

## Quarterly Project Report

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Rwanda IHSSP

October, 2013 – December, 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](http://www.msh.org)



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INKUNGA Y'ABANYAMERIKA

## **Rwanda Integrated Health Systems Strengthening Project:**

# **Quarterly Project Report - Narrative**

**(October – December, 2013)**

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## ACRONYMS

CBHI	Community Based Health Insurance
CSOs	Civil Society Organizations
DHs	District Hospitals
DHS	Demographic and Health Survey
DHIS-2	District Health Information System (New Rwanda HMIS System)
DHMTs	District Health Management Teams
DHSST	District Health System Strengthening Tool
EICV	Integrated Household Living Condition Survey
eIDSR	electronic Integrated Disease Surveillance and Response
HCs	Health Centers
HISP	Health Information System Program
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HRH	Human Resources for Health
HSSP III	Health Sector Strategic Plan III
iCCM	Integrated Community Case Management
ICT	Information and Communication Technology
iHRIS	Integrated Human Resources Information System
IHSSP	Integrated Health Systems Strengthening Project
M&E	Monitoring and Evaluation
MINALOC	Ministry of Local Government
MOH	Ministry of Health
MOU	Memorandum Of Understanding
MSH	Management Sciences for Health
NUR	National University of Rwanda
PBF	Performance-Based Financing
PH	Provincial Hospital
QI	Quality Improvement
RBC	Rwanda Biomedical Center
RDQA	Routine Data Quality Assessment

RHMIS	Routine Health Management Information System
SARA	Service Availability and Readiness Assessment
SOPs	Standard Operating Procedures
SPH	School of Public Health
TB	Tuberculosis
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
WISN	Workload Indicators for Staffing Needs
WHO	World Health Organization

## EXECUTIVE SUMMARY

In this reporting quarter (October – December, 2013), the Integrated Health Systems Strengthening Project (IHSSP) continued the work of strengthening health systems across five health components: Health Management Information Systems (HMIS), Health Financing (HF), Quality Improvement (QI), Human Resources for Health (HRH), and Decentralization.

The main activities completed in the Health Information component continued to focus on ensuring that good information for decision making is available to MOH staff. The project also focuses on building a culture of data-based decision making, which will be an ever-greater focus as we reach the end of the project. Specifically, IHSSP worked on: finalization and publication of the 2012 statistical booklet; HMIS data recording, reporting and use guidelines; assessment of the barriers to data use; continuous support to the MOH to prepare and implement new functionalities on the District Health Information System (DHIS)-2 platform; HMIS related support to the PBF-Accreditation integration process; follow-up on negotiations of the mobile money payments for the Mutuelle Membership system; and capacity building of MOH staff.

The Health Finance component focused on continued refinements in the health financing policies in Rwanda, particularly focused on ways to link quality improvement to payments, review of insurance coverage, and policy review. Main areas included: active participation in the design and dissemination process of the new framework of linking PBF to Accreditation; health financing policy review and the start of strategic plan development, follow up with districts for the implementation of Community Based Health Insurance (CBHI) routine data quality assessment, training on Integrated Community Case Management (iCCM) costing, and continued follow up and support on CBHI studies.

The Quality Improvement component team continues to focus on the quality of care provided to the people of Rwanda. Activities in the reporting quarter focused on:

- Facilitation of accreditation standard implementation in Provincial Hospitals (PH) primarily by supporting the drafting and alignment of policies and procedures,
- Designing the framework and tools for the integration of PBF and health facility accreditation,

- Dissemination of the 2013-14 national quality and patient safety goals in 37 district hospitals, and
- Development of a concept paper to establish the accrediting body for the Rwanda accreditation program.

The activities completed in the Human Resources for Health component are the development and validation of the activity standards for Workload Indicator for Staffing Need (WISN) methodology, customization of the WISN software/tool to the Rwandan context, application of the WISN tool in the five provincial hospitals and facilitation of the accreditation, and WISN technical working group meetings.

The Decentralization component work was concerned with Civil Society Organizations (CSOs) capacity assessment carried out by the contracted consultant firm, including a workshop to validate the assessment report. The team also facilitated a workshop with Nyamasheke and Musanze District Health Management Teams (DHMTs) to discuss DHMT quarterly activities, and share their common practices to learn from each other.

