

USAID | IHSSP Quarterly Progress Report

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Rwanda Integrated Health Systems Strengthening Project (IHSSP)

Quarterly Project Report – Narrative

(April – June, 2014)

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ACRONYMS

CBHI	community-based health insurance
CHWs	community health workers
C-PBF	community performance-based financing
DHIS 2	District Health Information System 2
DHMTs	district health management teams
DQA	data quality assessment
DRG	diagnosis-related group
eIDSR	electronic Integrated Disease Surveillance and Response
GIS	geographical information systems
HISP	Health Information System Program
HMIS	health management information system
HRH	human resources for health
ICT	information and communication technology
iHRIS	Integrated Human Resources Information System
IHSSP	Integrated Health Systems Strengthening Project
IPC	infection prevention and control
JCI	Joint Commission International
M&E	monitoring and evaluation
MOH	Ministry of Health
MSH	Management Sciences for Health
PBF	performance-based financing
QI	quality improvement
RBC	Rwanda Biomedical Center
R-HIS	Routine Health Information Systems
RSSB	Rwanda Social Security Board
SMS	short message service
SOPs	standard operating procedures
SPH	School of Public Health
TB	tuberculosis
TracNet	A data entry, storage, access, and sharing system created in 2005 by the Treatment and Research AIDS Center (TRAC)
USAID	US Agency for International Development

WHO World Health Organization
WISN Workload Indicators for Staffing Needs

EXECUTIVE SUMMARY

In this reporting quarter (April – June, 2014), the Integrated Health Systems Strengthening Project (IHSSP) continued to strengthen Rwandan health systems across five health components: health management information systems (HMIS), health financing, quality improvement, human resources for health, and decentralization. The activities completed this quarter focused primarily on preparing the transition of IHSSP activities to the Ministry of Health (MOH) as the project prepares for close-out.

The health information component activities focused on: development of HMIS data use guidelines, HMIS Information for Action; development of data management standard operating procedures for district units; representation of Rwanda and IHSSP at international conferences (Montreux and Bujumbura); analysis of data from the health facility information and communication technology infrastructure survey; implementation of the new functionalities on the DHIS 2 platform, including the TracNet/electronic Integrated Disease Surveillance and Response (eIDSR) transition to the DHIS 2 platform; development of a performance-based financing (PBF) module for DHIS 2; and capacity building, including the DHIS 2 Academy held in Rubavu and training of the accreditation/PBF assessment teams to use LimeSurvey on Google Nexus Tablets.

Health financing component activities included: the review of public health facility service tariffs in preparation for the determination of service tariffs based on their real costs; development of the first health financing strategic plan; starting the feasibility study of health facilities self-financing; transition of community-based health insurance (CBHI) systems to the DHIS 2 platform, including the CBHI monitoring and evaluation (M&E) database, the CBHI Financial Modeling Tool, the CBHI Weekly Report Tool, and the CBHI progress report on district hospitals' and health centers' reimbursements; follow up and mentorship on the institutionalization of the Routine Data Quality Assessment (R-DQA) tool in 11 district hospitals; continuation of CBHI studies on the equity of the CBHI system; technical support to ensure a smooth transition of CBHI to the Rwanda Social Security Board (RSSB); and the documentation of specific CBHI best practices and interventions in selected districts.

The quality improvement component activities included: mentorship of Rwandan facilitators on infection prevention and control; mentoring for facility management to ensure safe and secure

environments for clinical services; training for hospital directors and MOH technicians on the key principles of safe health design (i.e., the principles of designing health facilities' physical environments to support safety, quality, and operational effectiveness); revision of hospital accreditation standards to include PBF assessment criteria; revision of the accreditation surveyor and facilitator guides; establishment of the accreditation measurement framework; and trainings on clinical treatment guidelines and use of LimeSurvey.

The human resources for health component finalized the Human Resources for Health Sustainability Plan, which outlines strategies to ensure the Rwandan health system's financial sustainability and reduce its donor dependency. The component also finalized the Allied Health Professionals' strategic plan and the continuous professional development strategic plan for the pharmacists and organized validation workshops for both. The project communicated the results of the Workload Indicators for Staffing Needs (WISN) study to the health facilities.

Under the decentralization component, the project reviewed and updated the Nyamasheke district health work plan for 2014-2015 and provided technical support to conduct a District Health Management Team joint quarterly meeting in Nyamasheke district.

INTRODUCTION

In November 2009, the US Agency for International Development (USAID) launched the five-year Integrated Health Systems Strengthening Project (IHSSP), implemented by Management Sciences for Health (MSH). IHSSP 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 present report presents a summary of IHSSP activities and achievements from April to June, 2014. IHSSP will end on November 1, 2014. The completed activities presented here are among the last project interventions.

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 health management information system (HMIS) data use guidelines**

IHSSP completed essential steps in the development of HMIS data use guidelines, HMIS Information for Action, with the support of the Health Information System Programme (HISP) consultant. The project completed the field work and will finalize the HMIS guidelines next quarter.

➤ **Data management standard operating procedures (SOPs) for district health units**

The project completed the draft SOPs and shared them with the MOH. Following the assessment carried out last quarter on barriers to data use, IHSSP developed the data management SOPs for district units, through the Futures subcontract. The SOPs establish a harmonized framework of data management across the districts and will coordinate the operations of collection, recording, and processing of data. The next steps will be finalization of the SOPs, validation, and dissemination.

➤ **Presentation of Rwanda health management information system (HMIS) experience at international conferences**

The IHSSP Senior HMIS Advisor represented Rwanda and IHSSP at the international conference organized by the World Health Organization (WHO) in Montreux, Switzerland on *Strengthening Routine Health Information Systems (R-HIS)*. He presented the Rwandan experience on interoperability between R-HIS systems, which contributed to the development of a checklist for community health information systems.

IHSSP also presented at the *Results Based Financing Community of Practice* meeting in Bujumbura, Burundi. The presentations included demonstration of the performance-based financing (PBF) module for DHIS 2 and facilitation of a session on the interoperability between health insurance, PBF, and HMIS systems.

➤ **Health facility information and communication technology (ICT) infrastructure survey data analysis**

The IHSSP HMIS team provided technical support to the MOH ICT directorate to analyze data from the health facility ICT infrastructure survey. The results of this analysis were critical for the directorate's report on health infrastructure, and to develop the budget to fill the gaps. One example of information collected, the comparison of the number of desktops and laptops in district hospitals and health centers, is shown in Figure 1.

