

## Rwanda Health Systems Strengthening Project Quarterly Report (April-June 2015)

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Randy Wilson

July 31, 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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USAID RHSS  
Management Sciences for Health  
200 Rivers Edge Drive  
Medford, MA 02155  
Telephone: (617) 250-9500  
<http://www.msh.org>

# Rwanda Health Systems Strengthening Project

**Quarterly Report**  
(April – June, 2015)

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MSH Rwanda  
Kigali-Kicukiro,  
KK 341 St. Plot No. 22  
Tel. (250) 788-308-081/82

MSH  
200 Rivers Edge Drive  
Medford, MA 02155  
[www.msh.org](http://www.msh.org)

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## ACRONYMS

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
CDC	US Centers for Disease Control and Prevention
CHD	Community Health Desk
CHWs	community health workers
DH	district hospital
DHIS 2	District Health Information Software
DHMTs	district health management teams
DHUs	district health units
EMR	electronic medical records
eLMIS	electronic logistic management information system
FGD	focus group discussion
FMT	finance management system
GIS	geographical information system
GoR	Government of Rwanda
HC	health center
HMIS	health management information system
HRH	human resources for health
HRTT	health resources tracking tools
HSS	health systems strengthening
HSSP III	Third Health Systems Strategic Plan (2012-2018)
IGA	income generating activity
IHSSP	Integrated Health Systems Strengthening Project
IPPS	integrated personnel payment system
KM	knowledge management
L&G	leadership and governance
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
PIH	Partners in Health
PPP	public private partnership
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
SWOT	strengths, weaknesses, opportunities, and threats
SoW	scope of work
SPH	school of public health
STTA	short-term technical assistance
ToRs	terms of reference
TA	technical assistance
TWG	technical working group
USG	United States Government
USAID	US Agency for International Development
WHO	World Health Organization

## SUMMARY OF KEY ACHIEVEMENTS

The Rwanda Health Systems Strengthening (RHSS) project was awarded by the US Agency for International Development (USAID) to Management Sciences for Health (MSH) on November 17th, 2014. Over a period of five years, RHSS will help build a country-owned, sustainable health system capable of leading and managing changes. After start-up activities and first year work plan approval in the previous quarter, the project made great strides in implementation of the plan this quarter.

The activities completed in the areas of **leadership, governance, and decentralization** included a baseline assessment of ten districts and selected health units and facilities in those districts, primary data analysis, strength-weakness-opportunities-threats (SWOT) analysis and a draft of the baseline assessment report was produced. RHSS supported the Ministry of Health (MoH) in organizing technical working group (TWG) meetings and monitoring the implementation of TWG decisions. The project supported the Ministry of Health (MoH) to start the process of reviewing and updating the human resources for health (HRH) strategic plan. RHSS organized a field visit for a USAID team to the Nyamasheke district to oversee the implementation programs funded by USAID.

The **health finance** component's activities were focused on: presentation of the community-based health insurance (CBHI) sustainability study to government officials, continuing support to transition CBHI from the MoH to the Rwanda Social Security Board (RSSB), an update of public sector costing and tariffs, development of pre-feasibility and feasibility assessment tools and case studies for public private partnerships, and support to the MoH for the transition of health financing activities to the Rwanda Biomedical Center (RBC). The first phase of an assessment of community health worker cooperatives was completed and the second phase has started. RHSS completed a facility self-financing feasibility study to determine if health facilities are able to auto-finance. RHSS continued to meet with an established task force to decide on the implementation of financial management software in district hospitals and health centers. Finally, RHSS started the private sector facility costing study to calculate the “real” costs of providing private sector services at all levels.

In the area of **quality improvement of health services**, RHSS organized a workshop for health professionals to review service packages in both public and private health facilities. RHSS

continued to support the MoH in the process of establishing a national healthcare accreditation organization. It was decided that this will be established as a not-for-profit, nongovernmental organization. The hospital accreditation progress assessment was conducted in five provincial hospitals (Ruhengeri, Bushenge, Kibungo, Rwamagana, and Ruhango) to determine their current status in relation to the Rwanda hospital accreditation standards. To build the capacity of accreditation facilitators, RHSS conducted an accreditation facilitators' training course for 32 health professionals from six hospitals and a training needs assessment. The project revised and updated a facilitators' manual and a refresher course for facilitators trained two years ago. The project provided ongoing mentorship for the accreditation processes as well.

With regard to the **M&E, learning and knowledge-based practices component**, RHSS continued support to the MoH to operationalize the Rwanda health data portal and provided support for institutionalizing existing health information platforms including system documentation, interoperability of the systems, training for roll-out of the new performance-based financing (PBF) modules in the District Health Information Software (DHIS) 2, and support for community health worker (CHW) PBF payments using the new DHIS 2-based PBF module. RHSS initiated discussions with MoH partner (Swiss Cooperation) on expanding the use of geographic information systems for data management and use. The project provided support to review and design of knowledge management software using WordPress. The RHSS senior technical advisor participated in the One Million Community Health Workers Campaign conference held in Accra, Ghana in June. The project continued to support transition of the CBHI system to the RSSB by organizing a workshop to develop an enterprise architecture framework and long-term roadmap for integrating CBHI information systems.

In relation to overall **project management and administration**, nine new staff were hired and orientated. The project completed its five-year strategic plan and a draft work plan for year 2 of project implementation (fiscal year 2016). RHSS also developed and finalized detailed terms of reference and budgets for RHSS sub-contractors (Jembi, Tulane, University of Rwanda/School of Public Health, Banyan).

## INTRODUCTION

Since 1994, Rwanda has made remarkable progress in improving the health of its citizens, as illustrated by indicators for infant, child, and maternal mortality. Access to health services has significantly improved with the effective implementation of the community-based health insurance (CBHI) program. There are promising efforts in improving the quality of service delivery including establishing sustainable hospital accreditation processes and infrastructures. However, many challenges remain, especially in addressing critical resource shortfall projections.

The United States Government (USG), through USAID, has contributed significantly to the improvements in the Rwanda health system and health status through initiatives such as HIV Performance-Based Financing project (2005 – 2009) and the Integrated Health Systems Strengthening Project (2009 – 2014), both of which partnered with the Rwandan government to strengthen foundational systems required for the provision of quality health services, such as financial management, quality improvement and assurance, data management, and human resource management and support. MSH was proud to be chosen as the implementing partner for these projects and is continuing its commitment to strengthening the Rwandan health system through USAID’s five-year Rwanda Health Systems Strengthening (RHSS) project.

RHSS started officially on November 17<sup>th</sup>, 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.

This report presents the RHSS activities implemented and results achieved from April through June, 2015.

## LEADERSHIP, GOVERNANCE, AND DECENTRALIZATION

This section addresses the work completed during the quarter related to two intermediate results: institutionalized health systems thinking to increase advocacy, leadership and stewardship; and improved policy, planning, and implementation at central and district levels.

