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INKUNGA Y'ABANYAMERIKA

**Rwanda Integrated Health Systems Strengthening Project:**

## **Quarterly Project Report Narrative**

**(January – March, 2013)**

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## ACRONYMS

AHP	Allied Health Professionals
CBHI	Community Based Health Insurance (Mutuelle)
CHWs	Community Health Workers
CPD	Continuous Professional Development
CSOs	Civil Society Organizations
CTAMS	Cellule Technique d'Appui aux Mutuelles de Santé (Mutuelle Technical Support Cell)
DG	Directorate General
DH	District Hospital (s)
DHIS-2	District Health Information System (New Rwanda HMIS System)
DHMTs	District Health Management Teams
DHSST	District Health System Strengthening Tool
DQA	Data Quality Audit/Assessment
DRG	Diagnosis-Related Group
FMT	Financial Modeling/Management Tool
FY	Fiscal Year
HC	Health Center (s)
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HR	Human Resources
HRH	Human Resources for Health
HRMIS	Human Resources Management Information System
HSSP III	Health Systems Strategic Plan III
iHRIS	Human Resources Information System
IHSSP	Integrated Health Systems Strengthening Project
JANS	Joint Assessment of National Strategies
JCI	Joint Commission International (NGO)
M&E	Monitoring & Evaluation

MINALOC	Ministry of Local Government
MOH	Ministry of Health
MSH	Management Sciences for Health
MTEF	Mid Term Expenditure Framework
NCNM	National Council for Nurses and Midwives
NGOs	Non-Governmental Organizations
PBF	Performance-based Financing
PFM	Public Financial Management
QI	Quality Improvement
RBC	Rwanda Biomedical Center
RHMIS	Rwanda Health Management Information System
RFHP	Rwanda Family Health Project
SARA	Service Availability and Readiness Assessment
SISCom	Community Health Information System
SOPs	Standards Operating Procedures
SPH	School of Public Health
SQL	Structured Query Language
SWAp	Sector Wide Approach
TB	Tuberculosis
ToT	Training of Trainers
TWG	Technical Working Group
UN	United Nations
USAID	United States Agency for International Development
USG	United States Government
WISN	Workload Indicators for Staffing Needs
WHO	World Health Organization

## EXECUTIVE SUMMARY

In this second quarter (January – March, 2013), IHSSP/MSH made a number of achievements in strengthening health systems across all the five components of health information system, health financing, quality improvement, human resources for health and decentralization.

The health information component's main activities included enhancing the use of RHMIS data by M&E officers, implementation of new DHIS-2 modules for TB and HIV, migration of the professional council licensing and registration system to iHRIS Qualify, implementation of a variety of surveys in the Lime survey platform, and continuing support for the district health strategic plan costing exercise.

In the area of health finance, IHSSP supported strategic-plan development for health financing and community health as well as development of district SWAp guidelines. IHSSP also participated in the development of the PBF equity policy to be included in the PBF procedures manual, made field test visits and revised the CBHI SoPs manual for assessing sections CBHI data quality, and participated in the assessment of the coverage and CBHI adherence factors for the FY 2012/13.

IHSSP provided trainings of district- and section-level staff in financial management (through the FMT), participated in the elaboration of the CBHI mid-year financial report, organized the second auto evaluation workshop of the CBHI, supported the development of the questionnaires to be used for CBHI studies, and provided support for drafting the TORs for the advisory technical team on provider payment mechanisms.

In the quality improvement component, IHSSP organized and conducted a surveyors' training program, surveyors completed their initial on-site observation on how to conduct an accreditation survey, disseminated essential accreditation standards to the provincial and district hospitals and conducted the accreditation baseline survey in five provincial hospitals.

IHSSP also facilitated the start up of the registration of Allied Health Professionals (AHP) and supported the development of strategic plan as well finalization of the database for the National Council of Nurses and Midwives (NCNM).

IHSSP provided technical support to the MOH in the development of district SWAp guidelines and facilitated a one-day workshop of District Health Management Teams (DHMTs) with Rwanda Family Health Project to define the roles and responsibilities of the DHMTs.

## INTRODUCTION

In November 2009, USAID launched the 5-year Integrated Health Systems Strengthening Project (IHSSP) focused on the 5 technical results areas of: improved utilization of data for decision-making and policy formulation across all levels; strengthened health financing mechanisms and financial planning and management for sustainability; improved management, productivity and quality of human resources for health; improved quality of health services through implementation of standardized approach; and extended decentralized health and social services to the district level and below.

This report summarizes the activities and main achievements of the Project for this reporting quarter.

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

### 1.1. Increase capacity of policymakers to collate, analyze, use and disseminate information

#### 1.1.1. Development of annual health statistics booklet 2012

This task is not yet complete, but IHSSP staff assisted the Health Management Information System (HMIS) team to prepare for this task by conducting a comprehensive exercise to check the RHMIS for data quality issues (extreme outlier values for key indicators and internal data integrity). The errors in data were communicated to the health facilities in order to have them corrected. A workshop with the Ministry of Health (MOH) and Rwanda Biomedical Center (RBC) departments to finalize the analyses is scheduled for the next quarter.

#### 1.1.2. Data management standard operating procedure development

IHSSP staff worked with the team from the MOH/Directorate General (DG) of Planning, and HMIS and monitoring and evaluation (M&E) staff from various RBC and MOH departments to develop the first draft of Standard Operating Procedures (SOPs) for central level M&E and data

management functions. As there was considerable confusion in the roles and responsibilities of central level M&E staff who have been working more or less independently in the past, the SOPs development should help to clarify the situation.

