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# USAID Rwanda Integrated Health Systems Activity (RIHSA)

## Annual Report

**September 1, 2020–September 30, 2021**

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## Acronym List

| | |
|---|---|
| CBHI | Community-based health insurance |
| CHAI | Clinton Health Access Initiative |
| AMELP | Activity Monitoring Evaluation and Learning Plan |
| API | Application Programming Interface |
| CBHI | community-based health insurance |
| CHAI | Clinton Health Access Initiative |
| COHSASA | Council for Health Service Accreditation of Southern Africa |
| CPD | Continuing Professional Development |
| DCA | Development Credit Authority |
| DFC | U.S. International Development Finance Corporation |
| DH | District Hospital |
| DHMT | District Health Management Team |
| DHU | District Health Unit |
| DQA | Data Quality Assessment |
| eCMS | electronic Claims Management System |
| EMR | Electronic Medical Record |
| eSSS | electronic Social Security System |
| FY | Fiscal Year |
| HMIS | Health Management Information System |
| HRTT | Health Resources Tracking Tool |
| HSS-MAG | Health Sector Staff Mutual Aid Group |
| HSSP IV | 4th Health Sector Strategic Plan |
| ICD-10 | International Classification of Diseases, Tenth Revision |
| IEEA | International Society for Quality in Health Care External Evaluation Association |
| IFMIS | Integrated Financial Management Information System |
| IGA | Income Generating Activities |
| ISQua | International Society for Quality in Health Care |
| IT | Information Technology |
| LDP+ | Leadership Development Program |
| M&E | Monitoring and Evaluation |
| MEL | Monitoring, Evaluation, And Learning |
| MINALOC | Ministry of Local Government |
| MINECOFIN | Ministry of Finance and Economic Planning |
| MNCH | Maternal, Newborn, and Child Health |
| MOH | Ministry of Health |
| NBA | Non-budget Agency |
| NGO | Non-governmental Organization |
| PHC | Primary Health Care |
| PIP | Performance Improvement Plan |
| PPM | Provider Payment Mechanism |
| PPP | Public-Private Partnership |
| PSE | Private Sector Engagement |
| PY | Program Year |
| QI | Quality Improvement |
| RAAQH | Rwanda Agency for Accreditation and Quality of Healthcare |
| RBC | Rwanda Biomedical Centre |
| RFP | Request for Proposal |
| RHAP | Rwanda Health Analytics Platform |
| RHF | Rwanda Healthcare Federation |
| RIDS | Research Innovation and Data Science |
| RIHSA | Rwanda Integrated Health Systems Activity |
| RSSB | Rwanda Social Security Board |
| STG | Standard Treatment Guideline |
| SWOT | Strengths, Weaknesses, Opportunities, and Threats |
| TA | Technical Assistance |
| TWG | technical working group |
| USAID | U.S. Agency for International Development |
| WHO | World Health Organization |

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# SECTION 1. ACTIVITY OVERVIEW

## 1.1. Activity Description

| | |
|---|---|
| **Activity Title** | USAID Rwanda Integrated Health Systems Activity (RIHSA) |
| **[Contract/Agreement] Number** | 720-696-20-F-00001 |
| **Name of Prime Implementing Partner** | Palladium International, LLC (Palladium) |
| **Name(s) of Subcontractors** | ● RTI International<br>● Council for Health Service Accreditation of Southern Africa (COHSASA)<br>● Zenysis Technologies, Inc.<br>● Rwanda Agency for Accreditation and Quality of Healthcare (RAAQH) |
| **Activity Start Date** | April 2, 2020 |
| **Activity End Date** | June 30, 2023 |
| **Reporting Period** | **Fiscal Year 2021**<br>(13 months, September 2020–September 2021) |


## OVERVIEW

The USAID Rwanda Integrated Health Systems Activity (RIHSA) is a three-year activity (2020–2023) made possible by the support of the American people through the U.S. Agency for International Development (USAID). Its main objective is to strengthen the Rwandan health care system with a wide combination of financial and technical support in concert with the Government of Rwanda. The goal of this activity is both to improve the quality of health care services and to reduce the financial barriers to accessing health care for all Rwandans. In addition, this activity also ensures the financial resilience of the Rwandan health system by increasing domestic funding.