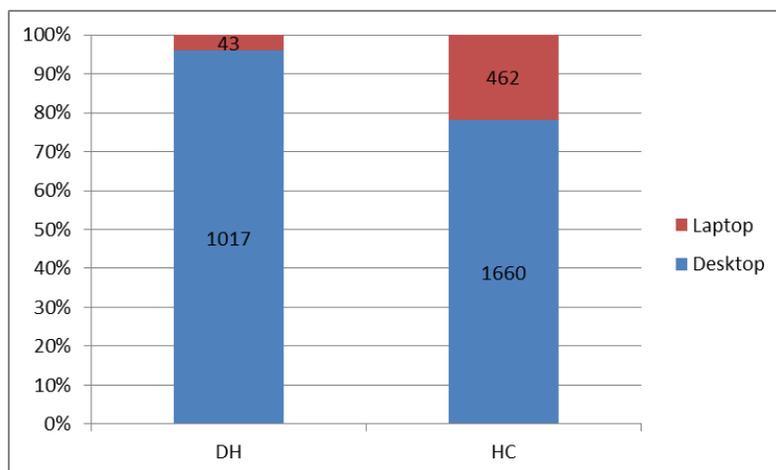


Figure 1: Distribution of computers in health centers (HC) and district hospitals (DH)

➤ Capacity building

- HMIS and Rwanda Biomedical Center (RBC) M&E team:** The IHSSP HMIS team designed and facilitated a three day "mini" DHIS 2 Academy for RBC, MOH, and other USAID implementing partner staff (Family Health Project and Access Project) in Kigali. The workshop provided professionals with the necessary prerequisites to attend the DHIS 2 Advanced Academy in Rubavu.
- DHIS 2 Advanced Academy:** IHSSP co-hosted and facilitated a two-week DHIS 2 Advanced Academy for more than 80 participants from 18 countries: Rwanda, Tanzania, Kenya, Zambia, Uganda, Ethiopia, Namibia, Nigeria, Mozambique, Madagascar, Zimbabwe, Malawi, South Africa, USA, Norway, Switzerland, Spain, Mexico and Guatemala. The workshop strengthened national and regional capacity to successfully set up, design, and maintain the DHIS 2 Software, an open-source and web-enabled tool that allows users to efficiently manage health information for better programming. The workshop took place in Rubavu beginning May 27, 2014 and was the largest DHIS 2 Academy held to date. Fourteen participants from Rwanda attended the Academy, which was organized in partnership with the MOH and the University of Oslo. The Minister of Health opened the session and the University of Oslo sent six technical staff for facilitation. Staff from IHSSP facilitated the sessions on data quality management, disease surveillance, and geographical information systems (GIS).

Figure 2: Photo from the opening session of the DHIS 2 Academy, presented by the Minister of Health



- **HMIS/OpenMRS team:** Two MOH staff members participated in a 10-day course on Ubuntu system administration in India. They manage the growing number of servers for DHIS 2 and OpenMRS that are hosted at the National Data Center.

1.2. Strengthen HMIS to provide reliable and timely data

➤ **Implementation of the new functionalities on the DHIS 2 platform**

- **TracNet module:** The IHSSP team supported the RBC to revise the TracNet monthly reporting forms with new indicators and designed the data entry screens for the new system on the DHIS 2 platform.
- **Disease surveillance:** IHSSP facilitated a session at the DHIS 2 Academy to identify the generic requirements for implementing disease surveillance within the DHIS 2 platform. This information will contribute directly to the University of Oslo's blueprint for future releases of DHIS 2.

➤ **Migration of RBC and MOH data collection systems to the DHIS 2 platform**

- **Electronic Integrated Disease Surveillance and Response (eIDSR):** IHSSP prepared a request for proposal for short term technical assistance to assist the eIDSR team with the development of new eIDSR requirements for the DHIS 2.
- **RBC electronic Tuberculosis (eTB) system:** The project made additional changes to the RBC electronic Tuberculosis (eTB) system based on recommendations provided by WHO consultants and facilitated the training of TB supervisors in its use.

- **Still-birth audit form:** IHSSP provided technical support to the maternal and child health team to design a still-birth audit form to add to the current death audits entered in the DHIS 2.

➤ **Development of the PBF module for DHIS 2**

The IHSSP HMIS team continued monitoring the work of HISP/India to develop a PBF module for DHIS 2. The PBF data are being entered into the system for testing and the project has developed a transition plan for the migration from the PBF system to DHIS 2.

1.3. Cross-cutting support

➤ **Training of the accreditation and PBF assessment teams in LimeSurvey**

IHSSP trained the accreditation and PBF assessment teams to conduct assessments using Google Nexus Tablets. Using the software and collecting the data with the tablets allows for immediate tabulation of the data.

1.4. Challenges/constraints and next steps

➤ **Challenges/constraints**

- The MOH HMIS team is receiving a high volume of requests for data and/or quantified evidence. Many departments have requested support to transition their systems to the DHIS 2 platform simultaneously. The project is supporting the transition of the TracNet, PBF, and eIDSR databases simultaneously, which require development, training, and support.

The Minister is eager for all systems that were supported by Voxiva to be transitioned to DHIS 2 before the end of September 2014, when the US Centers for Disease Control and Prevention grant to Voxiva will end. The Minister is not interested in extending the timeframe, but the HMIS team is overstretched and unlikely to meet the deadline. The HMIS team hopes to avoid a data blackout by setting up the data entry features first, then developing the surveillance algorithms and alerts as a second step.

- Support to RBC health information system activities: The funding from the Bill and Melinda Gates Foundation has been successfully reprogrammed to support the eIDSR transition. However, the RBC has faced challenges in releasing the funds in a timely

manner to support the activities that are due to be completed by September. IHSSP was asked to recruit regional consultants to assist with the eIDSR transition.

- Community health worker (CHW) supply chain system: the community health and eHealth desks have not yet reviewed or accepted the concept paper produced for implementing the CHW supply chain system. With the IHSSP and DELIVER projects ending soon, the project is working to ensure that the ministry has the resources to roll out and support the system running costs, before investing more effort in the prototype.
- Consolidation of mHealth systems: The MOH has faced serious problems in contracting with MTN to set up a virtual private network between MTN and the National Data Center, and in determining how to pay for the mobile phone short codes needed for moving RapidSMS, eIDSR, and CHW supply chain servers to the National Data Center. This process has taken more than five months and the system is not yet functional. In part, this delay is due to multiple project funding streams that make it difficult to suggest consolidating all mHealth systems.

➤ **Lessons Learned**

- The MOH team has realized that it is very useful to engage implementing partners in its training activities, from DHIS 2 Academies to trainings of trainers for rolling out the new RBC systems. Participants from the Family Health Project and Access Project have increased the pool of people available to serve as trainers. The projects have an ongoing presence in the districts and can serve as mentors in health facilities as their staff begins using the systems.