### 1.1. RHSS baseline assessment

The baseline assessment absorbed most of the leadership and governance (L&G) component's time and energy this quarter. The team relied on strong involvement from the rest of RHSS team, school of public health (SPH) researchers, and the MoH and other stakeholders. The main activities implemented during this quarter were:

- 1) From the concept note developed during the last quarter, the team developed a more detailed protocol describing the objectives and methodology of the assessment and shared it with the TWG.
- 2) Each of the RHSS component teams completed a desk review of key documents describing the situation of the Rwandan health system. The purpose of this desk review was to document available information and identify additional data to be collected through the assessment.
- 3) RHSS staff designed data collection tools in close collaboration with researchers from the SPH. These include focus group discussions (FGD) at the central level with government staff (MoH and RBC) as well as non-state actors (development partners, private sector, and NGOs). FGD agendas were also prepared to obtain qualitative information from governing bodies (district health management teams (DHMT), district health units (DHU), district hospitals' board of directors (BoDs), and health centers' committees) and questionnaires were developed to obtain quantitative information from staff in health facilities (district hospitals, health centers and health posts, district pharmacies, and district CBHI offices). The RHSS team decided on topics and questions to be covered based on the indicator grids prepared by each of the RHSS component teams.

- 4) The SPH statistician finalized the questionnaires used to collect quantitative data and the data collectors were trained to perform data entry using tablets to speed up the process of primary analysis. The questionnaires were pre-tested in a district hospital and health center near Kigali (Nyamata) and final adjustments were made according to results of the pretest.
- 5) Ten districts (out of 30 districts nationwide) were selected for data collection. To ensure the best possible variety of districts in the sample, two districts were purposefully selected in each province and two in the city of Kigali. All districts were ranked according to their performance on key health management information system (HMIS) indicators and PBF assessment scores. The best performing and worst performing districts were selected in each province. A team of six data collectors, including representatives from MoH/RBC, from SPH and from RHSS made a three-day visit to each selected district. One hospital was chosen for each district, mostly district hospitals, but in some cases provincial or referral hospitals, to capture various hospitals' situations. The team visited two health centers and wherever possible, two health posts, in each selected hospital's catchment area. DHMTs, DH BoDs and one HC health committee in each district participated in a FGD about their achievements and key challenges.
- 6) After primary analysis was conducted by the SPH researchers, RHSS held a SWOT analysis workshop with key stakeholders of the health sector to summarize the key findings of the baseline assessment and generate recommendations. The results from this workshop were integrated in the baseline assessment report.
- 7) The team produced the first draft of the baseline assessment report and presented the results to the planning, health financing, and information system (PHFIS) TWG, who is using them to inform the TWG joint action plan 2015-2016. The report will also serve as reference document for the health sector strategic plan (HSSP III) midterm evaluation planned for August.

## **1.2. Support to the PHFIS TWG, JSR and HSWG**

A mandate of the MOH's directorate of PHFIS is to coordinate partners to ensure fruitful results from the implementation of health system interventions. During this quarter, RHSS supported the directorate in organizing TWG meetings, monitoring the implementation of TWG decisions, and assuming secretariat roles. RHSS designed a monitoring tool to follow up on implementation of the TWG joint action plan. The project is also supporting the development of a knowledge management (KM) platform for rapid and effective information sharing between TWG members.

The TWG joint action plan had been initially designed for the six-month period from January to June 2015. The progress of planned activities was assessed in the last meeting of the quarter (June 26<sup>th</sup>) and the conclusion is that, in this short time period, the TWG has already achieved completion of most planned activities. A new joint action plan will be developed shortly for the new GoR fiscal year, July 2015 - June 2016.

The forward-looking Joint Sector Review (JSR) was held on May 27<sup>th</sup>, 2015 and responded to the requests from MINECOFIN:

- To assess progress towards implementation of the 2014/15 policy actions;
- To present and discuss areas prioritized during the planning and budgeting process;
- To discuss and validate the 2015/16 sector targets and related policy actions;
- To select policy-related studies to be conducted in 2015/16 fiscal year and briefly report progress on 2014/15 analytical works;

A few additional points were also discussed during the meeting:

- The relevance of a mid-term review of the sector strategic plan;
- Brief information on the report on implementation of the 2012/13 office of Auditor General report's recommendations;
- Information on the roles and responsibilities of MoH and RBC.

The Health Sector Working Group (HSWG) met on June 30<sup>th</sup> to review the functioning of the different TWGs and agree on the way to reactivate those which have been idle. Other points of discussion were the indicators to be reported on for the HSSP III mid-term review, updates on progress of health resource tracking tools (HRTT), CBHI transition, Capacity Development Pooled Fund, and priority analytical studies to be planned for the coming year.

### **1.3. Support for the review and extension of HRH strategic plan**

The HRH TWG meeting took place during this quarter and the main topics were to discuss the HRH sustainability agenda and review the HRH strategic plan. RHSS prepared a presentation to share key information during this meeting with MOH staff. The main outcome of this meeting was a consensus to update the HRH strategic plan 2011-2016 and align it with the HSSP III which goes until 2018. The TWG meeting also agreed to use the information from the HRH sustainability agenda as proposed by the senior management meeting of the MOH. RHSS supported the MoH to start the process of reviewing and updating the HRH strategic plan by:

- a) Facilitating the development of the terms of references (ToRs) for the consultant to do this exercise;
- b) Participating in discussions to design and review the tools to be used;
- c) Recruiting a local consultant to undertake the assignment of reviewing and updating the HRH strategic plan.

#### **1.4. USAID site visit to Nyamasheke district**

At the request of USAID, a field visit was organized with their team to Nyamasheke district to see how the DHMT is functioning and to Bushenge provincial hospital (in Nyamasheke district), which is participating in the accreditation program. The visit was very successful; the team was impressed by the district's progress in owning their health activities and the hospital's innovative responses to the needs of the population it serves.

#### **Encountered challenges**

- Stakeholders' participation in FGDs was quite limited. Several appointments had to be made to succeed in obtaining inputs from key stakeholders, both governmental and non-state actors.
- Delay in data collection was due to the period of Genocide commemoration (month of April) during which it was not possible to organize meetings and trainings.

#### **Next steps**

- Finalization of the baseline assessment report and use of the findings for future planning (RHSS and HSSP III implementation);
- Development of an action plan for health systems strengthening (HSS) (removal of barriers to leadership and stewardship and development of L&G capacity building plan);
- Support to the HSSP III midterm review process;
- Review and updating of the HRH strategic plan in alignment with the HRH sustainability agenda;
- Installation of district technical advisors in their respective districts areas/provinces of support; and
- Training district teams on integrated planning and supporting the district planning process.