The RIHSA is accomplishing these strategic goals with technical assistance (TA) to generate innovative health financing strategies, support quality improvement (QI) initiatives tied to accreditation standards and increase the use of data for decision-making in order to strengthen the Rwandan health system. RIHSA has been working closely with government entities—including the Ministry of Health (MOH), Ministry of Finance and Economic Planning (MINECOFIN), Rwanda Biomedical Centre (RBC), and Rwanda Social Security Board (RSSB)—and other USAID implementing partners and private sector stakeholders to ensure the country achieves its health systems strengthening goals on its journey to self-reliance.

## ACTIVITY OBJECTIVES

1. **Reduced financial barriers to health care** which includes assessing health sector information systems, supporting the Ministry of Health to increase health sector resource allocations, developing capacity for income generation across health facilities, and developing electronic claims management systems (eCMSs). RIHSA also focuses on improving the financial sustainability of community-based health insurance (CBHI), strengthening strategic purchasing of health services, facilitating public-private sector dialogue, and expanding private sector participation in the provision of services.

2. **Improved quality of essential health services at the national, facility, and community levels** which includes ensuring effective leadership and governance for quality at the district level, institutionalizing sustainable quality structures, and strengthening and supporting the accreditation process at hospitals. RIHSA also works toward improving data use for quality and governance as well as enforcing quality of service delivery by linking private facilities' licensing and relicensing to the accreditation process as part of institutionalization of continuous quality improvement

This activity supports the tenets and objectives of the Government of Rwanda's Health Financing Strategic Plan (HFSP), the Health Sector Strategic Plan Four (HSSP IV), the Country Development Cooperative Strategy (CDCS)- Development Objective 1 (DO1): THRIVE - Improved Health Outcomes, and USAID's Global Vision for Health Systems Strengthening. In partnership with the MOH, the activity engages key stakeholders in collaborating for equitable and sustainable health systems. The activity works with RSSB to improve the financial sustainability of the CBHI scheme and enhance underlying data systems. RIHSA aims to ensure that clearly defined, quality services are available at all levels of the health system and the government has increased capacity to domestically finance a larger portion of the health system.

## KEY APPROACHES TO ACHIEVING ACTIVITY OBJECTIVES

- Promote income generation across health facilities.
- Strengthen CBHI
- Increase PSE through strategic partnerships to improve quality and increase health resources.
- Develop and support quality accreditation standards and implementation.
- Integrate support teams to provide targeted TA in data use for decision-making, health information systems,


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## 1.2. Executive Summary: FY 2021 Report (September 1, 2020–September 30, 2021)

**MAJOR ACHIEVEMENTS**

In FY 2021, USAID RIHSA accomplished the following key programmatic achievements:

### REDUCE FINANCIAL BARRIERS TO HEALTH CARE

- ✔ Increased number of people enrolled in financial protection schemes in geographic areas that USAID supports with technical or financial assistance from 79.6% (2019-2020) to 85.9% (2020-2021).
- ✔ Increased Citizen Satisfaction Rate from 70,8% (CRC report 2018) to 73.7% (CRC report 2021).
- ✔ Trained 552 health centers, district hospitals (DHs), and district non-budget agency (NBA) accountants across the country on the Integrated Financial Management Information System (IFMIS). The training aimed to refresh and improve the accountants' skills in planning, budgeting, and effective use of the IFMIS, and to strengthen decentralized efforts to achieve efficient, effective, and accountable use of health sector resources for maintaining and accelerating progress toward universal health coverage.
- ✔ Supported data collection and reporting of Health Resources Tracking Tool (HRTT) data for three fiscal years (FYs 2017/18, 2018/19, and 2019/20). A total of 172 out of 182 (95 percent) of targeted health sector players, including government and non-governmental agencies, submitted their health expenditure data.
- ✔ Provided written feedback on development of the CBHI Sustainability Plan and participated in its subsequent validation. The plan outlines scenarios toward CBHI financial sustainability, including increased government budget allocation, increased CBHI member contributions, implementation of a mixed provider payment mechanism (PPM), and increased contributions through levies and taxes.
- ✔ Facilitated development of the PSE Master Guide for the health sector which is planned to be disseminated in FY2022. The guide identifies potential investment opportunities and facilitates creation of a platform to connect health sector investors/entrepreneurs with financial institutions.
- ✔ Facilitated four information sessions on financial access, bringing together approximately 115 participants, including private health sector entrepreneurs and financial institutions, to discuss available financing opportunities, bottlenecks, and possible solutions to increase health sector lending. These sessions included Development Credit Authority (DCA) information session, a U.S. International Development Finance Corporation (DFC) town hall, a webinar on Credit Guarantees, and an investment fair.
- ✔ Supported the MOH in review of dual clinical practice policy and the roadmap to guide the implementation process.
- ✔ Participated in joint review of the updated Ministerial Instruction No. 20/0005 of 6/12/2019 governing private health facilities in Rwanda and developed a summarized information toolkit to guide investors on licensing.
- ✔ Conducted an organizational capacity assessment of the Rwanda Healthcare Federation (RHF).