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

In the next quarter, the IHSSP HMIS component will complete the following activities:

- Continue to assist the RBC and MOH in migrating their data collection systems to the DHIS 2 platform;
- Issue a contract to a regional firm to support eIDSR migration;
- Conduct a training of trainers for TracNet migration;
- 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;

- Continue the work on the HMIS data use guidelines with HISP consultants, Arthur Heywood and Jon Rohde;
- Complete the development of the analysis tools for the web-based CBHI Financial Management Tool, which are built on the CBHI quarterly and weekly reporting modules of the DHIS 2 platform that were re-launched last quarter;
- Complete the development of the CHW Logistic Management Information System, based on the DHIS 2 SMS module. This will allow the MOH/Community Health Desk to better manage distribution of essential drugs and supplies to villages;
- Complete the testing and data transfer to the DHIS 2 PBF module developed by HISP/India. Begin the roll-out process so that data are entered from July 2014 onwards;
- Complete the extraction and analysis of data for the health systems strengthening impact evaluation;
- Conduct the second round of the Performance of Routine Health Information Systems (PRISM) assessment; and
- Begin closeout activities for the IHSSP.

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

2.1. Review of public health facilities' service tariffs

The MOH has a list of tariffs on which the reimbursements from the insurance schemes are based. These tariffs have been updated over the years, but do not reflect the true costs of providing those services.

The current tariffs reflect an itemized billing process—with the items reflecting individual inputs (e.g., labor and medicines). In recent years, the MOH has been considering changing payment mechanisms and commissioned a study of diagnosis-related group (DRG) costs. A number of countries are facing similar policy choices as they expand coverage and find that fee-for-service payment can challenge the financial sustainability of their systems and bias service delivery toward high-cost curative services rather than primary care and prevention.

After reviewing the required policy and systems changes needed to implement a reimbursement system based on DRGs, the MOH has decided to continue with an itemized billing system, but will now use more accurate estimates of the costs of items, and perhaps simplify the pricing

system. The MOH thus commissioned IHSSP to undertake a review to estimate the actual costs of the inputs, compare them with the current tariffs, and suggest options for revising the tariffs. The study also included estimates of the financial impact on public health facilities and the CBHI scheme, and could provide additional comments and recommendations on financing.

First, IHSSP reviewed the existing tariff structure and determined the costs that would be relevant. There are, however, no national guidelines on what the existing tariffs represent and there is, reportedly, some confusion at the facility level on how to charge. To match the costs with the tariffs, IHSSP assumed that the tariffs were based only on direct labor (and perhaps indirect facility running costs), since medicines and supplies are billed separately.

IHSSP conducted the costing update for the health center (3), district hospital(2), and referral hospital (1) levels. Due to time constraints, the project did not conduct a separate costing for health posts, but the direct costs can probably be based on relevant health center costs.

The project did not cost laboratory tests during the DRG costing process, as there was not sufficient time during this exercise. Hospital laboratories are complex and costing takes a considerable amount of time and effort. In addition, the exercise did not cost radiology and other imagery services to a sufficient degree of detail. Based on the insurance billing analysis at the health facilities, laboratory services currently generate about 13 percent of health centers' total insurance revenue and about 7 percent of district hospitals' insurance revenue. The project recommends that the MOH conduct a costing exercise and review the tariffs for laboratory, radiology, and other imagery services separately. The ambulance, mortuary, and administrative services were not costed either.

The project developed the Tariff Setting Model to estimate the costs of the most common services and set the tariffs.

In the following table, current tariffs (second column) of medical acts (first column) are compared with actual costs (last column). There are many and important discrepancies.

Table 1: Comparison of current health center tariffs and costs (RWF)

	Tarif B	2014 full costs						
	RSSB,MMI,Mutu elles d'Universites et Institutions Superieures	Drug Cost per Service	Supply cost plus transport costs	Lab Cost per Service	Non-gov Salary Cost per Service	Operating (indirect) Cost per Service	Total cost per service excluding medical supplies	Total cost per service including medical supplies
ACTES MEDICAUX								
I.CONULTATION:20%								
Consultation infirmier(A2+A1)	600	0	-	-	116	365	481	481
Consultation infirmier(A2+A1)/nuit,week end jou	720	0	-	-	139	438	577	577
Consultation CPN (Gratuit)	0	0	260	-	108	341	449	709
Consultation PF (Gratuit)	0	0	-	-	116	366	483	483
Consultation Nutritionnelle (Gratuit)	0	0	-	-	152	478	629	629
II.HOSPITALISATION:+20%								
Hospitalisation salle commune	360	0	-	-	392	1,235	1,626	1,626
Hospitalisation chambre	1,200	0	-	-	1,306	4,116	5,422	5,422
IV.CHIRURGIE +20%								
Injection IM	120	0	755	-	40	128	168	923
Injection IV	180	0	823	-	40	128	168	991
Actes de perfusion	180	0	762	-	40	128	168	930
Pansement simple	600	0	542	-	61	191	252	794
Pansement Complique	1200	0	2,338	-	163	513	676	3,013
Frein lingual	240	0	672	-	30	96	126	798
Seringuage	300	0	2,205	-	109	342	451	2,655
Suture simple	1,200	0	1,948	-	81	255	336	2,284
Suture complique	1,800	0	3,249	-	163	513	676	3,925
Ablation des fils	480	0	860	-	30	96	126	986
Incision d'abcès superficiel	1200	0	1,129	-	90	284	374	1,503
Extraction simple d'un corps étranger	720	0	462	-	121	383	504	966
Extraction d'une dent de lait	600	0	120	-	121	383	504	624
Extraction d'une dent définitive	1,200	0	144	-	121	383	504	648
Obturation provisoire	3,000	0	144	-	202	638	840	984
Obturation définitive	3,600	0	144	-	202	638	840	984
Detartrage	1,800	0	110	-	121	383	504	614
Devitalisation	1,800	0	144	-	121	383	504	648
Reduction de l'ATM	2,400	0	112	-	81	255	336	448
Circoncision Therapeutique	3,000	0	1,614	-	121	383	504	2,118
V.SOINS INFIRMIERS:20%								
Curage	550	0	375	-	40	128	168	543
Insertion DIU (non remboursable)	0	0	81	-	121	383	504	585
Ablation DIU (non remboursable)	0	0	81	-	61	191	252	333
Insertion Norplan (non remboursable)	0	0	81	-	121	383	504	585
Ablation Norplan (non remboursable)	0	0	81	-	121	383	504	585
Curetage	1,320	0	433	-	121	383	504	937
Acc.Apres 4 CPN(Acte)	0	0	1,786	-	845	2,662	3,506	5,293
Acc.eutocique sans episiotomie	1,650	0	1,786	-	845	2,662	3,506	5,293
Acc.eutocique avec episiotomie	2,200	0	3,854	-	845	2,662	3,506	7,360
Acc.Dystocique	2,750	0	2,040	-	845	2,662	3,506	5,546
AMIU (accouchement mort in utero)	600	0	1,628	-	638	2,011	2,650	4,277