The IHSSP team has almost finalized the development of a plan to transition project responsibilities directly to the Ministry of Health (MOH); IHSSP is implementing this plan as we continue to refine it jointly with the MOH. The senior project leadership also organized a meeting with the MOH senior management team to discuss those activities that require extra attention from the Ministry of Health (MOH) for a successful project transition.

## INTRODUCTION

In November 2009, the United States Agency for International Development (USAID) launched the five-year Integrated Health Systems Strengthening Project (IHSSP) which focuses on five technical results areas: improved utilization of data for decision-making and policy formulation across all levels; strengthened health financing mechanisms, financial planning, and management for sustainability; improved management, productivity, and quality of human resources for health; improved quality of health services through implementation of a standardized approach to service delivery; and effective decentralization of health and social services to the district level and below.

This report summarizes the activities and main achievements of the project for the reporting period of October – December, 2013.

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

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

#### Finalization and publication of the 2012 annual health statistics booklet

After completing the editing of the 2012 annual health statistics booklet, the MOH has published it with IHSSP assistance. . The entire process of preparation and design, data collection and analysis, and the editing and publication of the manual took several months. This booklet provides summaries and shows trends in key statistics of the health sector for 2012, and where relevant, comparisons with data from 2010.

Among other statistics, the report indicates that the leading cause of mortality for all ages in Health Centers (HCs), District Hospitals (DHs), and Provincial Hospitals (PHs) in 2012 was neonatal illness with 33 percent of all reported deaths. This was followed by pneumopathies (8 percent), cardiovascular disease, malaria, obstetrical problems, and physical trauma/fractures, all representing 7 percent of reported deaths each.

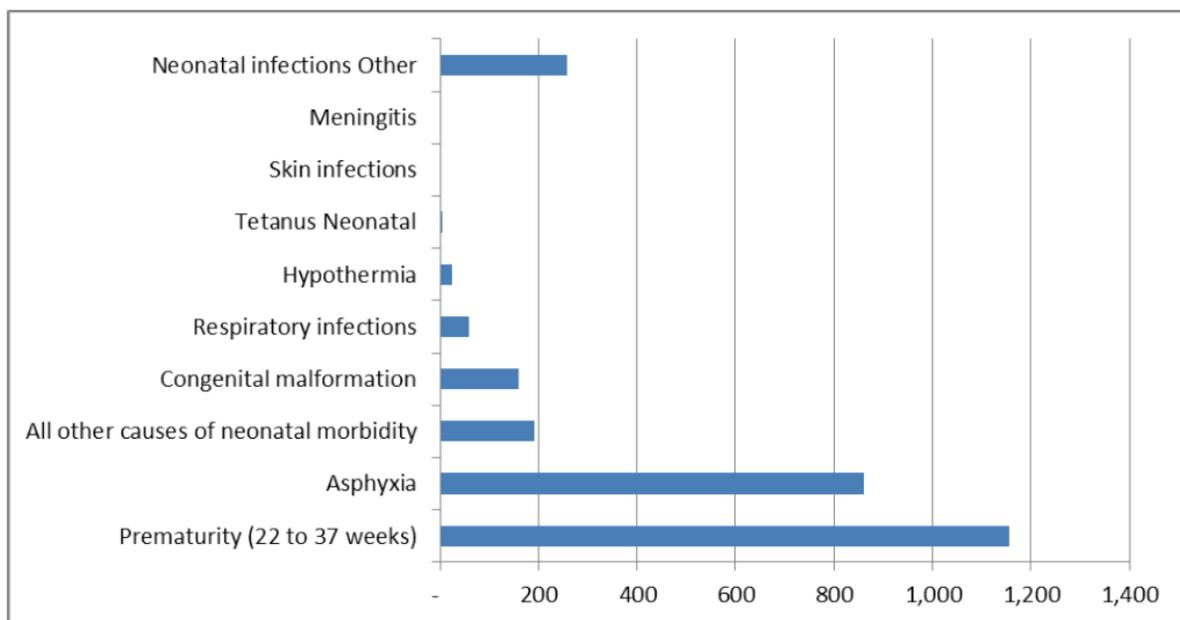
Table 1: The 10 first causes of mortality in HCs, DHs, and PHs

