

Quarterly Project Report

Rwanda IHSSP

July, 2013 – September, 2013

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Quarterly Project Report Narrative

(July – September, 2013)

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Table of Contents

ACRONYMS	iii
EXECUTIVE SUMMARY	1
INTRODUCTION	2
I. IMPROVED UTILIZATION OF DATA FOR DECISION MAKING AND POLICY FORMULATION	3
1.1. Increase capacity of policymakers to collate, analyze, use, and disseminate information	3
1.2. Strengthen HMIS to provide reliable and timely data	5
1.3. Cross-cutting support	6
1.4. Challenges/constraints and next steps.....	7
II. STRENGTHENED FINANCIAL SYSTEMS FOR THE RATIONAL USE OF AVAILABLE HEALTH RESOURCES	9
2.1. PBF approach to support the accreditation program.....	9
2.2. Capacity transfer on PBF budget forecasting	10
2.3. CBHI studies (Rockefeller Foundation funded)	10
2.4. ECSA conference on strengthening the responses to emerging health concerns in the region	11
2.5. Institutionalization of community and CBHI data quality assessment.....	12
2.6. Data validation process using the FMT and CBHI annual report development	13
III. QUALITY IMPROVEMENT FOR RESULTS IN ACCESS TO AND QUALITY OF SERVICES THROUGH STANDARDIZED APPROACH.....	15
3.1. Development of patient quality and safety framework.....	15
3.2. Training workshop on accreditation standards, development of accreditation procedures, and PBF link to the accreditation.....	15
3.3. Facilitation of provincial hospitals with regard to standards implementation.....	16
3.4. Patient safety workshop at Harare	17
3.5. Challenges and next steps	18
IV. IMPROVED MANAGEMENT, PRODUCTIVITY, AND QUALITY OF HUMAN RESOURCES FOR HEALTH.....	18
4.1 Finalization and validation of the CPD strategic plan for the NCNM.....	18
4.2. Development and validation of Pharmacists Council strategic plan	19
4.3. Development and validation of an integrated CPD policy for health professionals.....	19
4.4. Presentation and approval of WISN implementation plan	19
4.5. Review and approval of WISN TORs	19
4.6 Challenges/constraints, and next steps.....	20
V. EXTENDED DECENTRALIZATION OF HEALTH AND SOCIAL SERVICES	20
5.1. Assessment of the District Health Management Teams (DHMTs)	20
5.2. CSOs capacity needs assessment.....	21

5.3. Challenges/constraints and next steps:.....	21
VI. CROSS-CUTTING AND MANAGEMENT TASKS	22
6.1. Final year work planning workshop	22
6.2. Development of transition/sustainability plan	22
ANNEXES	23
Annex 1: IHSSP results framework.....	23

List of Figures

Figure 1: CBHI sources of funding.....	14
Figure 2: CBHI expenditures	14

List of Tables

Table 1: List of procedures developed in hospitals	17
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ACRONYMS

BTC	Belgian Technical Cooperation
CBHI	Community Based Health Insurance
CDC-COAG	Centers for Disease Control and Prevention – Cooperative Agreement
CHW	Community Health Worker
CPD	Continuous Professional Development
CSO	Civil Society Organization
CTAMS	Cellule Technique d’Appui aux Mutuelles de Santé (Mutual Technical Support Cell)
DHs	District Hospitals
DHIS-2	District Health Information System (New Rwanda HMIS System)
DHMT	District Health Management Team
DHSST	District Health System Strengthening Tool
DQA	Data Quality Audit/Assessment
ECSA	East, Central, and Southern Africa Health
FHP	Family Health Project
FMT	Financial Management Tool
HCs	Health Centers
HISP	Health Information System Program
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HRH	Human Resources for Health
HRMIS	Human Resources Management Information System
HSSP III	Health Sector Strategic Plan III
ICT	Information and Communication Technology
iHRIS	Human Resources Information System
IHSSP	Integrated Health Systems Strengthening Project
JCI	Joint Commission International
MDR -TB	Multi-Drug Resistant Tuberculosis
M&E	Monitoring and Evaluation

MINALOC	Ministry of Local Government
MOH	Ministry of Health
MOU	Memorandum Of Understanding
MSH	Management Sciences for Health
NCNM	National Council for Nurses and Midwives
NDC	National Data Center
NURSPH	National University of Rwanda/School of Public Health
PBF	Performance-Based Financing
PIH	Partners in Health
QI	Quality Improvement
RBC	Rwanda Biomedical Center
RFHP	Rwanda Family Health Project
RHMIS	Routine Health Management Information System
SARA	Service Availability and Readiness Assessment
SIScom	Community Health Information System
SMM	Senior Management Meeting
SOP	Standard Operating Procedure
SPH	School of Public Health
TB	Tuberculosis
TOR	Terms Of Reference
TOT	Training Of Trainers
TracNet	A data entry, storage, access, and sharing system created in 2005 by the Treatment and Research AIDS Center (TRAC)
TWG	Technical Working Group
USAID	United States Agency for International Development
WISN	Workload Indicators for Staffing Needs
WHO	World Health Organization

EXECUTIVE SUMMARY

In this reporting quarter (July – September, 2013), the Integrated Health Systems Strengthening Project (IHSSP) continued the work of strengthening health systems across the five health components: health information, health financing, quality improvement (QI), human resources for health (HRH), and decentralization.

