

Annual Project Report

Rwanda IHSSP

October 2012 – September 2013

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Rwanda Integrated Health Systems Strengthening Project (IHSSP)
Management Sciences for Health
200 Rivers Edge Drive
Medford, MA 02155
Telephone: (617) 250-9500
www.msh.org



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INKUNGA Y'ABANYAMERIKA

Rwanda Integrated Health Systems Strengthening Project:

Annual Project Report Narrative

(October 2012 – September, 2013)

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ACRONYMS

BTC	Belgian Technical Cooperation
CBHI	Community Based Health Insurance (Mutuelle)
CDC-COAG	Centers for Disease Control and Prevention – Cooperative Agreement
CHW	Community Health Worker
CPD	Continuous Professional Development
CSO	Civil Society Organization
CTAMS	Cellule Technique d’Appui aux Mutuelles de Santé
DHs	District Hospitals
DHIS-2	District Health Information System (New Rwanda HMIS System)
DHMT	District Health Management Team
DHSST	District Health System Strengthening Tool
DQA	Data Quality Audit/Assessment
DRG	Diagnosis-related group
ECSA	East, Central and Southern Africa
RFHP	Family Health Project
FMT	Financial Management Tool
HCs	Health Centers
HISP	Health Information System Program
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HRH	Human Resources for Health
HRMIS	Human Resources Management Information System
HSSP III	Health Sector Strategic Plan III
ICT	Information and Communication Technology
iHRIS	Human Resources Information System
IHSSP	Integrated Health Systems Strengthening Project
ISQua	International Society for Quality in Health Care
JCI	Joint Commission International
M&E	Monitoring & Evaluation
MINALOC	Ministry of Local Government
MOH	Ministry of Health
MOU	Memorandum Of Understanding
MSH	Management Sciences for Health
NCNM	National Council for Nurses and Midwives
NDC	National Data Center
NURSPH	National University of Rwanda/School of Public Health
OVC	Orphans and Vulnerable Children
PBF	Performance-Based Financing

PH	Provincial Hospitals
PIH	Partners in Health
QI	Quality Improvement
RBC	Rwanda Biomedical Center
RRFHP	Rwanda Family Health Project
RHMIS	Routine Health Management Information System
SARA	Service Availability and Readiness Assessment
SIScom	Community Health Information System
SOP	Standard Operating Procedure
SPH	School of Public Health
SQL	Structured Query Language
STTA	Short Term Technical Assistance
TB	Tuberculosis
TOR	Terms Of Reference
TOT	Training Of Trainers
TRACNet	A data entry, storage, access, and sharing system created in 2005 by the Treatment and Research AIDS Center (TRAC)
TWG	Technical Working Group
USAID	United States Agency for International Development
VTC	Voluntary Counseling and Testing
WISN	Workload Indicators for Staffing Needs
WHO	World Health Organization

EXECUTIVE SUMMARY

In its fourth year of the implementation (the reporting year of October 1, 2012 to September 30, 2013), the Integrated Health Systems Strengthening Project (IHSSP) continued the work of strengthening health systems across the five health components: health information, health financing, quality improvement (QI), human resources for health, and decentralization. The emphasis for this year was on innovation, capacity building, consolidation, and fine-tuning of previously introduced initiatives that will collectively contribute to the sustainability of the health system.

In **health management information**, the focus was on the continued upgrade and implementation of new functionalities for the District Health Information System (DHIS-2) platform by creating new modules and tools within the system. To strengthen the management of the Health Management Information System (HMIS), e-Health, monitoring and evaluation (M&E) functions, and structures, the project provided support to integrate additional information sources using automated importing functions into the new HMIS. The data from different databases were consolidated in the data warehouse and a dashboard was created within DHIS-2 to enable the customized use of those data. The CBHI weekly and monthly reporting system was created within DHIS-2 and the process of developing a web and mobile phone based membership system within DHIS-2 was initiated.

To advance the accreditation program, the LimeSurvey software was introduced and an android tablet computer tested, for baseline assessments in provincial hospitals. Other new features to highlight include: the introduction of the Service Availability and Readiness Assessment (SARA); support for the operationalization of other databases (Ubudehe, iHRIS, Performance PBF, etc.); development of SOPs to clarify the functions, roles, and responsibilities; and the capacity building of central and district level program managers to use, maintain, and update the systems and use data.

The **health finance component** focused on continued support to improve the efficiency and sustainability of the Community Based Health Insurance (CBHI) and Performance-based Financing (PBF) in Rwanda. This includes: the implementation of the national and decentralized CBHI Financial Management Tool (FMT); development of CBHI policy documents and SOPs for data quality assessments; CBHI program research; capacity transfer on PBF budget forecasting; development of the equity policy for PBF budget allocation; Community PBF counter verification and system audit; and the approach to link PBF with accreditation.

A capacity transfer of CPBF national trainers initiated the Data Quality Audit/Assessment (DQA) mechanism to monitor the progress of the national CBHI coverage rate and management of CBHI funds. The new process of integrating PBF to the accreditation program will foster the improvement of quality health care services. IHSSP also supported the initiation of designing a provider payment mechanism by facilitating the by facilitating a workshop to discuss the use of Diagnostic Related Groups (DRGs).

The focus of the IHSSP/**quality improvement (QI) component** was the establishment of a Rwanda-owned accreditation system that will meet International Society for Quality in Health Care (ISQua) standards. Basic health care accreditation system structures and SOPs for implementation have been established including an accreditation steering committee, elaboration of essential standards, development of an accreditation strategy and guiding principles, establishment of accreditation by-laws, and development and costing of the Rwanda health care accreditation strategic plan for 2012–2018.

IHSSP/QI supported the elaboration of Rwanda Essential Hospital Accreditation Standards and their dissemination to all district hospitals. Accreditation surveyors and facilitators were selected, trained, and provided with onsite mentoring to ensure that they are skilled with competencies to carry out their responsibilities successfully. Accreditation baseline surveys were carried out in provincial hospitals and an additional 10 district hospitals. The QI team also facilitated the development and dissemination of national quality and patient safety goals and treatment guidelines, and supported the Provincial Hospitals (PHs) with regard to standard implementation by developing new procedures.

For the **human resources for health and decentralization components**: despite reduced budgets and reduced dedicated staff, these components nonetheless undertook important work especially in support of the health professional associations and District Health Management Teams (DHMTs) of the PHs. The project supported the Continuous Professional Development (CPD) strategic plan development and finalization of the database for the National Council for Nurses and Midwives (NCNM), development of pharmacists' council strategic plan, registration of the Allied Health Professionals (AHPs), development of an integrated CPD policy for all professional councils, and began building the capacity at the central level to apply the WISN methodology for evaluating deficits and/or surpluses in the health workforce.

IHSSP provided technical assistance to the managers from the districts of the five provincial hospitals to define the roles and responsibilities of District Health Management Teams and assess their capacity gaps. Closing the gaps will be addressed in the coming fiscal year.

Technical support was also provided for the finalization of the Strategic Plan for Decentralization, finalization of the district strategic plans, and capacity needs assessment of civil society organizations (CSOs).

As **cross-cutting health sector** support, IHSSP supported the Ministry of Health (MOH) to carry out the analysis of the alignment of MOH policies and strategic plans against the Health Sector Strategic Plan III (HSSP III), final drafting of the (HSSP III), completion of the Rwanda Biomedical Center (RBC) situation and functional analysis, and the development of the district Sector Wide Approach (SWAp) guidelines.