Rank	Cause of death	Total	% of total
1	Neonatal illness	2,722	33%
2	Pneumopathies	660	8%
3	Cardio-vascular disease	608	7%
4	Malaria	603	7%
5	Obstetrical problems	595	7%
6	Physical trauma and fractures	550	7%
7	HIV/AIDS opportunistic infections	432	5%
8	Diarrhea	335	4%
9	Cancer	321	4%
10	ARI	283	3%
11	All other reported deaths	1032	13%
	<b>Grand Total</b>	<b>8,141</b>	<b>100%</b>

Source: R-HMIS, 2012

In health centers, district, and provincial hospitals, the report shows that the major leading causes of deaths in neonatology were prematurity (22 to 37 weeks) with 43 percent, asphyxia (32 percent), and other neonatal infections (10 percent). These three causes accounted for 85 percent of all causes of neonatal deaths (see figure 1).

Figure 1: Leading causes of deaths in neonatology at HCs, DHs and PHs



### **Preparations of the publication of HMIS data recording and reporting guidelines**

IHSSP staff worked with the MOH staff to produce the translation and final layout of HMIS data recordings and reporting guidelines, and arranged for their publication.

### **Development of HMIS data use guidelines**

The project began to work on the development of HMIS data use guidelines. This will be carried out with support of the Health Information System Program (HISP) consultant, Arthur Heywood, due to arrive in country next quarter.

### **Assessment of barriers to data use**

The IHSSP/HMIS team conducted an assessment of barriers to data use at district health units. The assessment report is under preparation and will help formulate interventions and develop data management standard operating procedures (SOPs) for the district level.

### **Capacity building:**

- **DHIS system administrators:** the MOH and IHSSP/HMIS prepared and sponsored the training of three MOH data management staff, who attended the DHIS-2 Academy, held in Malawi in December, 2013. The training covered maintenance and modification of the DHIS-2 platform.
- **UBUDEHE (household-level socio-economic categories) database administrators:** the IHSSP/HMIS staff provided on-job training for staff from the Ministry of Local Government (MINALOC) to complete the handover of this database.
- **Training of district and health center data managers in Routine Health Management Information System (RHMIS) data use:** The IHSSP/HMIS staff continued support to facilitate a final round of training sessions for familiarizing Eastern province district and health center data managers with the new analysis tools of RHMIS (pivot tables, enhanced charts and maps). 108 data managers participated in this training.
- **Preparation of training in Structured Query Language (SQL) and DHIS-2 reporting and design of web portal:** In preparation for the training in SQL queries and DHIS-2 reporting and design of a web portal, all required training materials have been developed by IHSSP. This training will be provided to the small team of data managers/programmers and monitoring and evaluation (M&E) staff at central level staff (MOH and Rwanda Biomedical Center (RBC)); it is scheduled early next quarter.

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

#### **Implementation and preparation of the new functionalities on the DHIS-2 platform**

The IHSSP continued its support to the MOH to prepare and implement new functionalities on the DHIS-2 platform:

- Created new iReports to produce top 10 outpatient department diseases, admissions, and death reports from DHIS-2 which will be used by data managers and policy makers at all levels (from health centers to central level)
- Worked on adding custom attributes to the indicator and data element tables of the DHIS-2 and designed a report to print a metadata dictionary
- Worked with the MOH/Community Health Desk to develop a concept paper on transitioning away from the mUbuzima system towards the DHIS-2, including the design

of an SMS reporting system for community health workers' essential drug stocks from each village