2.2. Health financing strategic plan development

After the project finalized the review of the health financing policy in the first quarter 2014, IHSSP continues to support the development of the first health financing strategic plan that will be aligned to the Third Health Sector Strategic Plan. The plan will contribute to the following

areas: (i) economic growth through workforce development; (ii) attracting foreign investments in health and exports of quality health services; and (iii) contribution to poverty reduction through reduction or elimination of catastrophic health expenditures. IHSSP continued to provide its technical expertise to the process via participation of its technical staff in the core team, which was established under the health financing technical working group. A national consultant hired by IHSSP provided overall technical guidance to the core team and drafted several chapters for review by members of the health financing technical working group.

After presenting the draft to the Joint Health Sector Review in June, the project will validate the plan with different stakeholders, including allied ministries (Ministries of Finance and Local Government), before final validation by MOH senior management.

2.3. Health facilities self-financing feasibility study: Inception report development

The Government of Rwanda is currently in the process of fast-tracking financial resource mobilization for health using the Health Tracking Tool. This process will ultimately enable the government to have a clear picture of financial flow in the country. In recent years, the performance of some public health facilities has been a concern and the MOH is considering a model of business-oriented health facility management. This can be achieved if the decentralization process in Rwanda allows the local administrative units to be more autonomous in managing their funds allocated from the central government and donors. The health facilities are currently dependent on the central government for funding.

In this context, the feasibility study of a self-financing system will show how district hospitals and health centers can ensure effective financial management autonomy, as part of the decentralization process.

In this quarter, the IHSSP contracted the Adventist University of Central Africa (AUCA) to conduct a feasibility study of health facilities' self-financing mechanisms, focused on the following key components:

- Conduct a feasibility study among selected district hospitals and health centers in Rwanda about their self-financing mechanisms and clarify their financial dependence on central government and donors;
- Propose a financial model/projection to determine sustainable financing and develop concrete measures to increase health facility self sufficiency;

- Provide a self-financing action plan for health facilities, including options in the case that facilities do not meet financing targets;
 - Analyze and discuss issues in line with the effective implementation of financial management functions; and
 - Ensure that the financial management gaps in health facilities can be overcome through the recommended improvements and optimizations.
- **Next steps:** In this reporting quarter, the AUCA developed an inception report describing how the study and validation will be conducted. The next step will be to organize interviews with stakeholders, including the MOH/Permanent Secretary, MOH/Planning, and MOH/Clinical Service units, the Health Financing Technical Working Group, and the RBC/Business Unit.

2.4. Transition of CBHI systems to the DHIS 2 platform

In March 2014, IHSSP trained the CBHI district directors in Musanze on how to report CBHI data in DHIS 2. Previously, the CBHI sections reporting to the districts with paper based forms and the district CBHI offices entered the data into the CBHI M&E database. With the new reporting capability, the system allows CBHI sections to report directly into DHIS 2. The DHIS 2 was customized to combine reports from the CBHI M&E database, the CBHI Financial Modeling Tool, the CBHI Weekly Report Tool, and CBHI progress on the health facilities' (district hospitals and health centers) reimbursements.

The majority of the CBHI sections have computers, printers, cell phones and internet access: 88 percent of district sections are equipped with computers (laptop or desktop), 97 percent have sufficient energy (electricity or solar energy), and 59 percent of the CBHI sections have internet facilities (modem, optical fiber, or landline). Thus, web-based reporting is possible in most districts and offers an opportunity to reinforce decentralization.

Table 2: IT infrastructure in CBHI sections

Indicators	Have Computers	Have Printers	Have Electricity	Have Internet
Average number of sections per district	13.37	9.80	14.83	8.97
% of sections per district	88%	64%	97%	59%

Source: Health Financing Unit

Based on this progress and opportunities in IT, the health financing team conducted mentorship supervision in eight districts (Nyamagabe, Huye, Nyanza, Nyaruguru, Karongi, Kicukiro, Nyabihu and Rubavu) on CBHI DHIS 2 data entry. To maximize the training with concrete data application, each section brought their monthly reports from July 2013 to February 2014. During the training, CBHI sections entered their monthly reports into the DHIS 2. The current status of the South Province's progress (before the end of the fiscal year) is indicated in Table 3.

Table 3: South Province CBHI section monthly reporting (01 July, 2013 to 30 June, 2014)

Name	Actual Reports	Expected Reports	Percentage
Nyamagabe District	173	216	80.1
Kamonyi District	105	144	72.9
Muhanga District	121	180	67.2
Nyanza District	122	192	63.5
Huye District	127	204	62.3
Gisagara District	84	156	53.8
Nyaruguru District	25	192	13
Ruhango District	4	144	2.8
Total	761	1428	53.3

Source: <https://hmis.MOH.gov.rw/healthfinance/dhis-web-reporting/>

- **Next Step:** The next step for the data entry will be to ensure the completeness of data in all districts and assist districts on reporting and projections.

2.5. Follow up on Community Routine Data Quality Assessment (C-RDQA) at the district level

After training community supervisors and data managers at district hospitals in February and March 2014 on Community Routine Data Quality Assessment (C-RDQA), IHSSP follow-up

with the institutionalization of the C-RDQA tool in 11 district hospitals: Nyamata, Kibagabaga, Gicumbi, Masaka, Musanze, Kicukiro, Rwamagana, Muhanga, Kibuye, Kabutare, and Kigeme. The main objective of this activity was to familiarize supervisors and data managers with the C-RDQA tool and build their capacity to train health centers' staff to use the tool. The follow up and mentorship exercise took two days.

➤ **Main data-quality related observations made as a result of the C-RDQA**

- The following registers are missing at the CHW level:
 - Register of under-five children residing in the village;
 - Register of breastfeeding and pregnant women monitored for nutrition; and
 - Register for information, education, and communication (IEC) consultations.
- There is misunderstanding and confusion concerning some indicators.
- Some source documents related to family planning, IEC, voluntary counseling and testing, prevention of mother-to-child transmission, and immunization are missing.
- The data recorded in the registry of maternal health is different from data reported in monthly CHW reports.
- Weight records for children under the age of five exist everywhere, but registers are not updated.