#### 1.1.3. Capacity building:

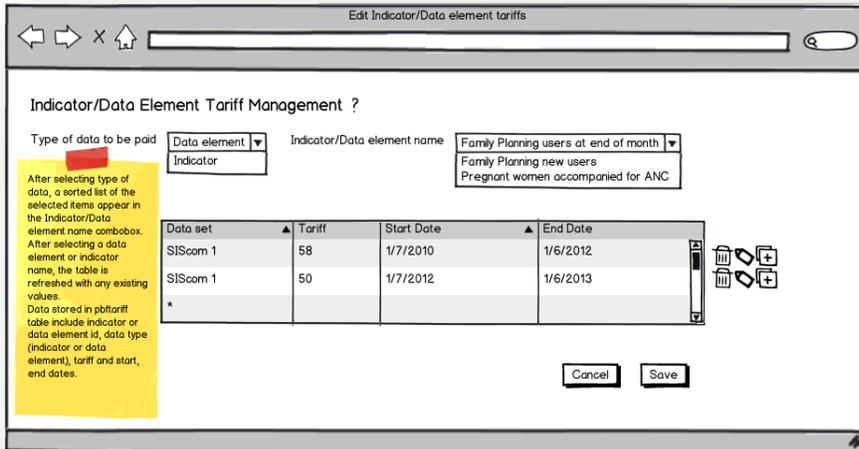
- **Central level M&E officers and data managers:** IHSSP staff worked with Futures Group sub-contractor to design and implement a one-week workshop on M&E fundamentals for central level staff involved in M&E from RBC and various MOH departments. In addition to establishing a common understanding about M&E fundamentals and strengthening capacity for evidence-based decision-making, this workshop developed a detailed set of SOPs for M&E and data management functions at the central level. Twenty-eight MOH staff participated in this workshop held at Credo Hotel in Huye.
- M&E fundamentals workshop for **Administrative district M&E officers:** IHSSP worked with the MOH/DG Planning, HMIS and M&E, and lecturers from the Rwanda School of Public Health (SPH) to design a second workshop, similar to the one for the central level M&E staff, but this time will be for the 30 district M&E officers. This workshop will take place from April 1-5, 2014 with funding provided by the Belgian Technical Cooperation.
- **TB supervisors and health facility data managers:** IHSSP assisted in planning and facilitation of a series of 4 week-long training sessions on using the District Health Information System (DHIS-2) for managing Tuberculosis (TB) program data. Over 500 people were trained in this activity financed by the Global Fund.
- **Family Health Project M&E staff:** IHSSP organized a half day orientation on using data from the DHIS-2 for 7 staff from the Rwanda Family Health Project (RFHP). This team should play an important role in enhancing evidence-based decision-making in the 14 districts supported by that project; the data will also support its own monitoring & evaluation needs. During the session, IHSSP staff provided a user access to each participant and covered basic data analysis with maps, data visualizer and pivot tables.

## **1.2. Strengthened HMIS to provide reliable and timely data**

### **1.2.1. Implementation of new functionality on the DHIS-2 platform**

- Completed the creation of on-line payment vouchers for the migrated the Community Health Information System (SIScom) to the DHIS-2 platform
- Developed the new module for district level reporting of peer educator data for RBC/HIV division
- Revised the TB data entry module adding individual records component to track TB multi-drug-resistant cases
- Worked with the MOH/HMIS team to implement a variety of changes to the monthly HMIS reporting forms and incorporate them into the DHIS-2. This included revising the case definitions for some indicators that were not clear and introducing data elements for new programs such as ophthalmology
- Completed several analyses of data from the death audit reporting system designed in the individual records module of DHIS-2
- Created a variety of special queries that can be used to analyze data from the data quality assessment (DQA) module in the DHIS-2. This module will be tested in the next quarter using the data gathered during the latest round of DQA held in March/April 2013
- Developed some wire-frames (see figure 1) as the start of detailed specifications for the development of a PBF add-on module to the DHIS-2

**Figure 1: Sample wireframe for PBF module of DHIS-2**



### 1.2.2. RBC/HIV division's peer educator data collection system review

Due to some management changes within RBC, IHSSP worked with the remaining team members to review the complete data flow process for peer educator data collection. The four separate reporting formats were consolidated into one and an integrated register was designed. This will greatly simplify the system implementation within DHIS-2 and minimize the need for printing and manual filling of a wide variety of paper data collection tools.

**Figure 2 Consolidated peer educator monthly reporting format**



**MONTHLY DATA COLLECTION FORM  
For PEER EDUCATORS**

A Healthy People. A Wealthy Nation

a. Name of administrative district					
b. Year of reporting period		c. Month			
d. Name of the implementing partner					
<b>Type of MARPs</b>	<b>FSW</b>	<b>MSM</b>	<b>TD</b>	<b>Fishermen</b>	<b>PwD</b>
1. People reached by peer educators					
2. Contacts with people where interpersonal communication was provided					
3. People who received condoms					
4. Condoms distributed by peer educators					
5. People referred for STI screening					
6. People referred for SGBV services					
7. People who received vocational trainings					

### 1.2.3. Dashboard and data warehouse

IHSSP staff continued its support to import data from TracNet into the data warehouse. More importantly, Terms of Reference (TORs) were developed for short term technical assistance from Health Information Systems Program (HISP) staff to complete the import of GESIS data from 2007-2011, and operationalize the synchronization of metadata between the different DHIS-2 instances. MSH is currently finalizing the consultant agreements.

### 1.2.4. Health facility registry

IHSSP staff worked with the MOH/HMIS database manager to re-import the data into the health facility registry, held a conference call with INSTEDD staff and other stakeholders on features of the system that were not functioning, and prepared a roadmap for moving forward.

## 1.3. HMIS cross-cutting technical support

### 1.3.1. Upgrade of the Human Resource Information System (iHRIS)

The HMIS team continued to support the transition of the professional council licensing database, originally designed in MS-Access, to the web-based iHRIS Qualify platform. The short term technical assistance was provided by the Uganda-based iHRIS developer consultant to customize the platform to the needs of the nursing council. The first phase of customization is

now complete, and staff from the national Council for Nurses and Midwives (NCNM) are scheduled to be trained to manage key registration functions using the system in the next quarter. A second phase will include the implementation of self-service modules to enable nurses themselves to maintain their data once the first phase is complete.

#### **1.3.2. Support for UBUDEHE population income categorization database**

IHSSP staff assisted DelAgua (NGO for health & development program) to extract data required to target low income families for the scheduled provision of improved stoves and water purification devices.

#### **1.3.3. Enhancement of CBHI information systems**

- **Mutuelle/CBHI M&E database:** the progress was a bit slow in finalizing the weekly and monthly data collection formats from Community Based Health Insurance (CBHI) sections. The validation process is now complete and IHSSP will help the CBHI team to implement the new tools in the DHIS-2 platform during the coming quarter and begin the design of the web-based financial modeling tools.
- **Mutuelle/CBHI membership database:** IHSSP staff met with the technical committee to provide oversight to JEMBI health systems to develop the web and mobile phone based membership system. A sub-contract with NetSolutions has been signed, and the system specifications have been revised and documented in the inception report that is still waiting a signature of the MOH eHealth coordinator. This system will also be integrated to work with UBUDEHE database.

#### **1.3.4. Support for the PBF accreditation assessment process**

The open source system, Lime Survey, was configured on the PBF file server; the latest forms for provincial hospital accreditation survey, and the hospitals and health center PBF assessment forms have been created on-line. The quality improvement (QI) team is waiting for other pieces of the accreditation process to be put in place before field testing the forms next quarter. IHSSP staff are also evaluating the options for a tablet device that can be used for field-based data collection.

