policy formulation across all levels of the health sector.
- 2) The Health Financing component seeks to strengthen and harmonize the health financing mechanisms to obtain efficient and viable provider payment mechanisms while offering quality health services. It will strive towards efficiency in allocation and use of health sector financial resources and achieving an appropriate balance between purchasers, payers and stewards.
- 3) The Human Resources for Health component will improve management, quality, and productivity of human resources for health and related social services.
- 4) The Quality Improvement component aims to improve quality of health services through implementation of a standardized approach to quality improvement (QI) so that every district hospitals offer clinical quality of care according to national standards, that a continuous and self-sustaining process of quality improvement is institutionalized at every health facility and that the client/patient has a voice in provision of quality services.
- 5) And finally, the decentralization component will help to build a fully functional district able to achieve the above goals and to implement extended health and social services to the district level and below.

IHSS Project Results Framework

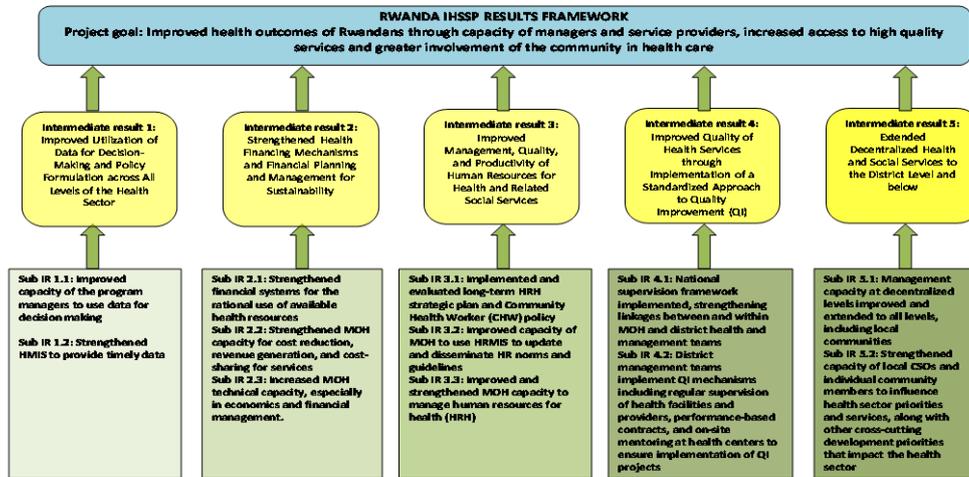


Figure 1: Rwanda IHSSP Results Framework

Setting the stage for the project.

The start-up phase of this new project was implemented concurrently with activities from the previous HIV/PBF project which was closing down. Many of the previous project's activities were incorporated into the new IHSSP project.

The IHSSP in collaboration with the MOH and USAID held a series of technical workshops between December 2009 and January 2010 to identify priority gaps in the Rwandan Health System and to formulate related priority health systems strengthening interventions and activities that would support the MoH's vision and objectives as expressed in the Health Sector strategic plan 2 (HSSP-II).

As a result of this participative process, a 5-year operational work plan and budget were completed, and the project was officially launched in a well attended one-day stakeholder's workshop, organized by IHSSP in collaboration with the MoH.



Figure 2: Picture of MSH/IHSSP, MoH and USAID representatives during launch of IHSSP (l to r: Kathy Kantengwa, Stephen Karengera, Dennis Weller, Yogesh Rajkotia)

Building on this exercise, the MoH and the USAID-mission requested MSH support to develop a health system strengthening strategic plan. This document represents the strategic thinking and priority tactics that the MOH will use to pursue its health systems strengthening goals as elaborated in the multisectoral Economic Development and Poverty Reduction Strategy (EDPRS), the Health Sector Strategic Plan II (HSSP-II), and the National Health Policy. It pulls together the disparate pieces in order to:

- ensure greater coherency across sub-sector policies: reduce overlaps and inconsistencies;
- develop a clear vision and strategic direction for health systems development over the next 5-10 years;
- improve coordination among the partners supporting HSS;
- provide a roadmap and strategy for future funders of HSS.



Through a participative process (from February 2010 to June 2010) involving the MOH, MSH, USAID and other key stakeholders in HSS, Rwanda National Health Policy and strategic documents were reviewed and via a subsequent situational and gap analysis of the 6 WHO-building blocks of a health system along the lines of Health Sector Strategic Plan (HSSP-II) this culminated in the publication of the *Health Systems Strengthening Framework and Consolidated Strategic Plan (HSSF/CSP) for 2009-2012*

Figure 3: Rwanda Health Systems Strengthening Framework and Consolidated Strategic Plan

II. Main Activities and Results

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

The project supported the MOH to respond to the need to improve utilization of data for decision making and policy formulation. The main issues identified in the initial situation analysis were the large quantity of data collected and reported from health facilities and community health workers without adequate use, the uncertain data quality, the lack of national data sharing mechanisms, limited ICT infrastructure and the need to ensure that HMIS sub-systems are better integrated and fully operational at the MOH, Districts and health facilities.