INTRODUCTION

Since November 2009, with funding from USAID, , the Integrated Health Systems Strengthening Project (IHSSP), implemented by Management Sciences for Health (MSH), has been working with the Rwanda Ministry of Health to strengthen health systems. The project was originally designed around five Intermediate Results, which are:

- Improved utilization of data for decision-making at all levels of the health sector
- Strengthened Health Financing Mechanisms and Financial Planning and Management for sustainability
- Improved management, quality, and productivity of human resources for health and related social services
- Improved quality of health services through a standardized approach to quality improvement
- Decentralized health and social service systems extended to the community level

The main goal of IHSSP is to establish a fully functional health system so that “The Rwandan population has improved financial and geographic access to quality health services that are sustainable and efficiently managed by well-trained health sector staff with clear functional responsibilities, using readily available and viable data to inform their management and policy decisions. Reinforced and strengthened district administrations will have become the hub for managing health service delivery supported by actively engaged community and civil society organizations.” (Rwanda’s Second Health Sector Strategic Plan – HSSP II)

The IHSSP has completed four years of the implementation and has made crucial contributions to the remarkable changes of health systems that have supported significant advances in health services and outcomes. This annual report summarizes the key activities and achievements of the project during the 4th year of implementation (October 2012 to September 2013).

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

I.1. Increase capacity of policymakers to collate, analyze, use and disseminate information

I.1.1. HMIS data collection and reporting manual

IHSSP supported the development and finalization of the HMIS data collection and reporting manual. IHSSP staff also worked with Futures Group consultants to finalize the documentation of some registers and reporting formats which were missing. This will help to improve data quality for data managers across the country.

1.1.2. Data management SOPs development

IHSSP staff worked with the team from the MOH/DG Planning, HMIS and M&E, and staff from various RBC and other MOH departments to develop the first draft of Standard Operating Procedures (SOPs) for central level M&E and data management functions. The SOPs development helped clarify the functions as there was confusion in the roles and responsibilities of central level M&E staff who have been working more or less independently in the past.

To provide further inputs in the development of district data management SOPs, IHSSP contracted a Futures consultant who helped design a district data management assessment tool and prepare a detailed activity plan to support HMIS initiatives through the final year of IHSSP. This assessment tool was pre-tested and is ready to be used for the assessment at the district level.

1.1.3. Development of annual health statistics bulletins for 2012

IHSSP staff assisted the MOH/HMIS team to prepare the 2012 annual statistical booklet. This was accomplished by conducting a comprehensive exercise to check the Routine Health Management Information System (RHMIS) for data quality issues, preparing HMIS data, implementing a web-based health facility survey to gather crucial infrastructure data, and organizing workshops with MOH and RBC staff to analyze data. The 2012 annual health statistics booklet will be posted on the MOH website and distributed in print to key program managers. The online survey was completed by data managers from hospitals and health facilities, and enabled the team to report updated figures on water sources, electricity, and computer/internet access, as well as key hygiene indicators from health facilities.

1.1.4. Implementation of data sharing policy

IHSSP supported the completion of a data sharing policy to determine who and how can access the RHMIS (DHIS-2) on the web and this has been approved by the MOH. With that approval, IHSSP worked with the MOH/HMIS unit to develop a system to track data access requests; provided access to the MOH/Planning, M&E, HMIS staff, and to other MOH stakeholders; and provided initial series of orientations to the DHIS-2 dashboard for staff from USG and other partners.

1.1.5. Trainings for central and district level managers

- **MOH/HMIS team:** IHSSP provided the technical training in the design of Structured Query Language (SQL) and specialized reports using DHIS-2. IHSSP also provided training to this team on using LimeSurvey, which enabled them to conduct a resource and infrastructure survey throughout all health facilities nationwide.
- **Central level M&E officers and data managers:** IHSSP staff worked with Futures Group to design and implement a workshop on M&E fundamentals for central level staff involved in M&E from RBC and various MOH departments. This provided a common understanding of M&E fundamentals, strengthened capacity for evidence-based decision-making, and ended by developing 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.

- **Administrative district M&E officers:** With funding provided by BTC, IHSSP worked with the MOH/DG Planning, HMIS and M&E, and lecturers from the Rwanda SPH to design a second workshop for the 30 district M&E officers (similar to the one provided to the central level M&E staff).
- **DHs and administrative district health teams:** IHSSP funded and facilitated two workshops organized in Musanze and Huye by the MOH/Planning unit to train 152 district health teams and hospital administrators in the use of the strategic plan-costing tool.
- **RBC M&E team:** At the request of the RBC M&E coordinator, the IHSSP/HMIS team organized training sessions on the use of the DHIS-2 software platform for the RBC team. During the training, the RBC team was able to create the monthly reporting system for OVC support – previously collected on spreadsheets and aggregated by the districts.
- **TB supervisors and health facility data managers:** IHSSP assisted in planning and facilitation of a series of 4 week-long training sessions on using DHIS-2 for managing TB program data. Over 500 people were trained in this activity financed by the Global Fund.
- **Data managers from eastern province DHs and HCs:** IHSSP facilitated a session on health indicators and use of data from RHMIS as part of the week-long course funded by RRFHP in Rwamagana where over 130 participants were trained.
- **RFHP:** IHSSP organized orientation session to the 7 staff from RRFHP on using data from DHIS-2; this helps in enhancing evidence-based decision-making in the 14 districts supported by that project.
- **DH and HC data managers:** IHSSP staff worked with the MOH/HMIS team to design the training curriculum and facilitated a series of training sessions to familiarize districts and health centers' data managers using the new analysis tools of RHMIS (pivot tables, enhanced charts and maps). More than 500 staff have been trained and training costs were funded by Centers for Disease Control and Prevention – Cooperative Agreement (CDC-COAG), BTC/CTB and RFHP.
- **Central level planning directorate staff and MOH/RBC program managers:** IHSSP staff supported the MOH to design and facilitate a training session for around 20 senior managers on using RHMIS analysis and reporting tools.
- **DHIS system administrators:** IHSSP worked with the MOH to prepare a two-week DHIS-2 training for the MOH/HMIS staff held in Kampala, Uganda. The advanced course helped in the implementation of public web dashboard and teaching MOH staff how to use and manage new features in the latest DHIS-2 (version 2.12). IHSSP also contracted the Health Information System Program (HISP) consultant who supported the MOH/HMIS team to prepare for and complete the move of the DHIS-2 servers to the National Data Center (NDC) and building their capacity on systems administration tasks.

1.1.6. Management of HMIS, e-Health and M&E functions and structures

➤ HMIS and eHealth functions and structures

IHSSP facilitated a workshop in Gashora with the MOH/DG Planning, M&E and HMIS team to develop a consolidated work plan, review options and propose changes for the organizational structure of the new directorate.

➤ M&E teams within departments and districts

IHSSP developed a costing spreadsheet for district strategic plan costing; provided technical assistance and participant training costs for capacity building sessions (But are and Musanze) of M&Es and hospital administrators on planning and costing; provided feedback to all districts on the costing of their strategic plans and corrected all of their spreadsheets; and facilitated a session on health indicators and use of data from the RHMIS as part of the week-long course funded by the RFHP in Rwamagana where over 130 participants were trained.

1.2. Strengthened HMIS to provide reliable and timely data

1.2.1. Upgrade and implementation of the new functionality on DHIS-2 platform

Supported by IHSSP, MOH rolled out a new Rwanda HMIS (DHIS-2) and this year, the Project continued to support the implementation of new functionality on DHIS-2 platform. These include:

- Reconfiguration of organization unit hierarchy to display data entry sites by administrative sector;
- Collection of GPS coordinates for health centers, hospitals and VCT centers;
- Migration of SIScom to the DHIS-2 platform and implementation of Community PBF payment and performance against targets within DHIS-2;
- Development of module for entering the routine data quality audits that are done every 6 months throughout the country;
- Added TB module for quarterly reporting and death audit reporting;
- Added new TB multi-drug resistance patient tracking module;
- Created new analyses using the child/infant death audit modules;
- Worked with RBC staff to create a reporting system for HIV peer educator reporting. With RBC, this system was rolled out to CSOs and district implementing partners to record HIV support activities carried out in the districts by implementing partners;
- created new series of queries to calculate the top 10 causes of outpatient department (OPD) services, hospitalization, and death;
- Worked with different MOH partners and researchers to extract and analyze RHMIS data.