#### **1.3.5. Adapted LimeSurvey to collect key infrastructure data**

Due to fact that the latest round of the District Health System Strengthening Tool (DHSST) survey was postponed, the MOH requested assistance from IHSSP on gathering the missing data

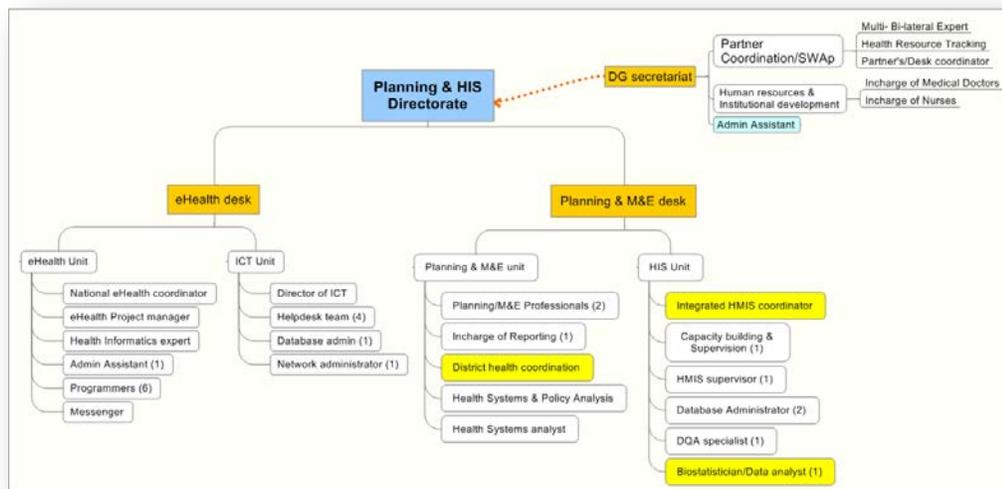
for the annual statistical report. Staff from the MOH/HMIS unit were trained on using Lime survey and an infrastructure-hygiene questionnaire was developed. All data managers will complete the questionnaires and the analysis will be finalized in the next quarter. A similar questionnaire was developed for the CBHI sections to assess the availability of electricity and internet access.

#### **1.3.6. Technical assistance to MOH M&E unit:**

IHSSP provided the following technical support:

- Provided technical support to a 2-day workshop to review and provide feedback to districts on their health strategic plans. In addition, the IHSSP staff reviewed and corrected the strategic plan costing spreadsheets from all 30 districts.
- Planning for the implementation of the Service Availability and Readiness Assessment (SARA), a key element of the HSSP III recommendations from the Joint Assessment of National Strategies (JANS) team. IHSSP staff worked with a WHO consultant to discuss the survey methodology and presented it to the new state Minister. Pending approval from the Minister, this should move forward next quarter and will provide important data on service coverage.
- Participated in the annual planning workshop for the new DG for Planning, HMIS and M&E. This resulted in some recommendations on a more efficient structure of the new DG (see the figure 3) and a consolidated work plan for eHealth, HMIS and M&E activities. That activity also simplified the completion of the Mid Term Expenditure Framework requested by the Ministry of Finance and Economic Planning.

Figure 3: The proposed organizational structure for the DG-Planning, M&E and HMIS



### 1.3.7. Support to the one UN planning exercise

IHSSP staff readapted the district costing tool for support to the one UN planning exercise. IHSSP led a half-day workshop for the teams from various UN agencies to help master the tool.

### 1.3.8. Support to finalize the family planning policy and strategic plan

Technical assistance was provided to the MoH Family Planning Program to finalize the family planning policy and strategic plan. IHSSP staff facilitated to extract additional data from the HMIS and incorporate the Permanent Secretary and Minister’s suggestions into these documents.

### 1.3.9. Support to the development of the community health policy and strategic plan

IHSSP staff facilitated a brainstorming exercise for the development of the community health policy and strategic plan.

## 1.4. Challenges/constraints, lessons learned and next steps:

### 1.4.1 Challenges/Constraints:

- Lack of counterpart at MOH/HMIS unit: The national HMIS coordinator has been absent for 7 months and it is still unclear when the replacement will be hired;

- Heavy implication of HMIS staff in field activities (TB training, PBF assessment and data quality audits) meant that some core activities were not completed – this includes the finalization of the annual health statistics booklet and the implementation of the RHMIS web portal;
- Limited capacity within MINALOC to manage the Ubudehe income categorization database: IHSSP has been asked to move this application over to MINALOC, but currently that ministry has no data center or internal IT capacity to support the system. The MOH needs these data to be maintained regularly in order to correctly manage the mutuelle/CBHI membership, but yet the database is ‘owned’ by MINALOC;
- Difficulties for finalizing the scope of work with IHSSP subcontractor, Futures Group: This has delayed the implementation of key deliverables including the HMIS user manuals, SOPs for community level data management and use, implementation of program specific dashboards, and the establishment of a comprehensive data dissemination and use strategy. Given the closing of the Futures Group country office in Kigali, there is some concern about their capacity to provide the human resources necessary to complete these tasks.

#### **1.4.2 Lessons Learned:**

- The new DG for Planning, M&E and HMIS has made a good start at combining a variety of disparate units that should be working much more closely. The joint work planning exercise held in March enabled the team members to get to know each other, discuss possible changes in the structure of the directorate and develop a consolidated work plan;
- The M&E fundamentals workshop has proven to be an excellent method to promote the use of key data sources (particularly the RHMIS), as well as enhancing coordination between the different stakeholders working on M&E at the central level.
- IHSSP’s efforts to reach out to and coordinate with the RFHP should help with the implementation of several key interventions. In particular, the training provided to the RFHP M&E team in using data from the RHMIS should enable them to better support evidence-based decision-making within the 14 districts that they are supporting. Similar initiatives could also be undertaken by the IHSSP health financing and QI teams to reinforce the PBF assessment process and integrated supervision.

#### 1.4.3 Next steps and plans for next quarter:

- Incorporate the newly validated CBHI periodic reporting systems into the DHIS-2 platform and create analyses necessary for the web-based CBHI financial management tool
- Assist the DG Planning, M&E and HMIS to plan for the implementation of the SARA and incorporate key semi-permanent data (e.g. facility infrastructure) into DHIS-2 or LimeSurvey platforms if the DHSST platform is dropped
- Complete training of nursing and medical council staff in using iHRIS qualify for health professional licensing and registration
- Evaluate tablet-based platforms for implementing the LimeSurvey questionnaires and train QI team to maintain LimeSurvey-based accreditation survey tool
- Continue the oversight of CBHI membership database implementation and establish a comprehensive training plan with JEMBI
- Finalize consulting agreements with HISP to proceed with enhancements to the DHIS-2 platform, including the import of GESIS data and the synchronization of organizational units with health facility registry
- Assist the Ministry with the finalization of the 2012 annual health statistics booklet and other periodic analyses
- Work with the Ministry and WHO to complete the implementation of the national health observatory (web portal for national and district health profiles)
- Continue to assist RBC and MOH units to migrate their data collection systems to the DHIS-2 platform
- Support the move of most of the MOH web servers to the national data center and re-configuration of a smaller data center
- Facilitate M&E fundamentals workshop for District M&E officers.