### 2.1. Improved functioning and sustainability of an integrated and equitable health insurance system

#### 2.1.1. Validation of the CBHI sustainability study

In 2014, through USAID's Integrated Health Systems Strengthening project, MSH supported an assessment of CBHI program's sustainability. The Micro Insurance Academy/Social Re-consultancy Ltd. (MIA/SRC), an internationally recognized insurance consulting firm, supported this study with the goal of providing a roadmap of the steps required to ensure CBHI financial sustainability. In this quarter, an MIA/SRC consultant returned to Rwanda to present the final CBHI sustainability report at a workshop with GoR officials and to develop a draft model of a fully-functional CBHI system. The report's recommendations were discussed including the suggestions to eliminate CBHI co-payments, develop and implement a re-insurance scheme, and to enforce mandatory CBHI membership. The decision was made to send the report to high-level officials for validation.

#### 2.1.2. CBHI transition to RSSB

RHSS continued to meet with the RSSB team to provide technical assistance (TA) during the CBHI transitional phase and develop TA plans for the post-transition phase. The project organized a planning workshop to develop a transitional roadmap that includes plans to transfer the CBHI monitoring system, the financial management tool, and the mutuelle membership management system. Workshop participants also proposed the development of a long-term strategic roadmap for the development of insurance information systems within the RSSB. RHSS also continued to support the MoH in preparing the official hand over of CBHI transition to the RSSB, mainly gathering CBHI official documents, CBHI historical documentations, and CBHI studies reports.

#### 2.1.3. Integrated CBHI membership management system

RHSS sub-contractor, Jembi, finalized plans for the rollout of an integrated CBHI membership and management system for the RSSB. This web- and mobile phone system allows CBHI members to check their membership status, pay their contributions electronically, and records membership payments.

## **2.2 Strengthen the capacity of the MOH/RBC to carry out economic analyses and financial feasibility of health system interventions**

### **2.2.1. Validation of updated public sector costing and tariffs**

In 2011, MSH carried out a public sector facility costing analysis through IHSSP. The MoH has updated and expanded this analysis, culminating in proposed revised tariffs, currently in the process of MoH validation. MSH supported a hospital director workshop to present and seek approval for both the costing methods and revised tariffs. The hospital directors/representatives endorsed the revised tariffs with minor changes. The costing document has been approved by the MoH/senior management meeting and is waiting for discussion with health insurance companies and health care providers.

### **2.2.2. Development of pre-feasibility and feasibility assessment tools and case studies**

An RBC gap analysis conducted in the previous quarter concluded that RHSS should prioritize support to the RBC to identify and carry out analysis of potential public-private partnership (PPP) pipeline in the health sector, prepare a pre-feasibility and feasibility study assessment framework, and carry out a case study pre-feasibility and feasibility assessment. During this quarter, a Banyan Global consultant spent three weeks embedded at the RBC to:

- Develop a PPP identification process framework and a pre-feasibility and feasibility assessment framework;
- Complete feasibility assessments on three potential PPPs; and,
- Train the staff of the RBC business development unit (BDU) to apply the toolkit.

RHSS developed a toolkit for the RBC/BDU, which includes Microsoft Excel based models with detailed step-by-step processes to identify and select suitable PPP projects with limited data. These tools allow the RBC to determine whether PPPs are the best project delivery method during the pre-feasibility stage. Three pre-feasibility and feasibility case studies were carried out including assessments for establishing radiotherapy and laboratory centers. The project delivered a final report including the frameworks, case studies, a potential pipeline of additional projects, and inputs into the BDU strategy plan.

### **2.2.3. Support MoH organizational transitions**

During this quarter, RHSS continued dialogue with the MoH to develop a year 2 plan of activities that accommodates the many infrastructural changes taking place including: CHW

cooperative desk moving to the health financing unit; the community PBF desk moving to the health financing unit (from the community health unit at RBC); and the PBF processes becoming linked to accreditation.

## **2.3 Increased income generation capacity of various local entities toward staff retention and self sufficiency**

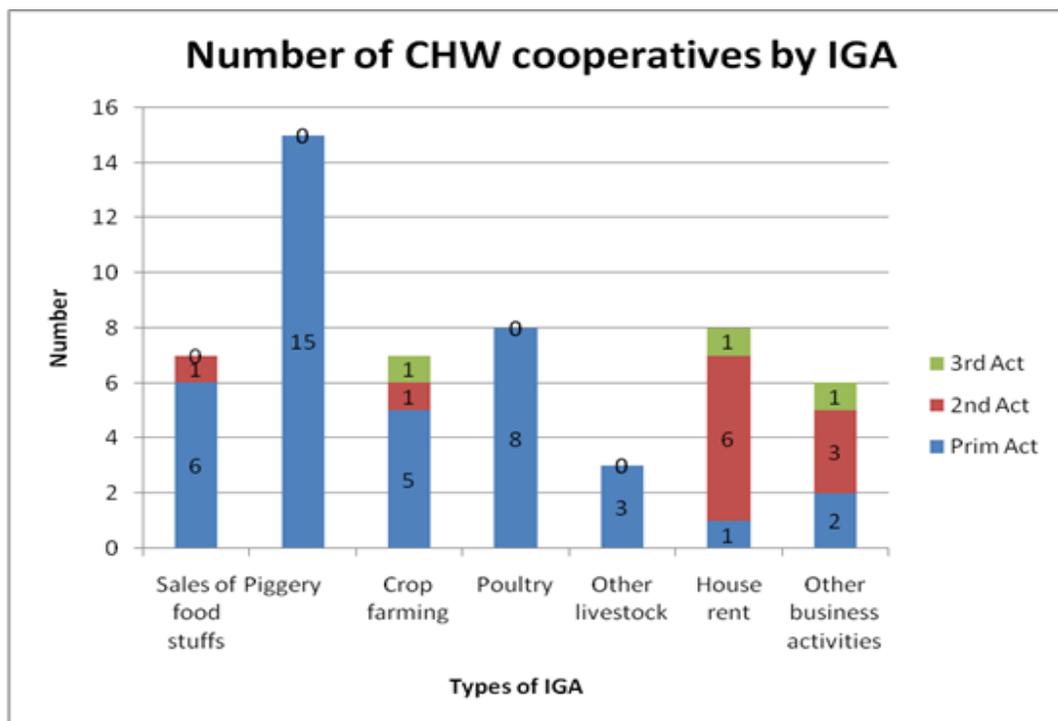
### **2.3.1. Rapid CHW cooperative assessment**

Last quarter, the MOH carried out, with RHSS support, the first phase of an assessment of CHW cooperatives. A key objective was to assess income generation results of a sample of cooperatives (No. = 40) and to:

- Assess the effective use of CHW cooperative management tools;
- Assess the level of technical support provided to the cooperatives by different partners;
- Evaluate the management of cooperative funds for the benefit of all members;
- Identify challenges facing cooperatives in doing business and performing community health activities; and
- Examine the disbursement of Global Fund PBF funds and earmarked transfers from MINECOFIN to cooperatives.