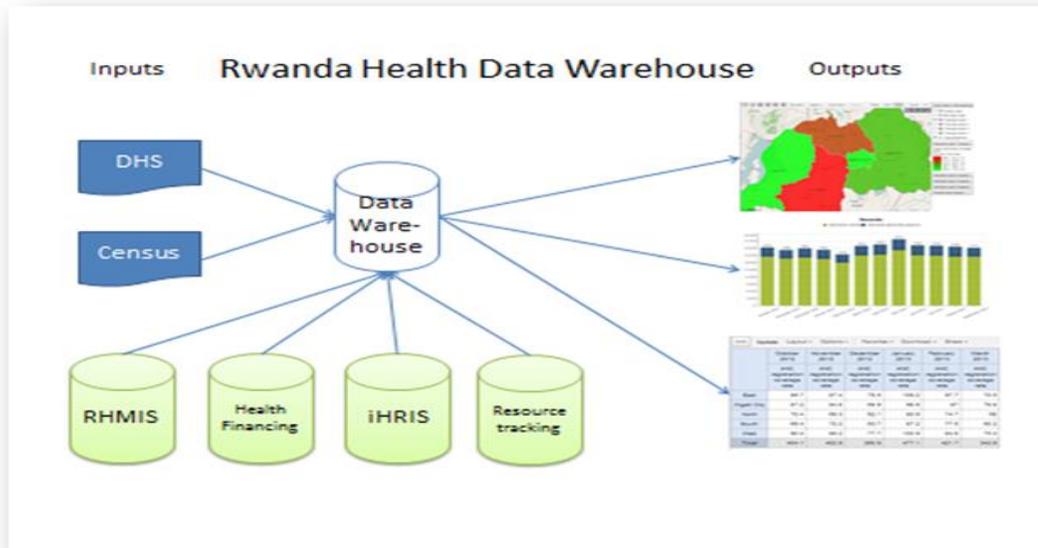
IHSSP held planning sessions to develop CBHI weekly reporting system within DHIS-2 and to enhance monthly reporting in order to collect data required for the CBHI Financial Management Tool (FMT). Monthly and weekly reporting forms were validated and their implementation within DHIS-2 was prepared. The Project worked with the CBHI team to prepare and finalize the data entry system for those weekly and monthly CBHI section reports – a precursor to implementing the web-based FMT.

As part of building sustainability of the system once the project ends, IHSSP prepared a detailed functional requirements document and issued an RFP for a company to build a PBF data management module for the DHIS-2. This will be used specifically for migration of the remaining PBF modules to the DHIS-2.

1.2.2. Implementation of national data warehouse and use of dashboard

IHSSP supports the MOH in implementation of national data warehouse by consolidation of all data in the data warehouse (see figure 1) and creating the dashboard within DHIS-2 which enables the use of those data. The importation of historical data from TRACNet, key malaria indicator data, CBHI monthly reporting data, and SIScom data was completed into the data warehouse.

Figure 1: Architecture of the national data warehouse



IHSSP also provided general orientation on the data warehouse and other DHIS-2 instances to the MOH managers and partners (DG/Planning, M&E and HMIS teams, USG staff, President's Malaria Initiative (PMI) team members) and introduced them to the use of the dashboard (see figure 2 as example of the dashboard).

Figure 2: Example of the dashboard in Rwanda DHIS-2



Moving forward, the TORs have been developed for the short term technical assistance (STTA) from HISP staff to complete the importation of GESIS (the old health information system) data from 2007-2011 into the data warehouse, and operationalize the synchronization of metadata between the different DHIS-2 instances. IHSSP staff also met with Miguel Piexoto, from the World Health Organization – Regional Office for Africa (WHO AFRO) office, to update plans for the Rwanda health information portal. This will be linked to the data warehouse that has been created using the DHIS-2 platform, which will allow formerly incompatible data sources from vertical programs to interoperate.

1.2.3. Support enhancements to iHRIS and Provider Registry

➤ Human Resource Information System (iHRIS)

IHSSP provide basic support for the human resources information system, helping to mentor district Human Resource staff through the data entry processes.

IHSSP supported the transition of the professional council licensing database, originally designed in MS-Access, to the web-based iHRIS Qualify platform. The STTA was provided by the Uganda-based iHRIS developer consultant (Martin Namutso) to customize the platform to the needs of the nursing council. IHSSP staff provided orientation to the IT manager for the council website management using Joomla and introduced her to iHRIS Qualify.

➤ Health facility registry

IHSSP staff worked with the MOH/HMIS database manager to re-import the data into the health facility registry, liaised with INSTEDD staff and other stakeholders on features of the system that were not functioning, and prepared a roadmap for moving forward. This was followed by preparation of the scope of work and consultant agreement and worked with him to support the Ministry with this activity implementation. The discussions with INSTEDD were held for a different approach that will use the Facility Registry Expansion Development. (FRED). An application program interface (API) used to exchange facility data between different applications, standards that are now built into the most recent version of DHIS-2.

IHSSP staff also met with staff from INSTEDD to develop a plan to move forward with the development of the interoperability profiles for DHIS-2. Decisions reached were about the types of health facility attributes that will be included in the system and those that will be captured through the health facility infrastructure survey.

I.3. HMIS crosscutting technical support

I.3.1. UBUDEHE population income categorization database

IHSSP/HMIS staff completed importing the spreadsheets from 14,000 villages to update the income categories. This is no longer seen as a health sector task – it will now be fully owned and managed by the Ministry of Local Government (MINALOC), whose recommendation is that the database should be integrated with the national identity card (NID) project and the civil registration systems under MINALOC's leadership.

IHSSP worked with MOH and National Data Centre (NDC) staff to move the UBUDEHE database server to its permanent location as a virtual server at the NDC.

IHSSP staff provided training for the system administrator and the database manager in the first phase of the training to use the National Income Categorization Database (NICD). The NICD is now used by many government programs including the CBHI that uses it to determine the premiums to be paid by members, the government of Rwanda and development partners.

I.3.2. Mutuelle/CBHI membership and M&E databases

➤ CBHI membership web and mobile phone based membership system

The MOH has signed a contract with JEMBI health systems to develop the web and mobile phone based membership system, and IHSSP/HMIS staff was appointed to oversee the mobile phone based membership system technical steering committee of the initiative. This system will include a mobile banking option to enable Rwandans to pay their *Mutuelle* memberships by cell phone. IHSSP staff regularly met with the technical committee to provide oversight and the web version is now complete and has been accepted by the MOH. The launch of mobile payment option is still waiting for the MOH to complete some arrangements with MTN and the banks.

I.3.3. PBF program support

➤ System for entering tariffs and calculating PBF payments

With technical support from IHSSP, a full set of queries to produce key performance analyses and PBF payment for Community-PBF was created; produced a set of initial specifications for the development of a new PBF module for contracting with HISP/India. The PBF content management system (Joomla!) was upgraded and a portion of the PBF website was updated. In addition, training for maintenance of the PBF website was provided for the health financing department staff.

➤ **International conferences on PBF global web platform conference**

IHSSP staff also assisted the SPH and CHD team prepare a presentation on Rwanda Community PBF program and facilitated an international session on integrating PBF with DHIS-2 at World Bank conference in Istanbul (Nov, 2012).

1.3.4. Technical support to the accreditation assessment process

After evaluating a variety of software options for entering and analyzing the data from the accreditation surveys, an open source system, LimeSurvey, was selected as a tool for the implementation of the accreditation survey. The quarterly HC and DH PBF assessment forms have both been imported into the system and demonstrated the use to the QI team. This will enable the accreditation team to analyze accreditation results over time and to produce special reports highlighting specific gaps in each facility.

IHSSP/HMIS team provided support for field testing of the LimeSurvey software on an android tablet computer during a round of baseline assessments in a provincial hospital. This should not only facilitate data collection and immediate feedback to facilities on quality gaps, but it will also provide the Ministry with a longitudinal database of accreditation scores for monitoring and evaluation.

