

Quarterly Project Report

Rwanda IHSSP

January, 2014 – March, 2014

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Quarterly Project Report – Narrative

(January – March, 2014)

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Table of Contents

ACRONYMS	3
EXECUTIVE SUMMARY	5
INTRODUCTION	7
I. IMPROVED UTILIZATION OF DATA FOR DECISION MAKING AND POLICY FORMULATION	7
1.1. Increase capacity of policymakers to collate, analyze, use and disseminate information	7
1.2. Strengthen HMIS to provide reliable and timely data	9
1.3. Cross-cutting support	11
II. STRENGTHENED FINANCIAL SYSTEMS FOR THE RATIONAL USE OF AVAILABLE HEALTH RESOURCES	14
2.1. Health financing policy review and update and development of health financing strategic plan.....	14
2.2. Programmatic and financial sustainability of the PBF	15
2.3. Training of PBF team on accreditation program and review of PBF-Accreditation integrated assessment tool.....	16
2.4. C-PBF Data Quality Assessment tools	17
2.5. Participation to the African Health Economics and Policy Association conference	17
2.6. ToT on CBHI membership management.....	18
2.7. PBF TB indicators review.....	18
2.8. Plan for the next quarter.....	19
III. QUALITY IMPROVEMENT FOR RESULTS IN ACCESS TO AND QUALITY OF SERVICES THROUGH STANDARDIZED APPROACH.....	19
3.1. Progress assessment with regard to the implementation of Rwanda hospital accreditation standards.	19
3.2. Training of surveyors.....	22
3.3. Facility management and safety training workshop	22
3.4. Training on infection prevention and control	22
3.5. Facilitation and mentorship of PHs’ teams to meet standards compliance	23
3.6. Support the establishment of the accreditation system	24
IV. IMPROVED MANAGEMENT, PRODUCTIVITY AND QUALITY OF HUMAN RESOURCES FOR HEALTH.....	25
4.1. Implementation of the WISN methodology in health facilities	25
4.2. Development of the CPD strategic plan for pharmacists.....	26
4.3. Development of the strategic plan for the Allied health professionals’ council.....	27
4.4. Challenges/constraints and next steps.....	27
V. EXTENDED DECENTRALIZATION OF HEALTH AND SOCIAL SERVICES	27
5.1. Review and finalization of the CSO capacity gaps assessment.....	27
5.2. Facilitation of the DHMT joint quarterly meeting.....	28
5.3. Review of Nyamasheke district health strategic plan	28

5.4. Challenges/constraints and next steps.....	28
VI. CROSS-CUTTING AND MANAGEMENT TASKS	29
6.1. IHSSP Impact assessment.....	29
6.2. Orientation of the US congressional office staff visitors.....	29
ANNEXES	31
Annex 1: IHSSP results framework.....	31

List of Figures

Figure 1: Comparison of risk areas average baseline and progress assessments scores.....	20
Figure 2: Hospitals average baseline and progress assessments scores on level 1	21

List of Tables

Table 1: Summaries of key RHMIS indicators from the quarterly bulletin	8
Table 2: Summary of WISN results from professional cadre.....	25
Table 3: Recommended average staffing based on workload data.....	26

ACRONYMS

AfHEA	African Health Economics and Policy Association
AHP	Allied health professionals
ANC	Antenatal Care
ARI	Acute Respiratory Infection
CBHI	Community Based Health Insurance
CDC	Centers for Disease Control and Prevention
CHD	Community Health Desk
CHW	Community Health Workers
CNTS	Centre Nationale de Transfusion Sanguine
C-PBF	Community Performance Based Financing
CPD	Continuous Professional Development
CSOs	Civil Society Organizations
DHIS-2	District Health Information System (New Rwanda HMIS System)
DHMTs	District Health Management Teams
DQA	Data Quality Assessment
eIDSR	electronic Integrated Disease Surveillance and Response
FMT	Financial Modeling Tool
GoR	Government of Rwanda
HF	Health Financing
HISP	Health Information System Program
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HR	Human Resources
HRH	Human Resources for Health
HSSP III	Health Sector Strategic Plan III
ICT	Information and Communication Technology
iHRIS	Integrated Human Resources Information System
IHSSP	Integrated Health Systems Strengthening Project
JCI	Joint Commission International
LMIS	Logistic Management Information System

M&E	Monitoring and Evaluation
MINALOC	Ministry of Local Government
MMS	Membership Management System
MoH	Ministry of Health
MSH	Management Sciences for Health
NCDs	Non-Communicable Diseases
NDC	National Data Center
NRL	National Reference Lab
OPD	Outpatient Department
PBF	Performance-Based Financing
PEPFAR	President's Emergency Plan For AIDS Relief
PHs	Provincial Hospitals
PNC	Postnatal Care
QI	Quality Improvement
RBC	Rwanda Biomedical Center
RHMIS	Routine Health Management Information System
RSSB	Rwanda social Security Board
SMS	Short Message Service
SOPs	Standard Operating Procedures
SOW	Scope of Work
STTA	Short-term technical Assistance
SQL	Structured Queries Language
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
U.S.	United States
USAID	United States Agency for International Development
WHO	World Health Organization
WISN	Workload Indicators for Staffing Needs

EXECUTIVE SUMMARY

In this reporting quarter (January – March, 2014), 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. With less than three quarters remaining in the IHSSP contract, the emphasis is on the consolidation of achievements to date and the transfer of capacity.

The Health Information component team's accomplishments this quarter include mentoring the new Ministry of Health (MoH) HMIS coordinator, enhancing the data warehouse and Integrated Human Resources Information System (iHRIS) platforms, completing HMIS-related documentation, designing the new short message service (SMS) reporting system for Community Health Workers (CHW) logistics, training the HMIS and Rwanda Biomedical Center (RBC) team in advanced programming report writing, and supporting the MoH/Planning Directorate to operationalize the mentoring and evaluation (M&E) plan for the Health Sector Strategic Plan (HSSP III). Overall, data availability and use for decision making in Rwanda has improved enormously over the life of the IHSSP largely due to the renewed RHMIS system based on the DHIS-2 platform.

