Rwanda Health Systems Strengthening Project Annual Report, Fiscal Year 2015 (with 4th quarter highlights)

Randy Wilson

October 30, 2015

Rwanda Health Systems Strengthening Activity (RHSSA) will enhance the resiliency of the Rwandan health sector to address new challenges and will help build a country-owned sustainable health system capable of leading and managing change, through provision of extensive technical support.

[Health systems strengthening – USAID – community health services]

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Acronyms

3MS	Mutuelle Membership Management System
ASH	African Strategies for Health (project of the USAID Africa Bureau)
BDU	Business Development Unit (a unit of RBC)
BoDs	Board of Directors
CBHI	Community-Based Health Insurance
CHW	Community health workers
DH	District Hospital
DHIS 2	District Health Information System
DHMTs	District Health Management Teams
DHUs	District Health Units
JADF	Joint Action District Forum
DP	Development Partner
EMR	Electronic Medical Records
eLMIS	Electronic Logistic Management Information System
FY15	Fiscal Year 2015
GIS	Geographical Information System
GoR	Government of Rwanda
HC	Health Center
HMIS	Health Management Information System
HRH	Human Resources for Health
HSS	Health Systems Strengthening
HSSP3	Third Health Systems Strategic Plan (2012-2018)
HSWG	Health Sector Working Group
ICT	Information and Communication Technology
IGA	Income Generating Activity
IHSSP	Integrated Health Systems Strengthening Project
KM	Knowledge Management
LGD	Leadership, Governance, and Decentralization
MINALOC	Ministry of Local Government
MINECOFIN	Ministry of Finance and Economic Planning
M&E	Monitoring and Evaluation
MIA/SRC	Micro Insurance Academy/Social Re-Consultancy Ltd
MOH	Ministry of Health
MSH	Management Sciences for Health
NGO	Nongovernmental Organization
OpenMRS	Open-Source Electronic Medical Records System
PBF	Performance-Based Financing
PHFIS	Planning, Health Financing, and Information system
PHSCC	Private Health Sector Coordinating Committee
PIH	Partners in Health

PPP	Public Private Partnership
PSE	Public Sector Engagement
PTAs	Provincial Technical Advisors
RBC	Rwanda Biomedical Center
RDB	Rwanda Development Board
R-HMIS	Rwanda Health Management Information System
RHSS	Rwanda Health Systems Strengthening Project
RSSB	Rwanda Social Security Board
SIScom	Community Health Information System
SOPs	Standard Operating Procedures
SWOT	Strengths, Weaknesses, Opportunities, and Threats
SPH	School of Public Health
STTA	Short-Term Technical Assistance
TWG	Technical Working Group
USG	United States Government
USAID	US Agency for International Development
WHO	World Health Organization
WISN	Workload Indicators of Staffing Need

Summary of key achievements

The Rwanda Health Systems Strengthening project (RHSS) officially started on November 17th, 2014 in order to help build a country-owned, sustainable health system capable of leading and managing changes. Due to the fact that the previous project, the Integrated Health Systems Strengthening Project (IHSSP), was granted a no-cost extension to continue health system strengthening activities through December, 2014, RHSS actually began implementation of interventions as of January 2015.

While continuing some work streams from IHSSP (including support for HMIS, Accreditation and Health Financing), the first year of RHSS work began by taking stock of the existing situation through the completion of a baseline assessment, conducting a work plan development process that engaged staff and stakeholders from all project components, and completing the recruitment of staff to support all of the new initiatives.

The **leadership, governance, and decentralization (LGD) team** oversaw the completion of the baseline assessment. This exercise identified resources, capacity gaps, and barriers in the Rwandan health system, as well as its strengths. The assessment was done in collaboration with the Rwanda School of Public Health (SPH) and included documents review, a facility assessment, focus group discussions and key informant interviews. The team then engaged national and district level stakeholders through a variety of meetings to discuss and disseminate the results.

RHSS recruited and deployed provincial technical advisors (PTAs) in the five provinces in September to work with district health unit teams to strengthen the decentralized health system. In the short time since the teams have been in place, they have already provided support for the organization of a joint action district forum (JADF) in Huye district to review their action plans for 2015-2016.

The LGD team supported the application of the Workload Indicators for Staffing Need (WISN) tool in Bushenge hospital and developed additional activity standards beyond the existing standards for doctors, nurses and midwives. These standards are expected to be improved and set as national standards.

At the central level, this component of RHSS supported the secretariat function of the Ministry of Health (MOH)/planning, health financing and information systems (PHFIS) technical working group (TWG) meetings, helped to monitor the implementation of TWG decisions, and established a web-based knowledge management platform to improve information sharing across the TWG members.

Important progress was also made by the team on updating the human resources for health (HRH) sustainability agenda with recent HRH data and a review of the current HRH strategic plan (2011-2016) implementation was completed. The updated plan includes strategies from the HRH sustainability agenda and is extended until 2018.

With regard to the **health finance component,** RHSS staff were actively engaged in the community based health insurance (CBHI) transition from MOH to the Rwanda Social

Security Board (RSSB). This included the development of a detailed roadmap for the transition process. The HF team organized a high level meeting with the MOH, Ministry of Finance (MINECOFIN), and RSSB to validate the CBHI sustainability study that was conducted during the no-cost extension period of IHSSP (Oct-December, 2014). They also supported updating and expanding the public sector facility costing analysis, culminating in a proposal of revised tariffs. Similarly, a comprehensive private sector costing study was conducted and a preliminary report was produced.

RHSS provided support in the development of the health finance sustainability policy and health finance strategic plan. A community health workers (CHW) assessment was conducted in two phases during the year: the first phase was completed on a sample of CHW cooperatives, and a second phase for a comprehensive assessment of all cooperatives (475) is ongoing. RHSS completed a facility self-financing feasibility study to determine whether health facilities are able to auto-finance all or a portion of their expenditures. The project has also been supporting the MOH to explore options for the implementation of improved financial management procedures in health facilities, including harmonized monthly reporting and plans for the development of financial management software.

The **private sector engagement (PSE)/public private partnership (PPP)** is a new area of RHSS focus. Originally a sub-component of the RHSS/health financing component, at the request of USAID, PSE/PPP became its own component with the recruitment of a new international technical advisor in addition to a local technical assistant. In September 2015, the project established a new unit to support the MOH in improving the participation of the private sector in the delivery of health care services. A concept note and mapping of PSE activities were completed as part of the ongoing development of the high-level private health sector coordinating committee. A gap analysis for the Rwanda Biomedical Center (RBC)/business development unit (BDU) was conducted and support was provided to carry out, finalize, and validate the results of a pre-feasibility study for a Radiotherapy Center. The RHSS/PPP team developed and conducted a PPP/PSE training session to increase the internal RHSS team knowledge and awareness of the opportunities and process of bringing the private sector into the delivery of health care and health care services.

In the area of **quality improvement of health services**, RHSS supported the review and updating of the health service packages, both for public and private health facilities. A concept note for the integration of supportive supervision with an accreditation facilitation process was developed in order to strengthen the regulatory framework and the decentralization of specialized services. RHSS presented the national policy for healthcare quality and accreditation. The project conducted the accreditation baseline assessment at the new Kinihira hospital and conducted the accreditation progress assessment for five other provincial hospitals. All 37 other district hospitals also started implementing the hospital accreditation standards, even though they are not yet completely incorporated into the full accreditation program.

The project conducted the facilitation process that accompanies the accreditation assessment of hospitals and used this as an opportunity to mentor the accreditation

facilitators in the hospitals. Capacity building has been a focus of the project and additional training sessions were organized for central level accreditation facilitators and surveyors. RHSS organized and facilitated a workshop to identify and prioritize indicators that will be used to measure the impact of accreditation, working with Tulane University and SPH staff to begin the design of a formal evaluation study over the life of the project. The project supported the process of establishing an accreditation organization and initiated the process of involving private health facilities in the accreditation program by including them in training sessions for facilitators.

In the **monitoring and evaluation (M&E), learning and knowledge-based practices component**, the project provided support to prepare for the e-health strategic planning workshop that will involve eHealth TWG and other stakeholders. To enhance the use of existing data, the activities completed included the development of 2014 statistical booklet, updating standard operating procedures (SOPs) for data management, developing a training curriculum for M&E officers and data managers on geographical information system (GIS), and developing a concept paper to conduct a functional analysis of information system support functions across the MOH and RBC.

The project continued to develop the Rwanda health data warehouse with timely support from JEMBI to automate the exchange of data between different information systems (RHMIS, HIV, iHRIS, etc.) and the data warehouse itself. Staff from this component continued to support the institutionalization of existing health information platforms including DHIS-2, eTB individual records system, OpenODK (tablet-based survey tool), iHRIS, and the CBHI membership management system (MMS). In order to increase the use of program evaluation, research and dissemination of best practice, RHSS facilitated a research agenda implementation workshop and proceeded with the establishment of a knowledge management platform to support TWGs and the proposed Research Community of Practice.

For overall **project management and administration**, the project developed a first- and second-year work plan, a five-year strategic plan, and a monitoring and evaluation (M&E) plan with the involvement of partners and stakeholders. RHSS completed the recruitment of new staff to enhance the capacity of the team to meet requirements of health system strengthening. Terms of reference and budgets for RHSS sub-contractors (JEMBI, SPH, and Banyan Global) were also completed to streamline the support that they will provide to the RHSS.

Introduction

The Rwanda Health Systems Strengthening (RHSS) project is a USAID-funded five-year project implemented by Management Sciences for Health (MSH) and its partners. RHSS officially started on November 17th, 2014, and its overall goal is to achieve *strengthened and expanded performance of the Rwandan health system at national, decentralized, and community levels*. The project has five strategic or intermediate results (see the results framework in Annex 1):

- Institutionalized health systems thinking approaches and practices to strengthen structural and process attributes towards increased advocacy, leadership, and stewardship at the central and district levels of Rwanda's health care system;
- Improved multi-level Government of Rwanda (GOR) policy, planning, and implementation capacity with broad based participation and district health decentralization plan effectively implemented;
- Increased revenue mobilized by the health sector through Rwandan domestic and private sector sources to achieve sustainability*;*
- Improved and expanded quality health services through more effective and efficient use of existing resources in the health system, achieving better value for money; and
- Improved monitoring and evaluation (M&E), health systems research agenda, learning and knowledge-based practices*.*

The current report is the project year 1 annual report. In addition to providing a full review of the achievements of the project since startup in November 2014, the report highlights specific achievements during quarter four.

I. Institutionalization of health systems thinking approaches and practices

I.1. Identifying structural and process barriers to enhance leadership and stewardship

1.1.1. RHSS baseline assessment

The baseline assessment was the biggest of the RHSS leadership and governance component interventions during the fiscal year 2015 (FY15). It was conducted in order to identify resources, capacity gaps, and barriers in the Rwandan health system, as well as its strengths. The assessment involved the participation of RHSS teams, SPH researchers, the MOH, and other stakeholders.