1.3.5. PMI program support

➤ **Support for integration of data collection systems in DHIS-2**

At the request of PMI and RBC, IHSSP staff met with Tulane University School of Public Health and Tropical Medicine (SPHTM) staff to discuss options to migrate the old malaria reporting system to the new DHIS-2 platform in Rwanda. IHSSP also supported the implementation of malaria indicator survey and funded the consultants who entered the data from that survey. The following map (Figure 3), produced from the results of that survey, and shows the burden of malaria as a proportion of all other outpatient diagnoses. The districts in red and orange have the highest proportion of malaria cases.

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

2.1. Increase capacity of policy makers related to health financing mechanisms

2.1.1 Development of health financing policy documents and SOPs for data quality assessments

➤ Health financing strategic plan development

IHSSP worked with MOH and other partners to develop the health financing strategic plan that operationalizes the implementation of the health financing policy. The main objective is to facilitate the implementation of and move towards universal health coverage within the country. The development of that plan was preceded by a situational analysis. The plan development is still ongoing and this takes into account the existing challenges in health financing and recommendations on strategic options resulting from the consensus reached with all the partners and stakeholders.

➤ Development of CBHI ministerial orders

IHSSP provided support to the MOH team to elaborate the CBHI ministerial orders. The main content of the ministerial orders was about the agreements that will be signed between the CBHI scheme and the health facilities at all levels (i.e. from the health centers to the referral hospitals). Those agreements give directives for different aspects like the access to care by CBHI members, the invoicing process by health facilities, and the payment process by CBHI scheme. The ministerial orders were elaborated and submitted to the Minister's office for review and signature.

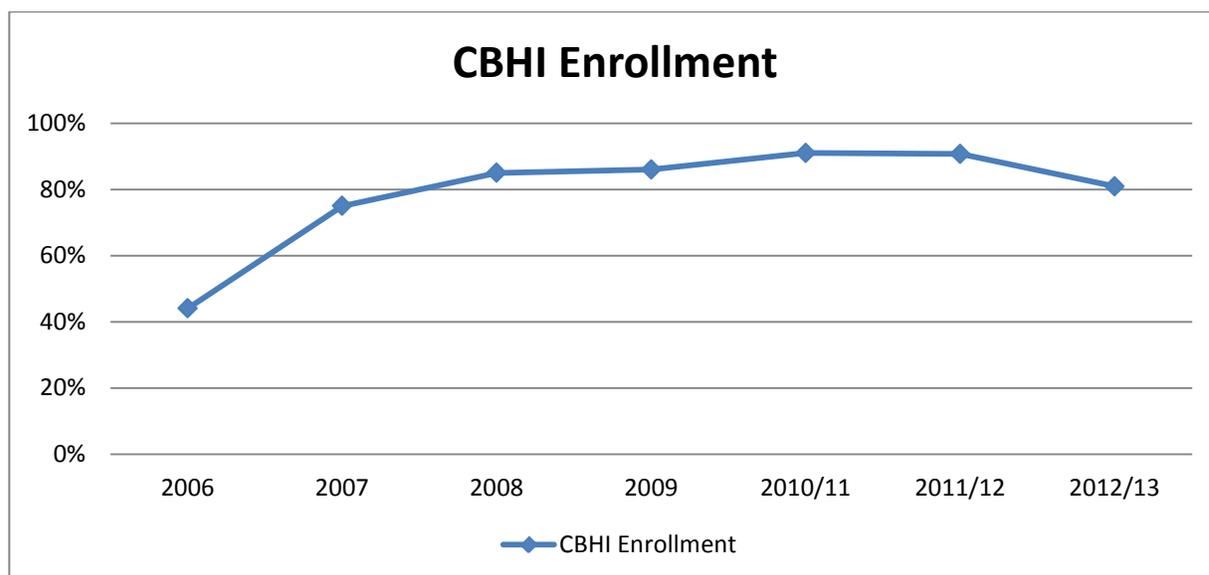
2.1.2 Implementation of national and decentralized CBHI - FMT

IHSSP organized auto-evaluation workshops to strengthen the financial management of the CBHI at the decentralized level. These workshops enabled participants to: 1) sort out the situation about the population enrollment within the CBHI for the second year of the new policy; 2) produce CBHI district-level financial analysis under the new policy; 3) review the new directives from Ministry of Finance and Economic Planning (MINECOFIN) on the CBHI funds management; 4) provide refresher training on the FMT; and 5) discuss the challenges encountered by CBHI district office.

➤ CBHI enrollment

The analysis of CBHI Data and the exercise of FMT data validation allowed having the accurate enrollment rate of the year 2012-2013. Here below the evolution of the Rwandan CBHI Coverage rate over time:

Figure 3: CBHI enrollment rate over the years



The last year 2012/13 has the least enrollment rate; there is a need of further analysis to know the reasons.

The factors which were anticipated that might explain the lower coverage include the economic situation and background of the district, the lack of awareness on CBHI benefits, the quality of data related to the catchment population, or the strategies of sensitization for CBHI adherence. The Rockefeller funded CBHI project is conducting a study to better understand the causes for this decline. See section 2.4 for further discussion of CBHI enrollment.

➤ **Financial situation of the sections**

The FMT allowed the collection of key indicators of the CBHI (i.e. enrollment, health services utilization by CBHI members per section and per district, revenue, and expenses). While analyzing the financial situation of the sections, the general finding was that the revenues were still lower due to the low CBHI coverage rate. On the expenses side, it was found that the operating costs were higher than the projected ceiling of 5% of the premiums, which should have been used for running costs (see pg. 18). The district directors were asked to work on that issue together with district CBHI boards.

➤ **Refresher training on the FMT**

The refresher training on the FMT was provided and the main focus was the projection function of the tool. All the districts used data for three months (the auto-evaluated quarter) and were able to do a guided exercise on projection of different indicators for the remaining period of the year, and learn how to make an analysis on projected data compared with

actual data. The following figure shows an example of the analysis that was produced (auto-generated report from the FMT for Kayonza district).

Figure 5: Financial Modeling tool: Section data analysis for Kayonza District

CBHI FINANCIAL MODELING TOOL : SECTION ANALYSIS - SUMMARY				
Data Entry from July / Juillet 2012 to September / Septembre 2012				
District: KAYONZA				
Cyarubare				
	Actual Data (3 months) July / Juillet 2012 to September / Septembre 2012	Expected Data - Actual Period (3 months) July / Juillet 2012 to September / Septembre 2012	Projected Data - Remaining Period (9 months) September / Septembre 2012 to June / Juin 2013	Full year Projection July / Juillet 2012 to June / Juin 2013
1. CBHI Enrollment				
Enrolled Population: Category 1	-	4,638	2,183	6,821
Enrolled Population: Category 2	10,744	12,014	5,653	17,667
Enrolled Population: Category 3	-	35	16	51
Total CBHI Enrollment	10,744	16,687	7,852	24,539
% of Total Population Enrolled CBHI	41%	63%	30%	93%
2. Utilization - CBHI Members				
Total Consultations Externes / Outpatient Visits	3,477	1,571	6,139	7,711
Consultations Externes per Capita (CBHI)	0.32	0.09	0.78	0.31
Total Hospitalizations / Inpatient Stays	132	58	225	283
Hospitalizations per Capita (CBHI)	0.01	0.00	0.03	0.01
3. Revenue				
Premium Contributions: Category 1	-	5,102,108	2,400,992	7,503,100
Premium Contributions: Category 2	32,231,300	36,040,680	16,960,320	53,001,000
Premium Contributions: Category 3	-	242,760	114,240	357,000
Total Premium Contributions	32,231,300	41,385,548	19,475,552	60,861,100
Co-Payments	500,800	235,263	919,111	1,154,375
Sale of Tools and all other Revenue	900	900	2,700	3,600

The results from this exercise showed that the coverage rate was below the expected one at the end of the quarter. The exercise allowed making recommendations for all the sections on many other aspects (revenue collection, expenses monitoring, etc.) of the program.

Another main topic discussed during this workshop was the data quality issue. While analyzing the reported data, some results showed that the collected data were not reliable. The recommendation was to conceive a system of regular data audit.