Improved Capacity of Program Managers in use of data for decision making

Support to increase capacity of policy makers to collate, analyze, use and disseminate data

Highlights of the activities implemented include:

- Roll-out of paper- and cell phone-based Community Health Information systems (mUbuguzima and RapidSMS): The project procured and distributed a total of 10,000 cell phones to Community Health Workers. About 1,000 people, including data managers and CHW coordinators from nearly all 450 health Centers were trained in the use of these reporting systems. The training was implemented in collaboration with MOH/ ICT department, Community Health Desk, UNICEF and Voxiva. The IHSSP/HMIS team helped the MOH negotiate a collaborative approach for the implementation of these 2 different cell-phone based reporting systems mUbuguzima and RapidSMS and prepared a joint action plan and budget that reflects the total cost of ownership of the system.
- The HMIS team designed the methodology and helped the MOH adapt survey instruments, to collect data for PRISM assessment and finalized planning for data collection from selected 20 Health Centers, 20 villages CHWs, 5 District Hospitals, and 5 Administrative Districts. This survey will inform the Ministry and project team on the status of data management and information use at the Districts, health facilities and by Community Health worker teams. This will provide the project with a baseline and helps to identify specific issues that need to be addressed through the project's interventions.
- Helped the MOH to implement a web-based application for sharing the Ministry of Health's health facility database - <http://www.pbfrwanda.org.rw/hf/index.php>
- Helped the MOH to produce the National Health statistical booklet of 2009
- The HMIS team worked with the RHEA team to support the development of functional specifications for:
 - The primary care medical module of OpenMRS (the open-source electronic medical records system currently being introduced with assistance from Partners in Health)
 - The Integrated Disease Surveillance and Response (IDSR) system, which is being upgraded with support from CDC and Voxiva.
 - The national data warehouse and web-based business intelligence portal (a 2nd working prototype has been developed now using a BI platform from JasperSoft and the team is also exploring the new DHIS-2 system.)

Strengthened HMIS to provide reliable and timely data

The project team continued support on reinforcing a functional HMIS at health facility level and the community by the CHWs.

The IHSSP/HMIS team implemented the following activities to reinforce health facilities-based HMIS:

- Conducted trainings on the data use and analysis for the MoH staff (CTAMS, e-health, Community Health Desk and HMIS departments)
- Supported the MOH to develop HMIS Guidelines for Health Facilities and community-based interventions and operationalization of Community HMIS.
- Supported the MoH to make the Community Health Information System/ SISCOM functional by developing a data entry manual, updating the database structure and website and conducting trainings. Since April 2010, data entry at district level began in earnest resulting in complete reporting for the year 2010. The MOH can now rely on this system to understand the daily work of health care workers at village ("umudugudu") level. From the reports produced by CHWs, the MOH receives the current status of reporting of community health activities and performance trends of core indicators and drugs use.

To reinforce HMIS for the community health interventions through the CHWs

The project:

- Supported upgrading of Community HMIS database with new rules added to reduce data entry mistakes
- Assisted the MOH Community Health Desk staff in automated computerized payments to allocate community PBF funds
- Worked with CH desk and World Bank team to develop the community PBF impact evaluation design - focusing in particular on how data would be collected routinely through the Community HIS and PBF database on both indicators and quality assessments.

In support of the Performance-Based Financing (PBF) database

The project HMIS team:

- Assisted the CAAC team with the processing of quarterly payments - introducing new payment tariffs for selected districts and redistributing payments for specific indicators across different donors.
- Helped develop an action plan for enhancing the web application over the course of the next year.
- Worked with PBF team at the CAAC to integrate portions of the Measure data quality assessment tool into the quarterly performance evaluations conducted in all health centers. This will enable the MOH to monitor the evolution of data quality more effectively down to the individual health center level.

Other Capacity transfer under HMIS component included:

- Assisted the PNL staff to obtain data and prepare analyses of malaria trends based upon HMIS data.
- Helped PNL staff design and implement a multi-user data entry application using Access to enter data from a data audit in 100 health facilities. Prepared initial analyses of data quality for presentation to a Global Fund team.
- Provided an HMIS orientation and the new M&E officer at PNL, and sponsored Dr. Irene Umulisa, PNL M&E Officer to attend a blended learning course organized in Ghana.

- The HMIS Advisor participated as a facilitator in the Routine Health Information Network (RHINO) conference in Guanajuato, Mexico. During the conference he facilitated 2 two-hour sessions on PBF and Routine Health Information Systems that included an in-depth presentation of the Rwanda PBF case study. The conference was also an excellent opportunity for practical experience using the PRISM tools for assessing HMIS performance.