After completion and submission of the first draft baseline assessment report, the MOH provided substantial comments requiring major review of the document. During the fourth quarter, the RHSS team revised the document along the following lines:

- Improving the desk review in order to give a clearer picture of the situation;
- Correcting mistakes in data and adding missing data;
- Rephrasing statements to clarify the source of opinions expressed and how those statements are represented among the interviewees/focus group discussion members;
- Reviewing and improving the strength, weakness, opportunity, and threat (SWOT) analysis tables and their link with recommendations for each component.

After revision of the document, a new draft was submitted to the MOH at the end of July. Unfortunately, the document was not reviewed and approved on time. The draft document was referred to by the consulting team that is conducting the HSSP3 mid-term review (MTR), the process where the RHSS team has been providing substantial inputs. The work continued to improve the overall presentation of the document, and a final draft was submitted to the MOH at the beginning of September. RHSS is now awaiting further comments from the MOH technicians before proceeding to the next steps for validation. The results from this baseline assessment are guiding and will continue to guide RHSS and MOH interventions, while suggesting areas for improving management and introducing effective health reforms that support sustainable health systems functioning and performance at all levels.

> RHSS completed a baseline assessment to identify resources, capacity gaps, and barriers in the Rwandan health system, as well as its strengths. The draft of assessment report was produced and is awaiting MOH validation.

1.1.2. Dissemination of baseline assessment results and work plan interventions

Upon guidance from the MOH and MINALOC (Ministry of Local Government), RHSS held a workshop with provincial and district authorities (Provincial Directors of Good Governance, Vice Mayors in charge of social affairs, District Health Unit Directors, and District Hospital Directors) to share initial results of the baseline assessment and to get their guidance on implementation and areas of interventions of the RHSS project. A three-day workshop was

held in Bugesera in August with provincial and district leaders in which RHSS presented the technical approaches, interventions, and coverage of the project.

Figure 1: District teams in a group activity session during a workshop in Bugesera district

Key messages delivered in the workshop include MOH and MINALOC guidance on the decentralized health systems structures and priorities for interventions, dissemination of baseline assessment findings, and clarification of the role of the RHSS project provincial technical advisors (PTAs). During the workshop, the participants agreed that more action should be taken on the following:

- creating synergy between different district health committees and harmonization of their legal framework for health decentralization;
- involvement of the provincial level in each district health related intervention;
- alignment of the project's interventions with districts' performance contract plans and continual collaboration with the JADFs; and
- consultation with local authorities by the MOH before taking decisions involving decentralized structures.

1.1.3. Deployment of provincial technical advisors (PTAs) in provinces

In the fourth quarter, the project recruited five PTAs and sent them to support the five provinces. They work hand-in-hand with the provincial director of good governance and social affairs. It was the MOH and MINALOC's idea to place the PTAs at the province headquarters and collaborate with provincial authorities, even though their targeted partners are mostly at the district level. This strategic positioning has proved to be very useful to ensure a positive reception of the PTAs by districts and health facilities. Although the PTAs are assigned to provinces, most of the time they will be working with district health unit teams to find out how best to support and strengthen the decentralized health system on district-specific issues.

Currently, the technical advisors are finalizing their introduction meetings with all the decentralized levels, including the Province Governors and District Mayors to get their guidance on the provincial and districts' health specific priorities. In the next quarter, the team will embark on facilitation of development of the district health annual action plans.

II. Improve multi-level GOR policy, planning, and implementation capacity

II.1. Strengthening national- and district-level capacity for planning

2.1.1. Coordination of TWGs and monitoring implementation of their decisions

RHSS supported the MOH's directorate of planning and health finance and information system (PHFIS) in organizing TWG meetings, monitoring the implementation of TWG decisions, and assuming secretariat roles. These activities included designing a monitoring tool to follow up on implementation of the TWG joint action plan, assessment of progress on planned activities in TWG joint action plan, development of a knowledge management (KM) platform with staff from the project M&E/health information component team, and supporting the organization of the forward-looking Joint Sector Review as well as health sector working group (HSWG) meetings.

The PHFIS TWG was very active this year with special meetings held to support the HSSP3 Mid-Term Review. The RHSS teams have also used the TWG platform to seek input and share ideas about the private sector engagement study, the project's baseline assessment, implementing the health research agenda, and the CBHI transition.

2.1.2. Support to the district JADF meeting

Towards the end of the fourth quarter, the RHSS staff in Southern province supported the joint action district forum (JADF) secretary to organize a two-day retreat that brought together most of the development partners in Huye district to review their action plans for 2015-2016. These plans were signed by the mayor of the district according to the performance contract model. RHSS participated in the retreat and shared its planned interventions in the coming year to strengthen the decentralized health systems in the district. The project was welcomed, and the mayor asked all the development partners to work with RHSS. The project will technically support the district health teams at all levels to improve the coordination of health services provided to the community. It was also an opportunity for RHSS to learn about challenges in the field which include, among others, the lack of coordination of development partners (DPs), limiting the opportunity for the district to tap into their resources for effective allocation to health priorities, and that the JADF health commission is not working.

RHSS learned from this experience that there is a need to engage with the MOH to get their support to establish/strengthen the JADF-health commission at the district level (it should have clear accountability and expected deliverables). There is also a need to develop a district monitoring tool to observe implementation of the JADF action plan/points. The

functioning of JADF and JADF-commissions in the district is very limited, and this structure needs to be strengthened by RHSS in collaboration with the MOH and the district.

II.2. Increasing multi-sectoral participation in policy, strategy and implementation

2.2.1. Support for the review and extension of the HRH strategic plan

The human resources for health (HRH) sustainability agenda was updated with recent HRH data and the review of the current HRH strategic plan (2011-2016) implementation was completed. The updated plan includes interventions to implement the HRH sustainability agenda and is extended until 2018. Both the HRH sustainability agenda and strategic plan are waiting for validation.

The HRH TWG meeting held in the third quarter reached a consensus to update the HRH strategic plan 2011-2016 and align it with the HSSP3 which continues until 2018. It also agreed to use the information from the HRH sustainability agenda to upgrade the HRH strategic plan, as was proposed by the senior management meeting of the MOH. The advantage of this merging is that priority interventions will be implemented within the context of the HRH strategic plan in alignment with HSSP3.

In July 2015, the project engaged a local company, Quality & Equity Healthcare, to support the MOH in the review of the current HRH strategic plan (2011-2016) implementation and the design of its extension until 2018. With support from the RHSS team, the consultant designed the data collection methodology and collected data from health professional councils, associations, and from selected facilities, including referral and district hospitals, School of Medicine, and private hospitals.

In August 2015, MSH HRH expert Ummuro Adano shared the global best practices of HRH with national stakeholders during the data validation workshop which took place at Hotel des Mille Collines. In September 2015, the project supported a core team of technicians to review the HRH strategic document. The project also updated the HRH sustainability agenda with recent HRH data, which was used to update the strategic plan. The core technical team agreed that both documents (strategic plan and sustainability agenda) would be validated together during the TWG meeting scheduled in October 2015.

II.3. Increasing capacity of district teams to use data generated by existing information tools

2.3.1. WISN application in Bushenge hospital

The MOH has used various methodologies over the past years to plan for HRH (population ratio, bed ratio, etc.) that have not enabled it to address staffing issues satisfactorily. The Ministry is now open to applying Workload Indicators for Staffing Need (WISN) as a key strategy for staff planning to respond to some of the issues raised from the service providers. The WISN methodology draws on activity standards and helps to estimate staffing needs based on the workload from the services provided at the facility level and the current

staffing patterns. It also ensures rational use of available skills based on the use of the right staff for the right tasks depending on training and competencies to deliver services of acceptable quality.

Bushenge hospital was chosen as a pilot hospital to start development of activity standards for all professional categories and application of WISN with regard to the standards developed. The MOH proposed approach is to use the standards developed by the Bushenge team as the basis for the development of the national standards. In the fourth quarter, the project supported the application of WISN in Bushenge hospital and developed more activity standards beyond the existing standards for doctors, nurses, and midwives. The project provided technical assistance for the following key activities:

RHSS supported the application of the Workload Indicators of Staffing Need (WISN) tool in Bushenge hospital and developed additional activity standards beyond those that were already documented for doctors, nurses, and midwives. These standards are expected to be improved, validated, and adopted nationally.

- Oriented the team on the WISN methodology;
- Facilitated the activity standards development exercise and WISN tool application;
- Developed lists of activities and the timing per professional category;
- Held a session for presentation, discussion, and validation of the lists of activities and time per each professional category; and
- Organized data from EMRS, HMIS, and iHRIS to be used in the WISN Application tool.

The hospital team estimated the standard time of the activities they do on a daily basis. They included the following professional categories: pharmacists, laboratory teams, anesthetists, nutritionists, dentists, physiotherapists, and finance teams. The proposed standards are still in draft, waiting for the MOH to decide whether to invite health professionals from all hospitals and national level staff to debate and finalize them as national standards.

Challenges/Constraints:

Delay in finalization of baseline assessment report: The draft report was submitted in line with the initial roadmap (end of June), but since then, the project has deviated from the timeline, both because of limited availability from the RHSS team staff, who had to make major contributions to improve the report but had important conflicting priorities, and the MOH, which provided substantial comments but was not available to do a joint review of the document to reach consensus on the final formulation of controversial statements. RHSS needs to reach this agreement with the MOH in order to move forward and use the assessment findings to guide future priority

- Limited availability of the MOH for finalization and validation of the baseline assessment report;
- Unavailability of MOH and MINALOC representatives to introduce the PTAs to the district teams;
- Staff turnover at the MOH hinders HRH activity implementation;
- Delay of the regulation of responsibilities of district health entities held up some implementation of project activities

interventions (plans for removing barriers to leadership and stewardship in the health system, development of a comprehensive health system strengthening (HSS) capacity building plan, etc.).

Delay in deployment of PTAs to provinces: The agreement by the MOH and MINALOC for the deployment of RHSS PTAs took longer than expected. PTAs were physically deployed in September instead of August as initially planned, leaving little time to start technical activities in the district during year one of the project. This was a necessary condition to give PTAs credibility and support from the central level. The project planned that MOH and/or MINALOC representatives would be present for the official introductory meetings with provincial authorities, but this has not yet happened due to the unavailability of representatives from these Ministries. As a result, some of these meetings have been postponed due to the unavailability of some provincial and/or district officials. Nevertheless, the PTAs have all received the authorization to start their technical support with the district teams and have started implementing their activities at the district level.

HRH management system: There has been a lot of staff turnover recently at the central level, especially in the MOH HR department, making it difficult for RHSS to implement some of the project's HRH priority interventions. There is a definite need to strengthen the use of HR management tools such as iHRIS and WISN at the central and decentralized levels, since those tools are not being uniformly used across all health facilities and there is not a common strategic vision of how to address the issue.