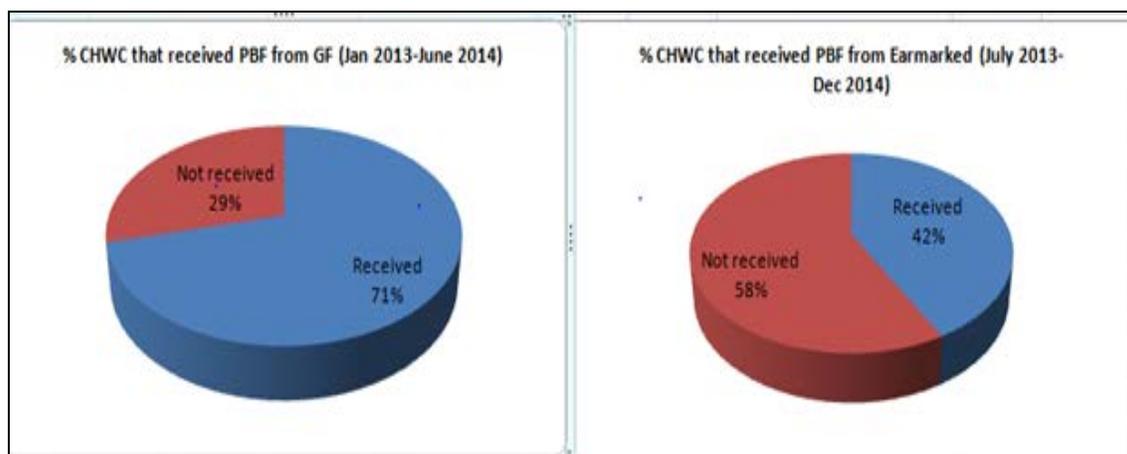
Phase 1 of the assessment has been completed and the project presented the final report to MOH technical staff and disseminated it to other stakeholders. Figure 1 shows the number of cooperatives by income generation activity. The majority of cooperatives are implementing pig farming as their primary 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.

**Figure 1: Number of cooperatives by income generation activity**



The assessment indicated that 71% of cooperatives received Global Fund PBF resources (Figure 2) for January 2013 – Jun 2014, while 42% received GoR earmarked support for July 2013 – December 2014. The latter are funds transferred from MINECOFIN to districts for distribution to cooperatives. The 29% from Global Fund and 58% from the GoR were not received by cooperatives. It was observed that these no received funds were used by health centers or districts for other activities and not transferred to CHW cooperatives accordingly.

**Figure 2: Global Fund PBF resources and GoR earmarked transfer to CHW cooperatives**



### **2.3.2. CHW cooperatives comprehensive assessment**

RHSS is supporting the MoH to carry out a comprehensive CHW cooperative assessment of all cooperatives (No. = 475). A consulting firm has been recruited, the logistics for the study completed, and the study methods finalized including indicators and questionnaire development.

Two key objectives of the study are:

- Carrying out a variation analysis of the cooperatives culminating in a ranking including best practices; and,
- Collecting two years of robust finance data to be analyzed to provide evidence on the level of cooperative performance in regards to business implementation, giving perspective on needed improvement to ensure cooperatives sustainability.

The tool to collect financial data will be developed in agreement with the MoH and may be integrated into the Rwanda DHIS at a later date.

### **2.3.3. Self-financing of district hospitals**

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. In this quarter, 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 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 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. The study report was finalized and is waiting validation by the MoH.

### **2.3.4. Finance management system development for district hospitals**

The HMIS and health finance team continued to meet with a combined MINICOFIN, MOH, and Rwanda Development Board (RDB) task force to support the implementation of financial management software in district hospitals and health centers. MINICOFIN has undertaken the role of developing and rolling out the financial management system software for health centers while the MoH continues 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 expand to meet health facility requirements and make it interoperable with the Ministry of Public Service and Labor's Integrated Personal Payment System, OpenMRS for patient encounter data, and the electronic logistic management information system (eLMIS) for drug stock management. This longer term approach will also permit the MOH and RSSB to complete discussions about more appropriate provider payment mechanisms that could simplify the design of the system. In the interim, RHSS is developing option papers for the MoH to be considered for financial management at district hospitals and continues providing TA to support the decision-making process.

In addition, RHSS started dialogue with the MoH on streamlining financial management at district hospitals. Gaps in financial management were highlighted by audit reports and there is a need to clarify the financial management procedures and standardize the financial management tools in all district hospitals.

### **2.3.5. Private sector facility costing study**

Following a RHSS presentation at a high level meeting sponsored by MINECOFIN, it was decided that RHSS will support the government to calculate the "real" costs of providing private sector services at all levels. The health finance team began start-up preparations including recruiting a team of expert consultants, defining a sample of facilities to include in the study, and visiting facilities for data collection. All facilities in the study have been visited and most of the data has been received and entered into the MSH costing tool (HOSPICAL). An appointed steering committee composed of representatives from health insurance schemes (public and private), private health facilities, and Government led by the RDB was mandated to follow up all steps of the costing study. The steering committee has met twice so far and endorsed the study methodology.

#### **Encountered challenges**

- Ongoing MoH organizational transitions, with units moved to RBC and dissolution of the health finance unit into the PHFIS directorate, have created obstacles in identifying the correct MoH counterparts and necessary technical assistance for some activities.

- The transition of CBHI to RSSB requires re-establishing RHSS-RSSB working relationships. There is still a lack of clarity in some functions to be carried out by either RSSB or MoH.

**Next steps**

- Finalizing the private sector costing study
- Finalizing the CHW cooperative comprehensive assessment
- Finalizing the year 2 work plan including scope of work of TA with all partners (MoH, RBC, RSSB and RDB)
- Finalize PPP pre-feasibility and feasibility assessments in accordance with PPP pipeline
- Prepare for the roll out of integrated CBHI membership and management system
- Follow up on validation of the CBHI sustainability study by high level officials

### 3.1. Service packages review for public and private health facilities

The service packages for both public and private health facilities were reviewed by health professionals in their relevant specialties. The validation process for both documents is ongoing.

#### Next steps

- Dissemination of updated health service packages
- Inform the review of ministerial instruction to implement health service packages

### 3.2. Establishment of healthcare accreditation organization

Since the launch of accreditation system in 2012, there has been interest in establishing a national healthcare accreditation organization to institutionalize continuous quality improvement and enhance patient safety.

Early in May, the RHSS team met with the Minister of Health to discuss different models of healthcare accreditation. After the meeting, the Minister decided to proceed with the establishment of a national healthcare accreditation organization. Consultative meetings were held with potential stakeholders to discuss the proposed model and concept paper and to obtain their agreement to participate as board members. A consensus building workshop was organized, chaired by the Minister of Health, with the objective of understanding the different models of accreditation agencies around the world and deciding on an appropriate model for Rwanda.