➤ **New proposition on reserve distribution**

Following a thorough review of the way reserves were distributed, the following was the new proposition of revenue distribution:

Table I: 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 experience from the 1st year in the implementation of the new CBHI policy, which started in July 2012.

➤ **Districts in different data analysis**

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

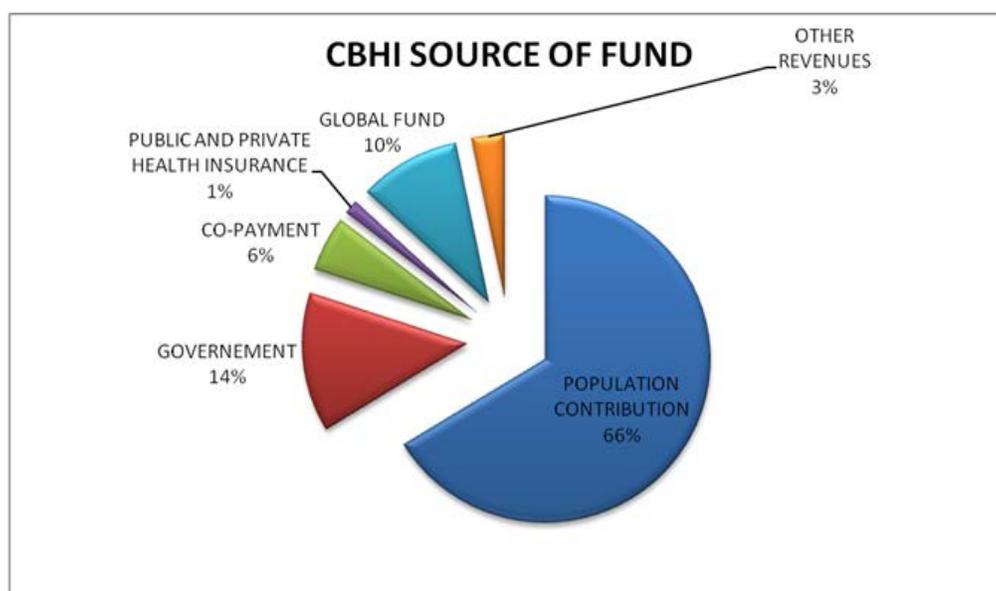
- Progress of coverage rate per section and district
- Average cost of reimbursement per sections and district

- Comparison between revenues and expenses per section and district
- Analysis of expenditures per category per section and district

➤ **Data validation and production of the CBHI mid-year and annual reports**

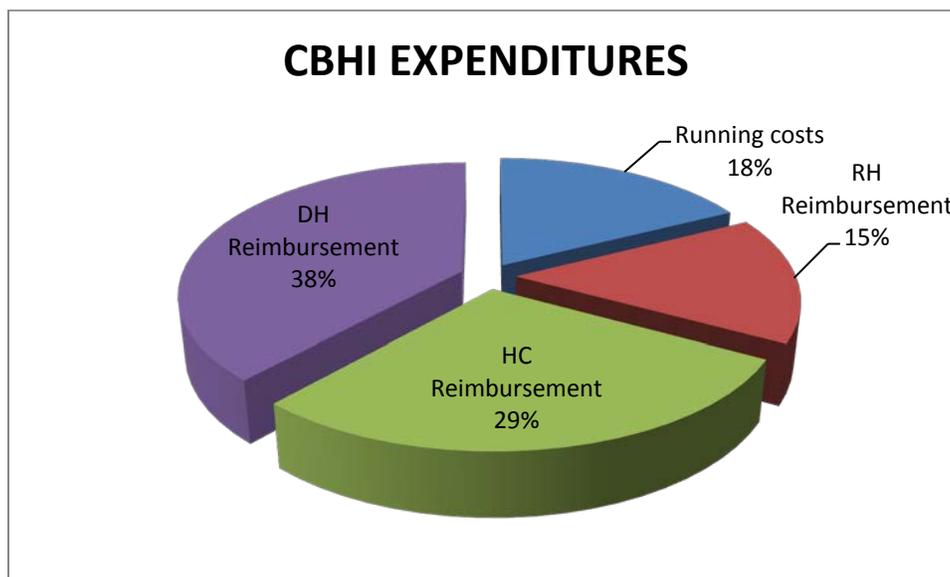
Using the FMT, the MOH/CTAMS (*Cellule Technique d'Appui aux Mutuelles de Santé*) assisted by IHSSP/HF team used the cleaned CBHI reports from districts reports to produce the CBHI mid-year financial report. IHSSP also supported the process of validating the CBHI financial data using the FMT to ensure the data accuracy collected during the year. Based on the corrected data, the CBHI financial annual report 2013 was produced. This is the 2nd CBHI year report using the new CBHI policy allowed to highlight CBHI management information such as the sources of funds, expenditures, etc. (see figure 6 and 7):

Figure 6: CBHI sources of fund



The main source of funds to the CBHI is the premium contributions collected from the population (66% of total funding). Other sources include the Government (14%), the Global Fund (10%), and co-payments (6%), with small amounts from other sources. The 14% contribution from government covers the premiums for indigent members and the payment of referral hospital bills. The remaining support goes to covering the running costs of CBHI.

Figure 7: CBHI expenditures



The above figure compares the CBHI expenditures across different levels of care. A total of 82 % CBHI expenditures are directly paid for reimbursement of health services provided to beneficiaries (29% to health centers, 38% to district hospitals and 15% to referral hospitals), and 18% of expenditures cover the running costs for the CBHI districts and sections.

2.1.3 Capacity transfer on PBF budget forecasting

During the reporting quarter, IHSSP conducted a review of all hospital PBF allocation budgets based on available funding for the new fiscal year. IHSSP used this review as an opportunity to transfer the capacity to the MOH PBF team on the process of defining and allocating PBF budget to each specific facility based on a certain number of criteria. The criteria include: 1) the size of the hospital; 2) number of staff; and 3) number of health centers to supervise. In addition, an equity index, which compensates for factors making motivation more difficult such as geographic position (distance, access), and the general desirability of the post has been applied to the final budget.

2.1.4. PBF framework review

As a member of the PBF extended team, IHSSP provided technical assistance to the MOH to review and finalize the development of PBF guidelines, the fiscal year PBF operational plan, the PBF remuneration budget forecasting for fiscal year 2013-2014, and methodology for the PBF sustainability analysis.

2.1.5. Development of the equity policy for PBF budget allocation

As a member of the PBF extended team platform, IHSSP participated in the development of the PBF equity policy, which was included in the PBF procedures manual. The equity policy was proposed and has been integrated into the PBF procedures manual. This is an innovative targeting approach for improving equity in access and utilization through PBF allocation.

2.2 Support the enhancement of the PBF approach

➤ PBF approach to support the accreditation program

The Rwanda MOH vision is to integrate the PBF strategy to the accreditation program, thus rewarding good performance through the accreditation process. PBF strategy is therefore seen as an advantage towards the hospital accreditation, by using accreditation standards compliance to assess the level of performance and receive payment based on that compliance. In that perspective, the PBF performance measurement and processes have been revised and refined in order to be incorporated into the accreditation process. The concept note was elaborated by IHSSP financing and quality staff and describes the process of PBF integration to the accreditation including the objectives, assessment tool and the process of assessment that will be used.

In collaboration with the clinical services and PBF technical cell at health financing unit, desired levels (semi-annual target) have been determined for each standard. The facility will be motivated by achieving this desired level of performance that has been defined for each standard.

2.3 Support and ensure CBHI and PBF data management

2.3.1 Development of SOPs and the manual for CBHI data management and audit

In order to address the need to provide districts and sections CBHI program managers with tools that can help maintain good quality data that support decision-making across the system, IHSSP provided TA to field test, revise and finalize the CBHI SOP manual for assessing sections CBHI data quality. These help to clarify the DQA process and explain the procedures for ensuring the collection of quality data.