  Facilitated training of 47 District Health Management Team (DHMT) members and hospital managers on the effective use of IFMIS in planning, budgeting, evidence-based decision-making, and proper monitoring, as well as on the national public-private partnership (PPP) guidelines. The training covered 10 districts (Gakenke,

Nyagatare, Rulindo, Ngoma, Karongi, Gasabo, Kayonza, Kamonyi, Bugezera, and Kirehe) and the remaining 20 districts will be cover in PY2.

## IMPROVE THE QUALITY OF ESSENTIAL HEALTH SERVICES

- ✔ Revised the second edition of the Rwanda Hospital Accreditation Standards and ensured compliance with the International Society for Quality in Health Care External Evaluation Association (IEEA) principles, and integrated maternal, newborn, and child health (MNCH) standards and Ministry of Labour Service Delivery Standards aligned with national priorities.
- ✔ Developed standards development guidelines that will guide future standards development in the health sector.
- ✔ Completed surveyor training course and certified 49 accreditation surveyors to strengthen the national accreditation program and increased the pool of certified surveyors from 35 to 84.
- ✔ Conducted accreditation baseline survey in 24 private health facilities and health care accreditation progress and baseline surveys in 44 public hospitals to assess current quality standards compliance levels and a baseline accreditation survey for one DH
- ✔ Successfully advocated for integration of QI courses and surveyor training program into continuing professional development (CPD) programs of health professionals as part of quality institutionalization.
- ✔ Supported the MOH in providing QI facilitation to four DHs with the aim of offering technical support to each hospital's QI committee.
- ✔ Conducted initial review of organizational structure of RAAQH and organizational development plan with a view to strengthening RAAQH as an independent accreditation body. Using the ISQua External Evaluation Association (ISQua EEA) standards and criteria for organizational accreditation.
- ✔ Supported RBC to develop analysis priority use cases, data quality dashboards, and a decentralization strategy for the Rwanda Health Analytics Platform (RHAP).
- ✔ Established essential partnerships with the MOH and the Ministry of Local Government (MINALOC) to obtain buy-in and support from key government leaders through a series of virtual and face-to-face codesign sessions.

**Major Challenges**

Implementation of RIHSA activities faced the following challenges:

1. ***National measures to prevent the spread of COVID-19 restricted public gatherings,*** such as trainings, workshops, and meetings, and ended up halting or delaying the implementation of RIHSA's FY 2021 planned activities—for instance, IFMIS training, workshops on twinning or capitation standard treatment guidelines, training of private health facilities inspectors and dissemination workshop licensing standards, and so on. To address this issue, RIHSA has adjusted planned activities when possible, coordinating and implementing remote trainings, workshops, and key meetings.
2. ***A dysfunctional HRTT reporting system*** caused delays in availability of health resources data, analysis, and reporting across targeted institutions. A two-part solution was proposed to mitigate this challenge: RIHSA will continue (1) supporting manual data collection, analysis, and documentation, and (2) providing both technical and financial support for the revamping of the HRTT system in FY 2022.
3. ***Delayed contracting of RIHSA subcontractors has affected the implementation of planned activities.*** The process for submission of approval requests and subsequent contract issuance took a long time due to prolonged due diligence reviews and contract negotiations. RIHSA continued to work with its subcontractors to finalize the contracting process. While waiting during this process, it used purchase orders within the simplified acquisition threshold to carry out key activities.
4. ***Delays in the procurement process and clearance of RIHSA consultants occurred.*** For example, the 4th Health Sector Strategic Plan (HSSP IV) midterm review has been delayed by the lengthy approval process of the local consultant, which was originally scheduled to be implemented in Q3 FY 2021. The project baseline assessment has also been delayed due to a lengthy procurement process to determine and negotiate with the selected organization.