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

### 2.1. Support the development of health financing strategic plan

#### 2.1.1. Strategic plan development for health financing and community health

IHSSP worked with the MOH and other partners to develop the strategic plans on health financing and community health for the upcoming five years (2013-2018). During this quarter,

the situational analysis for the development of a health financing strategic plan was conducted. This included gathering data on financing and an overview of governance and the policy context. A workshop that will bring together all stakeholders in the health sector to discuss and reach a consensus on existing challenges in health financing is under preparation. The workshop will provide the recommendations on strategic options to pursue what will be included in the plan.

For the health community strategic plan development, IHSSP participated in different technical working sessions for the development of strategies, activities, indicators, the costing and timeframe setting for key activities.

#### **2.1.2. District SWAp guidelines development**

As part of the core team, IHSSP contributed to draft specific sections of the district Sector Wide Approach (SWAp) guidelines. The core team is translating the existing SWAp's roadmap and manual into an operational reference guide—taking into account the different steps of district health planning, implementation, budgeting, M&E and reporting—to develop the district health SWAp reference guide.

### **2.2. Development of the equity policy for PBF budget allocation to Health facilities**

One of the main drivers of inequities in health status of the population is the access to and utilization of health services. Populations that lack access to services show consistently worse health outcomes than populations with better access to health services. As a member of the PBF extended team platform, IHSSP participated in the development of the PBF equity policy to be included in the PBF procedures manual. The equity policy was proposed and has been integrated in the PBF procedures manual for validation. This is an innovative targeting approach for improving equity in access and utilization through PBF allocation.

The PBF extended team is developing an updated PBF policy. One important aspect that the team is discussing is vertical equity. This was considered so that different treatment be provided for different needs, and that more resources (including PBF allocation) be devoted towards those with greater needs (e.g. parts of the country with a greater disease burden). Some additional considerations that have been proposed to improve equity through PBF allocation are:

- Geographic inequities: health facilities located in rural areas faces disproportionate barriers in accessing health resources and services compared with people in urban areas;
- Disparities between the rich and poor in term of access to health services across regions (provinces and districts).

### **2.3. Development of SoPs and the manual for CBHI data management and audit**

The decentralization process underway in Rwanda gives more and more responsibilities to the districts and sections to manage the CBHI program. This shift of roles and responsibilities requires innovative strategies to leverage the scarce resources availed at district level. There is a need to provide the CBHI program with tools that can help maintain good quality data that support decision-making across the system and build confidence among all stakeholders. The development of the data audit manual will help acheive this requirement.

The national CBHI data validation exercise held in August–September, 2012 identified challenges faced by CBHI sections and districts to implement the new CBHI policy, and highlighted gaps between the electronically reported data and the data reported through different CBHI management tools (registers) available at the sections and districts level. The MOH, through Cellule Technique d’Appui aux Mutuelles de Santé (Mutuelle Technical Support Cell) (CTAMS), is committed to conduct a DQA every semester. The traditional CBHI weekly reporting is also a powerful tool to monitor the progress of the national CBHI coverage rate and the management of the CBHI funds on weekly basis.

During this quarter, in order to revise and finalize the developed CBHI SoPs manual for assessing sections CBHI data quality, IHSSP team conducted a field test in Karongi, Muhanga, Musanze and Rulindo districts. Both the French and English versions of the CBHI SoPs were revised and finalized, and will guide the DQA manual. The purpose of this manual is to provide practical, easy to understand information and materials for district CBHI M&E staff and supervisors at the central level (MoH/CTAMS) to clarify the DQA process. It explains also the procedures for ensuring the collection of quality data.

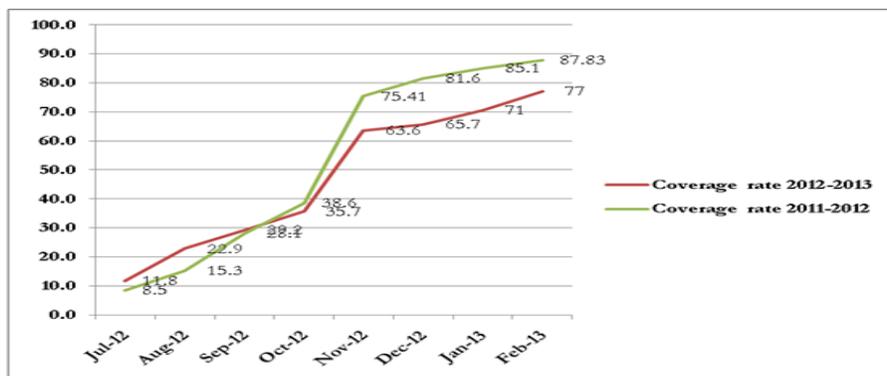
After validating the manuals, IHSSP will begin developing local capacity and conduct trainings to enhance MoH/CTAMS and district CBHI teams capacity for supervisions and technical assistance.

## 2.4. Support the CBHI extended team coordination mechanism and editorial committee for capacity transfer

### 2.4.1 Assessment of the coverage rate and CBHI adherence factors for the FY 2012/13

Although some measures and actions were taken to increase the CBHI enrollment, the analysis of the CBHI progressive weekly reports showed that, for eight months period of the CBHI exercise (July, 2012 to February, 2013), the enrollment nationally was at 77% of the population; this represents a low CBHI adherence compared to the FY 2011/12 where it was at 87% for the same period.

**Figure 4: Comparison of CBHI enrollment: FY 2011/12 and 2012/13**



Source: CBHI Progress Weekly Reports FY 2011/12 –fy2012/13, Ministry of Health, 2013.

With support from IHSSP, the MOH (the Ministry responsible for the managing CBHI), and MINALOC (the Ministry responsible for sensitization), are organizing a joint assessment exercise on “CBHI adherence factors”. The exercise was designed to identify the factors that influence CBHI adhesion/non-adhesion, the reasons for the FY 2012/13 low coverage, and the strategies for improving the next FY CBHI enrollment. The protocol for the assessment has been developed and both secondary data analysis of routine CBHI data and key informants interviews will be conducted. The assessment will address recommendations for sensitization policy and improvement in the population coverage.

Many reasons may justify why the coverage rate is high or low in a given district or sector, such as:

- the economic situation and background of the district,
- the lack of awareness on CBHI benefits,
- the reasons related to the faith,
- the quality of data related to the catchment population, or
- the strategies of sensitization for CBHI adherence.