- Continued to assist the RBC and MOH units to migrate their data collection systems to the DHIS-2 platform. Worked on a detailed transition plan and budget with the eHealth and RBC teams. This activity has been delayed a bit as RBC is in the process of negotiating with the Gates Foundation to reprogram some unspent money to help fund the transition
- Completed long overdue tasks related to automating the synchronization of DHIS-2 organization units with the health facility registry
- Issued a sub-contract to HISP/India to develop a PBF module for DHIS-2 and participated in a series of meetings to review their progress. The system is scheduled for completion next quarter
- Prepared an initial concept paper on requirements for a 'reactive surveillance system' for RBC/Malaria program. This would provide alerts from zones where malaria is almost eliminated for immediate case-based reaction
- Worked with the Tuberculosis (TB) program to rationalize their HMIS quarterly report and implement it on the DHIS-2 platform
- Worked with the MOH HMIS team and selected health programs to review the current HMIS monthly reporting formats and integrate changes requested. The revised formats will be effective from January, 2014. We also developed specialized monthly formats for private dentist and private eye clinics
- Developed an annual HMIS infrastructure and resource report to capture data required for the Service Availability and Readiness Assessment (SARA) as well as indicators previously gathered in the District Health System Strengthening Tool (DHSST), which was implemented by Clinton Health Access Initiative
- Continued development of the data warehouse platform— importing new data and creating shared dashboard using the latest version of the DHIS-2 software
- Oriented two Norwegian graduate students on the Rwanda DHIS-2 implementation and helped them make progress on two priority areas: developing interoperability tools to move data between the different DHIS-2 instances and operationalizing the SMS module of the DHIS-2

### 1.3. Cross-cutting support

#### **Support to the PBF- Accreditation integration process and HRH program**

The project's HMIS team worked on assessment tools in LimeSurvey (an open source system which enables entering and analyzing data from surveys) to support the integration of accreditation and PBF. The web developer has been updating the LimeSurvey tool as these two systems are merged. The PBF assessment and accreditation questionnaires were also combined on the LimeSurvey platform. As HRH program managers were willing to use the LimeSurvey for their assessments, the training was also provided to HRH data managers on how to use LimeSurvey for surveys of human resources mentors throughout the country.

#### **Mobile money payments for the Mutuelle membership system**

The project's HMIS team developed a follow up and provided regular support to the MOH health financing team, JEMBI, and Information and Communication Technology (ICT) staff in their negotiations with MTN and PivotAccess to provide mobile money payments services for the Mutuelle Membership system.

### 1.4. Challenges/constraints and next steps

#### **Challenges/constraints**

- **Lack of counterparts at MOH/HMIS unit:** The HMIS coordinator, biostatistician, and eHealth coordinator positions have remained vacant for over one and a half years. This limits the development, involvement, and representation on the work of the MOH/HMIS unit.

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

In the next quarter, the IHSSP/HMIS component has organized the following activities:

- Work with the Ministry and the World Health Organization (WHO) to complete the implementation of the prototype national health observatory (web portal for national and district health profiles)
- Continue to assist the RBC and MOH units to migrate their data collection systems to the DHIS-2 platform, in particular, the migration of the malaria surveillance system and the HIV division's TracNet/CNLSNet systems to DHIS-2. We will also work with the

Disease Surveillance team to assess the feasibility of migrating the electronic Integrated Disease Surveillance and Response (eIDSR) system to DHIS-2 as well

- Continue the development of the Data Warehouse platform by automating the synchronization of data from other DHIS-2 instances (Health Financing and RHMIS)
- Prepare a concept paper and identify participants and facilitators for a workshop in web-site content management to be held in collaboration with the RBC/Health Communications Center
- Publish the HMIS recording and reporting manual
- Complete the work on the HMIS data use guidelines
- Conduct training in Structured Query Language (SQL) and DHIS-2 reporting and design of web portal for central level data managers/programmers and M&E staff
- Complete the metadata dictionary for all Health Sector Strategic Plan III (HSSPIII) indicators and data elements
- Begin work on Malaria Active Surveillance System and Financial Management Tool in DHIS-2 with support from the University of Oslo/Health Informatics interns
- Continue to push IntraHealth to develop interoperability between the Human Resources Information System modules (iHRIS Manage, iHRIS Qualify) and the Provider Registry
- Support roll-out and training in Mutuelle M&E reporting and membership management systems

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

### 2.1. Design and implementation of PBF-Accreditation link at hospital level

The IHSSP led the way in the design and dissemination process of the new framework of linking PBF to accreditation for district hospitals quality improvement. The reasons for the linkage are:

- Both approaches are aimed at continuous quality improvement in health facilities
- To avoid duplication of efforts/resources
- To make use of existing PBF incentives to support the accreditation system
- To enhance PBF quality assessments using accreditation standards

The new framework involves the alignment of PBF indicators to accreditation standards. This will eliminate duplication during the assessment process and provide financial incentives to comply with accreditation standards. The MOH leadership supported and approved the proposed PBF/accreditation framework as an integral part of the process to improve quality of health care in the health sector.