It was decided at the meeting that a national healthcare accreditation organization will be established as a not-for-profit, nongovernmental organization (NGO) and will be financially supported by the MOH partners for a period of three years. Thereafter, it will transition to a private, not-for-profit entity. The proposed board members are from organizations that have quality and safety of health services as a part of their mandate. These include representatives of the health insurance association, public and private providers, and consumers of healthcare services.

#### Next steps

- Support the development of by-laws for the board of healthcare accreditation organization including the terms of reference for the Technical Advisory Committee;
- Develop a roadmap and milestones for establishing the entity in three years

- Assist in the development of a cabinet paper to establish the accreditation organization, mandatory health facility accreditation, and a public private accreditation framework
- Support launching of the accreditation organization in Rwanda

### 3.3. Hospital accreditation progress

A *provincial hospital* progress assessment was conducted between April 20<sup>th</sup> and May 8<sup>th</sup>, 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 will help 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 target. 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 assessment was conducted by Rwandan certified surveyors facilitated by the MSH RHSS team using a variety of methods: leadership interviews, interviews with hospital committees, document review, medical record review, and clinical unit and facility tours. The assessment used the revised tool that integrated PBF assessment check lists.

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	
	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%
<b>Overall average</b>	<b>87%</b>	<b>56%</b>	<b>89%</b>	<b>57%</b>	<b>85%</b>	<b>52%</b>	<b>96%</b>	<b>81%</b>	<b>94%</b>	<b>73%</b>

Three out of five hospitals maintained level-one standards, exceeding the minimum scores of 75% in all risk areas and an 85% overall score, and are progressing well in pursuing level two. 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 one 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. Risk area 3, safe environment, is an area where all facilities will need to make big improvements 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.

### Next steps

- Meet with the teams in hospital A and C to discuss and provide the support necessary to help them close their gaps
- Organize support on infection prevention and control

## 3.4. Capacity building for accreditation facilitators

### 3.4.1 Facilitators' training and mentorship

An accreditation facilitators' training course was conducted for 32 health professionals from 6 hospitals. The trained facilitators were mentored to implement knowledge and skills in the hospital setting. A practicum was held at Kinyihira hospital. The focus of the activity was on infection prevention and control, as this was critical area in



**Figure 3: training and mentorship of facilitators**

which hospitals underperformed. The same training was used as an opportunity to train national trainers. Each trainer was provided with individual coaching on developing and presenting their topics and writing performance evaluations. The facilitators training was upgraded to a certification course based on program requirements and received feedback, and the year-long course will end in June 2016. Once the trainees fulfill the course requirements, they will sit for a final examination and be certified.

#### **3.4.2 Training needs assessment**

RHSS also conducted a training needs assessment to determine current practitioners' current knowledge, skills, and experience and determine future facilitation topics.

#### **3.4.3 Update of facilitators' manual**

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.

#### **3.4.4 Refresher course for old facilitator trainees**

The project conducted a refresher course for facilitators trained two years ago. Participants discussed challenges and potential solutions to meeting standards. Internal facilitators were given assignments for each hospital based on challenges expressed by facility teams. Teams will present their work during a workshop scheduled in July.

## IMPROVED M&E, CULTURE OF LEARNING, AND KNOWLEDGE-BASED PRACTICES

### 4.1. Data production, conversion and increased evidence-based decision making and practices

#### 4.1.1. Support strategic and operational planning for MOH activities

There has been a delay in scheduling the eHealth strategic planning workshop due to ongoing discussions with the MoH. The MoH/Director General of PHFIS has finally agreed to conduct this activity and the RHSS team is actively planning the workshop (which is likely to be held in August) with Partners in Health's (PIH) electronic medical records (EMR) team and other stakeholders. Meanwhile, the RHSS team also worked with Jembi and a small team from RSSB to facilitate a workshop to develop an enterprise architecture framework and roadmap for integration and further development of CBHI information systems.

#### 4.1.2. Operationalizing the Rwanda Health Data Portal

A Jembi consultant worked with the MOH team to automate the import of data from all DHIS 2 instances into the data warehouse. The RHSS staff assisted the MOH/PHFIS directorate team to clean up indicator definitions and prepare an initial set of dashboards in preparation for public sharing. The WHO has recruited a full-time staff member to support Rwanda Health Observatory implementation for the next three to four years and RHSS began discussions with the WHO/AFRO team about integration of content from the data warehouse and health observatory.

#### 4.1.3. Assessing the use of existing data at all levels (policymakers, DHU/DHMT, facility)

The major activity in this quarter involved working with the RHSS L&G team to design the baseline assessment, focusing on integration of selected Performance of Routine Information System Management (PRISM) methodology to identify barriers to data use at all levels.

#### 4.1.4. Support for institutionalizing existing health information platforms

The RHSS team continued to support the enhancement and maintenance of the DHIS 2 platform in the following areas:

- **System Documentation:** RHSS led efforts to further develop and update system documentation for all of the DHIS 2 instances. This was in response to one of the Global

Fund audit findings of the MOH last year that there was not adequate documentation supporting system access, administration and use.

- **Data warehouse interoperability:** The Jembi consultant provided short term technical assistance to the MOH team to automate the synchronization of data between different DHIS 2 instances and the data warehouse. RHSS staff supported the MOH staff to refine the indicator definitions and create a basic set of dashboards that can be shared as soon as the Minister decides on open access to the data warehouse.
- **Interoperability of eLMIS and DHIS 2:** RHSS staff and Jembi met with the USAID funded Deliver project to discuss potential interoperability between the recently rolled-out eLMIS (electronic logistics management information system) and DHIS 2. There is an interest in using the DHIS 2 as a possible business intelligence dashboard platform for key logistics system performance indicators. RHSS proposed to start working with the USAID-funded DELIVER project team by implementing two use cases that it has prepared:
  - Aggregating eLMIS stock data and pushing monthly stock indicator data for tracer drugs into the HMIS, and
  - Pulling data from the health facility registry into eLMIS to keep the facility lists synchronized.
- **Training of trainers to prepare for the roll-out of the new PBF modules in DHIS-2:** RHSS 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. The workshop was also an opportunity to test and get additional user input on the new system. Additional workshops for national roll-out are scheduled for next quarter.
- **CHW PBF payment:** The first individual payments to CHWs were completed using the new DHIS 2 based PBF module.

#### **4.1.5. OpenMRS individual records system harmonization**

RHSS staff and Jembi met with staff from the RBC to discuss lessons learned from the Rwanda Health Enterprise Architecture project and begin to chart the way forward for supporting further enhancements for the OpenMRS platform. There is new focus (both from the MoH and RSSB) on implementing a billing system and support to RBC is under preparation for systems analysis

to help define the requirements. This work will require substantial resources. A conference call was held with PIH and Jembi staff in South Africa to discuss a related CDC-funded implementation science study being conducted to determine the costs and benefits of electronic medical record systems.