## **2.5. Support to the MoH in the implementation of national and decentralized CBHI financial modeling tool**

### **2.5.1. Continuous capacity transfer on CBHI - FMT**

The district financial analysis conducted in the CBHI auto evaluation of the 1<sup>st</sup> quarter, FY 2012/13 encountered data quality<sup>1</sup> challenges. The main reasons for this challenge was the lack of data audit, but also there may be a miscomprehension of CBHI reported indicators by section staffs. In response to the challenge, IHSSP supported the MoH/CTAMS to conduct a series of trainings for CBHI decentralized levels in 5 districts. The objective was to train the districts and sections level staffs in financial management (through the FMT) using their own data, and identify the main challenges encountered while defining indicators.

These two-day on-the-job trainings were held in each of the 5 districts, one day for the district level staffs (CBHI director, accountant and mobilizer), and another day for the section level staffs (section managers and accountant) through their monthly coordination meeting. The main activities were:

- Definition of CBHI indicators from the FMT tool (indicators, definition and source of data);
- Definition and calculations of CBHI M&E indicators (indicators, definition and formulas)

The table below shows the number of districts and sections' personnel trained in CBHI financial managements:

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<sup>1</sup> Refer to the Rwanda - Integrated Health Systems Strengthening Project quarterly Project narrative Report (October – December, 2012), P 15

**Table 1: districts and sections' personnel trained in CBHI financial managements**

Districts	Expected Number of trainees	Number of trainees
<b>Kicukiro</b>	District (4) Sections (16)	19
<b>Karongi</b>	District (3) Sections (21)	21
<b>Muhanga</b>	District (3) Sections (13)	15
<b>Musanze</b>	District (3) Sections (26)	19
<b>Rubavu</b>	District (3) Sections (20)	21

### 2.5.2. Mid-year CBHI financial report

At the end of December 2012, each CBHI district was required to elaborate its financial report using the financial modeling tool. Those reports were discussed during the CBHI auto evaluation, but due to data quality issues, it was not possible to finalize the national report. During this quarter, districts had to clean their reports and send them to the MoH/CTAMS. IHSSP provided technical support to the CBHI mid-year financial report; the final will be available in April, 2013. Annex two shows some figures of the report for Muhanga district; they were selected as they have fewer data errors.

### 2.5.3. CBHI auto-evaluation

In March 2013, the MOH/HF unit jointly with IHSSP organized the second auto evaluation workshop of the CBHI year 2012-2013. The main points discussed on the agenda of the workshop are:

- ❖ Reserve distribution : the following are the propositions after review of the way reserves are distributed:

**Table 2: Proposal for reserve distribution**

Level	Present distribution %	Proposed distribution %
Section	20	10
District	60	55
National Pooling Risk	20	35

Those propositions were based on drawn experience from the 1<sup>st</sup> year in the implementation of the new CBHI policy which started in July, 2012.

- ❖ Discussions on CBHI subscription for foreigners living in Rwanda. All participants expressed the need of foreigners to have access on CBHI, but under special conditions. The MoH should decide on those conditions and communicate them to districts.

The IHSSP also supported the districts in different data analysis. The main indicators analyzed are:

- Progress of coverage rate per section and district
- Average cost of reimbursement per sections and District
- Comparison between revenues and expenses per section and district
- Analysis of expenditures per category per section and district

Annex 3 shows some figures from districts' CBHI data analysis. Other analyses were conducted using each district's data. A deeper training on MS-excel and data analysis was recommended for CBHI managers.

## **2.6. Conduct an analysis of the access, equity and efficiency of CBHI system**

### **Support for CBHI studies**

In collaboration with the Rwanda SPH and the MOH, IHSSP provides support to conduct CBHI studies financed by Rockefeller via MSH. The objectives are: (i) conduct an analysis to determine the access and equity of CBHI system; and (ii) develop and document lessons learned with direct practical relevance to health policy makers and planners in Rwanda and other countries as they design and implement CBHI.

During this quarter, IHSSP staff participated in the review of the questionnaire that will be used for conducting key informant interviews for policy makers, scholars, experts, government officials, and representatives of international and local agencies who have been closely involved in the CBHI policy development and its implementation in Rwanda. IHSSP also supported the development of the questionnaires that will be used to collect households' information (composition, socio-economic status, etc.), health insurance coverage, and health care utilization. The household survey is supposed to be conducted at the end of April, 2013.

The IHSSP team also participated in the evaluation of the copayment study which was conducted by MoH/HF Unit; the objective was to find out whether the Copayments paid at all levels of the

health facilities present a problem to the affordability of care. While conducting this study, it has been decided to redo it as the methodology used was not agreed upon by all stakeholders.

## **2.7. Design of provider payment systems and their standard operating procedures**

Following the resolution of the October 2012 provider payment mechanisms workshop organized by the MoH with support from IHSSP, a new technical team was established to advise the MoH on the way forward for the implementation of case-based payment system and its implications for the Rwanda health sector.

IHSSP provided technical support for drafting the TORs of the technical advisory team. The technical team on provider payment will advocate and spearhead the coordination of provider payment reform in the country, and facilitate the effective execution of the work-plan set forth in the workshop. Bi-monthly meetings of the technical team are conducted through the established platform.

### **Next steps and plans for next quarter:**

- Provide direct support to the provider payment technical team at MoH: Conduct a study tour in Thailand on DRG.
- Financial sustainability analysis of health financing interventions: Conduct an assessment.
- In partnership with the SPH, test and conduct households' survey on access and equity for the CBHI studies.
- Link PBF approach with accreditation mechanism: Harmonization of PBF assessment tools and accreditation standards
- Test and train trainers on the CBHI data quality assessment (DQA) methodology and tools.
- Finalization of the health financing strategic plan: work on developing strategic options to pursue, activities, indicators for the strategic plan as well as timeframe for the key activities.
- Test the lime-survey tool (open source tool to be used online or offline by evaluators) by importing PBF assessment results into the system.
- Continue the oversight of CBHI financial modeling tool implementation at central and district levels.

- Develop SoPs for SISCom management and adapt the DQA manual for the community level data (SISCom and community PBF).

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

#### 3.1. Training of surveyors

The Rwanda National Accreditation Program is committed to ensuring that surveyors demonstrate the necessary competencies to carry out their responsibilities successfully, thus maintaining the integrity of the healthcare accreditation process. It's on this note that IHSSP organized and conducted a survey training program. The training program is designed to build surveyor skills aligned with a set of core competencies that have been identified as important to the tasks of the accreditation survey. The successful surveyors that have acquired the competencies necessary to carry out the assessment according to the established policies and procedures will be certified.

The training consisted of seven modules taught in class as theory part of the program:

- orientation to the accreditation program;
- quality improvement framework and methods;
- interpretation of standards;
- survey process;
- tools, scoring and documentation guidelines;
- communication skills such as giving and receiving feedback and interviewing techniques;
- and
- Professional manners and ethics.