Roles and responsibilities of district health management teams (DHMTs) and other decentralized health committees: The ministerial order clarifying the legal framework of decentralized health committees is still under preparation. This is the initial step to develop SOPs for DHMTs and other health committees. RHSS does not have control over this initial step and subsequent activities regarding the legal framework are on hold, including training on integrated district planning, which is postponed for several months.

Next steps:

- Use the baseline assessment report to develop plans to guide future RHSS interventions, such as a plan for removing barriers to leadership and stewardship and a comprehensive HSS capacity building plan;
- Develop a roadmap for collaboration between the MOH and RHSS for human resources management strengthening;
- Work with HSWG and PHFIS TWG to support implementation of MTR recommendations;
- Participate in JADF meetings at the district level as a strategy to improve collaboration between decentralized health technicians, managers, and local authorities;
- Organize training for district integrated planning to enable districts to develop annual action plans inclusive of all stakeholders;
- Work with the RHSS/M&E and health information component to improve access and use of information tools (IHRIS, WISN, eLMIS, HRTT, etc.) by decentralized health actors;
- Develop the DHMT SOPs based on ministerial order on decentralized health committees.

III. Increased revenue mobilization by the health sector

3.1. Improving the functioning and sustainability of an integrated and equitable health insurance system

3.1.1. Supporting CBHI transition to the RSSB

Following the GOR decision to transfer CBHI management from the MOH to the RSSB, which formally took place in July 2015, RHSS staff continually supported the transition process during this year. The project organized a planning workshop to develop a transitional roadmap. Key steps in the RHSS-RSSB transitional roadmap were implemented during the fourth quarter including: support in carrying out a national awareness campaign to boost CBHI membership (see figure 2); supporting preparations for the official MOH-RSSB handover of compiled CBHI official policies, historical documents and reports; and support in the development of the RSSB membership management system and other insurance information systems.

Figure 2: USAID and RHSS team during a CBHI Umuganda campaign in Eastern Province

RHSS partner Jembi, finalized the development of the integrated CBHI membership and management system for the RSSB that will be rolled out during FY16. This web and mobile phone system will allow CBHI members to check their membership status, pay their contributions electronically, and record membership payments. During earlier quarters, the RHSS/HMIS team facilitated workshops for RSSB staff involved in information systems and information and communication technology (ICT) which resulted in the development of enterprise architecture and medium-term vision for the enhancement of RSSB information systems. These initiatives are designed to improve efficiency and monitor the overall performance of CBHI.

3.1.2. Validation of the CBHI sustainability study

In the process of validating the CBHI sustainability study, RHSS organized a workshop in the second quarter of this year during which the lead consultant from MIA/SRC presented the final CBHI sustainability report to GOR officials. The attendees discussed the report's recommendations, including suggestions to eliminate CBHI co-payments, develop and implement a re-insurance scheme, and enforce mandatory CBHI membership. The decision was made to send the report to high-level officials for validation.

3.2. Strengthening the capacity of the MOH/RBC to carry out economic analyses and financial feasibility of health system interventions

3.2.1. Validation of updated public sector costing and tariffs

In 2009 and 2011, MSH carried out a public sector facility costing analysis through IHSSP. This year, the MOH with RHSS support updated and expanded this analysis by including laboratory costs, culminating in proposed revised tariffs. The aim of the current MOH study is to provide recent (2013-15) data on the cost of providing medical services to inform the revision of public facility tariffs. MSH supported a hospital director workshop to present and seek approval for both the costing methods and revised tariffs. The hospital directors and representatives endorsed the revised tariffs with minor changes. The costing document has been approved at a MOH/senior management meeting and is awaiting discussion from health insurance companies and health care providers.

3.2.2. Private sector facility costing study

In May 2015, the MINECOFIN requested that USAID, through RHSS, conduct a comprehensive costing analysis to determine the actual cost of providing private medical services in Rwanda using an internationally recognized methodology. The analysis would determine costs at all private provider levels: hospital, polyclinic, specialized clinics, general clinics, and paramedical clinics. The general assembly and the appointed steering committee agreed that MSH should apply an internationally recognized costing tool (HOSPICAL) for use in this study. HOSPICAL is a step-down costing tool that was previously used in Rwanda for costing facility-based services and procedures at public health sector hospitals and health centers.

A comprehensive private sector costing study was conducted in 15 facilities at the request of MINECOFIN.

The comprehensive private sector costing study continued throughout the fourth quarter culminating in a preliminary report that has been submitted to MINECOFIN. The facility-based costing exercise was conducted in 15 facilities applying 2014 financial data, and it costed over 900 procedures for provider services. A key finding of the study was the highly significant variability of costs between and within facility levels, largely due to diverse services provided, number of patients, staffing mix, salaries, and indirect costs. Unexpectedly, gross profitability varied substantially, with some facilities recording financial losses, while others, within the same level, recording profits. For example, two of the four private hospitals in Rwanda had financial losses for the year. The facility-based procedure costs will be provided for each facility, while a summary of the range of procedure costs was included in the preliminary report.

3.2.3. Health finance sustainability policy and health finance strategic plan development

To strengthen MOH capacity, RHSS provided support during the year in the development of the health finance sustainability policy and health finance strategy plan. The health finance TWG finalized both the policy and the strategic plan. The health finance sustainability policy

has been validated and is currently on the Rwanda MOH website. The health finance strategic plan is awaiting validation from the MOH leadership.

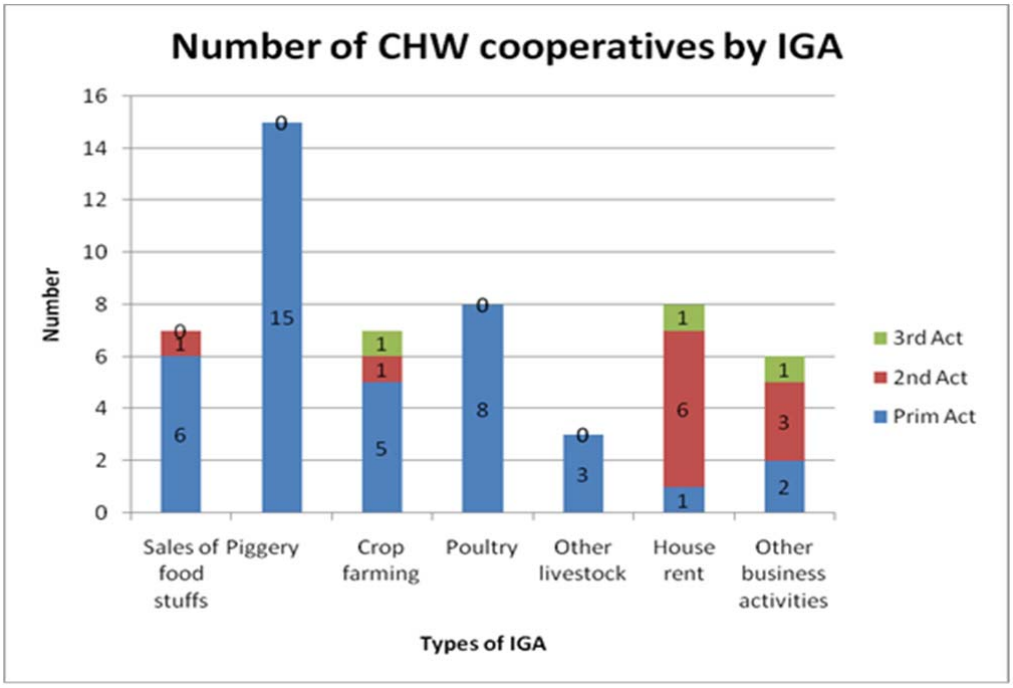
3.3. Increasing income generation capacity of various local entities toward staff retention and self sufficiency

3.3.1. CHW cooperative assessment

RHSS conducted a CHW cooperative assessment in two phases during the year. The first phase, which was conducted in a sample of CHW cooperatives, was completed in the third quarter, and the report was presented to the MOH technical staff and disseminated to other stakeholders. Some of the key findings included:

- Not all of the money intended for the cooperatives is actually transferred into their accounts.
- CHW cooperatives implement a variety of different income generation activities (IGAs) implemented by CHWs' cooperatives
- The majority of cooperatives implement farming as their primary activity, followed by poultry farming, as well as sale of foodstuffs, especially maize, beans, and sorghum. Almost all cooperatives are investing in commercial housing as their secondary activity (ref. Figure 3).

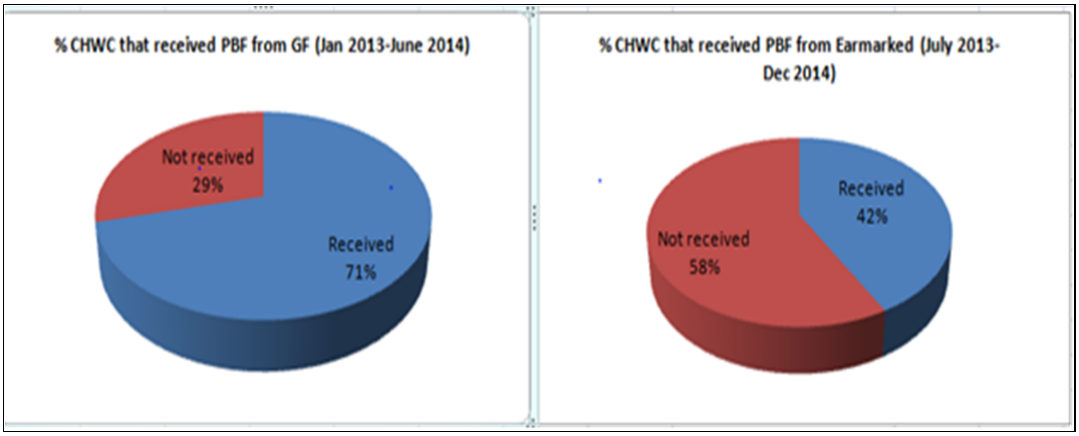
Figure 3: Number of cooperatives by income generation activity



The assessment indicated that 71% of cooperatives received Global Fund PBF resources (Figure 4) for January 2013 – June 2014, while 42% received GOR earmarked support for July 2013-December 2014. The latter funds are transferred from MINECOFIN to districts for distribution to cooperatives. However, 29% from Global Fund and 58% from the GoR were not actually received by cooperatives. It was observed that these funds were used by health

centers or districts for other activities and not transferred to CHW cooperatives as they should have been.