The health information component activities focused on continued support for use of Routine Health Management Information System (RH MIS) data, by targeting the central level planning directorate and select program officers, as well as peripheral programs managers (data managers at Health Centers (HCs), District Hospitals (DHs), and Community Health Worker (CHW) supervisors). The team also worked on: finalization of the 2012 annual health statistics booklet; development of a patient tracking module for multi-drug resistant tuberculosis (MDR-TB); technical assistance for interoperability between DHIS-2 instances and other systems (TracNet, iHRIS, Health Facility Registry); completion of data recording and reporting guidelines; and completion of the move of the HMIS servers to the national data center. As part of cross-cutting support, the team assisted with the field testing of the accreditation checklist/Performance-based financing (PBF) assessment using LimeSurvey and a tablet computer.

The health financing component focused on revising performance measurement and processes for PBF, and subsequently drafting a concept note which describes the process of PBF integration with accreditation. There was a review of PBF budgets for all hospitals based on available resources for the fiscal year. Other highlights of the year include: continuing Community Based Health Insurance (CBHI) studies, which highlight the access, equity, and efficiency of the CBHI system; participating in the East, Central, and Southern Africa Health (ECSA) conference on strengthening the responses to emerging health concerns in the region; supporting the process of institutionalizing the data quality assessment for community data collected through the PBF mechanism; technical support for validation of data using the Financial Management Tool (FMT); and development of CBHI annual report.

In quality improvement, IHSSP supported the development of a measurement framework for patient safety goals, which will help measure implementation these goals, patient quality, and progress towards meeting standards. In order to have a common understanding of Rwanda

essential hospital accreditation standards, workshops were implemented for teams that came from different partners (BTC, RFHP, new team of facilitators, and five provincial hospitals). Other activities supported by IHSSP include facilitation of provincial hospitals with regard to standards implementation backed by teams of external facilitators at hospitals (Ruhango, Ruhengeri, Rwamagana, Kibungo, and Bushenge) to draft a number of procedures; and participation in the patient safety workshop at Harare.

In human resources for health (HRH), IHSSP supported the finalization and validation of the Continuous Professional Development (CPD) strategic plan for the National Council of Nurses and Midwives (NCNM); development and validation of the strategic plan for the pharmacist's council; development and validation of an integrated CPD policy for health professional councils; and facilitated the development and approval of Workload Indicators for Staffing Needs (WISN) implementation plan and the terms of reference (TOR) for the WISN technical facilitators and core team.

In the decentralization component, IHSSP conducted an assessment of the DHMTs roles, responsibilities, and functions to identify the capacity gaps in the districts of Musanze and Nyamasheke and organized feedback workshops with the same districts to discuss and explain the assessment findings. Capacity needs assessment of Civil Society Organizations (CSOs) continued this quarter with identification of the CSOs to be included in the study.

The Project organized a workshop with MOH counterparts to share the draft work plan, finalize it, and achieve a consensus on the remaining activities before the project ends. IHSSP also developed the sustainability/transition plan that will be implemented in the project final year and serve as a tool for use by the MOH, USAID and IHSSP to help ensure that the necessary skills and capacity for health systems strengthening are effectively transferred to the MOH, and that the project has contributed to agreed results in each area.

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 result 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 quarter (July – September, 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

Development of the annual health statistics booklet for 2012

The MOH and HSSP HMIS teams completed the editing of the annual health statistics booklet; this was sent to RHCC for final formatting and printing. This booklet shows key statistics in the health sector from 2012 in a concise, easily accessible manner to ensure that valuable data is readily available to all interested parties. Comparisons with data from 2010 will help users to understand the evolving health situation in Rwanda.

Data have been extracted from a variety of sources including the Rwanda District Health System Strengthening Tool (DHSST), the Health Management Information System (HMIS), TracNet, PBF databases for clinical services, the Community Health Worker Information system (SIScom), the Community-based Health Insurance (CBHI) Indicator Database, and several surveys.

Design of an annual health facility resource/infrastructure report

Inspired by the World Health Organization (WHO)-designed Service Availability and Readiness Assessment (SARA) questionnaire and the fact that the District Health System Strengthening Tool (DHSST) is no longer functional or providing infrastructure reports, IHSSP worked with the MOH/HMIS team to develop an annual Resource/Infrastructure report. The objective is to

generate reliable and regular information on: service delivery (such as the availability of key human and infrastructure resources); the availability of basic equipment, basic amenities, essential medicines, and diagnostic capacities; and on the readiness of health facilities to provide basic health-care interventions relating to family planning, child health services, basic and comprehensive emergency obstetric care, HIV, TB, and malaria.

Health facility registry

IHSSP worked with the MOH to develop a plan to move forward with the development and definition of health facility profiles, to link the facility registry with the RHMIS (DHIS-2). This included helping the MOH make decisions about the types of health facility characteristics that will be included in the system and captured through the health facility infrastructure survey.