### Dissemination of the approved PBF-Accreditation framework

The MOH/HF unit and clinical services general direction, together with IHSSP technical and financial support, conducted workshops to disseminate the approved PBF-Accreditation framework to 43 hospitals. The entire process was driven with strong collaboration of the MOH-Health Financing and Clinical Services unit staff. The existing coordination mechanisms between the two entities were helpful in mounting a strong coordination process and gaining buy-in of the heads and staff of the two entities. The dissemination was done through four concurrent dissemination workshops held in one week in four provinces of the country.

### 2.2. Health financing policy review and strategic plan development

In collaboration with the MOH planning unit and WHO, the IHSSP/HF team participated in a workshop on policy and strategic plan development from November 11-15, 2013. The aim of the workshop was to provide knowledge and skills on a comprehensive process of policy and strategic plan development. The workshop covered key aspects to be addressed while developing the policies and strategic plans in terms of content and process. The roadmap for this development was defined, presented, and approved by MOH senior staff, after which the review

of the health financing situational analysis began. A summary of the preliminary diagnostics carried out on the health financing policy is described in table 2 below.

**Table 2: Health financing policy analysis**

<b>Policy elements</b>	<b>Comments/quality of document</b>
Situation analysis	The health financing situation needs to be updated to reflect the current situation.
Mission	The current health financing policy doesn't contain the mission statement.
Goal of health financing policy	The existing goal is still relevant but needs some improvement:
Guiding principles/ core values	There are missing components in the current document that need to be developed.
Policy objectives	After the update of the situation analysis and based on issues and challenges identified, this part will be adjusted so that key challenges are reflected in the HF policy objectives.
Policy orientations	<ul style="list-style-type: none"> <li>• Mainly the 5 objectives related to the health financing functions will be maintained and new issues can be integrated in the policy orientations.</li> <li>• If any new objective is defined, there must be strategic actions or orientations to pursue; emphasis on building block for each new strategic orientation should be identified.</li> <li>• The strategic orientations might be changed to policy orientations. For the policy document, the proposed indicators can be removed and will be helpful for the strategic plan development.</li> </ul>
Implementation framework	The status is OK. There is need to add some mention of the dissemination.

### **2.3. CBHI routine data quality assessment: district implementation follow up**

The MOH/HF is committed to conducting data quality assessments for every CBHI district directorate to improve the quality of data collected from CBHI sections and districts. In October 2013, district CBHI M&E staff were trained in Huye on “CBHI Routine Data Quality Assessment (CBHI-RDQA) and on Web Based Data Entry”.

After the training, participants recommended additional trainings to other CBHI staff for dissemination of RDQA and improvement in the use and application of the CBHI Procedure Manual, and provision of CBHI management tools to all sections. The RDQA Tool will be used by district CBHI as a supervision tool for CBHI sections. District CBHI M&E officers should ensure that a quarterly assessment is conducted for every CBHI section within their jurisdiction.

From November 26 to December 3, 2013, the IHSSP team supported the MOH/HF unit in a series of field visits in various districts. The objective was to support district CBHI managers to master the process of data quality assessment and data entry, and build the M&E capacity of the districts.

As the next step of this intervention, there will be training of district CBHI directors on RDQA during the auto-evaluation workshop, training of the CBHI Section Managers on CBHI SOPs, RDQA feedback and results sharing with CBHI section managers during the district coordination meeting, and follow up on routine use of the CBHI RDQA as a supervision tool to CBHI sections.

#### **2.4. Follow up on CBHI studies**

As mentioned in previous reports, IHSSP is providing technical support to the CBHI studies funded by Rockefeller Foundation and implemented by the National University of Rwanda (NUR) – School of Public Health (SPH). The main objectives of the studies include the documentation of the evolution of CBHI in Rwanda (mainly through key person interviews) and the impact of CBHI on access to health care (using Demographic and Health Survey (DHS)) data, Integrated Household Living Condition Survey (EICV) data, and household primary data).