**Plans for Q1 FY 2022**

**(October 1–December 31, 2021)**

- Provide technical assistance towards strengthening the health sector information systems and use of data for decision-making and resource allocation. This included assessing current information systems (e.g. the IFMS, HRTT) and supporting the MOH to improve them and enforce their use.
- Generate evidence and facilitate dialogue with MOH and stakeholders to increase health sector resource allocation.
- Facilitate the development of guidelines and capacities for income generating activities across health facilities.
- Provide technical assistance to the RSSB to enhance the CBHI claims and membership management systems as well as training of users
- Provide technical assistance to the RSSB to strengthen the CBHI´s financial sustainability. This include supporting the RSSB to identify new revenue streams for the CBHI and put in place mechanisms to contain the increasing cost.
- Provide technical assistance to the RSSB to strengthen the CBHI strategic purchase of health services and include the design and implementation of Capitation and DRGs.
- Provide technical assistance to strengthen stewardship for private sector inclusive health systems through advocacies, public-private dialogue and capacity development of the Rwanda Healthcare Federation (RHF).
- Support the MOH to leverage private resources for health sector financing through PPPs. This include establishing PPP guidelines and facilitating PPPs.
- Facilitate dialogue and development of policy frameworks towards expanding private sector participation in provision of health services.
- Train private health facilities inspectors (around 100) on a new set of licensing standards.
- Disseminate new licensing requirements for private health facilities.
- Support baseline assessment of 28 health centers (all 8 medicalized health centers plus a sample of 20 ordinary health centers).
- Hold a stakeholder workshop to outline and prioritize critical use cases for new and existing RHAP data sources and to develop analytics and dashboards for dissemination to decision-makers.

# SECTION 2. COMPREHENSIVE DISCUSSION OF ACHIEVEMENTS OF FY 2021

## OBJECTIVE 1: REDUCE FINANCIAL BARRIERS TO HEALTH CARE

**Sub-objective 1.1: Strengthen both central and decentralized efforts to increase domestic financing for health and efficient use of key health resources.**

Key highlights

- ✔ Supported effective use of IFMIS by facilitating training of 552 participants made up of health center, DH, and district NBA accountants across the country.
- ✔ Facilitated training of 47 DHMT members and selected hospital managers from ten districts[1] on effective use of IFMIS in planning, budgeting, evidence-based decision-making, and proper monitoring.
- ✔ Supported MOH in health expenditure data collection for backlog from past three fiscal years for all health sector institutions. Around 95 percent (172 out of 182) of targeted health sector players submitted health expenditure data. A local consultant is being recruited to clean and analyze the data and write the HRTT reports for the three fiscal years.

### 1.1.1. Strengthen health sector information systems and use of data for decision-making and resource allocation

#### 1.1.1.1. Financial Information Systems assessment

In 2021, RIHSA collaborated with MOH and MINECOFIN and reviewed the quality of reporting and data use of the HRTT and IFMIS. It emerged that most users at the health facility level are not reporting to the HRTT and IFMIS as expected, and this has resulted in gaps in revenue and expenditure reporting. This was further established in a recent audit[2] of NBA funds, where it was found that a "total of approximately 108 billion Rwandan francs of internally generated revenues and 170 billion Rwandan francs of expenditures were omitted from the government expenditure for the 2019/20 fiscal year ended on 30 June 2020.[3]" The omissions have been attributed to the lack of adequate skills and knowledge of accountants from health centers and district NBAs in the use of the IFMIS. Consequently, RIHSA and the respective partners agreed to prioritize the training workshops planned under activity 1.1.1.2.

Fiscal year 2016/17 was the last time the HRTT data was collected using the HRTT system. Since then, the system has been dysfunctional, and the sector was unable to effectively monitor

[1] The training covered 10 districts (Gakenke, Nyagatare, Rulindo, Ngoma, Karongi, Gasabo, Kayonza, Kamonyi, Bugezera, and Kirehe) and the remaining 20 districts will be cover in PY2.

[2] Source: The Republic of Rwanda office of the Auditor General of State Finances (OAG) June 2020 Annual Activity report

[3] Report of the Auditor General for the year ended 30 June 2020

the flow of resources until 2021 when RIHSA in collaboration with the Clinton Health Access Initiative (CHAI) supported the MOH to develop a manual tool for the collection of the HRTT-related data. The manual tool had limited functionalities and flexibility and could only capture expenditure data, excluding budget data, which are also critical for estimating the financial resource flow in the health sector. Efforts to conduct a full-fledged assessment of the health sector's financial information systems were initiated with the announcement of a request for proposal (RFP), and proposals are being reviewed. The consultancy contract and implementation of the activity will be completed in Q1 FY 2022. This was slightly delayed because of prioritization of the IFMIS training of all health center accountants, as requested by the MOH as an urgent need to address misreporting and underutilization of the full functionality of the IFMIS for planning, budgeting, and management purposes.