HMIS recording and reporting manual

IHSSP staff worked with Futures Group consultants to finalize the assessment of missing registers and reporting formats. The report that contains this information should be ready for publication by next quarter.

Finalization of the work-plan with Futures Group subcontractors

A Futures Group consultant provided a week of short-term technical assistance to recruit a local consultant to help design a district data management assessment tool and to prepare a detailed activity plan to support HMIS initiatives through the end of IHSSP. The assessment tool was pre-tested and the assessment should be completed by next quarter to provide input into the development of the “District Data Management Standard Operating Procedure (SOP)”. The goal is to enable district level managers to better use the array of data available to them to make programmatic decisions.

Capacity building

- **District hospital and health center data managers:** The HMIS team completed a series of training sessions to familiarize district and health center data managers in using the new analysis tools of RHMIS (pivot tables, enhanced charts and maps). IHSSP staff worked with the MOH/HMIS team to design the training curriculum and helped facilitate each of

the sessions through which more than 500 staff have been trained. The Centers for Disease Control and Prevention – Cooperative Agreement (CDC-COAG), Belgian Technical Cooperation (BTC), and the Family Health Project funded training costs.

- **DHIS system administrators:** IHSSP contracted an HISP consultant who spent two weeks with the MOH/HMIS team, supporting them, to prepare for and complete the move of the DHIS-2 servers to the National Data Center (NDC) and building their capacity on systems administration tasks.
- **Central level planning directorate staff and MOH/RBC program managers:** IHSSP staff supported the MOH to design and facilitate a three-day training session for 20 senior managers on using RHMIS analysis and reporting tools.
- **Roll out of HIV Peer Educator data entry system to CSOs and district implementing partners:** IHSSP assisted the Rwanda Biomedical Center (RBC) team, to complete the roll-out of the Peer Educator data entry system designed in the DHIS-2 platform. The system records HIV support activities that implementing partners carry out in the districts.
- **Orientation for the Nursing Council IT manager:** IHSSP staff provided orientation to the newly recruited IT manager for the council website management, and introduced her to the iHRIS Qualify module that associates training and continuous professional development with individual records for eventual use in regulation.
- **National Income Categorization Database administration:** IHSSP staff provided training on the National Income Categorization Database (NICD) to the system administrator and database manager its first phase. Many government programs, including the Community Based Health Insurance (CBHI), now use the NICD to determine the premiums paid by members.

1.2. Strengthen HMIS to provide reliable and timely data

Implementation of new functionality on the DHIS-2 platform

IHSSP continued the implementation of the new functionality in the DHIS-2 platform:

- Executed migration of the Minister’s daily flash reporting module in the DHIS-2 (migrated from a PHP/MySQL platform developed by IHSSP in 2009).
- Created new iReports that automate community PBF payment invoices and to list health facilities.

- Prepared detailed functional requirements document and issued a request for proposal for a company to build a PBF data management module for the DHIS-2. This will be used for migration of the remaining PBF modules to the DHIS-2 before the end of IHSSP; this is an important part of the project’s sustainability strategy.
- IHSSP provided support to plan and facilitate a weeklong workshop to help the RBC TB division design a patient tracking system for MDR-TB patients. The system has now been implemented in the DHIS-2 individual records instance.
- The Project worked with the CBHI team to finalize the data entry system for weekly and monthly CBHI section reports—a precursor to implementing the web-based FMT.

Terms of reference for local private company to support eHealth systems

At the request of USAID, IHSSP completed the TOR and initial cost estimates, for a local company that could in the future provide system and user support to the MOH for eHealth systems including DHIS-2, iHRIS, and OpenMRS. This will address the reality that the MOH cannot internally maintain the human resources or technical capacity to cover the range of support required—in most cases on a very partial time basis.

1.3. Cross-cutting support

Enhancement of CBHI Mutuelle/CBHI membership database

The IHSSP/HMIS team met with the technical committee to provide oversight to JEMBI health systems, the organization that develops the web and mobile phone based CBHI membership system. The web version is now complete and accepted by the MOH. The launch of the mobile phone payment option is on pause until the MOH completes arrangements with MTN (mobile carrier) and the banks.

Field testing of LimeSurvey accreditation/PBF assessment

The HMIS team provided support for field testing of the LimeSurvey software on an android tablet computer, during a recent round of baseline accreditation assessments in provincial hospitals. The use of the LimeSurvey tool on portable tablets will facilitate data collection and immediate feedback to facilities on quality gaps. The LimeSurvey program feeds easily into a longitudinal database of accreditation scores for monitoring and evaluation.

While the tablet worked very well for entering responses to closed-ended (multiple choice) questions, it proved less convenient for writing open-ended responses. Further reflection and discussion as to the long-term usefulness of the tablet for data collection will continue in the coming quarter.

Technical assistance to MOH M&E unit

IHSSP provided technical support for:

- Presentation of SARA concept at the MOH general senior management meeting (SMM); worked with HMIS staff to incorporate elements of SARA's service availability module into the DHIS-2.
- Meeting with Miguel Piexoto from WHO Regional Office for Africa (AFRO) office, to update plans for the Rwanda health information portal. This will be linked to the data warehouse that has been created using the DHIS-2 platform.