Figure 4: Global Fund PBF resources and GoR earmarked transfer to CHW cooperatives

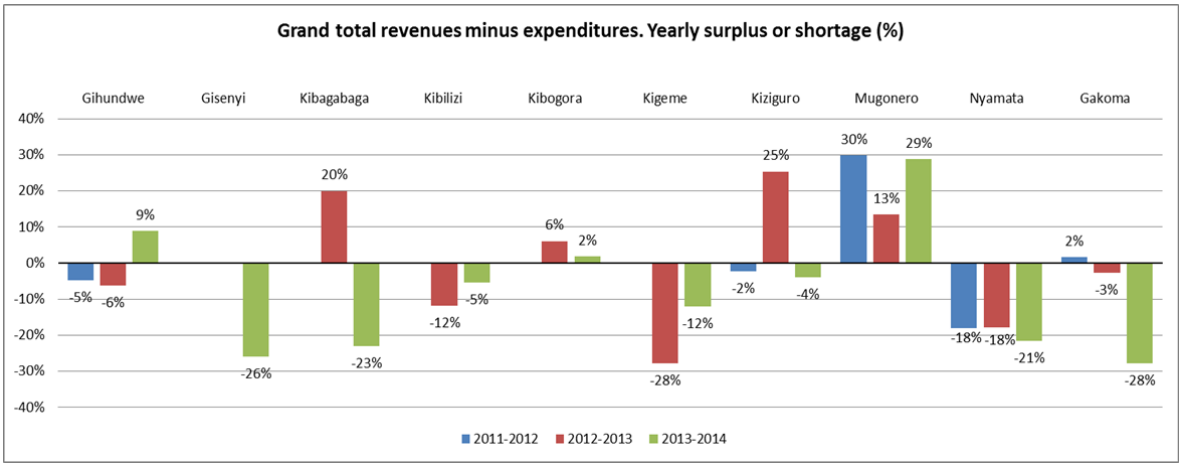


During the fourth quarter, the project designed and implemented a comprehensive assessment of all cooperatives (475). A survey tool was developed around four variables: leadership and governance, financial management, business implementation, and technical support effectiveness. Quantifiable indicators were defined for each of the four variables that were included in the questionnaire. A survey consulting organization was commissioned to recruit and train, with MOH and RHSS support, thirty data collectors. The results of this assessment should be available next quarter, and the report will include an analysis of cooperative organization and finance management, as well as a ranking of all cooperatives based on the assessed performance. Evidence from the survey will provide empirical information about the best performing cooperatives that will be applied to developing organizational and business models and projected scenarios for lower performing cooperatives to reach optimal performance.

3.3.2. District hospitals self-financing study

In 2014, through IHSSP, MSH initiated a facility self-financing feasibility study with the objective of determining whether health facilities, especially district hospitals, are able to auto-finance all or a portion of their expenditures. This year, the project analyzed data collected in 2014 from ten district hospitals and presented the final report to technical staff from the MOH and RBC. The report includes a facility variation analysis and ranking of the hospital performance along with a group of indicators, including income generation. It also includes optional finance models with a mix of scenarios for reaching self-financing through innovative income generation strategies. Results indicated a significant resource gap variation among the ten facilities considered in the study, with one facility having a shortfall of 107 million RWF in FY 2013-14 and another having a consistent surplus of 191 million RWF in FY 2013-14 (See Figure 5). The study report was finalized and is waiting validation by the MOH. The findings should provide good evidence to support the development of PPPs within district hospitals in future years.

Figure 5: Resource gap/surplus among the ten facilities that participated in the Self-Financing Study



3.3.3. Health facility financial management software

On different occasions over the year, the RHSS team had meetings with a combined MINICOFIN, MOH, and Rwanda Development Board (RDB) task force to support the implementation of financial management software in health facilities. It was determined that MINICOFIN will manage the process of developing and rolling out the financial management software for health centers, while the MOH will continue to explore options for district hospitals. In the longer term, the functionality of the Integrated Financial Management Information Systems (IFMIS - the GoR's standard accounting package) will be expanded to meet all health facility requirements.

The priority in quarter four focused on supporting the MOH to improve reliability and timely finance reporting from hospitals. The MOH has made adjustments to the MINECOFIN finance chart of accounts to make them fit better with health sector finance reporting. RHSS has planned, and will carry out in October 2015, a workshop to validate the revisions with the best performing hospital chief accountants. Following that, a training workshop is planned with staff from all 42 district hospitals to disseminate the revised template that will be integrated into the Rwanda Health Management Information System (R-HMIS).

Next steps

- Finalize and validate the private sector costing study;
- Finalize and validate the CHW cooperative comprehensive assessment;
- Develop the CHW cooperative fully functional model and carry out dissemination workshop(s);
- Roll out of the integrated CBHI membership and management system (3MS).

3.4. Supporting and incentivizing greater private-sector participation in health

3.4.1. Establishment of the private sector engagement/public private partnership component

RHSS established a new unit, with two permanent staff, to support the MOH in improving the participation of the private sector in the delivery of health care services.

Rwanda's national leadership recognizes the importance of the private sector role in the delivery of health care and health care services. To hone in on priority areas for the GOR identified in HSSP3 and the USAID private sector engagement assessment report, in September 2015 the RHSS team added a new component to the activity: the private sector engagement (PSE)/public private partnership (PPP). The objective of this component is to support the MOH, in particular through the Rwanda Biomedical Center (RBC), to improve the participation of the private sector in the delivery of health care and health care services.

The new RHSS PPP/PSE Unit is led by a PPP specialist provided by RHSS partner Banyan Global, and its personnel include one local technical assistant. The new unit focuses on three areas identified in three sub-results of cooperative agreement (RHSS Sub I.R 3.C.1):

1. Strengthening leadership and policy environment for PSE/PPP *(Sub 3.C.1.1)*
2. Increasing investment and access to finance for the private health sector *(Sub 3.C.1.2)*
3. Strengthening capacity for identifying and analyzing PSE/PPP opportunities and the establishment of PPPs, including building capacity on coordination and implementation of PPPs *(Sub 3.C.1.3)*

3.4.2. Assisting the MOH to develop a high-level private health sector coordinating committee

RHSS assisted the MOH in the development of a high-level private health sector coordinating committee (PHSCC) with representatives from the MOH, RBC, RDB, and other stakeholders. This committee is chaired by the Minister of Health to provide strategic oversight for a visible and sustainable PSE effort and includes a secretariat to provide implementation support. The work completed in the fourth quarter focused on the following:

- Developing a concept note with RBC to start the discussion about setting up the PHSCC and secretariat. The objective of these two committees is to improve the coordination and leadership within RBC/MOH for increased PSE and private sector dialogue;
- Mapping PSE activities under the health sector policy to support the PHSCC/secretariat PSE strategy. This map will be updated as needed.

3.4.3. Support to RBC/BDU in implementing and institutionalizing pre-feasibility and feasibility assessment tools to evaluate the value for money of PSE opportunities

Following a gap analysis that was completed by RHSS with the RBC/business development unit (BDU), a priority for technical assistance was for the project was to provide support to develop a PPP strategic plan and a private sector feasibility analysis framework. The first initiative that the RHSS PPP team supported was to carry out, finalize and validate the results of the pre-feasibility study of a Radiotherapy Center PPP project. A key outcome of the study was the adoption by RBC of a pre-feasibility and feasibility assessment toolkit including financial viability models. The team is currently helping RBC to raise the funds to perform the more detailed feasibility study of this potential project. The feasibility study will include the following analysis:

- Technical feasibility (design of the facility and related analysis)
- Environmental and social feasibility
- Market and demand analysis
- Project costs
- Value for money quantification financial model analysis.

3.4.4. Developing and conducting training for PSE and PPPs for central level managers

A great deal of work is needed to increase private sector participation in the health sector as set by HSSP3. To achieve some "quick results" and prepare the ground for longer-term successes, the RHSS PPP team needs to build business and PPP capacity at the MOH, RBC, and RDB. The capacity building will target both central- and district-level managers on PSE and PPPs. As a first step, the RHSS PPP team developed a PPP/PSE training session to increase the internal RHSS team's knowledge and awareness of the process to bring the private sector in on the delivery of health care and health care services. The training allowed the internal RHSS team to better understand and identify potential PPP interventions. The training materials will now be adapted for use with other stakeholders, particularly at the MOH, RBC, and RDB.

Next steps:

In the next quarter, the RHSS PPP team will focus its attention on:

- Leadership and policy:
  - Continue providing support to build RBC/MOH capacity to carry out the private sector engagement workshop;
  - Support the creation of a private sector platform to facilitate an environment for regular public-private dialogue by building the "trust bridge", which will help to close the current knowledge and information gap regarding health sector businesses, if the establishment of the PHSCC/secretariat is accepted by the MOH/RBC;
  - Develop a prioritized implementation action plan for key PSE activities;
  - Carry out the following feasibilities studies: local production of medical products and commodities; and increased private health sector engagement in the insurance system;

- Carry out a case study for CHW income generating activities;
- Investment and access to finance:
  - Develop a business plan framework and financial model to support USAID's Development Credit Authority (DCA) and corresponding partners such as banks and health sector stakeholders;
- Strengthening capacity to identify and analyze PSE/PPP opportunities:
  - Enhance the internal PSE/PPP training materials to include information on how to carry out PPP projects and other private sector engagement projects including information to develop business case and financial models. Use these materials to carry out various workshops for central level managers (MOH & RBC), district hospitals and facility managers, and private sector stakeholders to carry out PSE/PPP projects and to access financing;
  - Develop the pre-feasibility study of establishing the Rwanda National Accreditation Agency through PPPs.

IV. Improved and expanded quality health services

4.1. Improving, updating and institutionalizing service standards and quality assurance/accreditation

4.1.1. Strengthening the regulatory framework for continuous quality improvement of health services

To contribute to the strengthening of the Rwanda health regulatory framework and support decentralization of specialized services in district facilities, RHSS supported the review and updating of the health service packages, including defining mandated service packages at different private facility levels. The service packages for both public and private health facilities were reviewed by health professionals in their relevant specialties, and both documents are awaiting MOH validation.

> RHSS supported the review and updating of the health service packages for both public and private facilities.
>
> The project proposed a framework for integrating supportive supervision with the accreditation program.

RHSS also supported the RBC to draft a concept note for integration of supportive supervision with the accreditation facilitation process. A draft concept note was completed and submitted to the RBC and MOH for review.

4.1.2. Rwanda quality management policy

RHSS organized a one-day workshop for the Quality and Standards TWG session and presented the National Policy for Healthcare Quality and Accreditation for Validation. Inputs and recommendations have been incorporated, and the document has since been shared with all stakeholders. The policy will be presented to the MOH senior management meeting for final validation.

4.1.3. Accreditation assessments to identify performance quality gaps and standard compliance

- ***Baseline assessment of Kinihira hospital***

Following the upgrade of Kinihira hospital to the level of provincial hospital, the first step of program enrollment by this hospital was to conduct a baseline survey for readiness towards accreditation. Rwandan certified surveyors from MSH and the MOH performed the survey, which established the existing level of compliance with standards outlined by the national accreditation program. The findings indicated that Kinihira hospital received good scores, and it was clear that it started at a greater state of readiness than the previous cohort of five hospitals that started this process in 2013.