2.3.2. CBHI routine data quality assessment process

The MOH/CTAMS has introduced the DQA mechanism to monitor the progress of the national CBHI coverage rate and the management of the CBHI funds on a weekly basis. This mechanism will be used to verify the data quality for different CBHI reports submitted from sections to districts and from districts to the central level. IHSSP assisted the MOH in the testing of this process and in the development of the CBHI-RDQA manual. Subsequently, MOH and the IHSSP developed the CBHI-RDQA tool designed in MS-Excel which provides a quantitative comparison of recounted to reported data to assess the accuracy, completeness, reliability, precision and integrity of reporting on enrollment, treatment, and financial management. The MOH CTAMS has decided to institutionalize the DQA process.

The institutionalization started by capacity transfer of CBHI DQA to the national trainers. This will provide to the decentralized level the tools that can help maintain good quality that supports decision-making across the systems and builds good performance of CBHI sections.

The CBHI data quality assessment is designed to help CBHI program to:

- Verify the quality of reported health data for key indicators and verify the factors that contribute to the quality of data at each step of the data collection and reporting process;

- Identify data quality gaps that will help in supporting CBHI actors to improve quality of data collected;
- Assess the ability of data-management systems concerning data collection, management and quality of reported data;
- Identify strategies to improve the data collection system and provide practical feedback on how to improve the quality of reported data.

2.3.3 Community PBF counter verification and system audit

IHSSP supported the MOH/Community Health Desk to conduct the second community PBF (CPBF) system audit and counter verification exercise. The aim of CPBF is to realize higher performance by focusing on high impact indicators of the community level health interventions. The verification and system audit was implemented following the recommendation to perform regular counter verification by an independent unit for the following aspects of the PBF-model:

1. Accuracy of quantity as reported in the central PBF database
2. Control for existence of phantom patients and verify services rendered
3. Client satisfaction
4. Audit of the community PBF-system and procedures

The objectives of these exercises were two-fold: 1) assess whether the community PBF-framework was implemented as designed and 2) establish a system of audit and data verification. The survey was conducted in 15 districts, 15 DHs, 60 HCs, 53 CHW cooperatives, 180 CHWs, and 240 clients/consumers of the services from the villages. In this activity, the IHSSP provided technical assistance through the development of the audit's questionnaires, development of data entry mask (using CSpPro, see Figure. 8 as data entry mask sample), data consolidation, cleaning and analysis, and report production.

Figure 8: PBF counter evaluation and system Audit - Data entry mask for CHWs cooperatives questionnaire

The screenshot shows a data entry application window titled "III. Questionnaire de Contre verification et audit des donnees C-PBF (Cooperative)". The window is divided into two main sections: a list of cooperatives on the left and a data entry form on the right.

Left Panel (List of Cooperatives):

- 0103KUNDUBUZIMA
- 0104B-MIGONE YUBUZIM
- 0105DUHARANRE UBUBUZ
- 0206TURENGERUBUZIMA
- 0207GRUBUZIKYONZA
- 0208BMBONZUBUZIMA
- 0309Gubuzima
- 0310Gubuzimambazi
- 0311Turwamekubuzima
- 0312Ubusimabwiza
- 0413KOUBBU
- 0414KOU Gsakura
- 0415COCORU
- 0416KOPUGUKA
- 0517ubuzima/umusing
- 0518COCOPVBU
- 0520COCOMVI
- 0520Ubusima bwiza
- 0621GOMEZA COKO
- 0622TURUGABUGUZIMA
- 0623TWITEZIMERE
- 0624MPZUKUREMUHOND
- 0723KOPAI
- 0726Ubusimabwiza
- 0727OURATENEZUBUZI
- 0728Turengeubuzima
- 0829TWITEKUBUZIMA
- 0830DUSHYIGURUBUZ
- 0831Shyigikubuzim
- 0832HAKARUBUZIMA
- 0923KODULBU
- 0934KOVAKI
- 0935TWITEKUBUZIMA
- 0936COMBA

Right Panel (Form):

Identification du Questionnaire

Code District: 08
 Code CS: 29
 Nom de la Cooperative: TWITEKUBUZIMA

Q1

Q1A Date de verification: 07 | 12 | 0 | 12
 Q1b Code du Verificateur: NN
 Q1c Code District: 08
 Q1d Code Centre de sante: 29
 Q1e Nom de la cooperative: TWITEKUBUZIMA

Q2

L'equipe des repondants:

Q2_1 Comite complet: 1
 Q2_2 Comite incomplet: 0
 Q2_3 Aucun membre du comite: 0

Q3

Q3_1 Niveau d'etudes du President (mettez le chiffre correspondant a la reponse): 2
 Q3_2 Votre cooperative dispose des ces documents?

Q3_2a Contrat PBF entre Exec et Coop a jour: 1
 Q3_2b Contrat utilisation fonds PBF entre MoH et Coop: 1
 Q3_2c Statut legal de la cooperative (RCA): 1
 Q3_2d Livre caisse-banque: 1
 Q3_2e Registre des parts des membres: 1

At the bottom of the window, there is a status bar with the text "No Partial-MODIFY | Field = CODE_DISTRICT | Occurrence 1 of 1 | NUM | 4:29 PM | 1/28/2013".

2.4 Carry out studies and analysis with respect to efficiency of Health Financing mechanisms

2.4.2 Design of provider payment systems (DRG) and their SOPs

The Rwanda MOH with IHSSP support organized a workshop on Provider Payment Mechanism Reform, focusing on mechanisms based on DRGs. The primary goal was to explore different options available, including DRGs, and to ultimately establish a work-plan to guide the process. The workshop covered the components of a DRG system and the sub-systems that must be in place for successful implementation. It also briefly described actions taken to date and potential synergies.

IHSSP provided technical support for drafting the TORs of the provider payment technical advisory team appointed by the Minister. 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. Bi-monthly meetings of the technical team are conducted through the established platform.

IHSSP also assisted the MOH in organizing a study tour on the functioning of DRG's system for the provider payment technical team. The main tasks were the development of the TOR for the study tour to Thailand and contacts and arrangements with the experts in Thailand. However, the tour to Thailand has not taken place. Further progress on reforming the provider payment mechanism in Rwanda has been stalled due to lack of consensus as to which system to adopt.

2.5 Document and disseminate development experiences on health financing mechanisms

➤ Abstract for the ECSA conference

The MOH/CTAMS with technical assistance from IHSSP developed an abstract titled “Extending access to non-communicable diseases health care in Rwanda through the community based health insurance”. The abstract was submitted to the ECSA secretariat and presented in the East, Central, and Southern Africa Health (ECSA) conference in August in Arusha, Tanzania on strengthening the responses to emerging health concerns in the region.

The conference was called “Best Practices Forum” and brought together senior officials from MOHs, health experts, health researchers, heads of health training institutions from member states of the ECSA, health community as well as diverse collaborating partners in the region and beyond, with the aim of identifying key policy issues and making recommendations to strengthen response to emerging and re-emerging health concerns in the ECSA region. IHSSP CBHI technical advisor and the MOH health financing specialist participated in the conference, and presented the abstract and recommendations were jointly made for the members of the ECSA states and donors in the ECSA.

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

3.1. Establishment of accreditation system

3.1.1. Accreditation system structures and SOPs

The current year started with the roll out of the accreditation program by the MOH as a priority intervention for improving quality and safety within healthcare facilities. IHSSP supported the establishment of that system and started the roll out of the accreditation program in five provincial hospitals and two referral hospitals. The program includes training of surveyors, accrediting body /agency and definition of health service standards. Basic health care accreditation system structures and SOPs have been established including:

- the establishment of an accreditation steering committee with clear roles and responsibilities, and design of the accreditation system model
- adaptation of JCI essential standards
- development of an accreditation strategy that will provide direction to the national accreditation program
- development of guiding principles including transparency, confidentiality, efficiency, sustainability and integrity
- the establishment of accreditation by-laws

The accreditation system in Rwanda is expected to meet the set standards of the International Society for Quality in Health Care (ISQua).