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

To support strengthening financial systems for the rational use of available health resources, the project focused on reinforcing operational planning, putting in place accountability mechanisms and, streamlining financial procedures for implementation of Community Based Health Insurance (CBHI) and performance -based financing (PBF).

Strengthened financial systems for the rational use of available health resources

Elaboration and review of PBF Models

The Project Health Financing team led the process, in collaboration with the MOH, in the refinement of the PBF model and supported the MOH/CAAC to review indicators and to elaborate and pilot the updated Quality and Quantity performance evaluation of services at Health Centers and District Hospitals.

The team helped the MOH/CAAC in the on-going revision of PBF framework to respond to evolving demand of the model, including revising of the contracts, PBF tools, data collection formats, the PBF user guide and the revision of evaluation process to reflect the present context. In addition, the PBF web applications were updated taking into consideration the new performance indicators, revised tariffs, and new quality assessment checklists. The IHSSP also assisted in the Secretariat role of the national PBF Extended team platform.

In February 2010, a 4-day workshop was conducted in collaboration with MOH/CAAC and other partners involved in the implementation of the PBF-mechanisms to revise the framework. This workshop addressed the following issues, among the others:

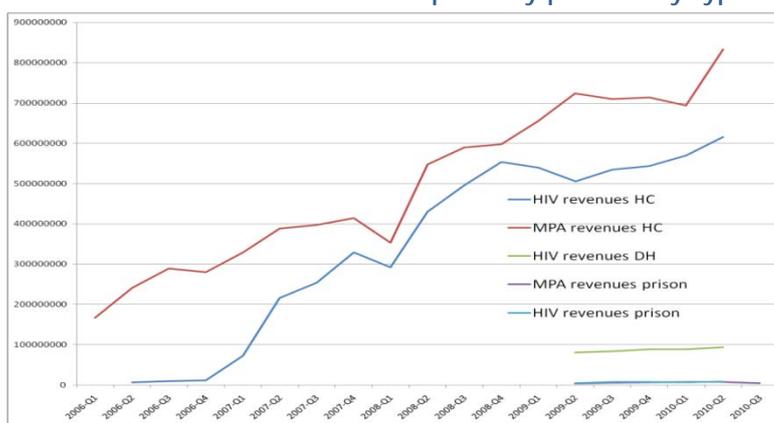
- The roles and responsibilities of different entities were slightly expanded and the district PBF steering committee will now be called district health steering committee having a broader scope of work, including to discuss all district health related issues during its monthly meetings.
- The health centre PBF-model was mainly updated with respect to the quantity indicators abiding to the following principles that 1) PBF should incentivize neglected area's and areas of huge Public Health importance; 2) PBF incentives should be more or less equally distributed over the different indicators (in the sense that they generate revenue across the whole PMA and HIV-care spectrum in a balanced way); 3) Indicators should be easy to collect; 4) Indicators should be harmonized with HMIS and TRAC+-indicator formulation and reporting (equivalent definitions) and 5) Quality indicators should focus on ensuring procedures and protocols are well followed and quality of care is given to patient

- The district hospital evaluations will from now on be conducted partially by the central level and partially by peers in order to attain more objective evaluations with a wider scope.

The newly revised PBF-indicators have been validated and are now operational and, incorporated into the web based reporting system. In addition, a series of trainings were conducted on the refined evaluation checklist whereby the definitions of the new indicators were also clarified.

The table below shows the trends of PBF-incentives disbursed quarterly by type of facility

Figure 4: Total PBF-incentives disbursed quarterly per facility type



District Hospital PBF evaluation implementation: All 39 district hospitals were evaluated by central level during the first quarter of 2010 and by peers during the second quarter of 2010. Lessons learned from the central evaluation helped MoH and extended team members to better define future hospitals evaluations through the PBF revision framework. Based on the experiences from the field, the performance indicators were revised to capture more reliably the quality of management of clinical care. Extra components related to observation of patients at hospitalization and infrastructure and equipment were added to the DH evaluation guide.