Success story/technical paper writing

IHSSP staff co-authored two abstracts for submission at the Young African Statisticians Conference, scheduled to take place in Rwanda next year. The first is on Neonatal and Child Death audits and the second is on a Partners in Health data quality assessment of the Rwanda HMIS.

1.4. Challenges/constraints and next steps

Challenges/Constraints

Lack of counterparts at MOH unit

The HMIS coordinator, biostatistician, and eHealth coordinator positions remain vacant for 1.5 year, 8 months and 2 months respectively. After failing to select a qualified candidate as HMIS coordinator last quarter, the Minister re-launched the recruitment process again. A new acting Information and Communication Technology (ICT) director, Edith Munyana, has been named and the HMIS team is aiding her in getting up to speed on various tasks including: the MOH network management, familiarity with the suite of HMIS applications and oversight of the Ministry's web applications.

Too much simultaneous training

The HMIS teams (from both IHSSP and MOH) facilitated multiple HMIS related training activities across the country in this quarter. This heavy emphasis on training may have been partly due to pressure to spend remaining funds before the end of the USAID/FHP fiscal year and the departments receiving CDC-COAG funding. As a result, in order to train 500 individuals, training sessions were organized with upwards of 100 participants at a time and all HMIS staff in the field for over a month. Though participant evaluations indicated satisfaction with the training conducted, these large numbers did not favor a quality learning experience—especially for hands on training using computers. We should work with the HMIS team and stakeholders to develop a training plan that continues throughout the year so that other HMIS implementation tasks and functions are not delayed.

Lessons learned

The capacity building sessions for central level planning staff proved to be an excellent opportunity to develop skills of some of the Ministry’s key data consumers. Most key staff attended the Huye workshop during the entire three days and are able to use the RHMIS to answer many of their own questions without having to rely on HMIS staff. There is a need to continue focusing on these strategic data users at the central level (RBC and health program managers) and in the districts (Chargé de Santé, Vice Mayors). Upon the return of staff after training, the SMM discussed the workshop and the Minister prepared a list of senior staff that will be given usernames and passwords.

Next steps and plans for next quarter

In the coming quarter, IHSSP is planning to complete the following activities:

- Support the health financing team to establish a comprehensive training plan with JEMBI for the rollout of the CBHI membership management system.
- Assist the Ministry to publish and disseminate the 2012 annual health statistics booklet.
- Work with the Ministry and WHO to complete the implementation of the prototype national health observatory (web portal for national and district health profiles).
- Continue to assist RBC and MOH units to migrate their data collection systems to the DHIS-2 platform, in particular, the migration of malaria surveillance system and HIV division’s TracNet/CNLSNet systems to DHIS-2.

- Complete tasks related to automating the synchronization of DHIS-2 organization units with the health facility registry, import of TracNet and iHRIS data, and integrating selected data elements of the converted HMIS data from the old GESIS into the data warehouse/dashboard.
- 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.
- Send the HMIS recording and reporting manual for final layout and publishing.
- Begin work on the HMIS data use guideline with HISP consultant (Arthur Heywood).
- Conduct training in SQL queries and DHIS-2 reporting and design of web portal. We plan to identify a strong iReport trainer from the HISP network to assist with this activity.
- Develop HTML report or dashboard and complete metadata dictionary for all HSSP III indicators.
- Begin work on integrating the malaria active surveillance system and FMT into the RHMIS (DHIS-2), with support from University of Oslo health informatics interns.
- Continue to liaise with IntraHealth to develop interoperability between 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. PBF approach to support the accreditation program

Performance-based financing (PBF) is well established in Rwanda and MSH has been at the forefront of its introduction and ongoing improvement since 2006. PBF seeks to improve quality and coverage of services by tracking carefully selected indicators through facility-based assessments and financially incentivizing achievement of appropriate targets.

Rwanda has now opted for the establishment of a health facilities accreditation system and IHSSP/MSH is working with the MOH in this effort. Accreditation will ensure the quality of health services by measuring it, through facility-based assessments, against an internationally

recognized set of quality standards. Recognizing the clear intersection between the PBF and the accreditation approaches (i.e. measuring performance against pre-determined indicators or standards), the Rwandan MOH's adopted vision is to integrate the PBF strategy with the accreditation program, in a manner that rewards sustained improvement and high performance. The process will require the harmonization of the assessment tools and performance measures (standards). It is anticipated that the addition of the PBF approach will accelerate the compliance with accreditation standards.

During this quarter, IHSSP supported the MOH in drafting a concept note that describes the process of PBF integration with accreditation, including the objectives, assessment tool, and the process of assessment that will be used.

2.2. Capacity transfer on PBF budget forecasting

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

2.3. CBHI studies (Rockefeller Foundation funded)

In the process of conducting CBHI studies through a sub-grant agreement with the National University of Rwanda - School of Public Health (NUR-SPH), secondary data analyses have been completed and a report has been drafted highlighting the access, equity, and efficiency of the CBHI system. This report is currently being reviewed and edited. The second phase of this process involves data collection at the household level to understand the effects of the CBHI premium changes that were not detected in secondary data sources. The data collection has been completed and NURSPH is leading efforts to finish entering the data in software, which will be used for the analysis. IHSSP will work with the SPH to perform analyses and compare results of this data in eight districts with the analogous secondary data from other sources. These findings will be made available at the end of December.