3.1.2. Accreditation standards development and dissemination

➤ Development of national standards and additional policies and procedures

IHSSP organized and sponsored a one-week working session at Musanze district that brought together the MOH team with professional councils, health facility' staff and other stakeholders to elaborate the Rwanda Essential Hospital Accreditation Standards. The standards describe the expected quality in five risk areas of patient care in the hospital: Leadership Process and Accountability, Competent and Capable Workforce, Environment for Staff and Patients, Clinical Care of Patients, and Improvement of Quality and Safety. These "Rwanda Hospital Accreditation Standards" have been adapted from the International Essentials of Health Care Quality and Safety designed by JCI, an organization with vast experience in accreditation of health services.

IHSSP supported the dissemination of Rwanda hospital accreditation standards in the five provincial hospitals and all district hospitals. Also, over **270** policies and procedures were disseminated: **each hospital received 10 hard copies** of policies and procedures in addition to the electronic copies that had been sent to each hospital by the MOH.

➤ Training workshop on accreditation standards, development of accreditation procedures, and PBF link to the accreditation

IHSSP organized a training workshop for 55 participants from different partners (BTC, RRFHP, new team of facilitators and five hospitals). The objective was to develop a common

understanding and interpretation of essential hospital accreditation standards to enable MOH partners to support the implementation of standards in hospitals in their catchment areas.

The intended integration of existing PBF incentives and accreditation process (PBF link to the accreditation) was explained to the participants, where the purpose was to effectively support quality improvement of health care services and patient safety delivered through the implementation of evidence-based standards.

3.1.3. Selection and training of surveyors

The national accreditation program strongly emphasizes training and qualification of the surveyors to ensure that they can carry out their responsibilities successfully, thus maintaining the integrity of the healthcare accreditation process. In keeping with that, IHSSP supported the MOH to initiate a quality monitoring and measurement mechanism for the accreditation program by developing the TORs (to facilitate the selection of competent health professionals to train as Rwandan accreditation surveyors/assessors with intent of building in-country capacity to manage the program), and developing their job description.

An assessment tool for surveyors and supervisors was also developed to guide the assessment of hospitals on the use of the Essential Hospital Accreditation Standards and measure their progress towards meeting standards. The same tool can be used by the hospital quality improvement teams to do their self-assessment.

IHSSP organized and conducted a surveyor training program. The surveyors that demonstrate competencies necessary to carry out the assessment according to the established policies and procedures will be certified to carry out future surveys. In addition, twenty surveyors completed on-site observation trainings for the survey conducted by JCI consultants as an in-training practical experience. A survey resource manual was developed to guide the survey process.

3.1.4. Accreditation facilitator selection, training and onsite facilitation at the facility

The MOH will use the accreditation facilitators to support the health facilities in the implementation of the accreditation program. IHSSP supported the development of facilitators' job description and selecting competent health professionals (external and internal) to train as Rwandan accreditation facilitators; 30 internal facilitators from the five hospitals and 10 external facilitators from MOH and RBC have been trained. Onsite trainings of facilitators were also provided at the five provincial hospitals and this provided hands on practical experience to the facilitators. This was also an opportunity for the health facilities to close some quality gaps in an effort to meet the standards.

Accreditation facilitator guide was also developed by the project and it has been shared with users for final input and validation. This will assist facilitators in providing education, technical assistance, and on-site consultations to facility staff and the accreditation support committees

to find solutions in the implementation process of the Rwanda essential hospital accreditation standards in hospitals.

3.1.5. Accreditation baseline survey

➤ Accreditation baseline survey for PHs and communication of the findings

IHSSP with the MOH/RBC surveyors conducted a baseline survey 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 tools, and provide practical training opportunities for the accreditation surveyors. This was done under the 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 reports of the findings and recommendations for each hospital were produced and feedback was given to each hospital. The results of the review show that many findings were below expectations.

Following the accreditation baseline assessments, the respective reports and assessment findings were communicated by the survey teams to the health facilities. IHSSP also facilitated the development standards implementation work plans and activities to close identified gaps for the five risk areas: leadership process and accountability, competent and capable workforce, safe environment for staff and patients, clinical care of patients, and improvement of quality and safety.

➤ Accreditation baseline assessment for 10 additional district hospitals

IHSSP supported MOH to conduct accreditation baseline assessments for 10 additional district hospitals in a bid to scale up the hospital accreditation program to the district hospitals. To meet this need, a team of Rwandan surveyors was used to conduct this survey/assessment using the Rwandan essential hospital accreditation standards. The IHSSP participation in conducting the surveys in these 10 hospitals was a one-time effort, performed in response to a MOH request as the Project scope is limited to five provincial hospitals.

3.1.6. Development and dissemination of national quality and patient safety goals

National quality and patient safety goals were developed by IHSSP and the MOH with the aim of making the hospital safer for patients, staff and other external clients. The 37 hospitals will start implementing goals to address patient safety issues in the essential hospital accreditation standards after the PBF team has finalized the PBF revised framework. New goals will be set annually and hospitals will be assessed for compliance with the safety goals and will ultimately receive incentives from the PBF payment mechanism as a reward for performance towards achieving specific goals. Rwanda quality and patient safety goals for 2013–2014 include: surgical site infection prevention, incident management to reduce risks, and customer care program.

The project also developed a measurement framework for patient safety goals which will help to measure its implementation and progress towards meeting standards.

3.2. Other Quality Improvement activities

3.2.1. Dissemination and training on treatment guidelines

The IHSSP facilitated the dissemination of treatment guidelines a Training of Trainers (TOT) approach to all district hospitals. The development of these guidelines was completed by professional bodies facilitated by the IHSSP and launched in the previous year.

3.2.2. Facilitation of PHs with regard to standard implementation

IHSSP assisted the teams of external facilitators who supported hospitals (Ruhango, Ruhengeri, Rwanagana, Bushenge, and Kibungo) to review and draft the following procedures:

- Contents of personnel file policy and procedure
- Staff orientation procedure
- Student Training procedure
- Patient Admission in Ruhengeri Hospital procedure
- Code of conduct policy and procedure
- External Referral/transfer information Management
- Billing procedure
- Budgeting process and approval procedure
- Hand washing guidelines
- Client flow analysis and use the data to decrease wait time and increase staff efficiency (policy and procedure)
- Incident reporting
- Root cause analysis and action plan framework

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

4.1. Technical support to the health professional councils

4.1.1. CPD strategic development and finalization of the database for the NCNM

IHSSP supported the strategic plan development for the NCNM. IHSSP recruited consultants who provided technical support to the NCNM in developing and finalizing their CPD strategic plan, which has been validated. This strategic plan will enable the nurses and midwives to implement HRH activities, strengthen the professional councils to implement the CPD activities for the members, improve health professionals practice, and ensure delivery of quality care. Professionals are expected to have regular self-learning mixed with organized professional trainings to update their skills and keep informed with standard clinical practices.

IHSSP supported the finalization of the database for the NCNM and 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.

4.1.2. Development of pharmacists' strategic plan

IHSSP provided support to the pharmacist's council in setting up its offices and updating its registration database. In addition, IHSSP recruited a consultant who supported the council in developing the strategic plan that will provide strategic direction for and establish operational structures of the council. This was finalized and the council is using it for resource mobilization.

4.1.3. Registration of the Allied Health Professionals

IHSSP assisted the Allied Health Professionals (AHP) council to start the registration process of its members. To date, good progress has been made in registering the members since the beginning of the exercise in January 2013. IHSSP continued its support by supplying furniture to help establish its new office after leaving the nurses' council building. The licensing and CPD programs development, including the development of the strategic plan for CPD activities, will be planned after the registration.

4.1.4. Development of an integrated CPD policy for all professional councils

IHSSP provided support in developing an integrated CPD policy, which will be referred to by all the councils in their CDP activities. The health professional councils appointed focal persons to work with IHSSP hired consultants throughout the process. The document was then finalized and validated by the forum of professional councils and is now in use.