#### 1.1.1.2. Training of district and facility teams to use HRTT and IFMIS and facilitate HRTT data collection

**Integrated Financial Management Information System (IFMIS)**

In its ongoing efforts to strengthen and promote transparency and effective use of information systems for decision-making, the RIHSA project has trained health center and district NBA accountants, as well as selected district management teams and hospital managers across the country in Public Financial Management and the proper use of the IFMIS for their daily transactions, and periodic financial planning, budgeting, and management.

*Figure 1. Health center accountants participating in the USAID-RIHSA supported IFMIS training (Musanze, September 2021)*

A total of 552 accountants, consisting of 35 DH accountants (74 percent of the 47 current DHs), 488 health center accountants (96 percent of the current 508 health centers), and 29 NBA

accountants (96.7 percent of the 30 district NBAs) were trained. Pre- and post-training assessments were conducted, finding an overall increase in the skill and confidence levels of participants in the use of the IFMIS tool. (Details of the training workshops have been documented in four separate reports.)

To ensure oversight responsibility and effective use of the management modules of the IFMIS, 47 DHMT members and hospital managers (6 females and 41 males) from 10 district assemblies and 14 DHs were trained on the IFMIS Planning, Budgeting, and Reports modules as well as a hands-on system demo that focused on analytical reports and dashboards. The remaining 20 districts along with their corresponding DHs will be trained in Q1 FY 2022. The training workshops were organized in collaboration with MOH and facilitated by MINECOFIN.

**Health Resource Tracking Tool (HRTT)**

The HRTT system has been dysfunctional since 2017, when it was last used for expenditure data collection. In FY 2021, the MOH embarked on a journey to track and collect all the sector's health expenditures to update the latest health resource tracking output report. Consequently, a manual template was developed for the expenditure data for FYs 2017/18, 2018/19, and 2019/20. RIHSA in collaboration with CHAI supported the MOH to develop and train eight data collectors and two data analysts to administer the manual tool. The data collection exercise was completed in April 2021, with a response rate of 95 percent (172 out of 182 submitted information; nonresponses were from partners who were no longer active in the country). After the MOH had cleaned and analyzed the data, RIHSA recruited an independent consultant to lead the reporting on the expenditure data from the three fiscal years, which is expected to conclude in Q1 FY 2022.

#### 1.1.1.3. Health financing strategy implementation status

Terms of reference for the Health Financing Strategic Plan 2018–24 midterm review have been developed, and RFP documentations have been prepared and are ready for announcement. Implementation of the mid-term review will draw on current ongoing assessment, including the health policy review and the HSSP Mid-Term review. Consequently, the Health Financing Strategic Plan Mid-term review is planned to start as soon as the current ongoing assessments have been concluded. Currently, RIHSA has provided written inputs to the draft health policy review report and is providing TA for the review of the HSSP IV.

#### 1.1.1.4. Gap analysis and health expenditure prioritization

The HRTT is a critical source of health expenditure data, and the successful implementation of an expenditure gap analysis will depend on data from the system. However, the HRTT system has been dysfunctional since 2017. To ensure that the health system has up-to-date expenditure data for analysis, RISHA in collaboration with CHAI supported the MOH to adapt a manual tool for collecting the HRTT data. MOH is currently cleaning the data collected, and it will have data available for analysis in Q1 FY 2022. Consequently, the gap analysis has been delayed until the expenditure data are available.

### 1.1.2.. Support to MOH to increase health sector resource allocation

### 1.1.2.1. Provide TA for innovative financing review to increase domestic resource mobilization (DRM)

A desk review of relevant publications on innovation financing mechanisms, mainly best practices, was started in Q4 FY 2021 and is expected to be completed in Q1 FY 2022. The expected outcome of this exercise is to develop one or two policy briefs from the findings, including briefs on social impact bonds and sin tax as alternative revenue mobilization mechanisms.