- ***Hospital progress surveys***

A ***provincial hospital*** progress assessment was conducted between April and May 2015 in five hospitals (Ruhengeri, Bushenge, Kibungo, Rwamagana, and Ruhango) to determine the current status of the hospitals in relation to the Rwanda hospital accreditation standards. The findings helped the facilitators close gaps in meeting level 2 accreditation standards and maintaining level 1 achievement. Since August 2014, hospitals have been working with their internal facilitators with minimal remote support from external facilitators to meet their performance targets. The target set for August 2016 for the five hospitals was to maintain level 1 and meet requirements for level 2, which involves the implementation of policies, procedures, and plans.

The survey findings for the five hospitals are presented in Table 1 (the five hospitals were named A, B, C, D, and E to ensure confidentiality):

Table 1: Accreditation progress scores of the hospitals for level 1 and 2 achievements

HOSPITALS	**A**		**B**		**C**		**D**		**E**	
LEVELS	**L1**	**L2**	**L1**	**L2**	**L1**	**L2**	**L1**	**L2**	**L1**	**L2**
R1. Leadership and accountability	71%	29%	89%	69%	96%	56%	91%	80%	98%	73%
R2. Capable and competent workforce	91%	61%	91%	49%	61%	27%	91%	79%	91%	88%
R3. Safe environment	87%	38%	91%	51%	78%	44%	96%	69%	91%	51%
R4. Clinical care	94%	75%	84%	49%	90%	59%	100%	87%	93%	73%
R5. Quality & safety	93%	74%	96%	78%	100%	67%	100%	93%	96%	89%
Overall average	**87%**	**56%**	**89%**	**57%**	**85%**	**52%**	**96%**	**81%**	**94%**	**73%**

Three out of five hospitals maintained level 1 standards, exceeding the minimum scores of 75% in all risk areas and an 85% overall score and are progressing well in pursuing level 2. All hospitals performed well in risk area 4 of clinical care and quality and safety.

Although hospital C had an overall score of 85%, its score of 61% in the workforce category is below the level required to maintain their level 1 accreditation. If this hospital does not meet the requirements for level 1 in the next assessment, the accreditation award will be revoked. Hospital A's 71% score in leadership and accountability caused it to fall short of

achieving level 1 status. These hospitals will have to make extra efforts to perform at both levels 1 and 2. All facilities will need to make big improvements in risk area 3, safe environment, to achieve level-2 status, as scores ranged from 38% to 69%.

All ***37 district hospitals*** have started implementing the hospital accreditation standards. Currently they are targeting achieving level 1 by the end of 2016. These hospitals will need technical support with regards to standards implementation and intensive capacity building of hospital teams, as they are new in the program.

- ***Translation of Standards and Assessment tool***

The hospital accreditation standards and performance assessment tool were translated and published in French to facilitate standards compliance and surveys process. Having these documents in one language (English) was identified as a challenge. The French version will be used during the accreditation survey scheduled in October-November 2016. The project expects that surveyors will provide feedback that will inform the next review of the tools.

4.1.4. Facilitation of hospitals to comply with accreditation standards

The project conducted the facilitation of the accreditation standards in the fourth quarter in the five hospitals: Kibungo, Ruhengeri, Ruhango, Kinihira, and Bushenge. This was also used as an opportunity to mentor national facilitators. All hospitals have made improvements, although major issues were identified, including physical structure, equipment, and capacity to support emergency services.

At Ruhango hospital, the project found that inventory management was a serious problem in general. Hospital staff need capacity building and expert assistance on-site to address the problem. Although this observation was made two years ago, the problem has persisted.

The project also found that medical records management needs continued support. It may be that the transition toward electronic records has not yet received enough support. However, if the standards are to be met, attention needs to be given to this area.

> The project conducted facilitation visits to support five hospitals in complying with accreditation standards. These visits were also used as an opportunity to mentor the accreditation facilitators in the hospitals.

Some cross-cutting hospital policies and procedures developed at each individual hospital are not standardized, e.g. safe medication, infection prevention and control, and emergency triage (pediatrics, adult, and maternity). These have been identified and can be reviewed and standardized by the MOH and RBC.

It was noted that hospitals are unable to meet some of the standards on their own, such as implementing effective kitchen and laundry services, dealing with water shortages, resourcing equipment needs, emergency services, and intensive care. It was recommended that the MOH work closely with its stakeholders to assist the hospitals to address issues that are affecting the hospitals' ability to meet the standards, especially resources to support critical care. We need a progressive plan to build the infrastructure, as well as capacity of

staff to manage these services. Moreover, the six hospitals that are currently undergoing the accreditation process need to work together to standardize the purchase of equipment and other processes.

4.1.5 Selection of indicators to measure impact of implementing accreditation

RHSS organized and facilitated a one-day workshop to identify and prioritize indicators that will be used to measure the impact of accreditation. Workshop attendees discussed potential indicators and first priorities. The clinicians were in consensus that emergency services were a key priority (resuscitation, triage, and emergency equipment/supplies). Further decisions still need to be made regarding which indicators to include on the research agenda to measure the accreditation process.

Potential indicators for study that will be discussed in a broader meeting include:

- Cesarean section infection rates
- Neonatal infection rates/outcomes
- Rational use of antibiotics: antibiotic prophylaxis & c-section
- Appropriate care: use of clinical protocols
- Costs savings: infection prevention, use of antibiotics, length of stay
- Efficient use of resources: decrease repeated X-rays and lab specimen rejections

Another session was planned in October 2015 with a broader range of stakeholders to agree on specific indicators to measure implementation of quality standards with the accreditation approach. These indicators will form part of the project's longer-term health system strengthening impact evaluation framework that is being designed by our partner Tulane University School of Public Health.

4.1.6. Establishment of a national accreditation organization

A nationally owned and managed healthcare accreditation system has been identified as one of the key initiatives that will contribute to health systems strengthening efforts. The project held consultative meetings with potential stakeholders to discuss a concept paper for a proposed model for a national accreditation body and to obtain their agreement to participate as board members. A consensus building workshop was organized, and it was decided to establish a national healthcare accreditation organization as a not-for-profit nongovernmental organization (NGO). This organization will be financially supported by the MOH partners for a period of three years before it transitions to a private, not-for-profit entity.

Following the consensus building process with potential stakeholders, the team drafted an accreditation organization statute/constitution to govern the organization. Discussion has continued in the fourth quarter with the Rwanda Governance Board (RGB) for guidance, and it has raised concern about MOH representation in a non-governmental organization. With the guidance of the MOH, the orientation of the organization is now changing to consider a public-private partnership (PPP) framework. This framework will allow the MOH to mobilize

resources to support the initial stages of the organization which will later become a private entity. The RHSS quality improvement team is currently working with the PPP team on a pre-feasibility study, after which it will conceptualize a sustainable financial model. Furthermore, the drafted by-laws will be re-aligned to match those of a public private partnership organization to guide the operations.

4.1.7. Engaging the private sector in healthcare quality regulation

As private health facilities will be initiated into the accreditation program, the project has started preparing them by involving private facility healthcare providers in training sessions of facilitators for the accreditation program. Six private facility healthcare providers have been enrolled into the facilitators training program. They will support standard compliance at their facilities once they have completed the training program.

Similarly, the Private Healthcare Federation will be represented on the accreditation steering committee and is already participating on the Quality and Standards Committee that plays an advisory role in regard to quality of healthcare.

4.1.8. Capacity building for accreditation facilitators

Capacity building activities completed during this year include:

- An accreditation facilitators' training course conducted in June 2015 in Musanze district for 32 health professionals from four public and two private hospitals (Kinihira, Ruhango, Kibungo, Bushenge, Croix du Sud, Plateau), with a focus on infection prevention and control. This training was also used as an opportunity to mentor/coach the trained facilitators on writing performance evaluations. In this process, RHSS also conducted a training needs assessment to determine practitioners' knowledge, skills, and experience and to determine future facilitation topics;
- The facilitators' manual was revised and updated. This provides guidance to accreditation quality improvement facilitators to assist facility staff in implementation of the Rwandan hospital accreditation standards in health care facilities.

- 32 accreditation facilitators from hospitals were trained;
- A facilitator manual was revised and updated;
- 18 national accreditation facilitators were trained;
- A refresher course was provided to the 24 certified surveyors

In the fourth quarter, RHSS continued to support continuous capacity building of Rwandan accreditation facilitators and surveyors with the following activities:

- The project held an accreditation facilitators' course in Kigali in July 2015 with eighteen participants from MSH, the MOH, and RBC. The intent of the course was to provide capacity building of RBC and other central level support staff to facilitate the implementation of standards. The facilitators will complete hospital practicum activities and once all the requirements are successfully met, the trainees will sit for a final examination in June 2016. The trainers will support capacity building in provinces once they qualify.

- The project conducted a one-day refresher workshop in August in Kigali for 24 certified surveyors that were trained two years ago to continue to build their capacity to interpret and measure standards reliably. A training needs assessment was again conducted to guide planning for capacity-building activities. Trainers used this as an opportunity to learn how to perform and analyze a training needs assessment. The workshop included a participative capacity building session on report writing, because reporting was identified as a significant area needing improvement in the survey process. Another session was held to discuss challenges and potential solutions when conducting surveys.

Key recommendations provided during this capacity building process were:

- Create an electronic newsletter to share information regarding new standards, interpretation of standards, and accreditation, which could also include new trends in healthcare quality improvement;
- Build capacity of all surveyors to master at least three risk areas. This requires both knowledge and mentoring. It was emphasized that training on particular topics is needed, and critical areas need support from mentoring;
- Build capacity of selected surveyors and facilitators to be trainers and develop a plan to support district hospitals toward meeting standards and thus achieve accreditation.

V. Improved M&E, culture of learning, and knowledge-based practices

5.1: Enhancing data production, conversion into information products and increasing evidence-based decision making

5.1.1. Support strategic and operational planning for MOH/e-health activities

The e-health strategic planning activity was initiated in the second quarter to begin the process of updating the eHealth strategic plan which expired in 2013. Things have evolved very quickly in Rwanda, especially with respect to eGovernance and investments in information technology, and it is crucial to adjust the MOH's plans to reflect some of these new realities. It was agreed to organize a strategic planning meeting/workshop with the eHealth TWG, though for a time the Directorate of PHFIS expressed concern that there were too many sub-sector strategic plans in the works. Finally in the third quarter, the eHealth coordinator reached a consensus with the Minister of Health and the Director General of PHFIS to conduct this activity, and RHSS started active planning of the workshop with the Partners in Health (PIH) team and other stakeholders.

RHSS provided support to prepare the e-health strategic planning workshop. This will involve the e-Health TWG and other stakeholders.

In the fourth quarter, RHSS developed a detailed concept note and program for the workshop agenda, which will be presented for approval at the Ministry's senior management meeting. The Minister of Health has supported this exercise in the past and

indicated her intention to participate in the workshop. The MOH expects the Minister of Youth and Information Communications Technology (MYICT) to deliver a keynote speech for the workshop so that it will be a high profile multi-sectoral event. The workshop is currently proposed for the first week of November in Gisenyi, and for the moment, RHSS is the sole sponsor. But with nearly 60 participants expected for a 3 day workshop, the MOH is seeking to get WHO and UNICEF on board as well.