A list of key stakeholders and informants involved in the design and implementation of the CBHI program has also been drafted. These individuals will be interviewed to understand and learn about their experiences in implementing a successful community-based insurance program in Rwanda. The findings will be available at the end of December 2013.

2.4. ECSA conference on strengthening the responses to emerging health concerns in the region

The East, Central, and Southern Africa Health (ECSA) community secretariat hosted a regional annual scientific conference on best practices in health. The conference is referred to as the “Best Practices Forum”. The forum brings together senior officials from ministries of health, health experts, health researchers, and heads of health training institutions from member states of the ECSA health community as well as diverse collaborating partners in the region and beyond. Overall, the aim is identifying key policy issues and making recommendations to strengthen responses to emerging and re-emerging health concerns in the ECSA region.

The IHSSP CBHI technical advisor and the MOH health financing staff were invited to the conference following acceptance of an abstract titled “Extending access to non-communicable diseases healthcare in Rwanda through the community based health insurance”.

The objectives of the forum were: 1) provide a platform for participants to review approaches to improving the quality, efficiency and effectiveness of healthcare services; 2) review progress in scaling up best practices in healthcare in the region; 3) share experiences on strengthening leadership and management in the health sector; and 4) review progress towards achieving the millennium development goals and other regional commitments.

The Rwanda delegation presented the study to the ECSA Directors’ Joint Consultative Committee. The following recommendations were generated as a result:

- The ECSA member states should diversify mechanisms to increase internal health funds
- The Donors in the ECSA region must follow the Paris declaration on aid effectiveness (February 2005).

The aim of these recommendations is to let the states take the lead in their planning and this will allow a better integration of non-communicable diseases within health service delivery packages at primary, secondary, and tertiary levels.

2.5. Institutionalization of community and CBHI data quality assessment

The project supported the process of institutionalizing the Data Quality Assessment (DQA) for community data collected through the PBF mechanism. This institutionalization will provide tools to the decentralized level that can help maintain good quality that supports decision-making across the system, and builds good performance of CHW cooperatives through the PBF scheme.

Data management at decentralized community level has been a challenge and major discrepancies were noted during the performance-based assessment conducted for CHW cooperatives. The MOH/CHD is committed to institutionalizing the DQA and linking it to PBF payments to cooperatives. The DQA will be organized and conducted at the district level where each CHW cooperative in the catchment area of the district will be assessed at least once per quarter.

The community health data quality assessment is designed to help CBHI and community health programs to:

- Verify the quality of reported health data for key indicators and verify the factors that contribute to the quality of data at each step of the data collection and reporting process.
- Ensure quality of data received and distinguish between good and poor quality data.
- Identify data quality gaps that will help in supporting community and CBHI actors to improve quality of data collected.
- Assess the ability of data-management systems concerning data collection, management, and quality of reported data.
- Identify the strategies to improve data collection system and provide practical feedback on how to improve the quality of reported data.

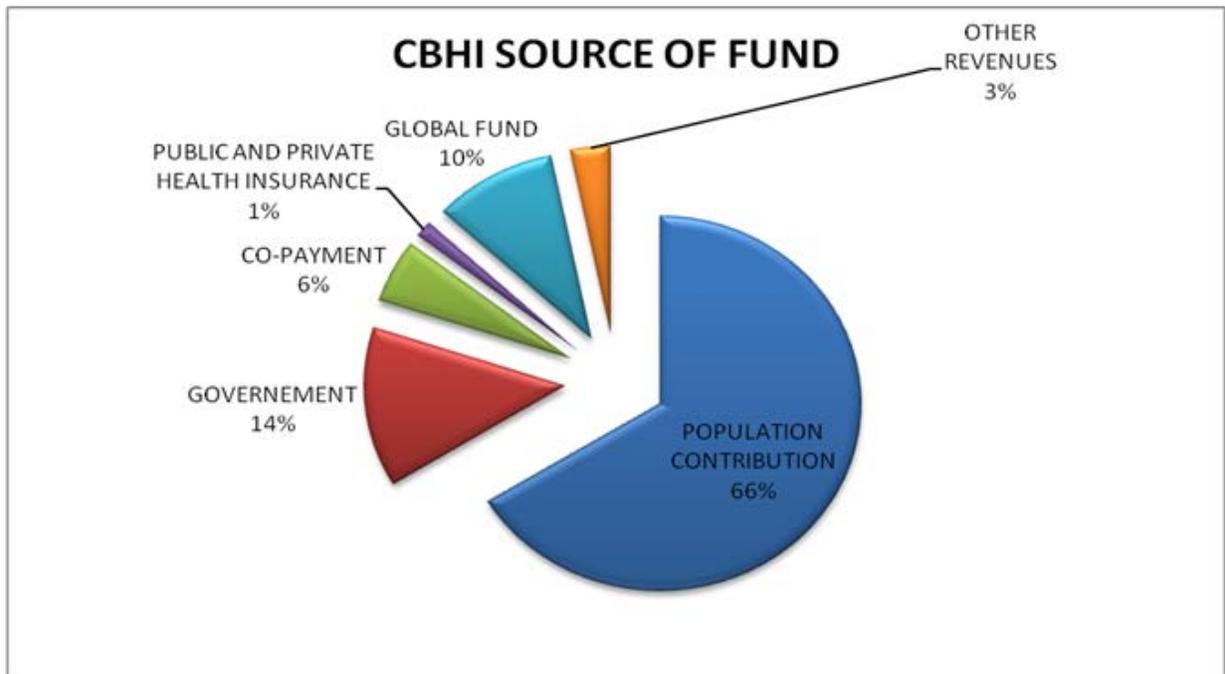
The institutionalization of this process started by developing the community data quality manual; IHSSP then followed with the development of the community health data quality assessment tool, which will provide a quantitative comparison of recounted to reported data, and a review of