### 1.1.2.2. Provide TA for advocacy and dialogue

As in the case of activity 1.1.1.4, advocacy and dialogue efforts are contingent on first identifying priority underfunded health areas (Maternal and Child Health (MCH) and Family Planning (FP) related) for the development of investment cases, which require access to current data from the HRTT. Consequently, this activity was deferred until the HRTT data are available.

### 1.1.2.3. Provide TA for innovative financing review

This activity will produce financial forecasting to better understand resource flows from central through decentralized levels. RIHSA's ongoing technical support to the current HSSP Midterm review includes components on financial forecasting. The Mid-term review is expected to be concluded in Q1 FY 2022.

### 1.1.3.. Develop capacity for income generation across health facilities

### 1.1.3.1. Provide TA to develop guidelines for income generating activities

RIHSA developed and disseminated an RFP including detailed terms of reference. Proposals received are currently being evaluated. This activity will be completed in Q1 FY 2022.

Prior to this, RIHSA supported the MOH in the review of Dual Clinical Practice Policy as well as the development of tools for assessment of health facilities' readiness to implement the policy, which is one of MOH's income-generating and staff retention strategies at the health facility level. The tools developed include an application form for medical doctors and health facilities seeking MOH approval to implement dual clinical practices. A template was also designed to guide MOH during the assessment of health facilities' readiness. Both tools were submitted to MOH for review and are awaiting approval.

The Dual Clinical Practice Policy will help health facilities to establish or expand income generating activities (IGAs). Creating private clinical practices in these public hospitals will be associated with an increase in revenues generated by hospitals as more patients tend to seek care from public health facilities. Also, implementation of the dual clinical practice policy and the supplementary income will contribute to staff motivation and retention of health professionals in public facilities, especially in remote areas, thus increasing quality of services.

### 1.1.3.2. Strengthen monitoring capabilities of district governments

During the DHMT training on the IFMIS and national PPP guidelines in Q4 FY 2021, it was emphasized that a successful IGA requires a comprehensive monitoring and evaluation (M&E)

framework. In FY 2022, RIHSA plans to train the DHMTs to develop an M&E framework for effective monitoring of IGAs in each district.

**Sub-objective 1.2: Strengthen community-based health insurance**

Key highlights

- ✔ Assessed the alignment of the RSSB new electronic claims (eClaims) system being developed to the Rwanda Digital Healthcare Transformation Roadmap and provided recommendations for future customization
- ✔ Supported RSSB to establish and document the readiness/exchange capabilities (including interoperability requirements) of existing electronic medical records (EMRs) (including OpenClinic, OpenMRS, MobiCube) to be integrated into the CBHI electronic social security system (eSSS) (medical module/claims management system).
- ✔ Facilitated codification of reusable digital data set of over 900 disease conditions and treatment profiles against international and national terminology standards (ICD-10).
- ✔ Provided written comments to the CBHI Sustainability Plan draft report and participated in the technical validation of the plan.
- ✔ Developed a tool for assessing the impact of an increased CBHI premium on members' ability to pay for their subscription and health care utilization.
- ✔ Supported RSSB to conduct a CBHI client survey to understand the bottlenecks to CBHI enrolment and the increasing defaults in premium contributions.
- ✔ Contributed to ongoing PPM reform by supporting the design of the capitation PPM at the primary health care (PHC) level. Technical contributions were offered to the M&E framework, capitation design as well as the communication strategy work streams.

### 1.2.1. Enhance CBHI information systems

#### 1.1.1.1. Ensure the detailed work plan and technical requirements of the electronic system are aligned with the Rwanda Digital Health Care Transformation Roadmap

This activity aimed to conduct an assessment to determine whether RSSB's detailed work plan and technical requirements for the eCMS, currently under development, aligned with the Rwanda Digital Health Care Transformation. RIHSA worked with MOH and RSSB to compile relevant documentation and conducted a desk review comparing the required MOH technical specifications with those of the claims management system being developed. The Rwanda Digital Health Care Transformation engagement report served as the main reference document against which the technical specifications of the electronic claim management system were compared. The specifications considered for alignment verification included deployment architecture, open application programming interfaces (APIs), interoperability, security, electronic master patient index, access channels, insurance system architecture, patient-centric design, ancillary service, payment facilities, sustainability and stability, and clinical knowledge services. Table 1 outlines the alignment status for each standard as well as recommendations.