In addition, twenty surveyors completed their initial on-site observation of the survey conducted by JCI consultants as an in-training practical experience. Under supervision, seven of these trainees have completed their second survey in which they participated in the process, and two individuals have been mentored to serve as team leaders. Performance feedback was given to the trainees that had completed two on-site surveys. Surveyors are required to participate in three on-site mentoring activities and take a final examination before they are certified. The mock surveys

planned to be conducted in January-February 2014 in the five hospitals will provide an additional opportunity to build the capacity of the trainees, including report writing.

### **3.2. Dissemination of essential accreditation standards to provincial and district hospitals**

IHSSP disseminated and communicated the essential accreditation standards to the five provincial and all district hospitals. IHSSP will engage the 37 district hospitals to improve quality and safety in a bid to implement some of the standards through agreed annual national patient safety goals.

### **3.3. Baseline survey**

The baseline survey was conducted in five provincial hospitals to establish the current situation and opportunities for patient safety and quality improvements. These assessments afforded the opportunity to determine the status of the hospitals in relation to the essential hospital standards, evaluate the standards and assessment tool, and provide practical training opportunities for the accreditation surveyors.

The baseline assessments were performed under guidance and mentoring of the JCI consultant, and included a leadership interview, interviews with the Infection Control and Quality Committees, document review, medical record review, and clinical unit and facility tours.

The medical record review was carried out with three facility staff members: each was given a data collection tool and was asked to review a record. This process, used commonly for accreditation surveys, provides an opportunity for the staff to gain insight into the areas of documentation that need improvement, and teaches them how to conduct a medical record review.

The reports of the findings and recommendations for each hospital were produced and feedback is to be given to each hospital by the team. The results of the review show that many findings were below expectations. These risk areas require further consideration and should be viewed as significant opportunities for improvement by senior management.

The confidentiality of these reports and data must be protected and thus, need to establish a policy and procedure to enforce this. The findings, facilitating factors, and recommendations serve as a guide to assist the leadership in working toward achieving the accreditation.

### 3.4. Challenges/constraints, lessons learned and next steps:

#### 3.4.1. Challenges/Constraints

- Inadequate resources for implementing the provincial level service package, particularly in relation to emergency supplies/equipment;
- Insufficient knowledge and skills to identify risks, plan risk reduction and providing oversight of the risks;
- Strategic plans do not focus on future hospital development, quality and safety improvement to enhance delivery of complete package of provincial hospitals;
- Lack of capacity and commitment in supporting the implementation of the guidelines, policies and procedures that have been developed;
- Difficulties in institutionalizing quality management and creating a culture of quality and safety.

#### 3.4.2. Lessons Learned:

##### ➤ **Quality improvement planning**

IHSSP initiated and facilitated quality improvement activity planning has been done to bridge the gaps identified during the survey. Ruhengeri and Ruhango hospitals have completed their plans and should have started the implementation. Rwamagana, Kibungo and Bushenge are scheduled to finalize their quality improvement plans in April.

##### ➤ **Accreditation policies and procedures**

Accreditation policies and procedures to guide operations and management of the accreditation system should be established. The surveyor confidentiality agreement has been developed to prevent staff from involvement in situations that might constitute or be perceived as conflict of interest with the mission of the accreditation system, including any misuse of confidential or proprietary information. Similarly, the accreditation document management policy and procedure has been developed.

#### 3.4.3. Next steps

- Continue to support the work of steering committee to finalize the strategic plan, accreditation model and by laws;
- Communicate the hospital baseline assessment findings to key stakeholders;
- Initiate staff planning based on WISN methodology;

- Provide technical assistance to the hospitals to implement the standards;
- Select five facilitators from central level and five participants from each of the five district hospitals to be trained in quality improvement in June;
- Begin revising the clinical policies and procedures based on the hospital standards.

## **IV. IMPROVED MANAGEMENT, PRODUCTIVITY AND QUALITY OF HUMAN RESOURCES FOR HEALTH**

### **4.1. Facilitate the development of CPD strategic plan for the NCNM**

During this quarter, IHSSP supported the strategic plan development for the NCNM. This strategic plan will enable the nurses and midwives to implement human resources for health (HRH) activities and strengthen the professional councils to implement the continuous professional development activities for the members.

The Rwanda Medical Council is currently the only council implementing continuous professional development activities for its members. The expectation is for the NCNM will do the same after validating their strategic plan.

### **4.2. Finalizing the database for the NCNM**

IHSSP supported the finalization of the database for the NCNM and three council members received orientation training on how to use this database. The database will be useful for the council in maintaining the updated registrations that will be referred to for issuing licenses, renewals and other planning for the council members.

### **4.3. Registration of the Allied Health Professionals**

The Allied Health Professionals (AHP) council was supported to start the registration process of its members, which is currently going well. Over 180 members have registered since the beginning of the exercise in January 2013. The licensing and CPD programs development, including the development of the strategic plan for CPD activities, will be planned after the registration.

### **4.4. Facilitate the health facilities in staff planning using the WISN methodology**

During this quarter, IHSSP prepared the trainings for five provincial hospitals' staff to implement the WISN approach in staffing needs. In the coming quarter, the five human resources

staff from provincial hospitals together with 20 staff from the MOH will receive the training on WISN methodology.

#### **4.5. Challenges/Constraints**

- The NCMN has a shortage of human resource and technical people like an IT staff. This challenge needs immediate attention if the council is to function as an independent body
- The Allied Health Professionals' Council does not have an office and permanent staff to run the activities except a registrar who is working on contract basis.

## **V. EXTENDED DECENTRALIZATION OF HEALTH AND SOCIAL SERVICES**

### **5.1. Development of the district SWAp guidelines**

In collaboration with other partners, IHSSP provided technical support to the MOH in the development of district SWAp guidelines. These guidelines will be used by the districts to ensure proper coordination of the activities and partners in the districts.

### **5.2. Training five DHMTs according to gaps identified in the roles and responsibilities**

In collaboration with the Rwanda Family Health Project, IHSSP provided technical assistance in the workshop with the managers from five districts to define the roles and responsibilities of District Health Management Teams (DHMTs). The activity was based on available DHMT guidelines elaborated by MOH in 2011. These guidelines may be revised after execution of the MOU between the MINALOC and the MOH.

### **5.3. Situation analysis of CSOs in the health sector**

A series of meetings with NGO's forum members have been held to discuss the way forward on the situation analysis of civil society organizations (CSOs). IHSSP organized another meeting that brought together the NGO-forum and Global Fund CCM representatives to agree on approach to be used to carry out the functional analysis. It was agreed that the available information on CSOs be provided to IHSSP for analysis. The next step will depend on information obtained from the provided documents.