5.1.2. Enhancing the use of existing data at all levels (policymakers, DHU/DHMT, facility)

- *2014 statistical booklet development and update of the SOPs for data management*

In a bid to scale up the production and use of quality data for evidence based decision making, RHSS supported the MOH in the second quarter in developing the 2014 Annual Health Statistics Booklet and updating the standard operating procedures (SOPs) for data management. The update of SOPs for data management was initiated to incorporate changes in processes and procedures for data management, access, and use since the country-wide roll out of the new R-HMIS in 2012.

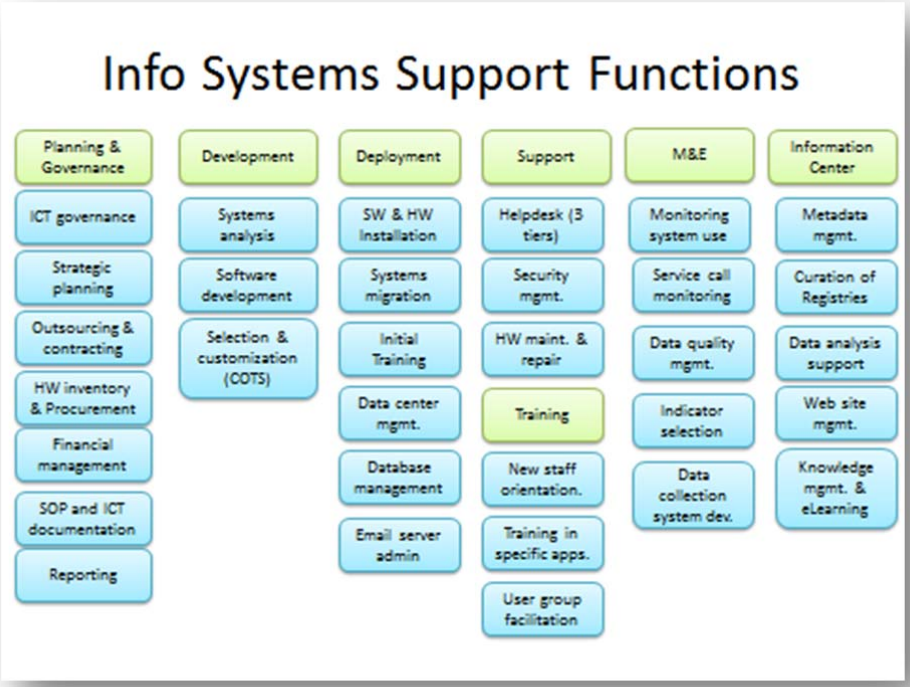
- *Training of M&E officers and data managers on GIS*

In the fourth quarter, RHSS staff and staff from Swiss Cooperation completed the development of a curriculum to train M&E officers and statistical officers at the district level in the use of GIS tools including DHIS-2 and QGIS open source software. The one-week course will include around 30 participants from three districts in Western Province and will be held in Kibuye in mid-October. The objective is to expand the use of GIS in the districts. After the initial course is completed, similar sessions will be organized for the other districts later in the year.

- *Analysis of information system support functions*

RHSS staff prepared a concept paper for RBC on the basic ICT and system user support functions required in order to support widespread use of DHIS-2, OpenMRS, and mobile platforms at the central and decentralized levels (see Figure 6 below). This should form the basis of discussions about how to rationalize staffing between the MOH and RBC and what support services should be considered for out-sourcing through PPPs. Currently there is some duplication of tasks between the two institutions, and recent cutbacks in staffing have left many critical support functions unmet.

Figure 6: Conceptual Framework of Information Systems Support Functions



5.1.3. Operationalize the Rwanda health data portal and data warehouse

Although the MOH has not yet made clear its timetable for opening up wider access to health sector data, considerable progress was made during this year on the technical front including:

- Drafting major sections of a country health profile that will be part of the narrative of the Health Observatory (quarter 1);
- Automation of import (data transfer) from all DHIS-2 instances into the data warehouse (quarter 2);
- Working with the MOH to propose a subset of data elements and indicators from the data warehouse that could be shared in the observatory (quarters 1 & 2); and
- Cleaning up indicator definitions and preparing an initial set of dashboards in preparation for public sharing (quarter 4).

5.1.4. Institutionalization of existing health information platforms

This intervention was focused on continued support for the enhancement and maintenance of the information systems built mainly on the DHIS-2 platform (RHMIS, eTB individual records, Death Audits, HIV reporting, eIDSR). Systems support was also provided to the accreditation surveys using OpenODK, iHRIS for HR management, and the CBHI membership management system (MMS). A summary of support for the enhancements to these systems is outlined below:

Table 2: Summary of interventions to enhance existing health information platforms

HMIS platform	Enhancements completed on the platform
DHIS-2 platforms	
TracNet module	Exported all of the historical data from the Voxiva database and transformed it for import into the DHIS-2.
Disease surveillance	- Provided support regarding troubleshooting issues; - Supported training of M&E officers in district hospitals and administrative districts on the use of platform; - Designed a new set of Jasper Studio analysis reports of completeness and timeliness of weekly reporting.
Data warehouse	- Completed a set of scripts to automate updates of the data warehouse with R-HMIS data elements (interoperability); - Provided support to the MOH team to automate the synchronization of data between different DHIS 2 instances and the data warehouse; - Supported the MOH staff to refine the indicator definitions and create a basic set of dashboards that can be shared.
DHIS 2 PBF module	- Funded and facilitated a workshop of selected national and district level staff to prepare for the nationwide roll-out of new PBF modules in DHIS 2 (these include hospital, health center, TB, and community PBF modules); - Developed procedures to import data from RapidSMS into the new DHIS-2 PBF module and calculate individual CHW payments, and completed first individual payments to the CHWs using the DHIS 2 based PBF module; - Started the study for assessing the feasibility of making mobile money payments to individual CHWs directly from the CHW PBF module.
System documentation	Led the effort to further develop and update system documentation for all of the DHIS 2 instances as per the Global Fund audit that found that there was not adequate documentation supporting system access, administration, and use.
DHIS-2 interoperability with eLMIS	Initiated and held discussions with the Pharmacy Task Force, Jembi, and the Deliver project staff on potential interoperability between the eLMIS (electronic logistics management information system) and DHIS-2. The RHSSA team documented three possible use cases and shared them with the eLMIS programmers.
Other system platforms	
eTB individual records system	Assisted the TB division to review the data collected through the eTB individual records system to reduce the burden of data collection by health facility staff and make analysis more efficient. Several upgrades were made to the DHIS-2 software to fix bugs found in the system.
OpenODK	Completed the conversion of tablet-based Accreditation Assessment tools from LimeSurvey to OpenODK. The new platform has better support for off-line data collection and should be easier for the MOH/RBC team to maintain.
iHRIS	Provided introductory training on system administration for the new iHRIS data system manager, who has no previous experience with the system. A plan was also developed for a more comprehensive training for the HR team during the next quarter.
CBHI support systems	- Facilitated a workshop with RSSB to develop an enterprise architecture framework and long-term roadmap for integrating CBHI information systems within RSSB. A consensus was reached on key sub-systems that RHSS will be supporting including the CBHI monitoring system, claims processing, and mutuelle membership management system. - Worked with RSSB ICT staff to test the Mutuelle MMS in health facility (Bethsaida Health Center). A number of enhancements were identified by the users and RSSB staff and most have been fully implemented. Progress on other information sub-

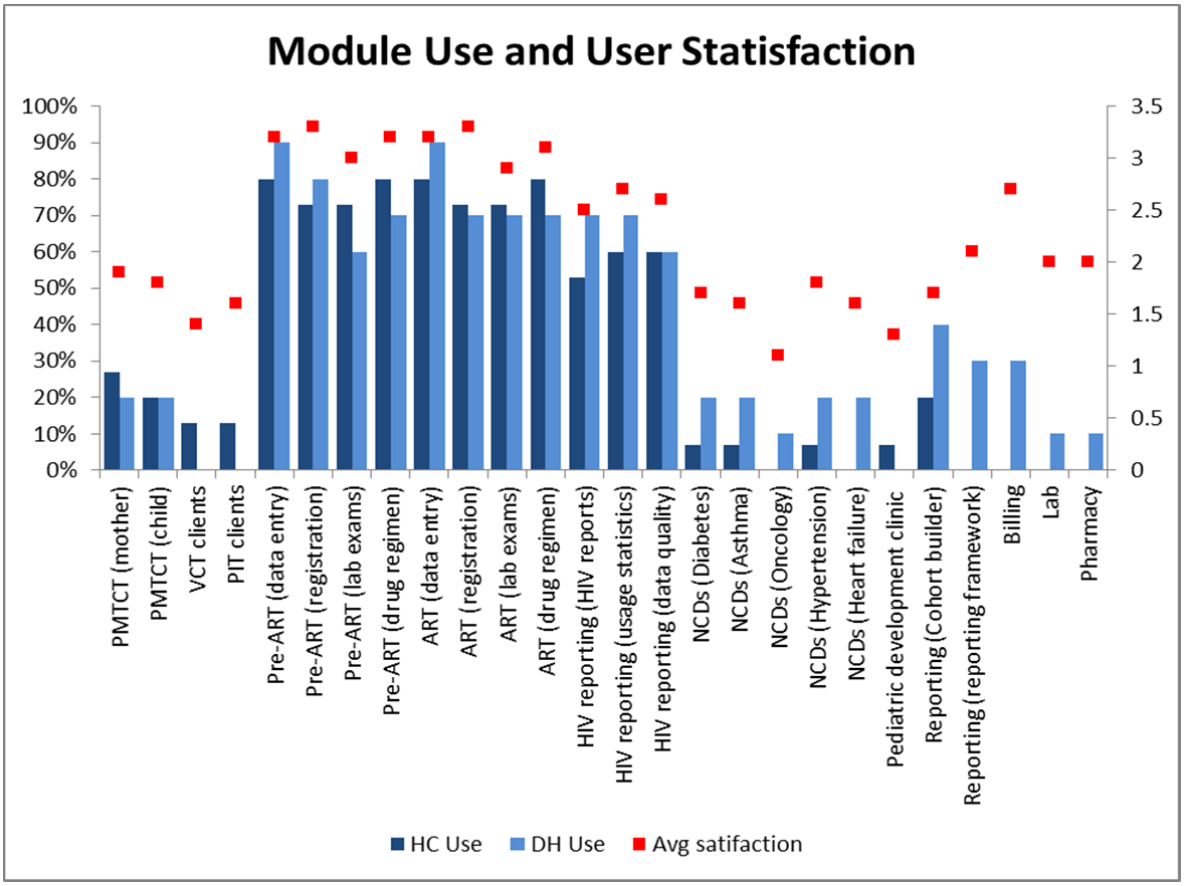
HMIS platform	Enhancements completed on the platform
	systems that were prioritized have stalled due to big changes in staff at senior levels of RSSB and the urgency of sensitizing the population in order to increase membership.
OpenMRS	- Facilitated the development of a plan to harmonize OpenMRS concepts and modules (with a focus on the HIV module) in order to facilitate support and national roll out; - Designed and conducted an assessment of OpenMRS use in approximately 30 health facilities. The assessment results will inform a roadmap for system harmonization and roll out across the country.