The Health Finance component team led the development of the health financing policy and strategy and the performance-based financing (PBF) sustainability analysis, and helped to link the PBF and accreditation programs. To institutionalize data quality assessment (DQA) in the CHW program, the team designed tools and provided training to supervisors and data managers. The team presented the abstract “Increasing equity among Community Based Health Insurance (CBHI) through a stratification process in Rwanda” at the African Health Economics and Policy Association (AfHEA) conference. Also completed during the quarter was a training of trainers (ToT) on CBHI membership management and a review of PBF-Tuberculosis (TB) indicators to reflect current priorities.

The Quality Improvement component made further progress in establishing the accreditation program, including completing the assessment of the five provincial hospitals for accreditation standards implementation, training surveyors, facilitators, and facility staff in the implementation

of the accreditation program, and facilitating and mentoring the provincial hospital (PH) teams to meet accreditation standards compliance. The process of creating a nationally owned accreditation system that provides national coverage is realizing an excellent start, which will require on-going external support for some time to come. The linking of CQI via accreditation to PBF will serve to accelerate the QI process. Additional attention will be needed to ensure the institutionalization of the accreditation system.

The Human Resources for Health component trained health professionals who manage the implementation of the Workload Indicators for Staffing Needs (WISN) methodology in the health facilities throughout the country, applied the WISN tool to all the health facilities to determine staffing needs and inform MoH of future staffing priorities, and supported the development of strategic plans for professional councils. This process for objectively measuring health workforce needs is useful at the facility level and aggregated results will also inform national level HRH planning.

The Decentralization component finalized the civil society organizations (CSO) capacity gaps assessment report, provided technical support to the District Health Management Teams (DHMT) quarterly meetings, and reviewed and updated the Nyamasheke and Musanze districts' health strategic plans. IHSSP will continue to build a model for building capacity of the DHMTs in these 2 districts, which can be rolled-out at a future point in time.

In terms of general project management, IHSSP supported phase one of the project impact assessment and coordinated the visit of the United States Congressional Staff Delegation to learn about IHSSP and health systems strengthening activities.

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 financial management for sustainability; improved management, productivity, and quality of human resources; improved quality of health services through a standardized approach to service delivery; and effective decentralization of health and social services to the district level and below.

The IHSSP is in its final year of implementation, and this report summarizes the activities and achievements of the project during the reporting period of January – March, 2014.

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

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

➤ Development of the template for the HMIS quarterly bulletin

The IHSSP assisted the MoH in developing a template for the new quarterly Routine Health Management Information System (RHMIS) bulletin and in preparing analyses and narratives for the first edition. This bulletin is intended for all health sector stakeholders who are interested in the health information system. The purpose of the RHMIS bulletin is to:

- Share data from RHMIS about a specific theme;
- Encourage active data use and dissemination;
- Share news about HMIS;
- Highlight new features of RHMIS; and
- Spotlight selected users of RHMIS.

Table 1 summarizes key RHMIS indicators from the quarterly bulletin for the period October - December, 2013, which was disseminated during this quarter.

Table 1: Summaries of key RHMIS indicators from the quarterly bulletin (October - December, 2013)

Key Indicators	Value
Malaria outpatient department (OPD) cases	334,985
Malaria OPD proportional morbidity	12.7%
Malaria slide positive rate	39%
Facility deliveries coverage	94.4%
Live births with PNC visits within 3 days	24.8%
Family Planning coverage rate - married women	56.4%
Antenatal 4 coverage rate	36%
Neonatal deaths in hospital	723
Deaths under 1 year from weekly mortality report	913
Deaths under 5 years from weekly mortality report	1,076
Acute respiratory infection (ARI) proportional morbidity under 5 years	49.1%
Diarrhea proportional morbidity under 5 years	6.8%
Malaria proportional morbidity under 5 years	10.6%
New nutrition rehabilitation admissions	11,113
OPD visits per capita	0.9

➤ **Development of HMIS data use guidelines**

The project, with the Health Information System Program (HISP) consultant, completed the HMIS data use guidelines (Information for Action), which will be printed during the next reporting period.

➤ **Development of user manuals for the RHMIS and iHRIS**

IHSSP developed RHMIS and iHRIS user manuals this quarter, which will be finalized in the subsequent reporting period. These manuals will facilitate the use and management of the RHMIS and iHRIS web-reporting systems at different levels.

➤ **Assessment of barriers to data use**

With support of the Futures Group sub-contractor, the IHSSP team conducted an assessment of barriers to data use at district health units. In Rwanda, local governments are increasingly expected to take responsibility for health operations and health outcomes at the local level. In order to manage and evaluate health programs effectively, program managers at the local level need to get better at using data for making decisions that pertain to their respective programs.

The assessment found that numerous barriers to data use exist at the district level, which places the district at risk for failing to adequately measure or meet their targeted health outcomes.

The assessment report was completed and will help formulate interventions and develop data management standard operating procedures (SOPs) at the district level.

➤ **Development of the M&E plan for HSSP III**

The IHSSP/HMIS team assisted the MoH/Planning department in the development (expansion) and operationalization of the M&E plan for the Health Sector Strategic Plan III. The plan will be finalized during a workshop in April.

➤ **Capacity building:**

- **Development of a training plan for HMIS:** IHSSP facilitated the development of a training plan by the MoH/HMIS team, in preparation for a series of training sessions on the configuration and use of DHIS-2 (District Health Information System) dashboard and analytical tools for the senior MoH and RBC managers.
- **Training for the HMIS and RBC M&E team:** The project team conducted a three-day training session on advanced Structured Queries Language (SQL), DHIS-2 reporting, and web portal design. The training built the capacity of a team of six data managers and programmers from the MoH/HMIS and RBC to create an initial set of standard reports for their respective programs that can be integrated into the RHMIS system.
- **Support for the ToT of CBHI membership System and Monthly/Weekly reporting:** The IHSSP/HMIS team (with the health finance team) also supported a one-week training of trainers for 46 district level CBHI staff on the use of these revitalized membership and reporting information systems.