Analysis of performance of PBF indicators

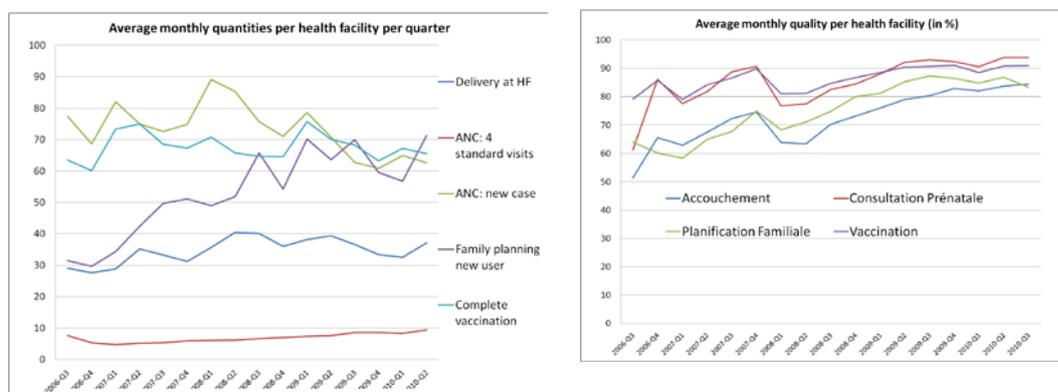


Figure 5: Trends of average monthly quantities and quality of MCH services : Source : PBF Data base, September 2010

Roll out of the community PBF model: The IHSSP project continued to support community PBF activities at both the central MOH/CAAC and district levels. At the central level, IHSSP participated actively in the development of training and implementation plans for the scaling up of the national PBF model and in the elaboration of the design of the impact evaluation of demand-side and supply-side incentives.

- The IHSSP worked in joint collaboration with the MoH , World Bank and the School of Public Health to design Community PBF impact evaluation study. The study aims to measure the additional benefit when providing in kind incentives to clients and financial incentives to community cooperatives and how this would influence utilization of health services and health status of the client.
- The design of the study has been finalized and the interventions to be evaluated are split up in 4 groups: the First group- consisting of 50 sectors, will receive demand side incentives; the second group of 50 sectors will receive only the national community PBF (combination of incentives for timely, accurate and complete reports adjusted by quality of cooperative management together with incentives for targeted improvements in 5 indicators being 1) early antenatal care, 2) institutional delivery, 3) monitoring nutritional status of children <5 years, 4) initiation of modern contraceptives and 5) use of long-term contraceptive methods); the Third group will receive both interventions and; the Fourth group will receive the average payment for the national community PBF model.

IHSSP contributed significantly to the elaboration of an operational manual for the roll-out of the Community PBF model.

The change of the national model did not only change the design of the impact evaluation but also the way the national program should be implemented and monitored.

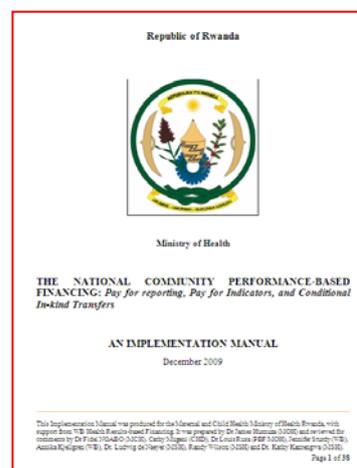


Figure 7: The National Community PBF : An implementation Plan

Other technical support activities implemented to strengthen the operational systems of PBF include:

- Conducting training on community PBF to introduce the revised PBF module and tools to the districts. Officials from 377 sectors- with a total of 1,416 participants attended workshops organized in 19 different parts of the country.
- Supporting the MOH /CAAC to revitalize the reporting on Community health activities in the framework of community PBF. As a result, the completeness of reporting increased from 17% to 100% by September 2010.

- Assisted the MOH/CAAC team with the processing of quarterly PBF payments - introducing new payment tariffs for selected districts and redistributing payments for specific indicators across different donors

The IHSSP in collaboration with the MOH facilitated a workshop to orient the members of the National PBF extended team on new changes in the model. In addition, the workshop also provided an opportunity to explain the process of entering data through the PBF database

(<http://www.pbfrwanda.org.rw/siscom>).



Figure 8: Pictured, one of the monthly reporting and supervision meetings of CHWs of the cooperative at Kinigi Health center.

These meetings revealed a number of implementation challenges in the field, mainly because the PBF sector steering committees were yet to be operationally effective, causing adverse consequences on coordination of the community health program and other activities associated with community PBF. Other issues identified include data entry into the community PBF database (SIS com) and payment to CHWs cooperatives.

To bridge these gaps, follow-up actions were f coordination mechanisms including elaboration of standard operating procedures (SOP).

Rwanda's presence to the First Symposium on Health Systems Research in Montreux, Switzerland.