#### **4.1.6. Enhancing data management and use**

RHSS staff met with staff from Swiss Cooperation to discuss possibilities to work together on expanding the use of geographic information systems (GIS) in the districts. It was decided to work together on designing links between DHIS 2 and QGIS (an open source GIS platform that has been introduced by USG through the Futures group) and developing guidelines and a curriculum for training district M&E officers and data managers.

### **4.2. Operational health system research is strengthened and supported for sustainable HSS**

#### **4.2.1. Establishment of knowledge management platform**

The KM platform supports forums where people can exchange experiences, best practices, documents, and data. RHSS assisted with review of the options for the KM platform in light of the additional features that the Ministry had requested. It was proposed to shift from WikiMedia to WordPress content management software, which has better collaborative functionalities. A prototype was developed and some of the content was transferred over to the new system. The platform now has an integrated events calendar and single sign-on (so that members of several TWGs do not have to create new profiles in each group they join).



**Figure 4: Dashboard of KM platform**

#### **4.3. Cross-cutting support**

##### **4.3.1. Participation in 1 Million CHW Campaign conference, Accra, Ghana**

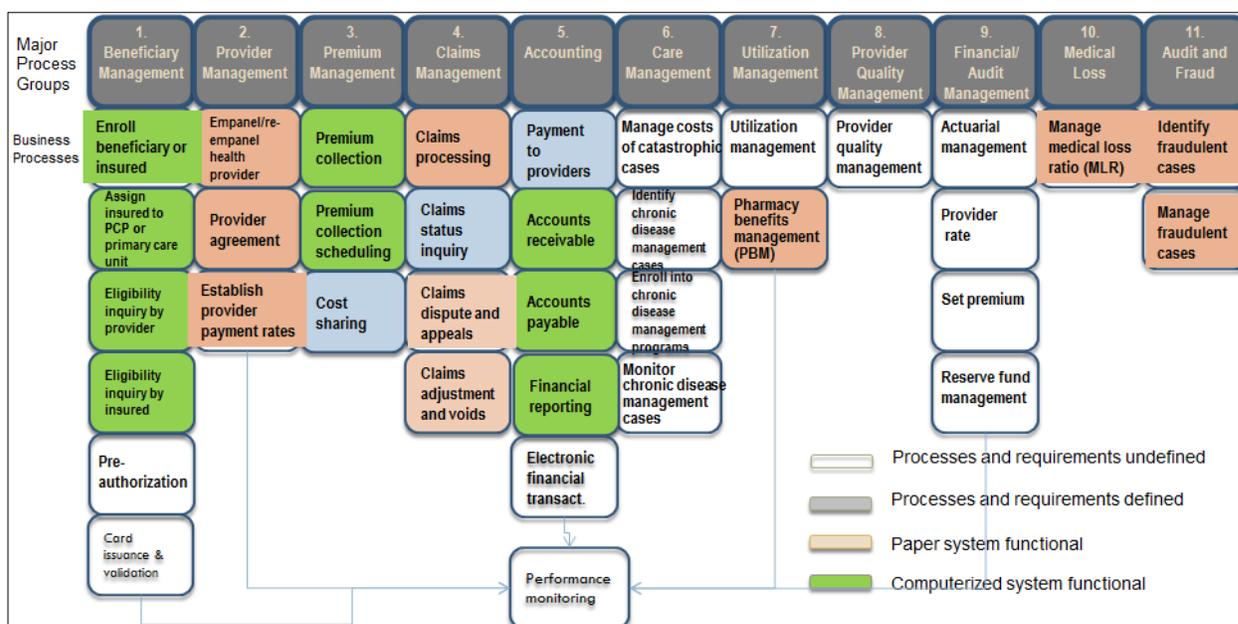
At the request of the MoH, the RHSS senior technical advisor (Randy Wilson) participated in this conference that brought together MoH and Ministry of Finance staff from over a dozen African countries to discuss different mechanisms to scale up and finance CHW programs. The Rwanda delegation was headed by the Permanent Secretary, Dr. Solange Hakiba. The RHSS

senior technical advisor presented an overview of the CHW program in Rwanda and he and MSH staff David Collins and Jean Kagubare made technical presentations on the Rwanda community PBF model and costing tools for integrated community case management.

### 4.3.2. CBHI system transition

RHSS staff team facilitated a three-day workshop with RSSB to develop an enterprise architecture framework and long-term roadmap for integrating CBHI information systems within RSSB. The discussions covered the full range of business processes involved in health insurance management (see Figure 5) and reached consensus on key sub-systems that RHSS will be supporting over the next few years including the CBHI monitoring system, claims processing, and mutuelle membership management system.

**Figure 5: Mapping of all of the RSSB insurance-related business processes**



### Challenges encountered:

- There are still challenges related to the MOH/RBC reorganization. Around half of the EMR team is still housed within the MOH and the other half at RBC. This ratio is almost the same for the HMIS team. A new national HMIS coordinator is not yet appointed, though one of the RBC planning officers (Sabine Umuhire) is currently informally acting in that position. RBC is interested in RHSS support to conduct a functional analysis to identify staffing gaps and duplications. However, RHSS thinks that some of the staff appointments in different institutions are based on available posts and not necessarily on functions and reporting lines.

- The official transition of CBHI to the RSSB was completed July 1st. However, follow-up on the activities with RSSB has not been timely and CBHI membership system roll-out has not yet begun.

### **Lessons learned**

- From the “1 Million CHW Campaign” conference, it was clear that Rwanda is well ahead of nearly all African countries in scaling up CHW programs, but there is something to learn from others about sustainability. The general consensus was that CHWs need to be recognized as health professionals and provided with adequate remuneration, be it through PBF, sales of health/medical products, or wages. There is a need for advocacy for domestic funding of the CHW program, potentially through the CBHI scheme by demonstrating cost benefit of shifting tasks to CHWs and reducing the burden on facility-based services that have higher costs. This should be part of the CBHI and CHW sustainability discussions.

### **Next steps:**

- Training of trainers for the roll-out of the new DHIS 2 PBF module
- Submit a proposal for CHW mobile money payment feasibility study to MOH for approval and begin the study;
- Support the eHealth strategic planning exercise
- Support implementation of the RSSB strategic roadmap for CBHI (roll out of membership system and discussions about adapting the M&E system)
- Design new analytical reports for eIDSR and build capacity within the RBC team to create JasperStudio reports for eIDSR and the HIV reporting system
- Support rapid assessment of EMR with RBC and identify short-term technical assistance to help with systems analysis tasks
- Complete the recruitment of the District M&E Advisor and begin desk reviews to harmonize district M&E frameworks
- Complete enhancements to the KM platform on the WordPress platform;
- Complete the conversion of tablet based accreditation assessment tools from LimeSurvey to OpenODK

## PROJECT MANAGEMENT AND ADMINISTRATION

### 5.1. Recruitment of new staff

The MSH country operations management team worked with technical units to recruit new staff for RHSS, including:

#### *Positions with the recruitment process completed and staff started the work:*

- Accountant
- Executive assistant/Strategic communication specialist
- Technical advisors for district capacity development (five positions)
- Technical advisor for health financing
- Technical advisor for HRH

All administrative processes were completed for hiring staff for the said positions, orientation was provided to these staff, and they started the work in their respective project components.