4.2. Implementation of the Workload Indicators of Staffing Needs (WISN) methodology

WISN is a methodology for objectively and accurately evaluating healthcare staffing needs in a given facility and by aggregation for the country in general. The MOH designated 37 staff members from the central level and PHs to be trained as trainers in WISN methodology and WISN software application. In collaboration with the WHO, IHSSP organized the training of trainers to implement the WISN approach. Following the training, a WISN implementation plan was developed and approved.

The trained team is expected to facilitate the establishment of all the necessary committees and structures for WISN methodology and application. The team will also develop the WISN standards for the priority professional categories specified by MOH (standards for doctors, nurses and midwives in the first phase).

IHSSP supported the development of the TORs for a steering committee that will make management decisions and commitments to apply the WISN results. In addition, committee members were nominated by the MOH. The WISN steering committee approved the TORs developed for the WISN technical facilitators and the WISN core team. This core team is expected to coordinate all the WISN activities in collaboration with the HR department in the MOH and the steering committee.

5.1. Finalization of decentralization strategic plan

IHSSP led the process of developing the decentralization strategic plan. Starting in Fiscal Year II, the IHSSP team and the MOH in collaboration with the Ministry of Local Government (MINALOC), MINECOFIN, the Rwandese Association of Local Government Authorities (RALGA), and development partners, participated in the process of developing the health decentralization strategic plan. In this year the plan was finalized. However, the MOH and MINALOC have not reached consensus to validate it.

5.2. Support to the coordination and assessment of DHMTs

In collaboration with the RRFHP, IHSSP provided technical assistance to the managers from five provincial hospitals to define the roles and responsibilities of DHMTs. The activity was based on available DHMT guidelines elaborated by MOH in 2011. IHSSP developed an assessment tool/questionnaire used to assess the capacities, roles, and responsibilities of the DHMTs and their needs to support the provincial hospitals in the accreditation program.

The project used the tool to assess the DHMTs roles, responsibilities, and capacity gaps in two districts (Musanze and Nyamasheke).

IHSSP organized a workshop with each of the assessed DHMTs to discuss the findings. This provided an opportunity for the DHMTs to understand the DHMT guidelines that have been provided by the MOH to the decentralized levels to guide their routine operations in the district. The teams also were able to understand the gaps and based on those gaps, they developed their annual action plans with IHSSP technical support.

5.3. Technical support in the finalization of the district strategic plans

The IHSSP with MOH and partners provided technical support to develop and finalize the district hospitals' strategic plans including the five provincial hospitals that the project supports. The finalized strategic plans for the provincial hospitals will be revised as necessary to accommodate any new activities when those hospitals will be fully upgraded to provincial or referral hospitals.

5.4. CSO's capacity needs assessment

IHSSP is supporting the process of an institutional capacity needs assessment of 36 civil society organizations (CSOs) operating around the country in the health sector. The goal of the assessment is to identify the strengths and weaknesses of the Rwandan CSO community in the areas of governance, administration and management, planning, etc. The project held a series of meetings with USAID and the Global Fund Country Coordination Mechanisms (CCM) representatives and the way forward with CSO's capacity needs assessment was agreed upon. The consulting firm to carry out the capacity needs assessment of the CSOs was identified and the preliminary activities have been completed including development of an inception note, activity timetable and selection process of the CSOs that will participate in the study. This

exercise is still in process as of the end of the year, but shall be completed within the first quarter of the coming fiscal year.

VI. CROSS-CUTTING SECTOR SUPPORT

6.1. Final drafting of the Health Sector Strategic Plan III

IHSSP supported the MOH in the production of the final draft of the HSSP III document. The project recruited a consultant to work with the MOH and IHSSP technical staff in the review of the document. IHSSP also used another consultant for proof reading, editing and formatting of this document, and the final product was given to the MOH.

6.2. Analysis of the alignment of MOH policies and strategic plans against HSSP III

IHSSP provided technical support to the MOH to review all the MOH policies and strategic plans in comparison with the Health Sector Strategic Plan III (HSSP III). The aim of this exercise was to assess how well health sub-sector policies and strategic plans meet basic national and international standards, how these are aligned with HSSP III, and to find whether there are strategic plans that are outdated or never validated, and the identification of areas that require additional policies or strategic plans. This exercise was completed and a detailed report produced with recommendations for MOH actions

6.3. RBC situation and functional analysis

IHSSP recruited international consultants to carry out an extensive situation and functional analysis of RBC. The team of consultants supported by the local IHSSP and SIAPS staff carried out this assignment for a period of six weeks, most but not all of which took place in FY 12. The final report with extensive recommendations has been finished and given to RBC as guidance for strategic planning and decision making process.

6.4. Development of the district SWAp guidelines

In collaboration with other MOH 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. This was a pathway of translating the existing SWAp's roadmap and manual into an operational reference guide, taking into account different steps of district health planning, implementation, budgeting, M&E and reporting to develop the district health SWAp reference guide.

PERSPECTIVE FOR NEXT YEAR

The next year is the final year of IHSSP implementation. The emphasis will be increasingly on institutionalization, capacity transfer, sustainability, consolidation, and fine-tuning of previously

introduced systems strengthening initiatives. As the project essentially provides technical assistance, the sustainability of innovations and improvements that it helped to introduce to the Rwandan system is of the highest priority and importance.

In Health and Management Information Systems (HMIS), IHSSP will continue to integrate additional information sources using automated importing functions into the new RHMIS (DHIS-2), develop SOPs guidelines and policy for its use, and continue to build the capacity of MOH staff to use, maintain and update it. The project will also design a variety of analytical report outputs to be generated regularly and automatically by the RHMIS including maps, listing reports and charts that can be integrated in dashboards and readily used for programmatic decision-making. IHSSP plans to develop the capacity of a private sector entity to provide technical support for key e-Health systems. The IHSSP HMIS team will continue its cross-cutting role in support of the other IHSSP components of HF and QI including the development of an accreditation monitoring database, introduction of a tablet-based survey data collection tool (for both Accreditation and PBF).

Health Financing, IHSSP will continue its work in reinforcing the capacity of the MOH to sustain and institutionalize PBF and Community Based Health Insurance including health financing sustainability analysis and plan; development of a web-based financial modeling tool for CBHI sections; creation with the HMIS team of an innovative cell phone and web-based interface with the CBHI membership database to facilitate such management functions as roaming and premiums payment.

IHSSP/HF will work on costing by reviewing the costing results and developing a pricing structure/policy for insurance reimbursement.

In Quality improvement, IHSSP will institutionalize the accreditation system. The project will provide the technical assistance to enable the Ministry to establish an independent accreditation board that will have the capacity to lead and maintain the entire accreditation process. IHSSP will foster support for quality and safety while strengthening the leadership at health facilities level.

IHSSP will build the capacity within provincial hospitals to carry out quality improvement activities that will meet pre-defined standards and upgrade health services according to international benchmarks. The IHSSP/HF, QI and HMIS teams will jointly work together to link PBF approach with the accreditation mechanism to support the QI process.

In Human Resources for Health, IHSSP will continue to help build the capacity of professional councils to function, regulate, and self-sustain including the development of the strategic plans for AHP and CPD for Pharmacists councils. For all professional councils, IHSSP will support the development of business plans to foster financial sustainability, complete its work in supporting the development of their computerized system of registration, linking the associations' databases to the iHRIS of the MOH. Finally, IHSSP will continue to support the roll-out of the WISN methodology in order to build a national capacity and mechanism for accurately evaluating evolving needs of the healthcare workforce.

For the Health Decentralization, IHSSP will continue to provide technical support to the District Health Management Teams through the roll out of a training program and provision of on-going mentoring to strengthen capacity of districts to shoulder the increased technical and managerial burden mandated by decentralization.

Other: In its final year, the project will also place emphasis on an **assessment of results**. The Performance of Routine Information Systems Management assessment will be implemented to measure the impact of HMIS program of the project. Anticipated outcomes of the other project components will also be critically examined. IHSSP will also place a greater focus on **communication** for the visibility of successes and impacts of the project to the wider community through publications, media, and an end-of-Project workshop.

Annex I: IHSSP results framework