Working in collaboration with the MOH, IHSSP technical staff helped drafting 4 abstracts on the Rwanda best practices in the design and implementation of PBF models. These abstracts were selected by the panel/organizers of the first Annual Global Symposium on Health Systems Research, held in Geneva in Nov.2010. The panel presentations will be made by a representative of the MoH, Dr. Louis RUSA (*implementation of the national PBF program*), and three MSH/IHSSP Senior Technical Staff: Dr. Kathy Kantengwa (*How has PBF program influenced maternal and child health national indicators*), Dr. Cedric Ndizeye, IHSSP' Financing Systems Advisor (*Modeling indicator fee levels to ensure the incentives achieve the greatest possible impact.*), and Mr. David Collins, MSH's senior advisor on costing (*Impact of performance-based financing on the cost of health centre services*)

Brief Rwanda's best practice of the PBF:

The PBF program has provided incentives to facilities to improve and increase key services. These incentive payments are additional to the funding of the services themselves, and a portion of these incentives are then paid to individual health workers. A total of 95 service quantity and quality indicators are used at the district hospital level and 152 at the health centre level, and a steering committee in each district monitors the quarterly results and validates the data before approving payment. Other important policy changes that have helped to support the PBF program include increases in the coverage of the Community-Based Health Insurance Program, the decentralization of decision-making to the facility level, and the implementation of systems to increase accountability (especially performance contracts between District Mayors and the President of the Republic).

Rwanda's presence at the Regional PBF-conference

Health actors in low-income countries are increasingly paying attention to PBF. This PBF system aims to improve the performance of health systems and to accelerate the achievement of the Millennium Development Goals in countries with low income. Rwanda is considered a PBF best practice in the region. In February 2010 a Regional PBF Conference was held in Burundi specifically to provide a forum for key practitioners in PBF to share specific technical issues, to present some experiences, and to start discussions around these topics. In this conference, IHSSP staff along with representatives of the MOH and other partners attended, and shared with the participants progress, experiences and challenges of implementation of PBF in Rwanda. Feedback on this conference can be found on: <http://performancebasedfinancing.wordpress.com/>

Strengthening the MoH capacity for cost reduction, revenue generation and cost sharing for services

Reinforcement of the performance of Community Based Health Insurance

The IHSSP team provided technical support to the MOH to elaborate the **National Community Based Health Insurance (CBHI) Policy**, incorporating the newly conceived Stratification approaches. The CBHI policy has been approved and disseminated.

The stratification of CBHI put members into 3 categories based on Ubudehe¹ criteria. The lowest contribution group will comprise the first and second Ubudehe category. The middle contribution group will consist of the third and fourth Ubudehe category and the highest contribution group of the fifth and sixth Ubudehe category. This new system of member contributions will assure sustainability of the insurance, equity and solidarity among its members as well as the financial viability of the system. This approach takes into account the capacity of the population to pay as well as the cost of health care, and, as a result will eventually raise domestic resources and reduce the dependence on external financing. IHSSP has taken a central role, participating in the whole process, and has completed the conception of a database for CBHI beneficiaries and its data entry mask.

The IHSSP team also took active part, collaborating with the MoH team, GTZ, BIT/ILO, to elaborate the draft **Law on Health Insurance**. This draft has been passed into law.

Updating CBHI Database user manual: The Community Based Health Insurance Database (CBHI DB) was initially developed in 2008 by MSH/PBF Project. Due to the revised CBHI policy and to increase user-friendliness of the database, the interface and the corresponding database manual had to be updated. Some initial conceptual mistakes were also corrected. This was done in collaboration with the CBHI data base editorial committee composed by MoH staff, GTZ, BIT/ILO.

¹ Ubudehe is a community-based targeting mechanism that categorizes the Rwandan population according to their revenues and vulnerability

Costing exercise of the Packages of Health Services

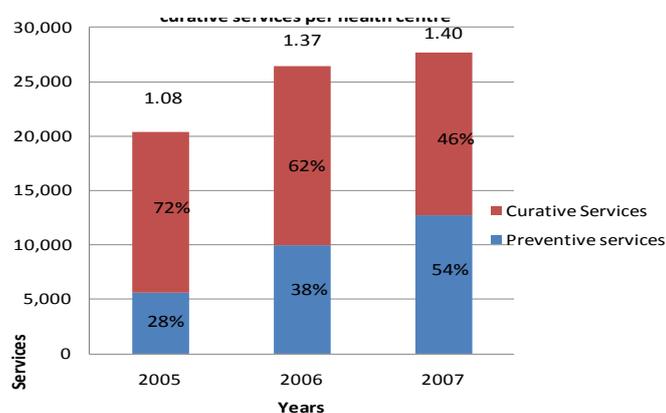
The project in collaboration with the MoH and partners started a costing exercise which aims to determine the true cost of each type of health activity provided as part of the minimum package of activities the complementary package of activities.

The true costs will be used to modify the ways the facilities are reimbursed and to determine the contributions from insurance, government and patients. The true costs will also help the Ministry of health to justify funding needs to the ministry of finance. The true costs will be based on Rwandan protocols and will reflect Rwandan best practices and good quality of care. Detailed Terms of Reference documents have been prepared for the MOH Costing Steering Committee and key phases of the costing exercise, including 1) the identification and selection of activities to be costed; 2) data collection and, 3) cost analysis.