1.2. Strengthen HMIS to provide reliable and timely data

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

- **CHW - Logistic Management Information System (LMIS):** The IHSSP/HMIS team began the implementation of a mobile SMS system for CHWs to report on their stock of equipment and medicine. A technical team to support the MoH/Community Health Desk (CHD) with this initiative was established, and the MoH/HMIS team was assisted to configure a DHIS-2 instance on a virtual server at the National Data Center (NDC), clean

up the list of 45,000 CHWs, and extend the DHIS-2 organization unit hierarchy to include cells and over 14,000 villages that are covered by CHWs. The team also developed a work plan and budget for the implementation of LMIS.

- **Metadata dictionary:** IHSSP assisted the MoH to complete the metadata dictionary for the HSSP III, district health units, East African Community indicators, and data elements of the data warehouse database.
- **Interoperability of the DHIS-2 with the OpenMRS** (national medical record system used at health facilities to support service delivery): IHSSP/HMIS, with the RBC OpenMRS team, developed mechanisms to automate the export of Antenatal Care (ANC) data from OpenMRS to DHIS-2.
- **Migration of data collection systems:** IHSSP/HMIS continued to assist RBC and MoH units to migrate their data collection systems to the DHIS-2 platform.
- **Integrated Disease Surveillance and Response (eIDSR) system:** IHSSP facilitated a full day workshop with the eIDSR team to identify core requirements of the system in comparison with the existing functionality of the DHIS-2. It was concluded that the DHIS-2 does not meet many of the requirements for disease surveillance. Rwanda should therefore explore initiatives currently under way in other countries where surveillance and response systems are under development, including West Africa, Tanzania and Uganda.
- **Review of the President's Emergency Plan for AIDS Relief (PEPFAR) indicator requirements:** The project team, with the RBC/HIV (Human Immunodeficiency Virus) team, reviewed the PEPFAR indicator requirements and revised monthly reporting forms for TracNet, a data entry, storage, access, and sharing system created in 2005 by the Treatment and Research AIDS Center (TRAC).
- **Transition of TracNet:** The project assisted the RBC team to negotiate with the Gates foundation on re-programming the funds for TracNet transition in the DHIS-2.
- **eTB module of the DHIS-2:** IHSSP, with the RBC/TB program team, finalized an eTB module in the DHIS-2 platform to track individual cases of multi-drug resistant TB and trained staff in the use of the module.
- **PBF module for the DHIS-2:** The project continued to manage HISP/India to develop a PBF module for DHIS-2. Most software requirements have been completed, with reports

in the final design phase. The module will be showcased at the PBF community of practice meeting in Bujumbura at the end of April 2014.

- **Data warehouse platform:** IHSSP continued the development of the data warehouse platform, training the HMIS staff on procedures for importing data from other HMIS and TracNet instances, and creating shared dashboards using the latest version of the DHIS-2 software. The data was also provided to the World Health Organization (WHO)/AFRO office to enable their team to build a prototype for the national health data portal.

1.3. Cross-cutting support

➤ **Integration of the Accreditation and PBF assessment tools in LimeSurvey**

As these two systems are being merged, the IHSSP/HMIS team updated the LimeSurvey tool that will be used to collect data for the assessment.

➤ **Human Resource Information System (iHRIS)**

The project facilitated a one-day workshop to assess iHRIS data quality and upgraded the iHRIS platform software based on recommendations from the workshop.

➤ **Transition of the CBHI systems to the Rwanda Social Security Board (RSSB)**

The project team participated in different meetings with staff and consultants from RSSB to discuss transition of CBHI systems to RSSB. The transition should be completed without loss of the investments already made in these systems and in the CBHI section staff capacity building.

1.4. Challenges/constraints and next steps

➤ **Challenges/constraints**

- **Overlapping field activities of the MoH/HMIS team:** The MoH/HMIS team has been out of the office for many weeks during the quarter for DQA and integrated supervision. The newly appointed professional in charge of HMIS promised to ensure that at least one HMIS staff member will stay in the office during periods of extended field work in the future.
- **Transition of the eIDSR:** The Minister is eager for all the systems that were developed by Voxiva to be transitioned to DHIS-2 before the end of September 2014 when Centers for Disease Control (CDC) grants to Voxiva will end. Progress is being made on the transition of TracNet, but the transition of eIDSR will require more time, based on

detailed requirements identified in the workshop with the RBC Disease Surveillance team. The HMIS/RBC staff seems unwilling to share this news with the Minister.

- **Implementation of CBHI systems:** Moving CBHI to the Rwanda Social Security Board (RSSB) has slowed implementation of CBHI systems (including monthly reporting, costing tool, and membership management databases), as MoH and RSSB staff is unsure of their future roles. IHSSP staff can provide support to ease this transition and to ensure that the CBHI systems are utilized.

The CBHI membership system relies on social categories from the Ubudehe database, which is now owned by the Rwanda Local Development Support Fund from Ministry of Local Government (MINALOC). Regular consultations or a permanent taskforce between the two ministries and the new CBHI owner (RSSB) would ensure that the CBHI continues as an effective system.

- **Insufficient interest in the enhancement of iHRIS:** Enhancement of iHRIS would add the functionality to provide all of the information needed and to be more useful at all levels (from central MoH to health facilities). However, the project has not received sufficient buy-in from the MoH Human Resource Department for the enhancement of iHRIS.

➤ **Lessons Learned**

Even before the R-HMIS is officially launched, the MoH departments and programs see it as a resource to improve data reporting. The data requests are overwhelming the already busy HMIS team. A policy to regulate responsibility for data sharing and manage changes on key data collection tools (forms, registers, indicators, etc.) must be developed to keep the system stable, to ensure continuity of data collected, and to guarantee that departments or programs maintain the sense of ownership of data that is reported through the R-HMIS.