During the last quarter, the main activities conducted were: (1) finalization of the data entry for the household survey questionnaires, (2) recruiting a consultant to assist the SPH for primary data analysis, and (3) testing of the interview guide. Meanwhile the secondary data analyses for the DHS and EICV data have been refined and results are expected by the end of January 2014.

The main challenge regarding this activity was the change of the NUR structure and staff. The principal investigator is no longer working with the SPH and the handover process delayed activities.

#### **2.5. Rwanda iCCM costing and financing tool workshop**

With support from the Management Sciences for Health (MSH) home office, the IHSSP health financing team was involved, technically, in the training on costing for Integrated Community Case Management (iCCM). The purpose of the training workshop was to train MOH staff (Community Health Desk) and the RBC Malaria division on the use of the iCCM Costing and

Financing Tool. In total 12 staff members were trained. This tool was previously tested in Rwanda and MOH managers had requested a training workshop in order to expand its use..

The training workshop took place on December 12<sup>th</sup> – 13<sup>th</sup>, 2013 in Kigali. David Collins and Kate Wright of MSH, who were both involved in the original development and testing of the iCCM tool, conducted the training. The workshop combined presentations on the tool with practical exercises where sample data elements provided by the trainers were entered into the tool. A revision of the tool was developed for a Rwanda-specific context and other aspects of the training focused on explaining to participants how to find and interpret relevant results from the tool.

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

#### **3.1. Facilitation of PHs with regard to accreditation standard implementation**

The MSH team continued to support the drafting of new policies and procedures, and the revision to align the existing ones to the accreditation standards in the five hospitals: Ruhango, Ruhengeri, Rwanagana, Kibungo, and Bushenge. A list of 46 policies and procedures have been completed and submitted to hospitals. This was done in parallel with the mentoring of external facilitators.

The challenge was the limited time to support the five hospitals. As a next step, the project will continue to support development of more policies and procedures to comply with accreditation standards and mentoring of facilitators to improve their capacity.

#### **3.2. Integration of PBF and health facility accreditation**

To promote continuous quality improvement of services provided by health facilities, the MOH decided to integrate two approaches: accreditation of health facilities and performance based financing (PBF). The aim is to use the existing PBF incentives to support the accreditation system, enhance quality assessments through a standards-based approach to quality evaluation, avoid duplication of efforts, and increase efficient management of resources.

This process started with the mapping of all the indicators provided by MOH and RBC programs with accreditation standards. Then PBF indicators were aligned to accreditation standards and a

common assessment tool was created. Finally the teams from clinical services (Accreditation surveyors) and MOH PBF were integrated and trained to become certified by JCI surveyors.

### **Challenges**

The integration process is still in its early stages and requires more support to strengthen the new initiative. The accreditation standards framework does not cover supervision of health centers ('encadrement'), HIV, and TB; these will continue to be evaluated as usual and will be included in the next review of standards.

### **Next steps**

- Train the PBF team to become competent certified surveyors
- Use the harmonized quality assessment tool in the next progress assessment
- Use next PBF incentive payment to support health facility accreditation process

### **3.3. Dissemination of national quality and patient safety goals for 2013-2014**

The national patient safety goals and their measurement framework have been disseminated to 37 district hospitals. The aim is to bring 37 DHs on board with the Rwanda accreditation process prior to initiating the full program at these health facilities. The hospitals can begin to work on patient safety issues and will ultimately receive recognition for achieving these specific goals.

The national quality and patient safety goals are included in the Rwanda essential hospital accreditation standards framework; the achievement of these goals by facilities will constitute a partial implementation of the standards. Every year, new goals will continually be established.

### **Next steps**

The MOH and IHSSP will continue to mobilize support from different partners to support implementation of safety goals. The safety goals will also be translated into French to facilitate a better understanding by hospital managers.

### **3.4. Establishment of the accrediting body for the Rwanda accreditation program**

A concept paper detailing the options of establishing an accrediting body for Rwanda's accreditation program was developed; it describes the considerations of housing the healthcare accreditation program so as to assist the accreditation steering committee in developing an accreditation model.

The evaluation, conclusions, and recommendations are based on the fact that: (1) there is a commitment by the MOH to pursue the establishment of a hospital accreditation program for the State of Rwanda, (2) there is a desire to create an “independent” body for conducting external assessments to minimize potential conflict of interest or bias. It is likely that the body will be housed by the Rwanda Development Board, which is free of MOH influence and is overseeing development of private sector health services.