Table 4 presents the assessment findings on completeness and accuracy of data at the village level.

Table 4: C-RDQA completeness and accuracy assessment finding at the community level

District	Completeness (%)	Accuracy (%)
Karongi	99.4	49.6
Nyamagabe (Kigeme)	97.3	58.7
Muhanga	96.7	49.6
Kicukiro	95.6	66.9
Musanze	94.6	67.8
Rwamagana	92	58.8

➤ **Next steps**

- Continue to follow-up on the implementation of C-RDQA at the district level.
- Facilitate the RDQA trainings for health center staff.

2.6. CBHI studies

With funding from the Rockefeller Foundation, and technical support from the IHSSP, MSH is conducting a study to determine if and how the CBHI system has improved access and equity of health care in Rwanda. The study used primary data analysis in addition to secondary data analysis and desk review. As of January 2014, the data collection was complete. All data incorporating the usage of health services (based on *ubudehe* levels) were entered and cleaned. The analysis of the primary data was conducted by the School of Public Health (SPH).

The preliminary results have been presented to the MOH Health Financing Unit staff for their comments. The general comment was that the analysis was well done but there is a need to go deeper and give more details on the findings. The SPH is currently working on this step. Once this is complete, MSH will initiate the validation process and plan a dissemination workshop.

2.7. Transition of CBHI to the Rwanda Social Security Board (RSSB)

IHSSP has provided strong technical assistance to the MOH in moving the CBHI program to the RSSB. After starting a process of defining the scope of work and conducting a search for the right experts, we became aware of RSSB's plans to engage expert consultants for the same purpose. This quarter, IHSSP coordinated and negotiated our contribution with the RSSB, according to their needs. While the transition of CBHI to the RSSB is moving slowly, IHSSP did begin providing technical support to ensure a smooth transition. The main activities conducted this quarter are described below.

➤ CBHI Financial and Bills Audit

The three ministries that are working together to transition the CBHI to the RSSB recommended that the MOH conduct an audit of the CBHI finances and counter verification of hospital bills.

Once the proposed Scope of Work (SoW) has been approved by the MOH, the Health Financing Unit and IHSSP will oversee the counter verification of hospital bills at district level. The project will hold a refresher session on verification procedures on the first day of the exercise. All medical bills will be brought to the CBHI district office with all related documents. The teams from the Health Financing Unit and IHSSP will move from one district to another according to a predetermined schedule. The next step will be to conduct the exercise once the proposed Scope of Work (SoW) has been approved by the MOH.

- Next steps: IHSSP will provide technical assistance to the RSSB to effectively transfer the CBHI to RSSB.

2.9. Documentation of CBHI best practices

During the quarter, the IHSSP hired a local company (FATE consulting Ltd.) to document CBHI best practices. The objective of this consultancy is to document specific best practices and interventions of CBHI in selected districts. The consulting firm will produce a report of best practices that will be shared with health insurance stakeholders, including district CBHI Directors, health sector management, relevant national level institutions and ministries, decision makers, and other actors involved in health insurance implementation. This report will also be summarized into a user-friendly booklet to simplify dissemination of the best practices.

The consulting firm has proposed an approach focused on qualitative data collection and analysis, including a literature review, analysis of relevant documents on CBHI, key informant interviews, focus group discussions, and case study development.

III. IMPROVED QUALITY OF HEALTH SERVICES THROUGH IMPLEMENTATION OF A STANDARDIZED APPROACH TO QUALITY IMPROVEMENT

3.1. Infection prevention and control

IHSSP mentored Rwandan facilitators on compliance with accreditation standards in the Bushenge, Ruhengeri, and Ruhango district hospitals. Goals of the mentoring included:

- Building the capacity of central level and facility teams on infection prevention and control (IPC);
- Enabling facility teams to identify risks related to IPC;
- Developing policies, procedures, and plans to manage risks; and
- Enabling infection control focal persons to carry out surveillance activities.

During the mentorship, the project developed a sterilization process monitoring form and recommendations for laundry management. IHSSP provided facility-specific reports and recommendations, which will help close infection prevention gaps when implemented.

➤ **Challenges and way forward**

Hospital leadership, IPC committees, and contracting companies need to discuss the current cleaning processes to:

- Evaluate current cleaning products to determine if the disinfection capabilities of the solutions are sufficient;
- Establish correct chemical use (proper amount of chemical to volume of water);
- Obtain written information from the management of the companies contracted to do the cleaning on the cleaning products being used; and
- The IPC Committee, IPC Focal Person, and hospital leadership should consider assuming the responsibility of providing cleaning products.

3.2. Facilitation on facility management

Facility management refers to the safety and security of each hospital's buildings, grounds, equipment, and people. Every day, hospitals provide clinical services to patients and these services must occur in a safe and secure environment. This quarter, IHSSP held site visits to provide basic and fundamental information on:

- Facility management, safety, and security;
- Management of hazardous materials;
- Emergency preparedness;
- Fire safety;
- Management of medical equipment; and
- Management of utility systems.

The site visits revealed that some hospitals had managed to complete a hazard vulnerability analysis of the hospital, finished facilities management plans, and performed a hospital facility inspection/tour that informed the facility management planning. Some of the hospitals also formed a facility management committee.

IHSSP completed hospital facility inspections and provided feedback to each facility on the findings and recommendations concerning compliance with the Rwandan Essential Healthcare Quality and Patient Safety Standards.

Challenges and way forward

The hospital teams do not yet understand the correlation between facility safety and the Rwanda Essential Healthcare Quality and Patient Safety Standards. It will be most important for the trained facilitators to schedule routine visits and communication with the hospitals to ensure that they remain on-track vis-à-vis their action plans.

There seem to be a high number of incinerators that are not functioning in the hospitals. This problem requires the attention of the MOH maintenance department to support the hospitals in proper waste disposal. Each hospital should have an alternative plan for waste management, should their incinerators fail.

3.3. Safe health design training and architecture hospital design review

As the MOH is in the process of building several new hospitals and doing major rehabilitations, IHSSP is supporting the ministry in introducing the concepts of safe health design—the principle of designing health facilities’ physical environments to support safety, quality, and operational effectiveness—to hospital directors and MOH technicians. IHSSP conducted two workshops, facilitated by a consultant from Joint Commission International (JCI), one for 35 hospital directors and another for 10 MOH staff involved in construction and facility management. The workshop participants visited Ruhengeri and Kinyihira hospitals to assess the infrastructures in terms of:

- Flow of patients;
- Flow of medications, supplies, and waste;
- Adequacy of facilities and services within operating theaters and the Central Sterile Processing Department; and
- Adequacy of family/visitor facilities and personal hygiene facilities for patients and staff.