The National Data Center (NDC) is a logical host for the government systems, as the institution has both a strong infrastructure and skilled personnel to ensure availability of the systems. However, the institution has been privatized to generate revenue from its clients. In order to ensure continued hosting of RHMIS, there is a need for a standard operating procedure or service-level agreement on the roles/responsibilities of the three ‘parties’ involved (NDC,

HMIS and departments or programs). Once the initial advance payment (of nearly RWF 100 million) paid by MoH to the NDC is exhausted, the NDC will bill the MoH monthly. A cost sharing arrangement should be developed between the MoH/ICT and programs that receive the most funds to use the NDC hosting services.

The R-HMIS end users of the systems are much more engaged when given guidance on the system. The HMIS team should regularly communicate with the users about system changes and enhancements. Regular training is needed for top managers, end user staff, developers, and system administrators. On-the-job training is best for the system developers and system administrators. Managers face time constraints, and they require an efficient training approach that does not take more than a half day.

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

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

- Continue to assist the RBC and MoH units to migrate their data collection systems to the DHIS-2 platform;
- Assist the RBC to test and deploy eTB module of DHIS-2 and update system documentation (e-TB policy, data dictionary, and TB data management manual);
- Complete the migration of TracNet monthly reporting modules by June 30, 2014;
- 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 in the third Quarter;
- Assist the Futures Group consultant to organize a workshop to develop administrative district data management SOPs (in early May 2014);
- Complete the work on HMIS data use guideline with HISP consultants;
- Complete the work on developing a web-based CBHI Financial Management Tool built on the CBHI quarterly and weekly reporting modules of the DHIS-2 platform that were re-launched last quarter;
- Complete the development of CHW LMIS based on the DHIS-2 SMS module, which will allow the MoH/CHD to better manage essential drug/supply distribution to the village level;

- Arrange for short-term technical assistance through, and funded by IntraHealth Capacity+ Project or individual consultancy (funded by IHSSP) to develop “inter-operability between iHRIS Manage and iHRIS Qualify”;
- Implement the use of a self service module for iHRIS and create a mechanism to synchronize data with iHRIS/Manage to improve HR data quality. Intensify work with the Nursing Council to build their capacity to sustain the system;
- Install the PBF module developed by HISP/India in the DHIS-2, and configure and test the system for launch in July 2014;
- Present the Rwanda PBF/DHIS-2 integration experience at the PBF community of practice meeting in Bujumbura at the end of April 2014;
- Support the MoH to host an advanced DHIS-2 Academy in Rubavu (Gisenyi) at the end of May 2014 with 60 participants from across Africa;
- Support the extraction and analysis of data for the health systems strengthening impact evaluation;
- Work with HISP/University of Oslo to develop international use cases for disease surveillance, based on requirements of eIDSR, which can be integrated into the DHIS-2 and used across the region. In the short term, create alert and surveillance rules for decision makers on programs that use the existing DHIS -2 functionalities.

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

2.1. Health financing policy review and update and development of health financing strategic plan.

During this quarter, IHSSP engaged a local company, Quality and Equity Healthcare, to review and update Rwanda’s health financing policy and health financing strategic plan. The IHSSP health financing team continues to play a pivotal role in the review and development of these two documents. This team also continued to work closely with the MoH health financing team and the health financing technical working group (TWG) core team to facilitate the finalization of the health financing situation analysis. In close collaboration with the MoH and a variety of partners at the central level, the IHSSP team conducted consultative meetings with stakeholders and

supported a workshop organized by the MoH on February 26, 2014, to present a first draft of the health financing policy. Comments raised during these consultations were used to improve the draft document. Currently, the draft is being presented to the Senior Management team at MoH for validation.

In addition, a roadmap and an outline for the health financing strategic plan development were discussed and agreed through the TWG core team. A workshop to reach consensus on the strategic orientations and log frame is planned in May of 2014, at which the IHSSP consultant will present the health financing strategic plan and priorities.

2.2. Programmatic and financial sustainability of the PBF

A sustainability analysis was undertaken to analyze the PBF program and to provide technical advice to the MoH on how the system can be enhanced programmatically and financially in order to sustain achievements. The analysis provides guidance to the MoH, including policy implications to inform future PBF schemes and to identify practical suggestions that could be used to sustain the PBF program.

In March of 2014, an international expert in PBF was hired to conduct the situation analysis. He held consultations with MoH and select partner stakeholders as key informants, reviewed existing documents on PBF, and conducted field visits to different facilities and communities to understand how PBF is working.

Key conclusions noted during the assessment include:

- The PBF policy has been resilient and is one of the Government of Rwanda's (GoR) arguments for enforcing channels of aid funds through the GoR.
- The financial sustainability issue is not specific to PBF, but is part of the reduction of aid money to health.
- Adjustments will be needed; this will require clear and transparent information to different stakeholders, including health facilities, and it will be crucial to redevelop the PBF narrative:
 1. PBF to reach MDGs;
 2. PBF to reform/strengthen the health system/public sector;
 3. PBF as a bonus;

4. PBF as a tool to improve quality and to support quality improvement.

- MoH health financing has to develop its capacity in strategic purchasing, not specific to PBF. PBF is the incarnation of strategic purchasing, and this narrative has not been fully adopted. This area needs to be focused on for future work.
- The technical capacity of the PBF unit has to be in line with the needs of the strategic purchasing function and must be able to adapt to new orientations. Benchmarking against the MoH strategic plan or between facilities, investigating causes of low performance, and analyzing trends are examples of functions that need to be executed by the PBF unit.
- Linking PBF and accreditation makes sense, but needs to be considered more than just in terms of team and data collection. It is important to analyze how the combined strategies address quality.
- The MoH must consolidate itself as a ‘learning organization’.

2.3. Training of PBF team on accreditation program and review of PBF-Accreditation integrated assessment tool

The pressing priority for the MoH is the rapid link and harmonization of PBF and accreditation programs in hospitals. The IHSSP/HF team offered continued support to the process of PBF - Accreditation program integration through training of the PBF team on the accreditation program and the integration of the assessment tool. In this reporting quarter, the focus was on the review of the assessment tool, which integrates the two programs (PBF and Accreditation), which is used in five provincial hospitals. The harmonization of the assessment tool was finalized during the training on accreditation assessment, and staff from both the MoH/HF and clinical service units participated. The harmonized tool was used during the progress assessment of the five provincial hospitals.