the accuracy, completeness, reliability, precision, and integrity. A field test of the tool was conducted and the final version has been officially adopted for future use. IHSSP supported the development of training curriculum for transferring CBHI DQA capacity to national trainers.

2.6. Data validation process using the FMT and CBHI annual report development

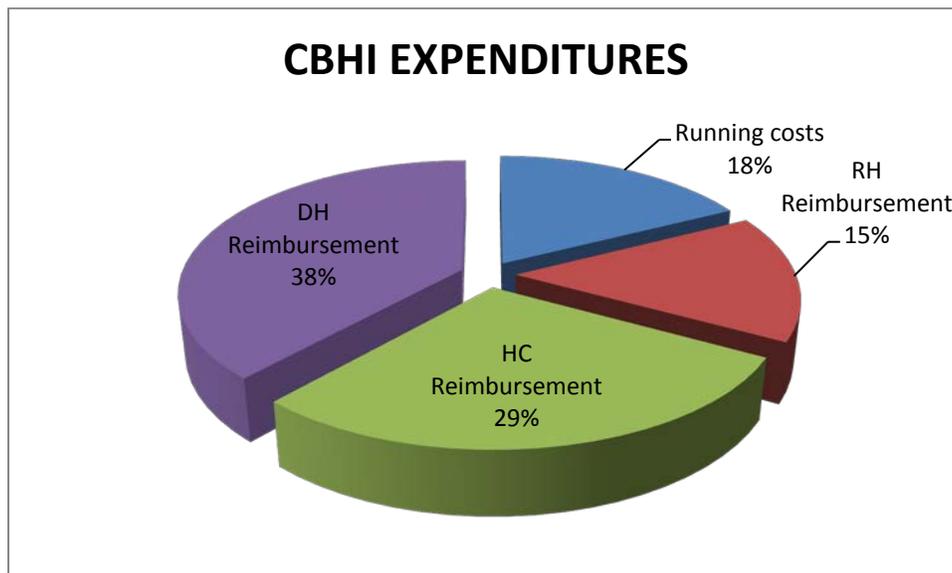
The new CBHI policy has completed its second year of implementation, which ended on 30 June. In order to produce the second year report of the new policy implementation, IHSSP reinforced the process of validating the CBHI financial data. This process was conducted using the FMT in order to ensure the accuracy of data collected throughout the year. Based on the corrected data, the CBHI financial annual report 2013 was produced. Here are some figures on the second CBHI year using the new policy:

Figure 1: CBHI sources of funding



The main source of funds to the CBHI is the premium contribution collected from the population (percent of total funding). The 14 percent contribution from government covers the contributions for indigent members, the payment of referral hospital bills, and the remaining support to cover costs of running CBHI.

Figure 2: CBHI expenditures



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

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

3.1. Development of patient quality and safety framework

Making healthcare safe for both patients and staff is an essential first step in assuring quality of care. For this reason, IHSSP supports the development of national patient safety goals as an initial phase of the accreditation program. This quarter the project developed a measurement framework for patient safety goals. This will help to measure implementation of patient quality and safety goals, and progress towards meeting standards.

The measurement framework for patient safety goals are organized according to three key selected goals and standards that comprise each goal. There is a list of required policies and procedures that will assist the team to prepare for the assessment. Given the contribution of patient safety to improving quality of care in the health system, Rwanda has integrated safe care standards and quality standards in the hospital essential accreditation standards.

Challenges and next steps

Since patient safety goals are tied to the existing PBF incentives, the implementation awaits the review of the PBF framework and indicators.

In the coming quarter, the project will facilitate the development of required policies and procedures to support implementation of national patient safety goals.

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

The training workshop was organized and conducted for teams from different partners (BTC, RFHP, new team of facilitators, and five hospitals). Fifty-five participants attended the workshop

from different institutions. The workshop aimed at developing a common understanding and interpretation of Rwanda's essential hospital accreditation standards, as those different MOH partners will be supporting the implementation of standards in hospitals in their catchment areas.

The integration of existing PBF incentives and the accreditation process was explained to the participants, with the purpose of effectively supporting quality improvement of healthcare services and patient safety delivered through the implementation of evidence-based standards.