- *Key findings from the assessment of OpenMRS use:*

The assessment provided a good picture of the situation on the ground, both accomplishments and challenges, and helped to gather input from users about their capacity, level of satisfaction, and a wish list of new functionality they desired. Below are some of the key findings:

i. **HIV module:** the use of Pre-ART, ART, and HIV reporting modules ranged from 53% to 90% of the assessed facilities (health centers and hospitals). The use of PMTCT, VCT, and PIT modules was very limited in these facilities. PMTCT is used in 20% of the DHs and 27% of HCs, whereas VCT and PIT were used in 13% of health centers assessed (see Figure 7, below).

Figure 7: Use of HIV modules of OpenMRS



ii. A "**primary care package**" was implemented in some of the hospitals, where it is used most notably for performing patient registration, billing (30% of DHs assessed), and laboratory and pharmacy requests for the patients (10% of the DHs assessed). However, the assessment teams found that this package was not harmonized across facilities, with some of the coding done to meet specific requirements of individual hospitals. The MOH has an aggressive plan to introduce this package in all hospitals, so RBC will need a lot of support over the next year to make this happen.

iii. The **HIV package and primary care packages** are installed on separate servers in facilities where they are both in use. This means that patients who are under HIV care and come to the hospital for other services are entered into two different systems. The two platforms are also running on different versions of OpenMRS, making it difficult to merge them without substantial effort. However, it seems a worthwhile investment to consolidate them into one platform for long term sustainability.

5.2. Strengthening and supporting operational health systems research for sustainable HSS

In line with increasing the use of program evaluation and harmonizing research and evaluation efforts with strategic planning implementation, three main activities were conducted in this year: i) organizing a research agenda implementation workshop, ii) establishment of a knowledge management platform, and iii) initiation of a CHW PBF mobile money payments study.

5.2.1. Research agenda implementation workshop

The workshop combined 21 high level participants from the MOH, RBC, academia, review committees, and heads of referral hospitals and schools. RHSS and the WHO provided support to the MOH to organize this workshop held in Rubavu which ended with the following results:

- Dissemination to and discussion with the participants of the research policy, guidelines, and health research agenda;
- SWOT analysis of key research enabling themes;
- Development of the implementation plan and M&E plan for the health research agenda;
- Definition of requirements and initial set up for a knowledge management platform.

5.2.2. Establishment of a knowledge management platform

The purpose of a knowledge management (KM) platform is to support forums where people can exchange experiences, best practices, documents, and data. This was initially developed using MediaWiki software and changed later to include options in light of the additional features that the Ministry requested. The new platform was developed using WordPress content management software, which has better collaborative functionalities (see the KM dashboard on figure 8). The platform has an integrated events calendar and a single sign-on profile that will allow members of several TWGs to sign in and access each group site's content that they join using their single credentials.

Figure 8: Dashboard of KM platform

In the fourth quarter, the system, along with all of the associated WordPress plugins, was moved to a local installation. A concern was also on sustainability and political acceptability of a cloud-hosted KM platform for Rwanda. For this, key staff from the MOH ICT unit and planning directorate have been oriented on how to use the system, but more formal training has to be conducted (scheduled in the next quarter).

5.2.3. CHW PBF mobile money payments study

The process for this study is in the initial phase. A proposal for the CHW mobile money payment feasibility study was developed and presented to the MOH e-Health TWG for approval. The TWG provided inputs and recommended the study pass through a MOH senior management meeting for approval. Work has begun with the African Strategies for Health (ASH) project team that is funding most of the study to develop the detailed activity plan. Dr. James Humuza from the SPH is on board as a co-investigator. The time for the first payments has been scheduled for January 2016, sparing time to obtain authorizations from the Minister and from the SPH before beginning the study. Preliminary work has also begun

by interviewing each of the mobile money providers to help in pre-selection of those who will participate in the study.

Challenges/Constraints:

- There is a challenge with the MOH/RBC reorganization that is not yet complete. HMIS and OpenMRS staff split between MOH and RBC offices. However, some deliverables have now been completed (EMR assessment and a concept note on rationalizing information systems support functions). The project also hosted many of the meetings to prepare the EMR assessment and analyze the results. So the project is currently more engaged than before.
- Work on the transition of CBHI to RSSB has been further delayed because of changes in senior management at RSSB. There is a need to engage the leadership again to kick start the process.

Next steps:

- Facilitate the GIS training session for M&E staff in Western Province in October – update curriculum and plan for additional sessions in other provinces;
- Complete the proposal for the CHW mobile money payment feasibility study and submit to it the Minister of Health and SPH internal review board to enable the study to begin work;
- Fund and facilitate the eHealth strategic planning exercise in November;
- Renew support for the implementation of the RSSB strategic roadmap for CBHI (roll out of the membership system and discussions about adapting the M&E system);
- Provide technical assistance to enhance the eIDSR outbreak module, design new analytical reports and build capacity within the RBC teams to create JasperStudio reports for both the eIDSR and the HIV reporting system;
- Based on the rapid assessment of EMR with RBC, clarify short term technical assistance (STTA) requirements from JEMBI to help with systems analysis tasks;
- District M&E advisor to begin desk reviews to harmonize district M&E frameworks with SPH staff;
- Complete enhancements to the knowledge management platform on the WordPress platform and train MOH/PHFIS planning staff to maintain it;
- Train surveyors and MOH ICT/clinical services staff on new tablet-based accreditation assessment tools developed using OpenODK;
- Begin roll-out of the CHW stock management mobile application with the Community Health Desk.

VI. Project management and administration

6.1. RHSS operational and strategic plans development

The RHSS plans were completed with the involvement of key stakeholders from USAID, MSH partners (SPH, Tulane University, Banyan Global, and Jembi), the MOH, RBC, RSSB, and MOH partners. This was done by presenting priority interventions of the plans and inviting stakeholder feedback. The plans that were developed and validated for implementation are:

- First year work plan, with interventions mainly covering the period of April to September, 2015;
- Second year work plan covering the period of October 2015 to September 2016;
- Five-year strategic plan that highlights the vision of the project to contribute to Rwanda's vision 2020 and HSSP3; and
- Five year M&E plan with performance monitoring indicator. A first version was completed in March for the first year of project implementation, and an updated version (with updated monitoring indicators) was completed in August for the 2nd year of project implementation.

6.2. Recruitment of new staff

To enhance capacity of the RHSS team to meet requirements of health system strengthening, the MSH country operations management team worked with RHSS technical units to recruit new staff for RHSS, including:

- Accountant;
- Executive assistant/strategic communication specialist;
- Technical advisors for district capacity development (five positions);
- Technical advisor for health financing;
- Technical advisor for HRH;
- District M&E specialist;
- Public private partnership specialist (local staff); and
- Public private partnership senior adviser (expatriate hired through Banyan Global).

RHSS currently has 46 staff with categories presented in the following table:

Table 3: RHSS current staff

Staff category	Number
Project Director (COP) & Country representative	1
Director of finance and operations	1
Team Leaders (senior advisors)	5
Other MSH central based technical staff	13
Provincial based technical staff	5
Strategic communication team	2
Finance and operations staff	11
Drivers	8
Total	**46**

6.3. Development of detailed program descriptions for RHSS partners

RHSS teams developed and finalized detailed terms of reference and budgets for RHSS sub-contractors partners (Jembi, Tulane, University of Rwanda/SPH, Banyan), indicating the support that these organizations will provide to the RHSS. This will facilitate planning of STTA visits of these sub-contractors and monitoring the achievement of assigned deliverables.

Conclusion

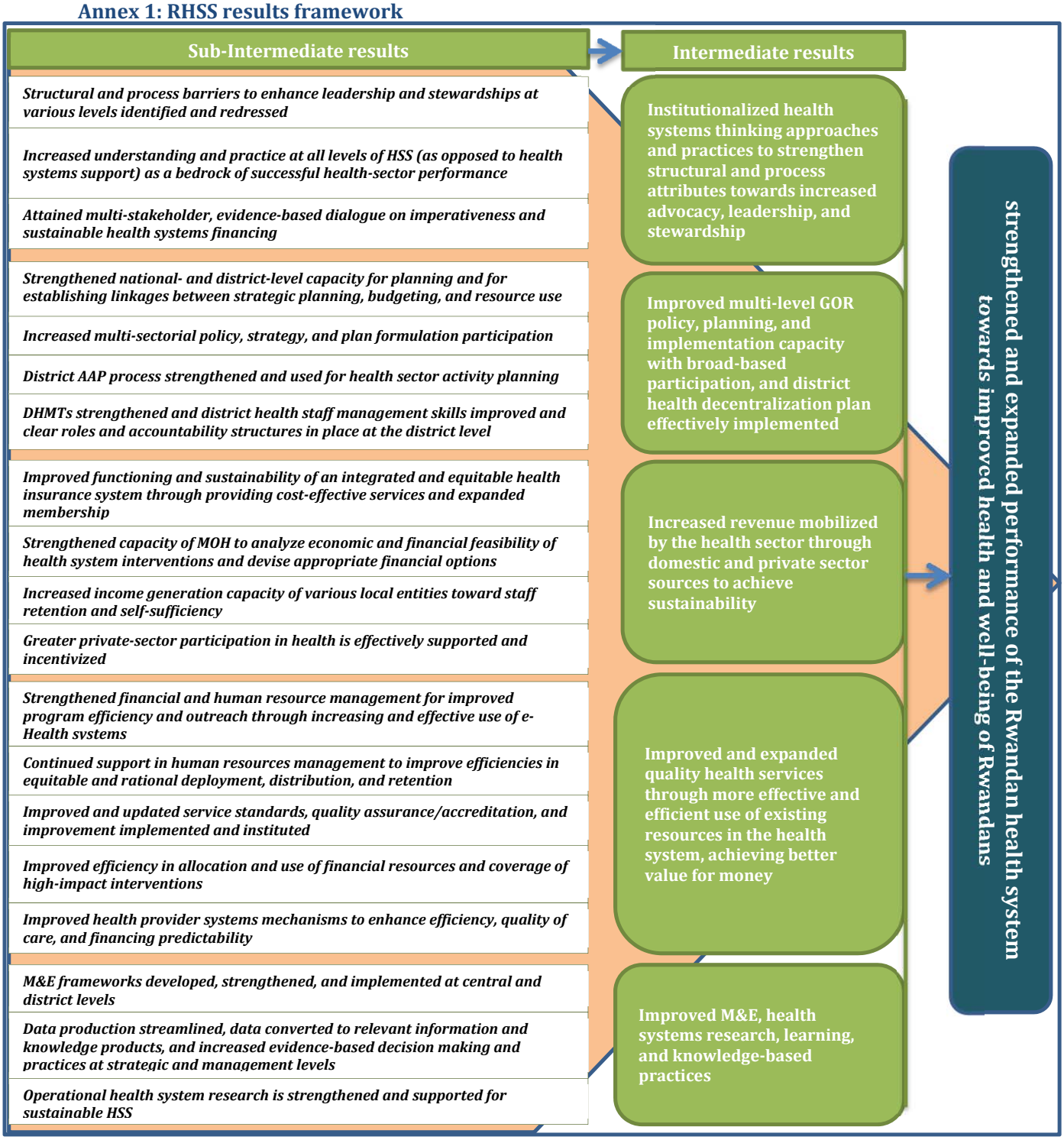
RHSSA is building the capacity of the GOR to move from health systems support to health systems strengthening. The first year of RHSS implementation was completed with interventions that are laying down a foundation for future interventions. Structural and process barriers have been identified during the RHSS baseline assessment, and the project presence in the districts has been enhanced by deploying provincial technical advisors to support decentralization of health services. Interventions initiating from different components of the project are also contributing to the enhancement of the health insurance system, the MOH/RBC capacity to drive health financing mechanisms, increased income generation capacity of various local entities such as CHW cooperatives, and greater opportunity and the potential for private-sector participation in health. The improvement of quality services through the implementation of standardized approaches towards accreditation, the building of a stronger health information system, and increased evidence-based decision making and practices are also targeted results for which the project has made an important contribution.