Spreadsheet tool called CORE Plus was used, and the preliminary findings are :

Figure 9: Total and per capita average numbers of preventive and curative services by health

The study objective was to see what changes in costs occurred, specifically: Did service increases or shifts result in more total costs?; Did unit costs decrease (because more services were produced from available resources)?



These are the average numbers of services per HC across the 6 HCs. The total number of services increased due to big increases in preventive services, especially in family planning - 2,120 to 12,808 to 18,511 and VCT from 6,966 to 17,092 to 29,084. This represented a change in service mix, with preventive services increasing from 28% to 54% of total services. In total the number of health services per capita rose from 1.08 to 1.40 after population growth.

Expenditure by Category and per Capital Health Center

Total average expenditure per HC rose from \$51,141 to \$70,132 and \$122,062. The main reasons for the increases between 2005 and 2006 were increases in input funding from the GOR and donors and output funding from insurance and PBF. Expenditure per capita more than doubled - from \$2.72 to \$6.16.

Figure 10: Average expenditure by category and per capita per health centre (US\$)



The increases in expenditure reflect more the additional funding received rather than changes in cost due to the shift to preventive services. Expenditures were not adjusted for inflation and a constant exchange rate was used. Data on expenditures and the cost of donated drugs and tests were incomplete and the figures were, therefore, adjusted to reflect the needed purchases based on standards. Salary expenditures increased dramatically in 2006 and 2007. Operating expenditures increased as more funding became available, although some of these figures include expenditures related to renovation and bonuses.

Top services by number and by expenditure

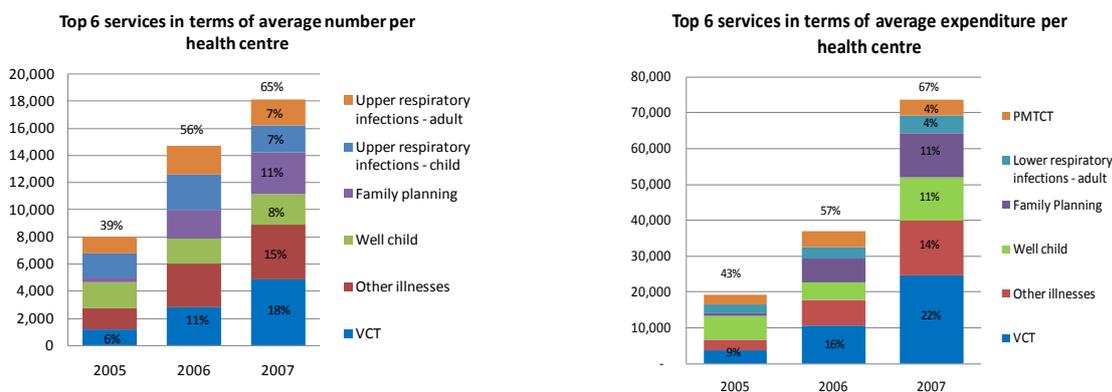


Figure 11: Average expenditure by health centers on the 6 top services :
 Source : Preliminary results of Costing Study of Package of Health services, MSH/MOH/2010

Based on these preliminary results, it was vivid that Performance based Financing (PBF) largely resulted into more services and a shift toward preventive services. PBF results in more services or shifts to higher cost services and a greater emphasis on quality then total expenditures will need to increase; and, the indirect costs of services are under-funded then expenditure per service will also need to increase.

II.3 Intermediate result area 3: improved management, quality, and productivity of human resources for health and related social services.

The IHSSP has been working with the MoH and the HRH Technical Working Group of partners to devise human resources management and development strategies to ensure staff retention and improve productivity. During the first year of implementation, the project focused on strengthening leadership and management and gave support to improve human resource productivity jointly with the Ministry and other Health Professional Bodies.

Completion of Human Resources for Health Strategic Plan:

The IHSSP/HRH team supported the MoH to review and update the Human Resources for Health Strategic Plan: Based on this strategy, the team, working through the HRH TWG, elaborated the costed operational plan for HRH Capacity Development, indicating timelines and distribution of financing. The Human Resources for Health Strategic Plan is expected to be completed, validated and approved early next year.

The IHSSP has continued to play secretarial role to the National HRH TWG. Besides, IHSSP continued to provide orientation and coaching to the Chair of HRH TWG, a newly recruited staff of the MOH.