The objectives for the integration of PBF and accreditation are to:

- Decrease duplication of effort.
- Support the accreditation system using the existing incentives to improve quality.
- Enhance PBF quality assessment for hospitals by using accreditation quality standards.
- Increase the effectiveness and efficiency of health systems.

Challenges and next steps

There is a need for continued technical support for the accreditation teams to ensure capacity of facilitators in supporting hospitals in standard implementation. The teams have been given the tasks to start drafting missing procedures as called for by standards at their facilities, and to share drafts with the facilitators for final inputs and validation of standards. Follow up and work with the health financing department teams is the next step of the PBF-accreditation integration process.

3.3. Facilitation of provincial hospitals with regard to standards implementation

The teams of external facilitators supported the following hospitals: Ruhango, Ruhengeri, Rwamagana, Kibungo, and Bushenge to draft the following procedures:

Table 1: List of procedures developed in hospitals

No	Procedures	Action done	Hospital
1	Contents of personnel file procedure	Reviewed to be aligned with standards	Rwamagana
2	Staff orientation procedure	Reviewed to be aligned with standards	Ruhango
3	Student Training procedure	Reviewed to be aligned with standards	Ruhango
4	Patient Admission in Ruhengeri Hospital procedure	Reviewed to be aligned with standards	Ruhengeri
5	Code of conduct policy and procedure	Reviewed to be aligned with standards	Ruhengeri
6	External Referral/transfer information Management	Reviewed to be aligned with standards	Ruhengeri
7	Billing procedure	Reviewed to be aligned with standards	Bushenge
8	Budgeting process and approval procedure	New procedure developed	Bushenge
9	Hand washing guidelines	New procedure developed	Rwamagana
10	Client flow analysis and use the data to decrease wait time and increase staff efficiency (policy and procedure)	New procedure developed	Rwamagana
11	Incident reporting	Reviewed to be aligned with standards	Rwamagana
12	Root cause analysis and action plan framework	New procedure developed	Rwamagana
13	List of Essential medicines and supplies	New procedure developed	Kibungo
14	Review of informed consent form and translated in Kinyarwanda	Reviewed to be aligned with standards	Kibungo
15	Review TOR of different committees, adapt them to their context	Reviewed and aligned to standards	Kibungo

3.4. Patient safety workshop at Harare

The WHO regional office organized a Patient Safety workshop in Harare, Zimbabwe. The IHSSP Senior QI advisor attended the workshop from September 9th-13, 2013. The knowledge

and skills acquired from the workshop will help the QI team to technically support MOH and facility teams in addressing patient and staff safety issues in the process of quality improvement, raise awareness on patient safety to health professionals and contribute to the development of a strategy for improving patient safety in Rwanda.

A trip report to both IHSSP project management and the Director General of Clinical Services, will advocate for the establishment of patient safety committees. This will occur concurrently as subcommittees of quality improvement at the facility level, in those hospitals, are pursuing accreditation. The lesson learned is that a multidisciplinary approach is necessary to address patient safety issues within framework of strengthening the health-care system.

3.5. Challenges and next steps

There is a lack of data at the hospital level and this is restraining the development of evidence-based strategies and relevant, effective solutions for improving patient safety and quality of care. Health systems need to be reoriented to make patient safety an integral part of quality care improvement activities, but not a parallel program, as the two are not separable. As a health priority, next steps will include advocacy for mobilization of additional resources for investment in patient safety.

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

4.1 Finalization and validation of the CPD strategic plan for the NCNM

As a continued support to the National Council of Nurses and Midwives (NCNM), IHSSP supported the validation of the CPD strategic plan for the professionals. Guided by this strategic plan, the council members will be able to update their professional skills and provide standard quality of care to their clients. Professionals are expected to have regular self- learning mixed with organized professional trainings, to update their skills and keep informed about standard clinical practices.

4.2. Development and validation of Pharmacists Council strategic plan

The development of the strategic plan for the pharmacist's council was finalized in this quarter. IHSSP supported the entire development process including the hiring of consultants, organization of work sessions, working with council members to provide inputs into the document, and also supported the final validation workshop of this document. The council is using this plan to mobilize resources from different sources in order to implement its activities.

4.3. Development and validation of an integrated CPD policy for health professionals

This quarter, IHSSP continued to support the development of continuous professional development policy, for health professionals. The health professional councils appointed focal persons to work with IHSSP hired consultants throughout the process.

In the development of this policy, IHSSP supported three working sessions with consultants and focal persons. The focal persons provided inputs to the consultants, mainly to determine the CPD credits/points and self-learning methods that will be used. To finalize this document, IHSSP organized a one-day workshop that brought together all the professional councils and validated their policy, which is now in use.

The integrated CPD policy provides an opportunity for professionals to have the same treatment towards earning CPD credits when they do joint CPD activities and it is in the best interest of the professional councils to ensure that their members provide quality services.

4.4. Presentation and approval of WISN implementation plan

The WISN implementation plan, developed last quarter, was presented to the technical facilitators and the steering committee for approval. After review and editing, the WISN steering committee approved the plan. The MOH team and partners are now using this plan to implement WISN activities.