The participants identified challenging design issues and how they could be resolved or improved. They also proposed elements of evidence-based design that could be applied in designing new hospitals in Rwanda, which touched on the following areas:

- Separation of clean and dirty flows/ processes for operating theaters and the Central Sterile Processing Department;
- Medication storage and dispensing processes;
- Hand washing facilities and compliance with hand washing requirements;
- Medical records processes and storage;
- Laundry service: clean/dirty flows, processes, and infrastructure;
- Waste management: clean/dirty flows, processes, location, and infrastructure;
- Provision of nutrition services;
- Housekeeping processes;
- Storage space;

- Way finding/signage;
- Toilet facilities for patients, staff, visitors, and handicapped persons;
- Provision of medical gases, including oxygen;
- Provision for safe storage of patient/family personal possessions; and
- Staff changing areas/lockers.

The consultant reviewed the design plans for the Ruhengeri and Munini hospitals, which are both still in the process of completion. The purpose of this review was not to conduct a comprehensive critique of the hospital plans, but rather to discuss design challenges in reference to hospitals in Rwanda. The consultant offered recommendations for safe health design and construction of new health care facilities and for major rehabilitations to be considered in future.

3.5. Surveyor and facilitator guide revisions

After a year of use, IHSSP reviewed the accreditation surveyor and facilitator guides. The review was based on the inputs and surveyors and facilitators' experience with their use. The project revised the documents and they are ready for formatting and publication next quarter.

3.6. Rwanda accreditation system measurement framework

During the reporting period, IHSSP developed a framework that will compare the improvement of certain indicators in facilities undergoing the accreditation process, compared to control facilities, with the goal of determining the accreditation system's initial influence on quality of care. The data gathered on the prescribed indicators will provide information for planning and improving services within the hospital. IHSSP selected the indicators based on priority areas identified by the MOH teams, including infection control, customer care, emergency services, maternal and newborn care, and non-communicable diseases. The data on the indicators will demonstrate the impact of the accreditation system on the quality and safety of healthcare services. The selected indicators are:

Hospital Measurement framework Indicators

1. Surgical site infections:
 - After cesarean section
 - Rate of infection in patients undergoing clean surgery
2. Neonatal sepsis
3. Newborn death rate
4. Newborn diagnosed asphyxia
5. Maternal death

6. Cesarean section rate
7. Post-partum sepsis
8. Post-partum hemorrhage
9. Non-communicable diseases:
 - Asthma
 - Congestive heart failure,
 - Metabolic control for diabetic patients according to HbA1c
- 10 Malaria case fatality rates
- 11 Patient satisfaction
- 12 Staff satisfaction

Some of the indicators are currently monitored through the national healthcare management information system (HMIS). Detailed definitions of each indicator have been elaborated to guide the process for data collection, analysis and reporting.

3.7. Trainings on clinical treatment guidelines and use of LimeSurvey

IHSSP trained 107 health professionals from the Western Province on clinical treatment guidelines concerning pain management and dermatology.

The project also trained 25 accreditation surveyors on the LimeSurvey software, a data collection tool that will facilitate the survey process scheduled to take place in July and August.

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

4.1. Technical support to develop the Human Resources for Health (HRH) Sustainability Plan

The MOH and the Government of Rwanda strongly believe that Rwanda can ensure the financial sustainability of its health sector and reduce its dependency on donor funds. Together with the MOH and other development partners, IHSSP provided technical support to the development of a ten-year HRH Sustainability Plan. With this plan, the ministry will be able to identify the country's HRH challenges and design the mechanisms to mitigate those challenges.

Since the government will have a real picture of the existing health workforce, including the source of funds for remuneration of employees—including staff paid for by development partners—the MOH will be able to make appropriate decisions to ensure that necessary staff are retained when donor support diminishes. The sustainability plan will be finalized in the fourth quarter.

4.2. Finalization of the Allied Health Professionals' Council Strategic Plan

IHSSP supported the development and finalization of the Allied Health Professionals' Council Strategic Plan.

4.3. Workshops to communicate the results of the application of the Workload Indicators of Staffing Needs (WISN) tool to the health facilities

After the completion of the WISN study last quarter, the MOH presented the findings to the hospital teams who had provided their input to central level decisions regarding the WISN assessment. The ministry is considering the redistribution of staff based on information provided by the WISN tool, to ensure that work pressure is more evenly distributed among all Rwandan facilities.

4.4. Finalization of the continuous professional development strategic plan for the Pharmacists' Council

During the quarter, IHSSP supported the development of a strategic plan for continuous professional development for the Pharmacists' Council. With this plan, the council will mobilize funds to support the members to upgrade their knowledge and skills.

4.5. Technical support to develop the pharmacy policy

At the request of the MOH, IHSSP provided technical support in the development of the pharmacy policy. The ministry provided financial support and invited a team of development partners to participate in a five-day workshop to review and update the national pharmacy policy. The team reviewed, updated and finalized the policy, which will help align most of the work that IHSSP supported, especially the quality improvement and HRH programs.

4.6. Validation of the developed strategies for the Allied Health Professionals' and Pharmacists' councils

IHSSP organized and facilitated four workshops in this quarter for the pre-validation and validation of the Allied Health Professionals' Council's strategic plan and continuing professional development strategic plan for the Pharmacists' Council. The project presented the situation analysis, draft documents, and final documents in validation workshops.

4.7. Challenges/Constraints and Next steps

➤ Challenges/constraints

- There are shortages of human resources in the MOH to manage HRH activities in a focused manner.
- The MOH's reactions and decisions regarding the WISN report were delayed, thus facilities continued to work with suboptimal staffing.
- The MOH team often has agenda conflicts, resulting in the postponement of important meetings where decisions could have been made on the way forward.

➤ **Next steps:**

- Validate the HRH Sustainability Plan.
- Support the HRM and iHRIS training for human resources managers in public facilities.
- Supporting the professional councils to develop business plans.

V. EXTENDED DECENTRALIZATION OF HEALTH AND SOCIAL SERVICES

5.1. Facilitation of the review and update of the Nyamasheke district health work plan

Following a series of quarterly meetings facilitated by IHSSP where Nyamasheke district authorities were encouraged to take a lead in organizing a joint planning meeting, IHSSP supported the district in the review and update of the Nyamasheke district health work plan for 2014-2015. Multiple implementing partners participated and integrated their activities to avoid duplication. IHSSP continues to mentor the District Health Management Team (DHMT) during their quarterly meeting.