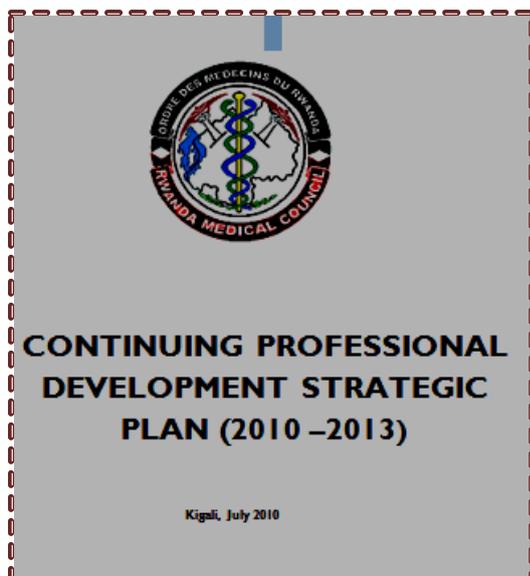
During this period, the IHSSP supported the MOH to design the Human Resources for Health component of Health Systems Strengthening (HSS) Strategic Framework;

In order to improve the capacity of the MOH to manage HRH through use of **Human Resources Information System (HRIS)**, IHSSP hired in support of the MOH an external consultant to conduct a situational analysis of Rwanda Human Resources for Health. It also facilitated the MOH to conduct a functional review of the iHRIS.

In collaboration with the MOH the team organized the steering committee on WISN approach and conducted two training of trainers (TOT) for 54 participants, from the MOH, KHI, Referral and District hospitals.

As of the assistance given to health professional bodies, the IHSSP helped:

- to define the framework and the implementation plan for the review of existing documents leading to the establishment of Council of Pharmacists
- to finalize the draft law establishing the Rwanda Allied Health Professions Council
- facilitating the finalization of the draft ministerial order determining the list of paramedical professions and their regulations.
- Held a series of consultative meetings with representatives of councils of Nursing and Midwifery to define norms and standards for licensing and;



The IHSSP provided technical support, and financed the Rwanda Medical and Dental Council to complete and validate the Continuing Professional Development Policy and its Strategic Plan.

Figure 12: Continuing Professional Development Strategic Plan (2010-2013)

Analysis of Human Resources for Health situation: The IHSSP/ HRH team took part, along with the MOH and WHO, in conducting a HRH situational analysis gathering data on institutional overview, stock utilization, education and training, governance and policy context. This analysis was done in response to the recommendation of the National Human Resources for Health Technical Working Group (HRH TWG).

Developing HRH supervision checklist: The IHSSP worked with the Ministry of Health's Integration and Decentralization desk to elaborate an integrated technical supervision check-list. Following this, the MOH came-up with a quarterly supervision schedule which involves key partners.

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

Quality improvement is central to health systems strengthening. The IHSSP has supported the efforts of the MOH to implement a national supervision framework at the national, district, health center and community level - to harmonize with the existing PBF mechanism. Other strategies supported by the project include accreditation of District Hospitals, establishing a governing structure for quality improvements.

Improve quality of health services through implementation of a standardized approach to quality improvement (QI)

The focus of the project on Quality Improvement was to complete the District Hospital Strategic Accreditation Framework - a Concept paper for the District Hospital Accreditation Program outlining the background, goals and objectives of the program, structure and the road map. The progressive accreditation approach has been designed to empower employees to achieve accreditation through their own efforts based on integrated, multidisciplinary, Continuous Quality improvement approach to ensure sustainability. This new initiative in its first phase will focus on reviewing and adapting the existing policies procedures and guidelines for the reference hospitals to the District level hospitals. A workshop of District hospital manager was conducted to share referral experience and have a common understanding of the program. Agreement on crucial

service areas in the progressive accreditation of district hospitals was reached and developing new missing policies, procedures and guidelines. A list of required policies, procedures & guidelines were identified and shared with DH teams inputs incorporated and adapted .

The QI team worked in collaboration with the MOH and partners to prepare methodology and approaches for conducting baseline assessment in 40 District Hospitals, to determine existence and, or gap in availability of policies, procedures and clinical guidelines required for accreditation , by standards of the District Hospital and a big gap was identified, 90% of DH had below 20% of required policies and procedures, 10% (3 DH hospitals) above 40% of required policies , procedures & guide lines .

In collaboration with the MOH and partners, the team elaborated an integrated supervisory tool used in supervising district hospitals and tested, health centers and community health services.

In the area of Quality Assurance, a lot of effort was put in the development of the tools for integrated formative supervision at District Hospital level to be used by central level as this was a new tool that did not exist

As part of the Health System Strengthening Strategic Framework, the QI team developed the Service Delivery part of the strategy

Given the role of Continuous Professional Development in quality improvement the QI team provided substantial contribution to the development of CPD strategy for the medical council.

II.5 Intermediate result area 5: Effective decentralization of health and social services to improve access

The IHSP support under the decentralization component intends to strengthen the administrative decentralization structures, engaging partnerships approaches at district level, and improving capacities of decentralized structures to manage health and social affairs programmes.

IHSP team assisted the MOH in elaboration of terms of reference for development of National Strategic Plan for Decentralization of Health Services. The MOH has requested MSH to help identify a potential consultant to help develop this strategy.