#### *Positions with the recruitment under process*

- District M&E advisor
- Public private partnership adviser (local staff)
- Public private partnership adviser (expatriate to be hired through Banyan Global)

RHSS currently has 42 staff and 3 positions under recruitment.

**Table 2: RHSSP current staff**

<b>Staff category</b>	<b>Number</b>
Project director/Chief of party (CoP)	1
Director of finance and operations	1
Team Leaders (senior advisors)	4
Technical staff (advisors, specialists)	17
Local finance and operations staff	11
Drivers	8
<b>Total</b>	<b>42</b>
Technical staff under recruitment pending new staff	3

## **5.2. Five year strategic plan development**

The project completed a five-year strategic plan that highlights the vision of the project to contribute to Rwanda's multi-sectorial Vision 2020 through partnership with the GoR and key stakeholders and key contributions to implementing HSSP III. The plan documents how RHSS will contribute to building a strong foundation that will allow the entire health system, from CHWs to central level decision makers, to make universal and equitable access to health care a reality for all, promoting a healthy, happy, and productive population.

## **5.3. Project Year 2 work plan development**

The project began work on the first draft of the Year 2 work plan, which will be submitted to USAID by the end of July 2015 for discussion and approval. It will also be used for discussion with MoH counterparts' inputs and getting consensus on scheduled interventions and activities. The final plan has to be approved by USAID by end September and implementation will start on October 1, 2015.

## **5.4. Development of detailed program descriptions for RHSS sub-contractors:**

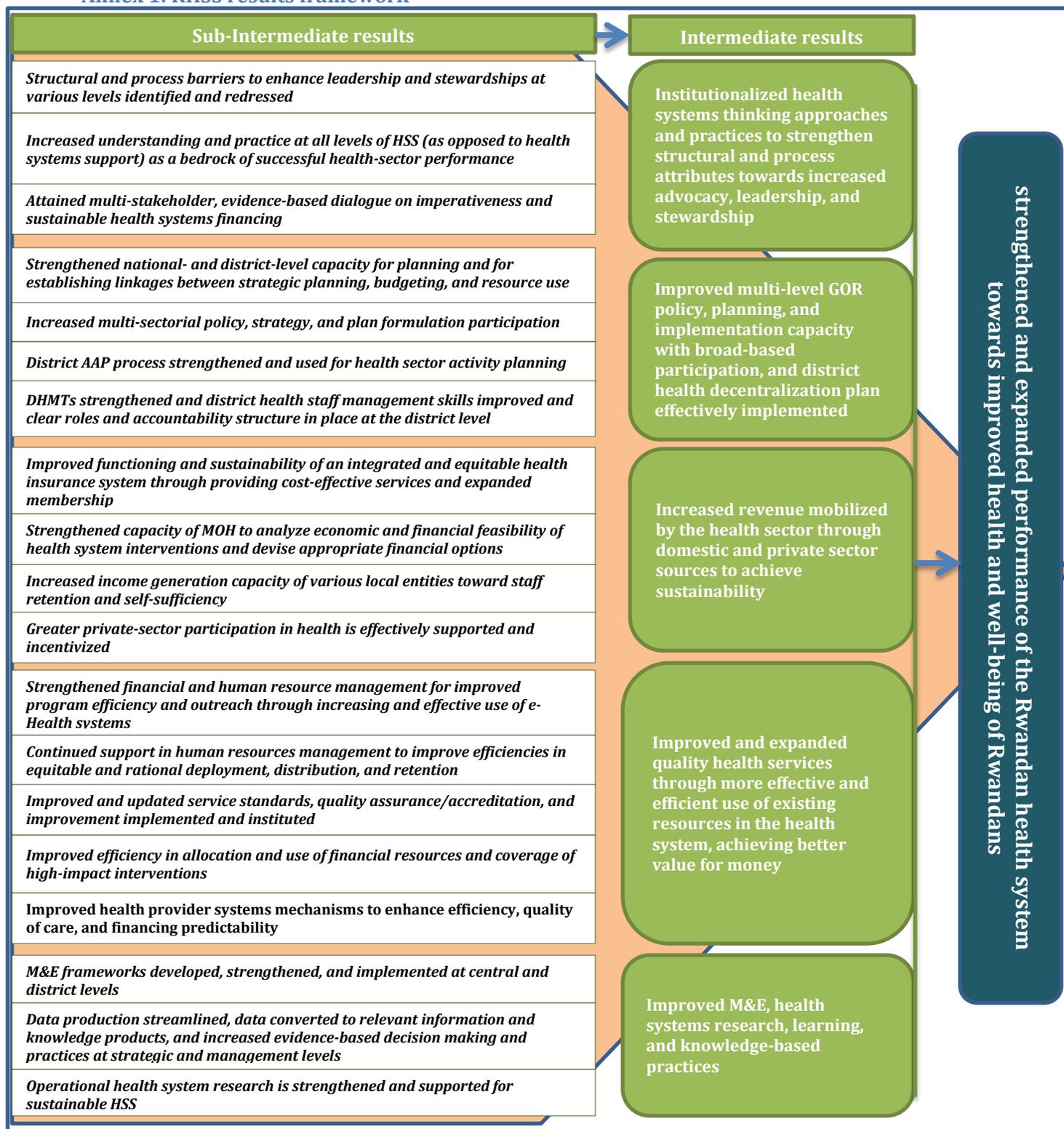
RHSS teams developed and finalized detailed terms of reference and budgets for RHSS sub-contractors (Jembi, Tulane, University of Rwanda/School of Public Health, Banyan), indicating support that these organizations will provide to the RHSS. This will facilitate planning of STTA visits of these sub-contractors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

## CONCLUSION

The effective implementation of project activities moved ahead within this reporting quarter of April – June, 2015. The implementation always focuses on the ultimate goal of building the capacity of the GOR to move from health systems support to health systems strengthening. During this reporting period, the major activities completed included a number of assessment and studies such as the RHSS baseline assessment, CBHI sustainability study, CHW cooperative assessment, private sector facility costing study and accreditation progress assessment. Other interventions included public and private services packages review, continued support for institutionalizing existing health information platforms, and establishment of a knowledge management platform.