4.5. Review and approval of WISN TORs

The WISN steering committee approved the TOR developed for the WISN technical facilitators and the WISN core team. The steering committee will prepare the letters of appointment to the members who have been nominated as the core team members. This core team is expected to

coordinate all the WISN activities in collaboration with HR department in the MOH and the accreditation steering committee.

4.6 Challenges/constraints, and next steps

Challenges/constraints and recommendations

These are challenges faced in the implementation of HRH programs:

- High turnover and attrition of MOH counterpart staff hinder continuity and capacity transfer.
- Lack of financial resources by the health professional councils, which make them, depend on the Ministry's support and decisions. This puts them at a risk of working for the MOH instead of complementing each other in decisions.
- Lack of prioritization, which leads to delays in implementing some key activities like the WISN activity standards development.
- Shortage of staff by the health professional councils, which has resulted in dependency on the employees of the health facilities to provide inputs in the process of documents development and finalization by the consultants.
- The MOH team always has conflicting agenda and this has resulted in postponing important meetings where decisions could be made moving forward.

Next steps:

- Development of WISN activity standards.
- Implementation of WISN activities in five provincial hospitals.
- Supporting the professional councils to develop business plans.
- Development of allied health council's strategic plan.

V. EXTENDED DECENTRALIZATION OF HEALTH AND SOCIAL SERVICES

5.1. Assessment of the District Health Management Teams (DHMTs)

Following the development of the DHMTs assessment questionnaire last quarter, which was reviewed and agreed upon by the MOH, this quarter the questionnaire was used to assess the capacity gaps of DHMTs roles, responsibilities, and functions in the districts of Musanze and Nyamasheke.

During the assessment exercises, group discussions and individual meetings were organized to obtain all the necessary information about DHMTs. The information was compiled and analyzed with a subsequent report produced on the findings.

The completed DHMT assessment findings report was followed by a two-day workshop organized with each of the assessed teams and findings communicated and discussed. This provided an opportunity for the DHMTs to understand the DHMT guidelines that have been provided by the MOH to the decentralized levels to guide their routine operations in the district. The teams also were able to understand their operational and capacity gaps and based on those gaps, they developed their annual action plans.

It is very clear that in the districts the DHMTs did not understand their roles and responsibilities in managing the health issues as described in the DHMT guide. At the end of the feedback meeting everybody was able to understand his/her roles in the districts' health affairs as defined in the guide. The program of capacity building for the DHMTs that IHSSP will strengthen. This year's activities will reinforce or otherwise continue to close the gap.

5.2. CSOs capacity needs assessment

IHSSP continues the process of supporting the assessment of CSOs. During this quarter, IHSSP engaged a consulting firm to carry out the capacity needs assessment of the CSOs. The firm completed the development of an inception note, an activity timetable, and the selection process of the CSOs that will participate in the study. The exercise will be completed in the next quarter.

5.3. Challenges/constraints and next steps:

The MOH and the Ministry of Local Government (MINALOC) have mandated the district levels to take charge and govern decentralized services. It will be up to the district authorities' initiatives to exercise the given powers. The district health management teams are largely unprepared for this and will need strong support to cope up with roles of governing and regulating the health services. Challenges include:

- A significant delay in the implementation of decentralization activities because the MOH and MINALOC delayed to establish a memorandum of understanding (MOU). This process took a much longer time than expected thereby causing significant delay of activities implementation.

- Hospitals designated as provincial hospitals have not yet received any official document upgrading them to the level of provincial hospital. This causes the district authorities to delay in making strategic moves to support the operations of those provincial hospitals.

Next steps:

- Finalize the CSOs institutional capacity assessment.
- Support the DHMTs to implement their action plans.

VI. CROSS-CUTTING AND MANAGEMENT TASKS

6.1. Final year work planning workshop

With one year remaining before the end of the project, discussing and sharing the final year work plan with the IHSSP's main partners was crucial. Therefore, this was through a workshop, which aimed to share, finalize, and achieve consensus on the remaining activities. Both the IHSSP and MOH management and technical teams were together and departmental planning sessions have been held. This workshop resulted on the agreed draft work plan, which has been submitted to the USAID for approval before proceeding to implementation.

6.2. Development of transition/sustainability plan

IHSSP developed the transition plan that will be implemented in the final year of the project. The plan primarily serves as a tool for use by the MOH, USAID, and IHSSP to help ensure that the necessary skills and capacity for health systems strengthening have been effectively transferred to the MOH, and that the project has contributed agreed results in each area. The draft of this plan has been completed, awaiting finalization and approval. This plan will be regularly discussed and continuously updated, with the following expectations:

- Common agreement on expectations for results, roles, and responsibilities in the final year.
- Establishing a point of departure for post-IHSSP planning by MOH and donors.
- Identification and mobilization of MOH units and staff for taking on increased ownership and responsibility in areas supported by the project.
- Heightened and collective focus on key tasks and progress towards results.
- Agreed support for a phased reduction of 'hands-on' technical support by project experts in favor of a model of greater mentoring and back-up support.

Annex 1: IHSSP results framework