### **5.4. Challenges/constraints**

- In two previous years, health decentralization had been dropped from the five IHSSP components. In this quarter, some activities of the decentralization component have been

planned but, unfortunately, the implementation delayed due to the lack of clarity on division of roles between the MOH and MINALOC. The ministries agreed to sign a MOU which will specify the roles of MOH at the decentralized level.

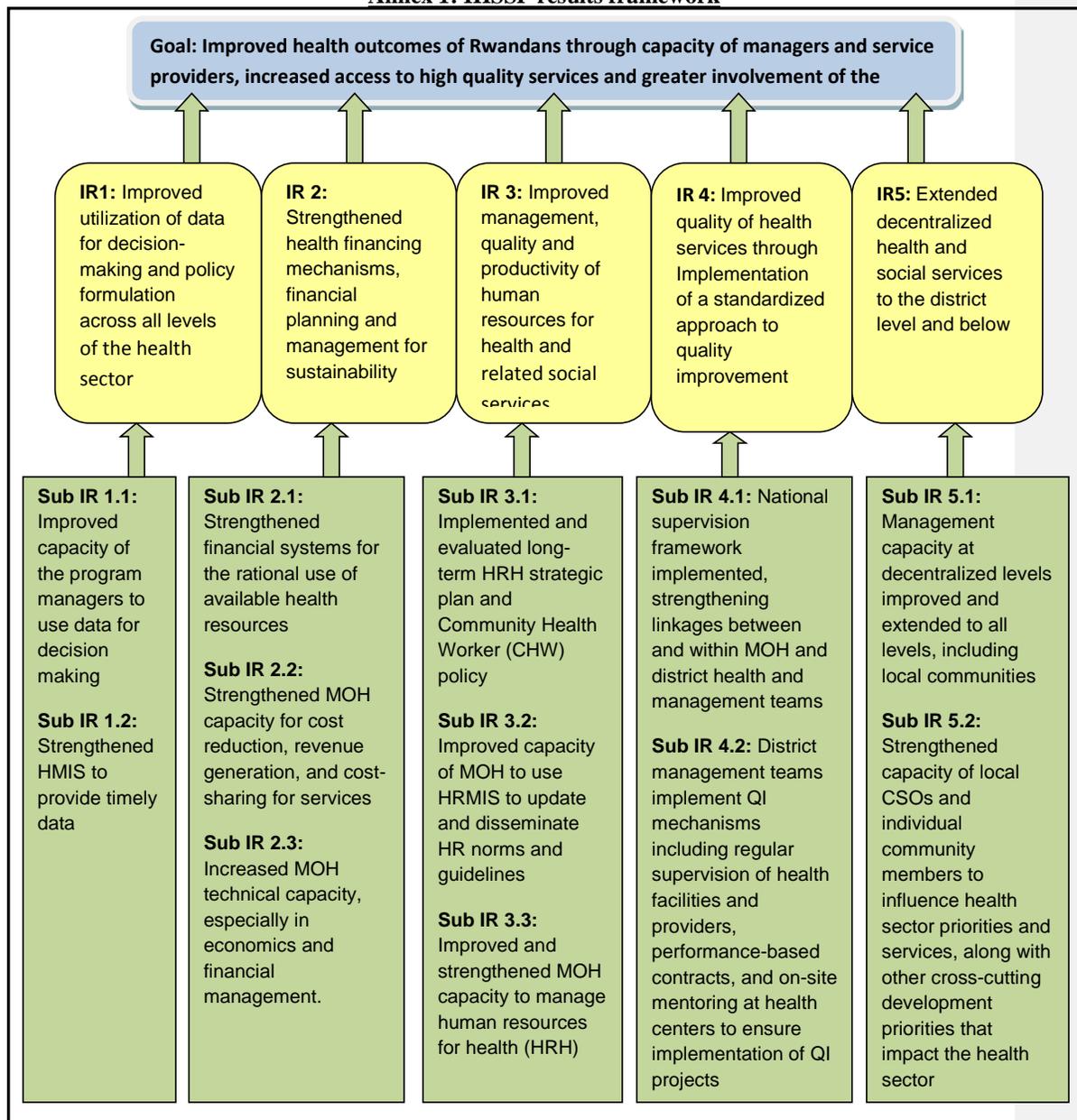
- The current document referred to as guidelines for DHMTs has been provided to MINALOC by the MOH, but MINALOC did not disseminate the document to the district teams. So, it's still a challenge to know whether MINALOC agrees with this document or not.
- The districts health teams' opinion is that the district authorities will not provide them with adequate support needed to provide quality health care, because those authorities don't understand much about important health care needs.
- The CSOs assessment may not be a priority for NGOs' forum. The forum views that many assessments have been done and is interested on planning how to address what has been identified in previous assessments.

**Next steps:**

- WISN training will be done and implementation plan developed
- Continue to support the profession councils for CPD.
- Continue to support MOH to improve decentralization of services