5.2. Facilitation of the DHMT joint quarterly meeting

During this quarter, the IHSSP supported the Nyamasheke DHMT joint quarterly meeting. During this meeting, the DHMT discussed their quarterly health outcomes, CBHI challenges, drug supply management, and the progress of accreditation program.

5.3. Challenges/constraints and next steps

➤ **Challenges/constraints**

- The hospitals designated as provincial hospitals have not yet received an official document upgrading them to the level of provincial hospital. This makes the district authorities reluctant to make strategic moves and support the operations at provincial hospital level.
- MOH teams have continuously failed to partner with IHSSP during the quarterly DHMT meetings due to conflicting priorities. This poses a threat to the success of the program and

weakens the DHMT's power to make decisions, especially in the areas where MOH still holds sole responsibility to act. There is need to empower the DHMTs to make their own decisions and set their own priorities.

➤ **Next steps**

- Find a way for the MOH to provide the same support to DHMTs as IHSSP has provided in Nyamasheke.

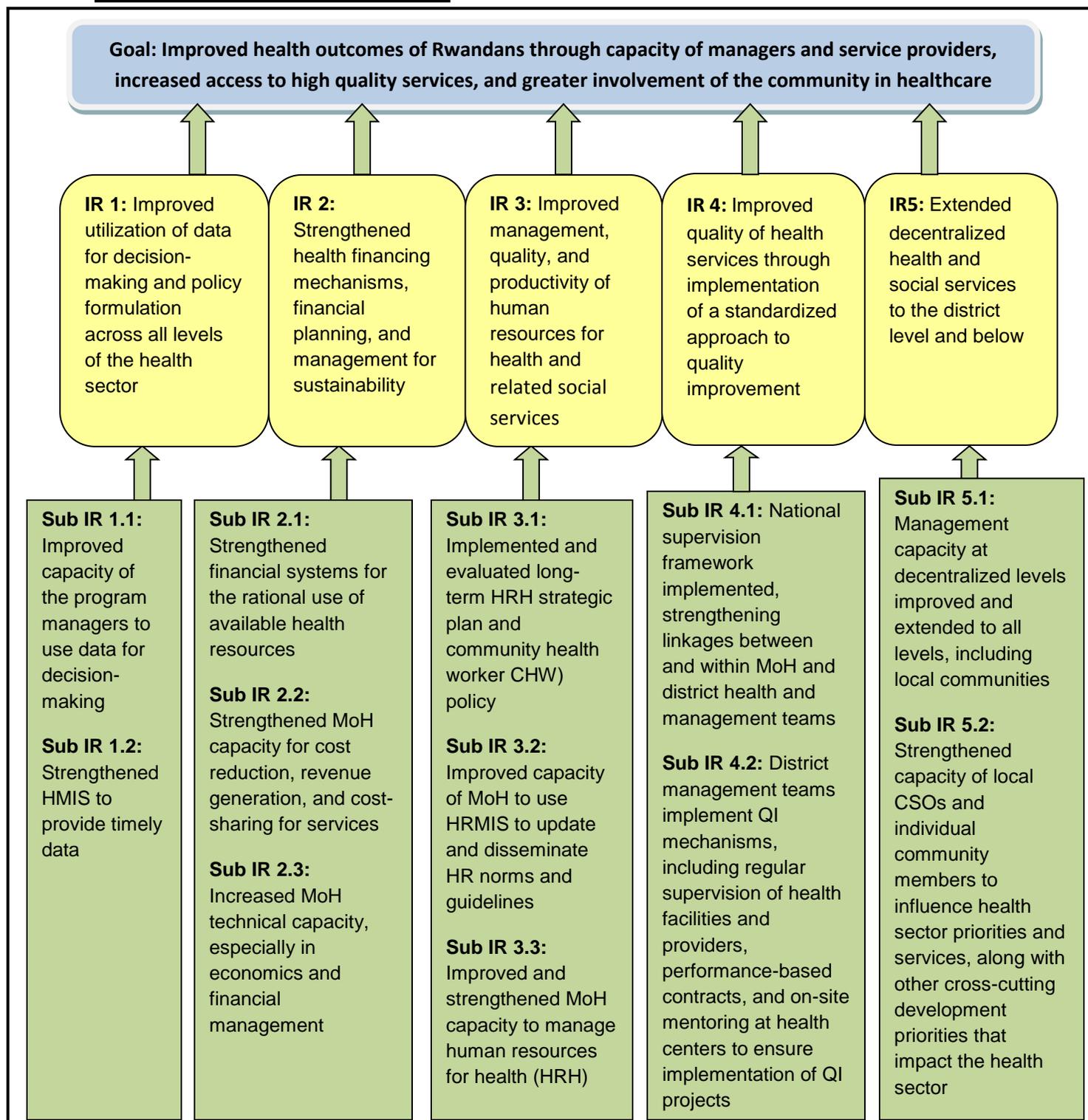
CONCLUSION

IHSSP is finalizing its five years of implementation. The next quarter will see the last of its technical support to the Ministry of Health.

IHSSP will continue to support and consolidate its interventions, ensuring the MOH's capacity to maintain and sustain the systems and processes IHSSP has introduced. The project will give special focus to:

- Migrating separate information systems and developing new applications to be integrated within one system (DHIS 2);
- Transferring CBHI information systems to the DHIS 2 platform, and transition of the CBHI to the RSSB;
- The hospital accreditation process, especially the progress survey and evaluation of the effectiveness of the program;
- Implementation of the human resources information system (iHRIS) at all levels; and
- Development of business development plans for the professional councils.

The project will implement a number of studies and assessments next quarter, which will provide information on systems management and improvement. These will include the PRISM assessment for data quality and use, the use of CBHI standard procedures and documentation of best practices, the feasibility study of health facility self-financing, assessments of accreditation progress and its effectiveness, and an experimental impact assessment of selected systems strengthening interventions. In the coming quarter, IHSSP will also start closeout activities, including preparation of the administrative, technical, and performance reports, documentation of lessons learned, and preparation for the end-of-project workshop.

Annex 1: IHSSP results framework

Annex 2: MSH eNewsletter article on IHSSP

Lessons in Resilience: Creating Stability and Universal Access to Care in Rwanda Health System

It has been 20 years since the genocide that killed over a million citizens and devastated the Rwandan health system and economy. In some respects, it feels more recent. Our memories of both the violence and our collective inadequacies in the international response are still raw. But the



progress Rwanda has made toward economic and social stability in just two decades is astonishing and a cause for celebration.

In 1998, just four years after the genocide, the new Rwandan government launched an ambitious plan to move the nation from a state ravaged by war to a middle-income country by 2020. Central to this plan was health equality—equal access and equal quality of care for all Rwandans - not a simple goal for the most developed countries, let alone one emerging from conflict. But the Rwandan government met its challenges head-on and addressed both access and quality of care from multiple angles.