The Decentralization team conducted a needs assessment and scope of technical assistance for the District Health Steering Committee in establishing coordination mechanisms for a new integrated supervision approach.

Other technical assistance activities provided by the team include:

- participation in coordination meetings on community PBF and CBHI activities organized by each district.
- Providing training sessions for the health Steering committee at sector level on health data management

- Recruitment and providing orientation to the newly hired district coordinators and community Mobilization staff. These orientation sessions covered all IHSSP components and its interventions.
- TA to the District:
 - Assisted Districts/ PBF steering committees (Huye, Nyanza, Gicumbi and Musanze districts) in Health Center quantity and quality evaluation for Q4 2009 and Q1 2010
 - Taking part in the Review workshop of PBF Framework and processes
 - Technical assistance in preparation of PBF steering committee meetings for Huye, Nyanza, Gicumbi and Musanze districts
 - Assisted MOH/CTAMS in monitoring of Mutuelle de sante activities in Huye, Nyanza, Burera, Gicumbi and Musanze Districts
 - Participated in District Hospital Evaluation for Q4 2009
- TA to MOH:
 - District Health Facility supervisory workshop: decentralization team assisted the MOH/decentralization task force to conduct the District Health Facility supervisory workshop. During this workshop, the District Hospital integrated supervision tools were developed. These tools will be used by the District Health Steering Committees to implement a new integrated supervision approach.
 - Community PBF: Decentralization team assisted MOH through District hospital to conduct training of staff in charge of Community PBF for Nyanza District/Southern Province.

III. Training Workshops conducted.

Training conducted	Number of persons trained	Category of people trained
Community Performance Based Financing (PBF)	1870 (Women 33 %)	MOH and IHSSP staff, CHW Supervisors, District AIDS Committee members, Health officers ,HFs M&E officers, data manager ,Community PBF supervisors
Integrated Formative Supervision tools	63 (Women 19 %)	Medical doctors CHUK, CHUB, TRAC + MOH, partners, IHSSP staff
Costing exercise	27 (Women 22%)	
Training of Trainers on mUbuguzima & RapidSMS	915(Women45%)	MOH staff, IHSSP, DH Data managers Supervisors CPBF DH M&E and data base Managers, District Directors of Health, HC Data managers and In charge of CPBF HC
TOT on Workload Indicators of Staffing Need methodology (WISN)	54 (Women 50%)	Directors of nursing, directors admin. and HR ,HR manager, ENT head of department

Training conducted	Number of persons trained	Category of people trained
Training workshop on facility PBF	32(Women 21%)	Central level PBF supervisors ,Director of PBF at district level
Training in PBF and Community based Health Insurance Data Base Management	19 (Women 42%)	MOH and IHSSP staff

Besides the training workshops indicated above, the project held a series of technical workshops, involving key stakeholders to discuss on the scope of IHSSP's health Systems Strengthening support. These workshops culminated into the project priority intermediate results, operational plans and budget- approved by USAID.

Other series of technical workshops held during this period include the revision of National Performance Based Financing Framework (Clinical and Community PBF), and workshops on Continuing Professional Development (CPD).

IV. Main implementation Challenges.

During this period, the project experienced the following programmatic challenges:

- Delays by the MOH to provide clarification of the scope of IHSSP support to decentralization at District level, and delays in recruitment of M&E Officer position at District level. Lack of definition of approach as well as roles and responsibilities of District teams resulted into lack of definition of project's support to decentralization process and therefore lack of progress.
- The elaboration of revised SOP for community-based, and health facility HMIS is behind the schedule
- Delays in Selection of Minimum package of indicators for HMIS. The MoH shifted this activity to the fiscal year 2011.
- There is delay in the execution of the costing exercise
- No progress yet in CBHI data audit mechanism as there is no M&E counterpart yet at the MOH
- Support of districts in strategic planning, resource tracking and financial management did not happen due to delays in recruitment of officials at the district level.
- There are some delays in implementation of accreditation process

V. Project Management Aspects

Staffing of key position: MSH/Boston announced the promotion of IHSSP Chief of Party, Dr. Kathy Kantengwa, to Senior PBF Advisor, based in Boston. As of the start of the third quarter 2010, Dr. Apolline Uwayitu took-over as the interim COP as the arrangements are made for a permanent replacement. A number of recruitments were made by the project management, with the support of the HR office at home office, to fill in the key position.

During the first year of implementation of the project, a total of 46 staff, including technical, administrative and support staff were recruited.

Revision of work plan and Budget: The IHSSP team completed the elaboration of a revised 4 year work plan and budget, and the 2010/2011 work plan and budget was approved by USAID. The project also elaborated the core performance indicators, linked to the five intermediate results. These indicators will be used to track and measure progress in the implementation of the project.

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