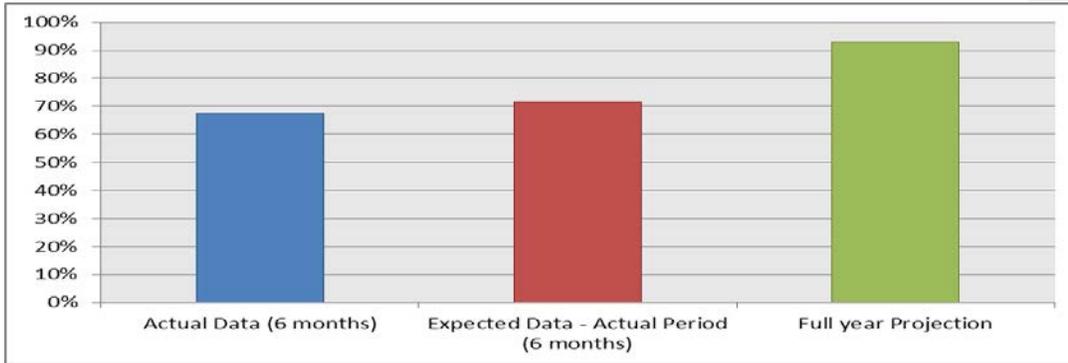
## ANNEXES

### Annex 1: IHSSP results framework

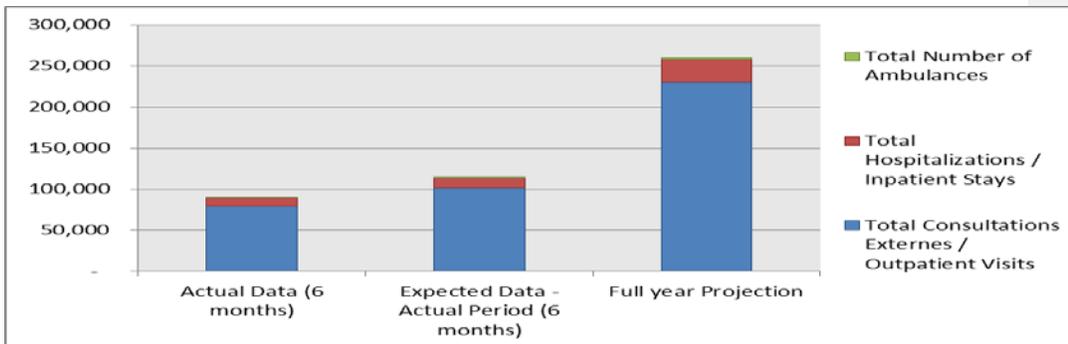


**Annex 2: Some figures of the CBHI mid-year financial report for Muhanga district**

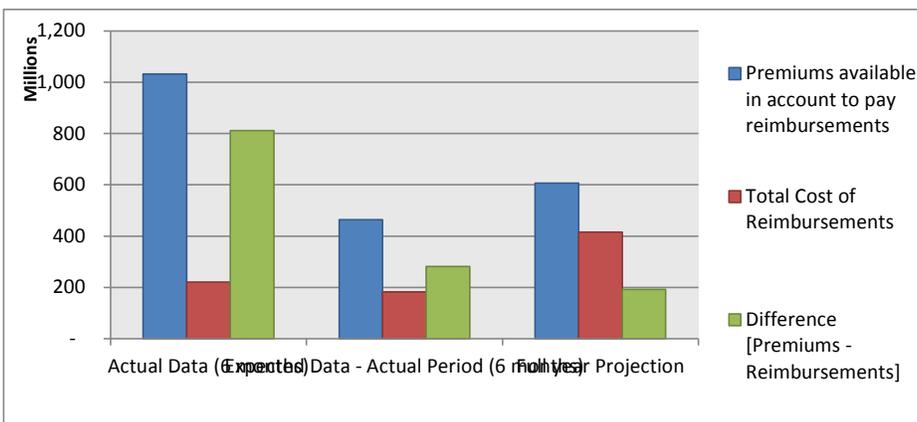
**Figure 5: Annex 2.1. Enrollment of the population on CBHI**



**Figure 6: Utilization of the services**

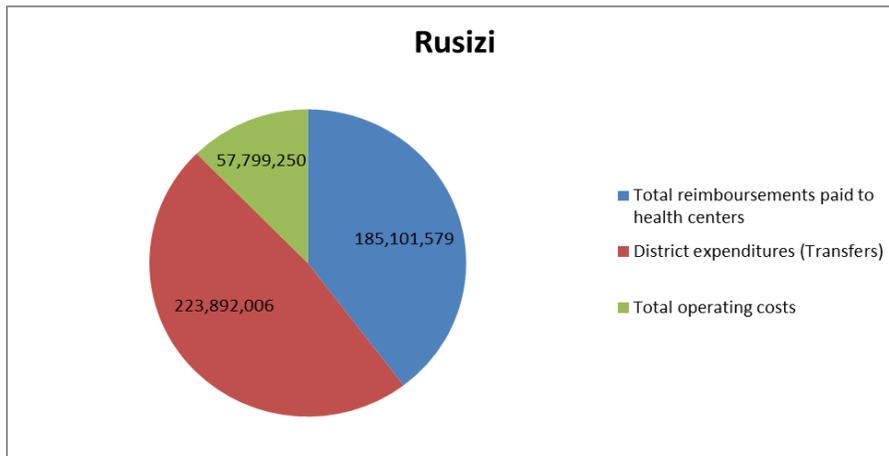


**Figure 7: Premiums and reimbursement costs: actual, expected, and yearly projection**



**Annex 3: Some figures from districts' CBHI data analysis (6 moths' data)**

**Figure 8: Proportion of different kind of expenses**



**Comment [mr1]:** Can you turn the second item to Title Capitals rather than ALL CAPS?

**Figure 9: Proportion of different kind of income**

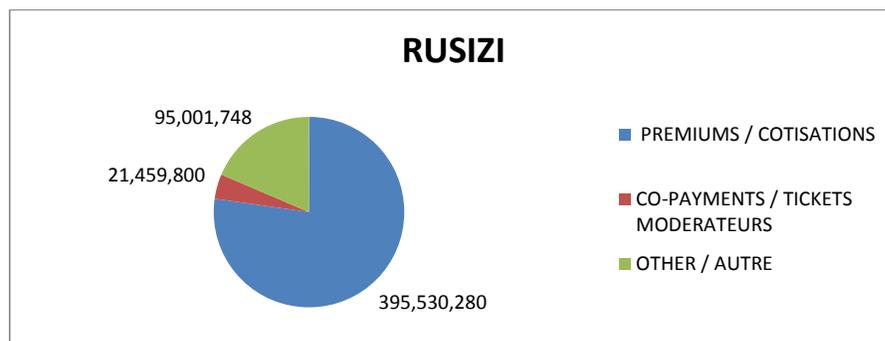
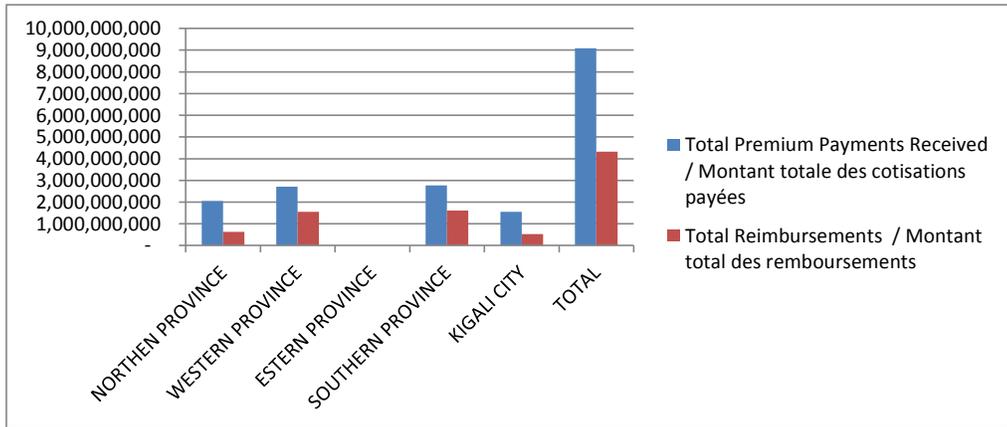


Figure 10: Comparison of premiums vs. health care expenditure



province (Eastern excluded)

res per

Comment [mr2]: Can you change "Estern" to "Eastern"? I can't access the file.