Improving Access with Community Health Workers and Community-Based Health Insurance Scheme



Community health workers are the frontline of health care in Rwanda. In the early 2000s, two key government initiatives worked to eliminate geographic and financial barriers to health care: 1) the deployment of three community health workers in each Rwandan village to bring health care closer to the communities, and 2) the implementation of a nationwide community-based health insurance (CBHI) scheme to mitigate the cost of facility-based care.

Both systems grew quickly, with notable success. From 2003 to 2012, the rate of enrollment in the insurance system

increased from 7 to 91 percent and the annual utilization of health services increased from 0.3 to 1.7 services per citizen. Community health workers provided first-line treatments in the community and referred clients to health centers for more advanced care, thus increasing both supply and demand of health care.

However, for the poorest Rwandans, the cost of facility-based services was still prohibitive. In 2009, the Ministry of Health tasked the US Agency for International Development (USAID) Integrated Health Systems Strengthening Project (IHSSP), led by Management Sciences for Health (MSH), with revising the system to lessen the financial burden of health care for the poorest Rwandans.

IHSSP developed a national database that holds information on every Rwandan household's assets, allowing the government to stratify citizens into three economic categories, and helped the government revise the payment system. Under the new system, Rwandans pay for their health insurance on a sliding scale according to their economic category. The poorest residents pay nothing, and their contributions are covered by the government and its partners.

Improving Quality

Access to health care means nothing if services aren't well performed. Many international partners focus on improving quality by providing training on medical techniques (e.g., no-touch IUD insertion; prevention of postpartum hemorrhage using uterotonics; or safe medical male circumcision) or improving a broad area of care, such as emergency or antenatal. While these



An accreditation visit with a lab technician at Kibungo District Hospital, Rwanda Photo credit: Mary Burket/MSH

interventions are beneficial, a stove-piped approach can leave patients open to harm.

What happens when a patient has been well cared for in the emergency department but receives the wrong medicine once admitted to the inpatient ward?

What about the mother saved from shock by an attentive midwife and a shot of oxytocin, whose baby then dies from neonatal infection?

Creating Measurable Standards for Care through Accreditation

In recognition of the interconnectedness of all

health care, the Rwandan Ministry of Health and IHSSP took a holistic approach to improving quality of care in Rwandan hospitals, and in 2009 began laying the groundwork to accredit Rwanda's facilities according to international standards.

IHSSP worked with Joint Commission International (JCI), an organization that facilitates accreditation of hospitals throughout the world, to develop a set of 69 standards that govern all aspects of Rwandan hospitals' administration and service delivery. The ministry selected five hospitals in which to implement the process first, and in 2012 IHSSP began working with these hospitals to develop the internal structures, policies, and competencies necessary to work toward accreditation.

The accreditation process and training are long and complex; it will likely be several years before the first hospitals in Rwanda are accredited, and many more years until all 430 health facilities meet minimum standards. But the process itself has nurtured a nascent culture of quality within the facilities.

In just six months since the baseline assessment, the changes implemented by the staff of Kibungo District Hospital in the Eastern Province have made tangible improvements in patient outcomes. Jean Marie Vianey Ukizentaburuwe, the hospital's Quality Improvement Focal Person, explains:

Before, we didn't have the habit of analyzing data. We didn't know the rates of neonatal infection, neonatal asphyxia, or the infection rate from C-sections. But now we know these rates and have a plan to improve them.

In the first six months of implementing their plans to improve maternal and neonatal outcomes, the percentage of deaths due to neonatal infection dropped from 24 to 18 percent in Kibungo Hospital. The hospital has set a goal of reducing this to 9 percent over the next six months.

Similarly, the staff is monitoring the rate of post-C-section infections. To decrease incidence, the infection prevention committee is reviewing



Rwanda.Photo credit: Todd Shapera.

the charts of every C-section infection case to see if commonalities arise that may lead to corrective actions. Their goal is to decrease the rate of C-section infections from a baseline of 3 to 1.5 percent over the next six months.

Supporting the Health Workforce through Professional Councils

Standardizing hospital procedures is one way to improve the quality of care, but equally important is supporting the professional growth of the health workforce. To do this, IHSSP helped establish three professional councils (the Rwandan Nurse's Council, the Allied Medical Professionals Council, and the Pharmacist's Council) and strengthened the Rwandan Medical Council to serve as governing bodies for their respective professional cadres.

The councils define the licensing standards and track the licensing status of all health professionals in Rwanda, thus reducing the number of unqualified people practicing.

The professional councils also conduct supervisory visits to health facilities—both public and private—either at random or in response to a reported incident of malpractice. In response to negligence, they can take disciplinary action up to and including revoking the provider's license.

More than just governing bodies, these councils provide opportunities for members to keep abreast of international best practices and cutting-edge discoveries. With IHSSP's support, all four councils developed a uniform continuing professional development policy to promote learning, inform their members about new developments in their field, and ensure that providers' skills remain current. The educational opportunities are a benefit for professionals but also a requirement for licensing and a way to ensure quality of care.

Working toward Universal Health Coverage

By broadening access to quality services, Rwanda is truly working toward universal health coverage (UHC) for its citizens. In 20 years, the country has made astounding and measurable improvements to its health system. In 1994, Rwanda's under-five mortality rate was the highest in the world, and their life expectancy was the lowest. In 2012, their under-five mortality had been cut by nearly two-thirds, to 55 deaths per 1,000 live births, significantly lower than the regional average of 95 per 1,000 births. Rwandan's life expectancy is now 63 years, 7 years longer than the regional average.

Rwanda is one of the few countries on track to meet or exceed all five health-related Millennium Development Goals. By all measures, its health is improving at unprecedented rates.

But there is more work to be done. Though the health sector's human resources are stronger than they were five years ago, and structures and policies are in place to further support their professional growth, there are still simply too few doctors and nurses to support the population and their distribution is uneven. And though the accreditation process is well underway in five hospitals, those five have not yet met international standards in many areas, and the remaining facilities have not yet begun the process.

The Rwandan government is not deterred. In the final months of the project, the Ministry of Health asked IHSSP to draft a sustainability plan to guide the health sector's priorities, growth, and financing over the next ten years in the face of declining donor contributions. The plan touches on every aspect of the health system, from pre- and in-service training to infrastructure and maintenance.

With the systems IHSSP helped put in place, the tools it left behind, and a comprehensive plan for the future, Rwanda's health system will continue to thrive, providing every Rwandan the opportunity to live a healthy life.