For the remaining 37 hospitals, the original PBF assessment tool was used for the first time after including some indicators on the national quality and safety goals. IHSSP provided significant technical support during this process.

The project also supported the translation of the assessment tools, which are now available in both English and French.

2.4. C-PBF (Community Performance Based Financing) Data Quality Assessment tools

In the implementation of the community health program, the CHWs provide basic health services to the population and submit periodic reports that are coordinated from the village, cell, CHW cooperatives, health center, district hospital, and national levels. Based on the periodic data quality assessments on some of these indicators, many discrepancies were identified from the reports from the village to cooperative levels. Major issues were mainly at the cell level due to the absence of source documents.

To cope with discrepancies in data reported from the community level, the IHSSP and MoH started the institutionalization of Data Quality Assessments (DQA). One type of tool was developed to help the national, district, and health center level teams to conduct routine data quality assessments. A simplified DQA tool was also developed to help the CHW cell coordinators to conduct DQA for community data and to ensure data quality at that level. These MS-Excel based tools are used to check the completeness and accuracy of the reported data, comparing the source documents, registers and reports.

The dissemination of DQA tools was done through the Training of Trainers (ToT) that were organized in two phases and conducted in February and March of 2014, respectively. The 84 trainees (Community Health Supervisors and Data Managers from district hospitals) were expected at these ToTs, and the participation level was 100%. The trainees from each hospital will also provide trainings to the actors from health centers in their catchment area and coordinate the routine DQA at lower levels.

2.5. Participation to the African Health Economics and Policy Association conference

The African Health Economics and Policy Association (AfHEA) organized a scientific conference in Nairobi, Kenya, March 10 – 13, 2014. The main theme of the conference was “Universal Health Coverage, Post 2015 Agenda”. The AfHEA’s overall mission is to promote and strengthen the use of health economics and health policy analysis in achieving equitable and efficient health systems and improved health outcomes in Africa, especially for the most vulnerable populations.

The Rwanda team in the AfHEA conference was represented by Ms. Kunda Thérèse, the Senior IHSSP Health Financing Technical Advisor, and Ms. Nyinawankunsi Joséphine, the MoH’s

Head of CBHI National Pooling Risk. The abstract “Increasing equity among community based health insurance (CBHI) through a stratification process in Rwanda” was presented in the conference, and a plethora of questions to the Rwanda CBHI specialists raised points of discussion leading to three major recommendations from the regional and international audience:

- Equity: it is important to take into account the socio-economic status of subscribers from the informal sector to promote equity among members.
- Community: The involvement of the community in the stratification of CBHI members into socio-economic categories may lead to better results because people in the community know each other. Oversight by the Government in the process is a must.
- Information and Communication Technology (ICT): the use of ICT is recommended to ease the CHBI implementation process.

2.6. ToT on CBHI membership management

From March 2 – 6, 2014, the MoH, in collaboration with the IHSSP team, organized CBHI Membership Management System (MMS) training for CBHI actors from the districts. The CBHI MMS is a web-based system that provides specifications for the management of the CBHI flow from adherences, medication, and collection of premiums (contributions). The training program covered the overall implementation of CBHI-MMS and the entry of CBHI data in DHIS-2. The training was scheduled as a first phase and focused on district CBHI directors and referral hospital invoice auditors where 46 participants participated in this training.

As a next step, the training will be organized for the CBHI section managers (scheduled as the second phase) and the CBHI section and district accountants (third phase). The district CBHI managers will also be mentored on providing trainings to the CBHI section managers on web data entry in the DHIS-2.

2.7. PBF TB indicators review

There are 26 TB indicators that were introduced in the PBF program since 2010, and three years after the introduction of these indicators they needed to be revised because 7 of the 26 indicators have been achieved and there are other priorities that the TB program prefers to focus on. In this quarter, the workshop to review the indicators was conducted on March 10 – 14, 2014. The seven indicators that were achieved were removed from the evaluation checklist of the PBF, and

five new ones were added to the checklist according to the new priorities of the TB program. The next step is to finalize the evaluation grid of the checklist with the weighted unit price of every indicator.

2.8. Plan for the next quarter

- Follow up on districts mentorship and support to the development of a web platform for CBHI DQA implementation;
- Follow up on Financial Modeling Tool (FMT) implementation in selected districts;
- Conduct CBHI sustainability analysis;
- Document CBHI best practices;
- Continue support to the CBHI studies (primary data analysis);
- Develop a pricing policy (development of scope of work (SOW), harmonization of the tools for data collection, and involvement of health finance unit staff);
- Assessment of the feasibility of auto-financing of the health facilities;
- Continue the development of health financing strategic plan;
- Preparation of the independent counter verification mechanism; and
- Support for the implementation of community DQA.

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

3.1. Progress assessment with regard to the implementation of Rwanda hospital accreditation standards.

The progress assessment of the five provincial hospitals was conducted from the third week of January to the first week of February, 2014. The hospitals assessed include Ruhengeri, Ruhango, Rwamagana, Kibungo and Bushenge. The assessment aimed to determine the current status of the provincial hospitals with regard to the implementation of the essential hospital standards. After the progress assessment, facilitators used the identified gaps to design plans and mentor facility teams for the appropriate interventions to bridge those gaps.