Building on the previous achievements, the RHSS will continue to support innovations and enhance country capacity to build a stronger system that responds effectively to the challenges of Rwandans' health. The interventions that the project will focus on in the second year will include:

- More engagement in the decentralization and institutionalization at the district level of health services facilitated by new RHSS provincial advisors;
- Implementing key PPPs (including support for a USAID Development Credit Authority (DCA) guaranteed loans program to encourage private sector lending for health-related investments);
- Supporting the implementation of financial management systems across all health facility types;
- Strengthening the community health worker (CHW) cooperatives to become more financially viable;
- Continuing to build the foundation for the national accreditation body;
- Supporting the harmonization and enhancement of the electronic medical records system;
- Building the communities of practice around the new knowledge management platform;
- Completing the feasibility study for mobile money payments for CHW performance-based funding (PBF); and
- Promoting health systems strengthening (HSS)-related research agenda.

Annexes

Annex 1: RHSS results framework



Annex 2: Implemented STTAs plan for the fiscal year 2015

Activity Number	Component/Intervention/Activity	Consultant name	Q1	Q2	Q3	Q4
1	**IR 1: Institutionalized health systems thinking approaches and practices to strengthen structural and process attributes towards increased advocacy, leadership, and stewardship**					
1.3.1.4	Recruit a consultant to facilitate development of resources allocation scenarios and describe the methodology and process	Ummuro Adano (MSH)				x
2	**IR 2: Improved multi-level GOR policy, planning, and implementation capacity with broad-based participation, and district health decentralization plan effectively implemented**					
-	-					
3A	**IR 3A: Increased revenue mobilized by the health sector through domestic and private sector sources to achieve sustainability**					
3.A.1.4.4	Development of the draft of the CBHI fully functional, sustainable model	MIA/SRC				x
3.A.2.1.3	Provide coaching on designing methodologies and tools for economic analyses	Bill Newbrander and David Collins				x
	Carry out "facility self-financing study data analysis"	Sanjeer Kumar & Eric Söderberg			x	
3.A.4.2	Support RBC to carry out PPP pre-feasibility and feasibility assessment	Enrique Cabrera				x
3.B	**IR 3B: Improved and expanded quality health services through more effective and efficient use of existing resources in the health system, achieving better value for money**					
3.B.3.1.1	Facilitate and advocate the establishment of Rwanda Healthcare accreditation body	Edward Chappy			x	
3.B.3.1.3	Support development and seek approval of the by- laws that guide operations of the accreditation body	Edward Chappy			x	
3.B.3.2.1	Facilitate review and update health service packages to include specialized services and private service packages at district facility, health centers, and health posts.	Joanne Ashton			x	
3.B.3.3.1	Design quality measurement indicators based on standards and service packages	Joanne Ashton				x
3.B.3.4.1	Train internal and external facilitators to support standards compliance	Joanne Ashton				x
3.B.3.7.2	Build capacity of the integrated teams to facilitate continuous quality improvement, standard compliance, and achievement of quality indicators to measure health outcomes	Joanne Ashton				x
4	**IR 4: Improved M&E, health systems research, learning, and knowledge-based practices**					
4.2.3.2	Integrate indicators from additional data sources into data warehouse (HRTT, eLMIS)	Jembi			x	x
4.2.4.1a	STTA from MSH knowledge management expert	Wayne Nissley			x	
4.3.1.2	Prepare a concept paper on the project's strategy for developing research capacity and closing the research-action loop.	David Hotchkiss and Augustine (Tulane)		x		x
4.3.1.3	Develop a list of proposed health systems evaluations and studies to promote for design/funding that responds to National and District evaluation needs.	Tulane		x	x	x
5	**IR 5: Project Administration**					
5.1.4	Support for recruitment and orientation of the new staff, including the induction of the new HR specialist	Veronique Mestdagh			x	
5.1.4.2	Technical assistance for project startup and work plan development	Sylvia Vriesendorp, Ken Heise,		x		

Activity Number	Component/Intervention/Activity	Consultant name	Q1	Q2	Q3	Q4
		Navindra Persaud				
	Operational assistance for project startup	Christele Joseph Pressat			x	
5.1.4	Technical assistance for finalizing RHSS communication plan and induction of the new project communication team	Mary Burket				x

Annex 3: Success story: Accreditation process propels improvement in Ruhengeri hospital Neonatal Unit

Ruhengeri hospital is a Provincial Referral hospital based in the Northern Province of Rwanda that has been operational for over 70 years. The hospital is among the five hospitals that are currently undergoing the process of accreditation – a substantive initiative championed by the Ministry of Health and supported by Rwanda Health Systems Strengthening Activity (RHSSA) to improve the quality of healthcare services across Rwanda. As part of the accreditation process, Ruhengeri hospital's internal facilitators underwent training in 2013 which resulted in the identification of a series of areas that required improvement, one of which was the neonatal unit. In 2013, neonatal mortality at Ruhengeri Hospital was recorded as 4.3% (August 2013 – February 2014) followed by 1.6% between March 2014 and July 2014 and most recently, at 1.4% between August 2014 and August 2015. In the span of 2 years, Ruhengeri Hospital has lowered neonatal mortality rate by implementing various strategies designed to improve the quality of standard driven healthcare services.

The quality improvement committee at Ruhengeri Hospital investigated the neonatal unit to identify challenges and establish actionable steps that could be taken immediately to reduce the spread of infections which were identified as the leading cause of infant mortality at the hospital. The first challenge identified was the distance between the maternity ward and the neonatal unit which stood at 300 meters. Hospital staff as well as newborn mothers had to repeatedly cover this big distance in order to provide the newborns with the adequate care they needed exposing them to the elements and potential sources of infection. Furthermore, there were only 2 rooms in the neonatal unit where stable newborns, newborns with infections, and newborns transferred from surrounding health centers were cared for simultaneously. This lack of separation between the different cases combined with the vulnerability of newborns contributed to the spread of infectious diseases in the congested neonatal unit. Additionally, prior to commencing the accreditation process, neonatal care guidelines and protocols as defined by the Ministry of Health were not being referenced when handling newborns. For instance, personal protective equipment (PPE) such as gloves, boots and hand sanitizers were not incorporated into safety procedures.

After identifying the shortcomings of the neonatal unit and the dire implications that they had on maternal newborn and child health, the Rugengeri Hospital set forth on making the necessary improvements. In 2013, the hospital constructed a new neonatal unit that now stands only 100 meters from the maternal ward. The new unit has 23 beds and 12 state of the art incubators where newborns are cared for separately depending on their condition at birth, whether stable, infected and requiring treatment, or in need of Kangaroo Mother Care.

Pictured: Clinician attending to a mother and her newborn in the old Neonatal Unit

Pictured: Clinician attending to a premature baby in one of the state of the art incubators in the new Neonatal Unit

Continuing on the path to accreditation, the hospital worked closely with RHSSA to promote safety and infection prevention and control measures in the newly built unit. To remind staff of the importance of abiding by these procedures, every room in the hospital has visible signage exhibiting safety protocols that must be followed by care givers at all times. Dr. Anne Mbiya, General Practitioner and Quality Improvement Coordinator at Ruhengeri Hospital, noted that "there are medical professionals at the hospital who all have different backgrounds and different approaches to providing patients with care. As part of the accreditation process we have been adamant about referencing the standards and protocols as stated in the clinical treatment guidelines; all our patients, both newborns and mothers, are receiving standardized care that is tested and trusted. What we have seen so far is that incremental improvements can culminate into positive change that is reinforced by data – that's exactly what we have observed with the new neonatal unit."

With the guidance of RHSSA, the hospital has also increased the utilization of data when seeking ways to improve their health service delivery. For instance, recent information from HMIS led medical professionals in the neonatal unit to conclude that most of the newborns that were suffering from infections were typically cases which had been transferred to Ruhengeri Hospital from nearby health centers. To prevent this from undermining their ongoing effort to reduce neonatal mortality, Ruhengeri Hospital began conducting trainings at health centers emphasizing the importance of adherence to clinical treatment guidelines and standard safety and infection prevention and control protocols. "We have tried to solve the problem right from the source. If we

are to increase the quality of care that we provide to our patients, especially mothers and newborns, we have to not only review our processes of operation, we also have to take our surrounding health care providers into consideration. Initially we were collecting data and simply sending it to the HMIS unit as required by the Ministry of Health, but now we take time to consider the data and what insight it can give us. ” Dr. Mbiya said.

Mothers at the new neonatal unit have also taken note of the advancements that Ruhengeri Hospital has made since 2013. Iradukunda Chantal is a mother who has delivered both of her children at the hospital. Her first child was born in 2013 and her newborn arrived in September 2015. “I was fortunate to have my first child at this hospital, because there are good doctors who followed up with me and provided me with an appointment. For my second child I arrived in an ambulance and delivered by cesarean section. They acted very quickly and because of that, I was able to deliver a healthy baby.”

RHSSA will continue to collaborate with hospitals like Ruhengeri Hospital and even to help Rwanda extend the accreditation framework to health centers and private health facilities to further improve quality of health care services and reduce preventable maternal and infant deaths.

-End-