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

The MOH is prioritizing the improvement of HRH and a special emphasis has been put on improvement of staffing at the hospital level, based on their workload. With the introduction and use of Workload Indicators for Staffing Need (WISN), it is hoped that each facility will be able to determine its staff needs based on evidence to guide decision making that prioritizes the most needed cadres.

### **4.1 Support for the development of activity standards for the WISN method**

Following the training of WISN technical task force members, IHSSP supported a six-day exercise of training and development of the activity standards for the WISN approach, based on the national health settings for doctors, nurses and midwives. Over 50 health professionals including doctors, nurses and midwives received training on developing the activity standards and subsequently developed their standards at health centers, district and provincial hospitals. The doctors developed their standards just at district and provincial hospitals level.

An activity standard is the time it would take a well-trained and motivated staff to perform a given task or health activity at acceptable professional standards and specific conditions of the country. Based on set activity standards, the health facilities will be able to calculate the required staff to accomplish their activities using the annual workload. This in turn will help to show the required staff at each facility and hence assist in developing relevant staffing plans.

### **4.2. Validation workshop of the activity standards**

After the development of the activity standards, a half-day workshop was organized by the MOH supported by IHSSP to validate the set standards. The validation exercise involved health

professionals, donors, and MOH leadership. The standards were validated and accepted for application in national health settings to determine the required staff (nurses, midwives, and doctors) from the health centers to the provincial hospitals. The health facilities can now apply these standards and determine their staffing shortages per category.

#### **4.3. Customize WISN tool to the Rwandan context**

During this quarter, IHSSP provided technical support for the customization of the WISN tool to the Rwandan context. A team of two IHSSP staff, a consultant recruited by IHSSP, and one MOH staff had an eight-day working session to customize this software. Currently, the WISN software includes the Rwandan health activities standards, workload data, and the health professional categories including nurses, midwives, specialists, and general practitioner doctors.

The tool also includes the available working time and, together with the workload statistics, will be used to calculate and make comparisons of available and required staff. Based on the difference generated by the WISN tool from the comparison of existing and calculated staff required, each facility will be able to know the shortage or surplus of its staff in a particular professional category. Below is a snapshot of the dashboard showing the customized WISN tool to the Rwandan context.

Figure 2: Snapshot of the dashboard for the customized WISN tool

Facility Properties	Type of Staff at the Facility	Available Working Time	Workload Statistics	Activity Standards	Staffing Comparison	Salary Cost Calculations																																																																																														
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#### 4.4. Application of WISN tool in the five provincial hospitals

After customizing the WISN software to the Rwandan context, the team applied the tool to the five provincial hospitals, to determine the staffing at each facility. It was observed that each of the five provincial hospitals had a staffing shortage in all three professional categories (doctors, nurses, and midwives), except Rwamagana PH which revealed an overstaffed number of nurses.

This information is still under review at the MOH and will be shared after the application of the tool to all health facilities. The results from this exercise will be validated together thus setting the appropriate measures to be taken by decision makers in the MOH and health facility management teams.

#### 4.5. Accreditation and WISN technical working group meetings

A number of technical meetings, including telephone conferences with the consultant, Grace Namaganda, to prepare WISN training and working sessions were held and supported by the

IHSSP in collaboration with MOH staff. Throughout these meetings decisions were made on the type of professional cadres to be trained, the number necessary, the training materials needed, and the development of the agenda.

#### **4.6. Challenges/constraints and next steps**

##### **Challenges/constraints**

- Shortages of human resources in the MOH to manage proper human resources for health activities in a focused manner
- Lack of prioritization by the MOH, which leads to delays in implementing some key activities like the WISN activity standards development
- The MOH team always has conflicting agenda and this has resulted in postponing important meetings where decisions could have been taken to advise on the way forward

##### **Next steps:**

- Application of WISN customized tool to all health facilities to determine the staffing requirements
- Training of the additional WISN technical task force
- Supporting the professional councils to develop business plans
- Finalizing the strategic plan development for the councils

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

The MOH and the MINALOC mandated that districts take charge and govern decentralized services. It will be up to district authorities to exercise their given powers. The district health management teams need strong support to successfully fill their new role of governing and regulating the health services in collaboration with the central level. Support for district teams can also be provided through strong partnerships with local Civil Society Organizations (CSOs).