➤ Method

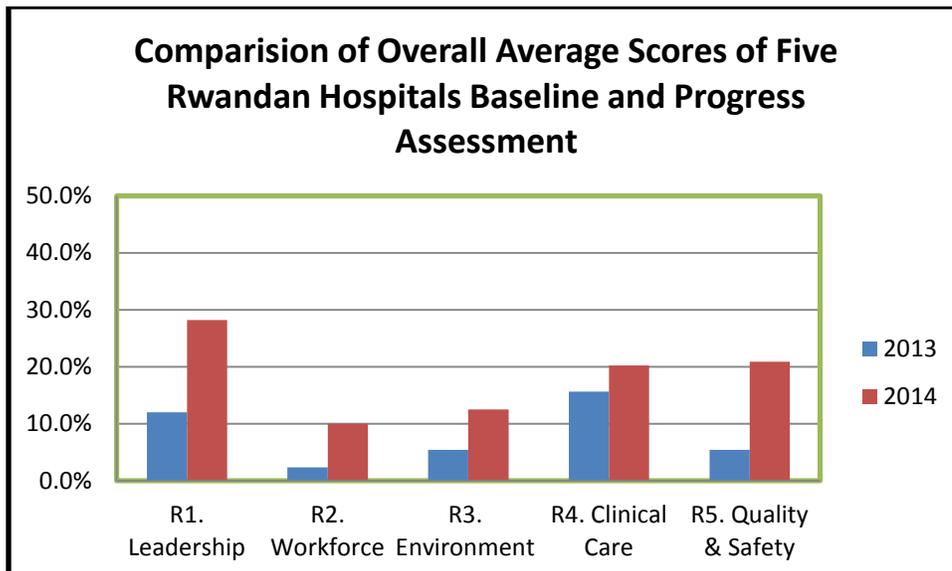
The assessment was carried out using a variety of methods, including leadership interview, interviews with the infection control and quality committees, document review, medical record

review, and clinical unit and facility tours. The Joint Commission International (JCI) consultants provided guidance and oversight for the Rwandan surveyors’ team as part of training to perform the assessments.

The most important finding is that improvements have been made in all hospitals and in all risk areas. Among those risk areas, the lowest score (with a high score better than a low one) was in the area #2 of competent workforce. The findings in that risk area can be explained by the lack of credentialing, privileging processes, the unavailability of cardio-pulmonary resuscitation training, ineffective management of personnel files, and lack of student oversight. The risk area #3 (environment) was also ranked relatively low. Some of the key findings related to structural issues included the availability of water, power supplies, and infection control practices.

The most highly ranked risk area was “leadership” (risk area #1). The key factors for meeting the standards in this risk area included effective strategic planning and contract and health information management. The figure below provides the comparisons of the baseline and progress assessments scores in all of the risk areas for all levels, one through three..

Figure 1: Comparison of risk area averages (baseline vs. progress assessments scores)

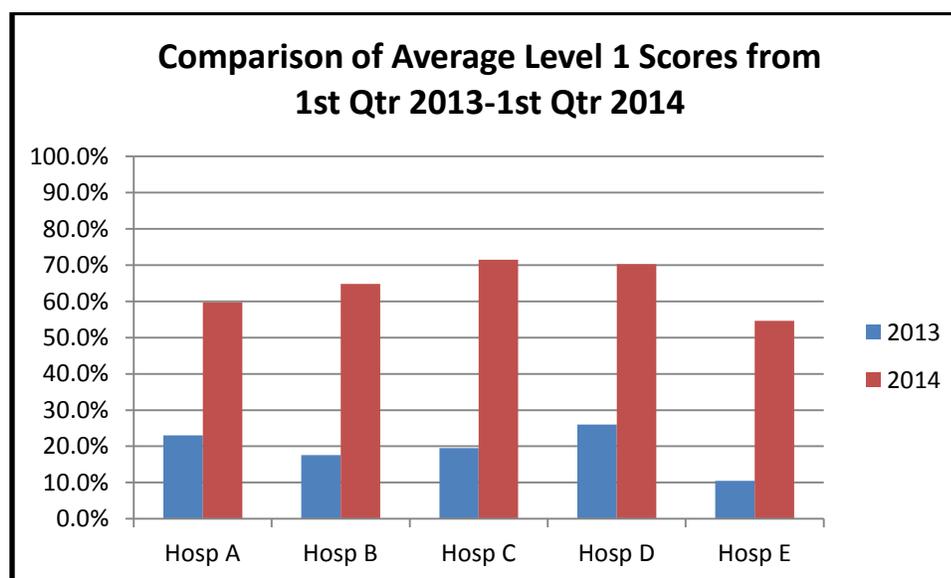


The provincial hospitals target to achieve level 1 implementation of the essential hospital accreditation standards to an overall score of 85% within one year. There is a marked increase

from the baseline assessment, as shown in Figure 2. Each hospital is working towards achieving the level 1 recognition by July of 2014.

Figure 2 compares scores of level 1 only baseline assessment (conducted in the first quarter of 2013) and progressive assessment (conducted in the first quarter of 2014) in five provincial hospitals implementing essential hospital accreditation standards.

Figure 2: Hospitals average baseline and progress assessments scores on level 1



➤ Challenges

The key challenges that have been identified include:

- Insufficient resources for implementing the provincial level service package, particularly in relation to water and electricity supplies and emergency supplies/equipment;
- Low staff knowledge on risk identification and reduction;
- Limited skills on evaluating the use of staff resources available at the individual hospitals;
- Limited facilitation support to implement the policies, procedures, and plans that have been developed;
- The institutionalization of quality management and creation of the culture of quality and safety, which are still low.

3.2. Training of surveyors

The second intake of the surveyors' training (theoretical portion) started in January 2014. The course was attended by 16 participants, which included the PBF assessment team and selected individuals from various hospitals. The course content included an introduction to quality improvement and accreditation, case studies to interpret and score the standards, and methodology to conduct the survey process. The team then proceeded to the practical part of the course. The team will continue their practical experience during the final hospital assessments due in July/August of 2014, and they are expected to complete their practical experience and take the exam before the end of August, 2014. In the first team/intake of surveyors, 14 have achieved all of the elements required for certification by JCI, which will be awarded next quarter.

3.3. Facility management and safety training workshop

Two facility management and safety training workshops were facilitated by the consultant for two days each. The 47 course attendees were a mixture of key hospital staff, such as infection control focal persons, facility management staff, hospital accreditation facilitators, and surveyors. The two day course consisted of four segments:

- Development of a facility management committee;
- Creation of a facility management plan;
- Education of staff on facility management plans;
- Conducting a hazards vulnerability analysis.

➤ Challenges and way forward

The knowledge and skills of facility staff with regard to their responsibilities in the development of a facility management program and/or an evaluation of the effectiveness of facility management program are still low. In response, the IHSSP/JCI team will provide in-site mentoring in facilities management next quarter.