In the next quarter, RHSS will emphasize enhancing mechanisms and processes for integrated planning, supporting the HSSP III mid-term review process, completing on-going studies and assessments to inform decisions on strengthening revenue generation and health finance, continuing the process of establishing healthcare accreditation organization, supporting quality improvement interventions, and continuing the enhancement of information systems (DHIS 2, CBHI membership, eIDSR, EMR, OpenODK, etc.) to support the use of existing data at all levels. The RHSS team, in consultation with USAID, will continue to provide support to the MOH by building the capacity of health sector providers, strengthening institutional capacity, and streamlining mechanisms to provide quality services for expanded performance of the health system at all levels.

Annex 1: RHSS results framework



## Annex 2: Implemented and planned STTAs for fiscal year 2015

Activity Number	Component/Intervention/Activity	Consultant name	Q1	Q2	Q3	Q4
<b>1</b>	<b>IR1: Institutionalized health systems thinking approaches and practices to strengthen structural and process attributes towards increased advocacy, leadership, and stewardship</b>					
1.3.1.4	Recruit a consultant to facilitate development of resources allocation scenarios and describe the methodology and process	Ummuro Adano (MSH)				X
<b>2</b>	<b>IR2: Improved multi-level GOR policy, planning, and implementation capacity with broad-based participation, and district health decentralization plan effectively implemented</b>					
-	-					
<b>3A</b>	<b>IR3A Increased revenue mobilized by the health sector through domestic and private sector sources to achieve sustainability</b>					
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.2.1	Develop a facility finance planning framework and two case studies	Nancy Natililon (Banyan)				X
3.A.4.2	Support RBC to carry out PPP pre-feasibility and feasibility assessment	Enrique Cabrera				X
<b>3.B</b>	<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</b>					
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 tools for 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 and DHMT to facilitate continuous quality improvement, standard compliance & achievement of quality indicators to measure health outcomes	Joanne Ashton				X
<b>4</b>	<b>I.R 4: Improved M&amp;E, health systems research, learning, and knowledge-based practices</b>					
4.2.1.3	Support Ministry & RBC to develop ICT guidelines and sustainability plan	Jembi				X
4.2.1.5a	Assessment of current mHealth applications and opportunities	Jembi				X
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	
4.2.6.1	Provide routine support to upgrade, refresher training and maintenance of existing platforms supported by USG: DHIS modules (PBF, eIDSR, TracNet, TB), iHRIS and Limesurvey	TBD				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

<b>Activity Number</b>	<b>Component/Intervention/Activity</b>	<b>Consultant name</b>	<b>Q1</b>	<b>Q2</b>	<b>Q3</b>	<b>Q4</b>
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
4.3.1.4a	Design and implementation of CHW mobile money payment study (co-funded by ASH)	Sherri				x
<b>5</b>	<b>Project Administration</b>					
5.1.4	Training of COMU Finance team in new financial management systems	Natalie Gaul				x
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, Navindra Persaud		x		
	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: From rubble to a regional referral hospital**

*Following the 2008 earthquake that left much of Bushenge Hospital completely destroyed, it has been rehabilitated and turned into a provincial referral hospital providing healthcare services to over 168,000 patients.*



***Pictured: Bushengye Hospital rebuilt after the earthquake***

Despite the devastation of an earthquake in 2008 where 80% of the hospital building was destroyed, the Bushenge hospital has successfully rebuilt components of the facility and gone on to achieve and maintain level 1 of the accreditation process. The construction of the new hospital was largely funded by the Belgian Technical Corporation (BTC) and the accreditation system that has helped improve the quality of services was implemented in Bushenge with USAID support through the Integrated Health Systems Strengthening Project and Rwanda Health Systems Strengthening Activity (RHSSA) which is implemented by Management Sciences for Health (MSH).

Bushenge hospital is among the five district hospitals that were recently upgraded to the status of provincial hospitals. After a recent field visit with the USAID team and RHSSA-MSH it became increasingly apparent that the Bushenge Provincial hospital, which serves over 168 thousand people across the six sectors of Nyamasheke District is a budding facility that is on the rise due to various interventions achieved through collaborative activities. One of these processes that have had notable impact on the quality of services provided by the Bushenge Hospital is Accreditation program

The Rwanda Ministry of Health (MOH) opted for an accreditation system to facilitate continuous quality improvement of health services as one of the key initiatives to strengthen health systems. The plan included development of standards health care services and establishing an accreditation organization to institutionalize continuous quality improvement in the country.

Moreover, as part of the accreditation survey, the team identified risk factors at the facility that were leading to a high number of neonatal deaths. Some of these risks included: lack of close observation of patients due to geographic barriers, instances of poor hygiene as none compliance with national neonatal protocols.

By training staff in the use of protocols, relocating and transforming the neonatal unit for closer patient observation and improving hygiene practices; the hospital has since recorded a decrease of neonatal deaths going from 1.8% between 2013-2014 to 1.5% between 2014-2015<sup>1</sup>. Additionally, MSH consultant provided consultation regarding ‘Safe Healthcare Design’ of the theater, providing advice on the redesign of theatre to address issues of infection prevention and control based on best practices and evidence based design to reduce patient safety risks.



*Pictured: Infection prevention measures in the neonatal unit*

Aside from infrastructural developments, which include the construction of an oxygen production plant to eliminate dependency on oxygen transported from Kigali; the Bushenge Hospital has also applied administrative tools that have contributed to more efficient operations at the hospital. A billing system was installed which has since given the management access to key information such as the volume of work done by each clinician (productivity measures) and tracking of procedures performed. Since the installation of the system, financial recovery rates have gradually increased, which will ultimately enable the hospital to better serve patients in the province. Despite some ongoing challenges with internet connectivity, the coupling of a full package electronic medical records system and billing system have positioned the Bushenge hospital as an exemplary case of the positive outcomes achieved through monitoring and evaluation of operations as well as dedication to continuous quality improvement.

The hospital has also received recognition from various leaders in Rwanda. Earlier this year, Hon. Prime Minister Anastase Murekezi visited the hospital accompanied by the State Minister of Public Health and Primary Care, Dr. Patrick Ndimubanzi. The Premier acknowledged that progress has been made in reconstructing the hospital and urged the management to speed up remaining repairs to the facility. He also commended the hospital on delivery of quality care services. “I’m very satisfied by the services provided to the patients,” said Hon. Murekezi.

As a provincial hospital, Bushenge has bridged the geographical access gap through provision of specialized care. Previously, patients were referred to hospitals in neighboring Huye or Kigali districts, this was both costly and time consuming for the local population not to mention potentially life threatening for emergency cases. Aside from improving the quality of health care they provide to patients in the immediate community, Bushenge Hospital also provided quality

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<sup>1</sup> Data Source: HMIS 2013 – 2014, 2014-2015  
Total deliveries: 2013-2014: 1711, 2014-2015: 1506  
Neonatal Admissions: 2013-2014:195,2014-2015:187

improvement trainings to health centers in its catchment area and Gihundwe hospital in the neighborhood, it also serves as an inspiration to other hospitals.