### **5.1. Assessing Institutional Capacity of Civil Society Organizations**

During this quarter, IHSSP commissioned an assessment of Rwanda's CSOs in the health sector, which was requested by USAID in order to identify their main institutional capacity gaps and strengths. The project supported a workshop which brought together over ninety CSO members and four consultants to discuss the CSOs capacity assessment and agree on the assessment

roadmap. This workshop assisted in information gathering for the consultants, so as to know the structure of CSOs before setting out for the assessment.

With these consultants, interview questionnaires were developed and tested. CSO members provided comments back to improve its quality. The assessment agenda was then agreed and communicated to the CSOs selected to participate in the study. The capacity assessment was carried out in November and December, sampling 36 (approximately one-third) of health sector CSOs. A draft report was produced; the findings will be shared and validated next quarter.

## **5.2. Workshop to validate the assessment report of the CSOs**

The CSO capacity assessment was followed by a validation workshop organized to discuss the assessment findings with stakeholders. The consultants presented the assessment findings and received comments and contributions to improve their report. The final report will be shared in the next quarter when all the comments and contributions have been integrated.

This assessment provided an opportunity to the CSOs themselves and their coordination office (NGO-Forum) to understand their strengths, weaknesses, threats and opportunities, and areas that should be prioritized for improvement.

## **5.3. Facilitation of the DHMTs joint quarterly meeting**

With continued support to strengthen the decentralized health services, IHSSP in collaboration with the Districts Health Management Teams (DHMTs) organized a workshop that brought together Nyamasheke and Musanze districts to discuss DHMT activities of the quarter, share their common practices and learn from each other.

This workshop experience and approach of learning from peers' strengths and weaknesses was greatly appreciated by both the teams as an excellent learning technique to improve the work of all involved. From this meeting, the two districts agreed to conduct regular and similar discussions, and requested MOH support for similar meetings with all the five districts.

## **5.4. Challenges/constraints and next steps**

### **Challenges**

- There is a significant delay in the implementation of the decentralization activities because the MOH and MINALOC wanted first to establish a Memorandum of

Understanding (MOU). The MOU has now been signed between the MOH and each district in Rwanda. This process took much longer than expected thereby causing significant delay of activity implementation.

- The district hospitals designated as provincial hospitals have not yet received any official document upgrading them to the level of provincial hospitals. This causes the district authorities to delay in making strategic moves to support the operations of these hospitals.
- Competing with conflicting MOH priority activities.

**Next step:**

- Support the DHMT quarterly meetings and implementation of their action plans in the districts of Nyamasheke and Musanze in collaboration with Rwanda Family Health Project.

## **VI. CROSS-CUTTING AND MANAGEMENT TASKS**

### **6.1. On-going development of the transition/sustainability plan**

In the last quarter, IHSSP developed a transition plan to be implemented in the final year of the project. The plan primarily serves as a tool for use by the MOH, USAID and IHSSP, and helps to ensure that the necessary skills and capacity for health systems strengthening are effectively transferred to the MOH. While the plan has not been finalized and approved by USAID, it is being implemented. This plan will be continually monitored, discussed, and where necessary updated.

### **6.2. Meeting with MOH senior management team to discuss project transition**

To ensure that IHSSP finishes the work it has initiated and implemented in collaboration with the MOH, the activities of the final year (FY 14) have been carefully reviewed to identify those that require special attention from both MSH and the MOH. It is in this context that a meeting with the MOH was organized to discuss how both parties could work together to ensure the accomplishment of key activities and a smooth transfer to the MOH in the course of the remaining period. The activities that were discussed are critical to ensure the effective transition of IHSSP supported work to the MOH once the project ends.

During the meeting, it was emphasized that the project has only 11 months to go, of which only eight months are implementation of activities, which implies that both MSH and the MOH need to dedicate special attention to some key activities. The commitments of both the MOH units as well as IHSSP are documented in mutually approved meeting minutes.

**Annex 1: IHSSP results framework**