3.4. Training on infection prevention and control

The JCI infection prevention expert provided on-site capacity building to the internal hospital facilitators to support implementation of infection prevention and control standards. A two day training workshop and mentorship for internal and external facilitators was conducted during the on-site visits of two hospitals (two days each). The objectives of this training were:

1. Build capacity of the Rwandan accreditation facilitators and targeted hospital staff members to assess the Rwandan infection prevention and control hospital standards;
2. Build capacity of hospital staff in identifying risks related to infection prevention and control and developing policies, procedures, and plans to manage risks;
3. To mentor infection control focal persons to carry out surveillance activities;
4. To mentor the accreditation facilitators to assist hospital staff to meet the infection prevention and control of the Rwandan essential hospital standards.

The course contents addressed specific needs of newly appointed infection prevention and control focal persons in five hospitals as well as the internal and external accreditation facilitators. The course was attended by a total of 30 participants. The training helped attendees to understand and acquire skills to help develop an infection prevention and control program.

3.5. Facilitation and mentorship of PHs' teams to meet standards compliance

The IHSSP provided facilitation and mentorship of the teams at Rwamagana, Kibungo, Musanze, Ruhango and Bushenge hospitals to help meet standards compliance. The support was provided in different standards implementation with these objectives:

- Emergency equipment and supplies: the objective was to assist one unit to implement an effective inventory management system.
- Patient satisfaction: the objective was to review the patient satisfaction policy and to analyze the patient satisfaction tool.
- Personnel files and credentialing: the objective was to visit the Human Resources (HR) department and review the preparation of files and advise on the credentialing policies and procedures.
- Efficient use of resources: the objective was to identify opportunities for resource management in different departments.
- Sufficient staff: the objective was to discuss how to develop staffing plans.
- Protocols for care of high risk patients and procedures: the objective was to develop a list of high risk patients and procedures, review protocols currently available, and discuss staff education regarding protocols.
- Medical and nursing assessments and complete documentation: the objective was to implement a medical record review process.

- Medical record management: the objective was to provide guidance in the development of an archival system.

The set objectives were met, but in one of the hospitals (Bushenge), the new leadership still needs to be oriented to the accreditation. One challenge is the limited time to provide technical support in the five hospitals. As a next step, the project will continue to support standard implementation and mentoring of facilitators to improve their capacity.

3.6. Support the establishment of the accreditation system

The IHSSP continued support for establishing the Rwanda accreditation system. The objective is to continuously improve the delivery of safe and quality healthcare provided to the public through accreditation of health facilities. The advantages of a national system include the reduction of costs for the accreditation (that would otherwise be conducted by external agencies), building of internal expertise, and developing processes that support maintenance of the standards. An important element of the design of the accreditation system is linking it with the PBF system, which has been operational for several years. In this quarter, the project provided support to the establishment of the Rwanda accreditation system by developing:

- A code of conduct policy and procedure to provide operational guidance and expectations of the accreditation bodies. This applies to the board, employees, surveyor and facilitator trainees, certified surveyors, accreditation facilitators, and independent contractors.
- Recognition and accreditation policies and procedures to provide guidance to the Rwanda healthcare accreditation board in making recognition and accreditation decisions. This applies to the board.

Similarly, a survey reports review committee was proposed to the accreditation steering committee and its terms of reference (ToR) developed for the steering committee's approval. The committee will assist the board in fulfilling duties pertaining to the approval of accreditation survey reports and recommendations provided by the accreditation surveyors. This will support the board's goals, ensuring that the country demonstrates excellence in the provision of health care services. The committee is constituted as a standing committee of the Rwanda healthcare accreditation board and has no executive powers other than those specifically delegated in the ToR.

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

4.1. Implementation of the WISN methodology in health facilities

➤ Training of WISN technical team

In this reporting quarter, the IHSSP supported the training of 18 staff from the MoH and public health facilities in WISN methodology. This team is added to the first group of 41 professionals, mainly from the MoH/HR section that was trained in April of 2013. The current training incorporated the recommendations from the first training (essentially made by the WHO team) that suggested the MoH have more health experts trained to manage and drive WISN implementation in both management and planning for HRH in the country. The trained team is now the technical source for WISN application for MoH at any time of need.

➤ Support of the application of WISN tool at district hospitals and health centers

After training the professional health experts in WISN application, they had to apply the WISN tool and determine the actual number of required staff at each facility in comparison with the existing ones using the workload data that was extracted from HMIS, TracNet, and iHRIS and entered in the WISN tool for analysis.

The assignment was carried out successfully, thus providing the MoH with the status of the health professionals (doctors, nurses, and midwives) in the health facilities. The aggregate data at the national level provides a summary of WISN results from different professional cadre.

Table 2: Summary of WISN results from professional cadre

Cadres	Current staff	WISN requirements	Staffing shortage /excess	Work pressure
Nurses	7,509	4,686	2,823	-60%
Doctors	431	417	14	-3%
Social workers	659	2,274	(1,615)	71%
Midwives	457	3,360	(2,903)	86%

*There were 42 district hospitals assessed. Work pressure indicates how occupied the category of professionals are. Negative scores are busy less than full time, and positive scores are more occupied than what is expected (Ex: -60% means as a group they are idle 40% of the time. 100% means they are doing twice as much as expected).

As indicated by results from Table 2, the nurses and doctors available can cover the available workload, meaning that the Ministry needs to ensure proper planning on deployment of those cadres, whereas the midwives and social workers' workload requirements surpass the capacity of available manpower, hence rigorous strategies need to be in place to meet the population needs.

The trained WISN professional experts proceeded with some analysis and provided recommendations to advise the MoH on how to move forward based on the staffing issues identified. Table 3 shows the recommended average staffing requirements of the health professional categories at the district hospital and health center levels.

Table 3: Recommended average staffing based on workload data

Cadres	District Hospitals		Health Centers	
	Current Staff	WISN requirement	Current Staff	WISN requirement
Nurses	60	46	11	6
Doctors	10	10	Not applicable	
Social workers	5	3	1	5
Midwives	9	28	0	5

➤ **Workshop to communicate WISN results to the HRH-TWG and MoH leadership**

During this quarter, the IHSSP also supported a half-day workshop that brought together the MoH team and its partners to discuss the WISN report and the proposed recommendations. The workshop facilitated clarifications of findings, and participants recommended meetings with more development partners and donors to discuss the WISN outcomes. Once all technical meetings have been held, and after the MoH has endorsed the report, the implementation of the proposed recommendations will be planned and executed.

4.2. Development of the CPD strategic plan for pharmacists

In 2013, the IHSSP supported the development of a Continuous Professional Development (CPD) policy for all professional councils. It would be of no value if the policy is developed and not operationalized. Among the four professional councils, only the nursing and midwifery council and the medical council have developed a CPD strategic plan to operationalize that common policy.

In this quarter, the IHSSP supported the pharmacist council in the development of its CPD strategic plan. This strategic plan is tied to council members' scope of professional practice, and the intervention strategies will help members to identify the areas of technical improvement. It is expected that the strategy will be ready for use by members in the next quarter.

4.3. Development of the strategic plan for the Allied health professionals' council

The project supported the development of the strategic plan for the Allied Health Professionals (AHP) council, which will enable the council to execute its duties as mandated.

4.4. Challenges/constraints and next steps

In the implementation of the HRH programs, the project faces a number of challenges, including:

- The shortage of human resources in the MoH to properly manage the HRH activities in a focused manner;
- Delayed MoH reactions and decisions on the WISN report, which delays facilities fixing some of the identified issues;
- The Ministry team always has a conflicting agenda, and this has resulted in the postponement of important meetings where decisions could have been made;
- The communication of WISN results to the health facilities has been delayed, which has prevented the redistribution of staff and planning at those facilities.

➤ Next steps:

- Validation of WISN results by MoH and health facilities;
- Support the dissemination of WISN results in five provincial hospitals;
- Support the professional councils to develop business plans;
- Support the development of the HRH sustainability plan; and
- Finalize the development of strategic plans for the councils.

V. EXTENDED DECENTRALIZATION OF HEALTH AND SOCIAL SERVICES

5.1. Review and finalization of the CSO capacity gaps assessment

During previous quarters, the IHSSP carried out an assessment to identify capacity gaps in a sample of Rwandan Civil Society Organizations (CSOs). The IHSSP team and its hired consultant finalized the assessment exercise in this quarter with the review and completion of the

final report. The report, including field findings and recommendations, has been submitted to USAID.

5.2. Facilitation of the DHMT joint quarterly meeting

The IHSSP provided support to conduct the DHMT quarterly meetings of Musanze and Nyamasheke districts in which specific health issues were discussed and decisions taken to resolve standing issues. In these meetings, the DHMTs were also able to review their health outcomes and the accreditation progress reports of their provincial hospitals and evaluate the implementation of their action plans.

The quarterly meetings have proved to be a good forum where health issues are brought to the attention of local political leaders (through participation of the Vice Mayor) to get support for the implementation of recommendations from those meetings. One example was an issue in the Nyamasheke district where the hospital director pointed out that the infrastructure issues that were previously communicated to the central level had not resulted in action. Based on these meetings, the Vice Mayor followed up with the Mayor and brought this problem to a higher forum of district's issues. The infrastructure issues were then tabled in the national dialogue and will be dealt with among the priority issues at the country level.

5.3. Review of Nyamasheke district health strategic plan

One of the notable accomplishments in this quarter was the review of Nyamasheke district's health strategic plan. The review involved different stakeholders (DHMTs, local and international development partners, health facilities, and CHW representatives). The plan was reviewed to take into account the DHMTs' roles and responsibilities and the stakeholders' contributions. This will enable the efficient and equitable use of available resources by the district (DHMT).

5.4. Challenges/constraints and next steps

➤ Challenges/constraints

- The hospitals designated as provincial hospitals have not yet been upgraded officially to the level of provincial hospitals, which prevents district authorities from making strategic decisions and supporting the operations of the provincial hospitals.

- The MoH teams have repeatedly failed to team up with the IHSSP team during the DHMT meetings due to conflicting priorities. This poses a threat to the success of the program and weakens the DHMT power, especially in the areas where the MoH needs to intervene. There is need to support and empower the DHMT in making their own decisions and establishing their own priorities.

➤ **Next steps:**

- Continue support to the DHMTs quarterly meetings and implementation of their action plans.
- Advocate to the appropriate Director General, the MoH participation in building DHMT capacity.

VI. CROSS-CUTTING AND MANAGEMENT TASKS

6.1. IHSSP Impact assessment

The IHSSP initiated an impact assessment process, with the objective of devising a practical methodology for assessing the impact of system strengthening interventions and applying the methodology using routinely available data in order to provide evidence of where the impact occurs. The first visit of the consultant (Steve Sapirie) who supports this initiative was held in March of 2014, which enabled staff of both the project and MoH to discuss and assess the activities, products, and performance of central level functions related to the project components. The assessment is still in process, and a second visit from the consultant is expected in June of 2014 to finalize and communicate the results.

6.2. Orientation of the US congressional office staff visitors

The IHSSP management team supported the orientation of nine United States (U.S.) study tour delegates, including senate staff who were interested in seeing global health programs up close. The purpose was to learn the key elements of the countries' health systems, with a particular focus on the importance of health systems strengthening and how such systems can be leveraged to address non-communicable diseases (NCDs). Field visits were organized to several locations:

- Busanza Health Center
- U.S. Embassy
- Centre Nationale de Transfusion Sanguine (CNTS) and National Reference Lab (NRL)
- Rwinkwavu District Hospital, NCD Clinic, and Health Center.

The study tour provided a good opportunity to showcase the existing collaboration between different health groups, such as the Ministry of Health, the U.S. Embassy and its agencies, Management Sciences for Health (MSH) headquarters, the LiveStrong Foundation, Partners in Health, and MSH-Rwanda.

Annex 1: IHSSP results framework