Table 1. RSSB claim management system alignment: findings and recommendations

| # | Standard | Rwanda Digital Health Care Transformation specifications | RSSB claim management system alignment (Yes / Partially / No) | Comments and recommendations |
|---|---|---|---|---|
| 1 | Deployment architecture | • Hosting of the primary deployment in National Data Center (NDC)<br>• Backup site<br>• Disaster Recovery (DR) site outside Kigali | Yes | RSSB takes the same infrastructure management approach. |
| 2 | Open APIs | • Privacy<br>• API store<br>• Security<br>• Data traffic management | Partially | RSSB takes the same approach but with assumptions due to lack of detailed requirements on the health care side. |
| 3 | Interoperability | • Interoperability standards<br>• Interoperability policies | Partially | RSSB is moving forward with assumptions due to lack of detailed requirements on the health care side (where policies and standards are not yet defined). |
| 4 | Security | • Account management<br>• Authentication<br>• Certificate authority<br>• Auditing | Yes | RSSB has considered all standard security functions. |
| 5 | Electronic master patient index | • Client registry<br>• Provider registry<br>• Organization registry | Partially | RSSB takes the same approach but with assumptions due to lack of detailed requirements on the health care side. |
| 6 | Access channels | • Web<br>• Mobile Based | Yes | RSSB takes the same approach. |
| 7 | Insurance system architecture | • Ability for insurance data lookup<br>• Preauthorization<br>• Claim Submission | Yes | RSSB takes the same approach. |
| 8 | Patient-centric design | • Considers patient journey | Yes | RSSB takes the same approach. |
| 9 | Ancillary service | • Designed to play an ancillary service role | Yes | RSSB is designed to serve and act as an ancillary service for the entire healthcare digitization architecture. |
| 10 | Payment facilities | • Online (banks/cards)<br>• Mobile money | Yes | RSSB has considered such payment facilities in its design. |
| 11 | Sustainability and stability | • Technical sustainability and stability | Yes | RSSB takes the same approach. |
| 12 | Clinical knowledge | Terminology services (ICD-11, SNOMED CT, LOINC, etc.) | No | RSSB implementation moves independently. These services |

| | | | | |
|---|---|---|---|---|
| | services | | | are planned and not yet operationalized. RSSB will use assumptions where applicable. |

The root cause of misalignment in some of the specifications is related to differences in the implementation timeline between the RSSB implementation plan and that of the MOH. Typically, since the Rwanda Digital Health Care Transformation Roadmap is the benchmark, the RSSB system should be developed along those timelines. However, the RSSB system development is far advanced, and in the absence of detailed requirements and standards from the Rwanda Digital Health Care Transformation, RSSB is left with limited options but to use assumptions based on the high-level guidance from the roadmap. In the future, RSSB might need to adjust some components in order to be fully aligned with final and approved health care digitization standards.

#### 1.1.1.2. Support the RSSB-contracted IT company with claims database management and effective integration of systems across RSSB, MOH, and health facilities

Collaboratively working with RSSB and other stakeholders, RIHSA completed a detailed implementation plan for supporting CBHI automation and integration and a roadmap for prototyping interoperability between CBHI eCMS and existing EMRs. These documents outlined future work for the activity, including a gap analysis of data capture tools and EMR data relevant for electronic claims management, mapped to the CBHI/EMR data sharing requirements. These were shared with Intrasoft, the RSSB-contracted information technology (IT) company, so that it could customize the CBHI medical module and eCMS. Finally, RIHSA also recognized the need to abstract and codify the 2021 validated Standard Treatment Guidelines (STGs) against the International Classification of Diseases, Tenth Revision (ICD-10). This was 50 percent accomplished in a workshop with RSSB-trained staff in the last two weeks of FY 2021. The remaining 50% of the codification, which includes customization and establishment of validation rules, will be completed in the first quarter of FY 2022. Ultimately, RIHSA's TA is aimed at improving the effectiveness and efficiency of CBHI electronic claims management. Addressing the efficiency and effectiveness of the CBHI claims management system is important for:

- creating visibility of service utilization at the health facility level;
- reducing turnaround time for claims reimbursements to health facilities by the RSSB;
- improving the patient experience at all CBHI-approved health facilities;
- improving accountability of both the payer and providers to the CBHI beneficiaries; and
- enabling a standards-based approach for data collection and use and the robust data analysis that is needed for improved patient care, hospital administration, and CBHI administration.

Following discussions with PricewaterhouseCoopers, which was advising RSSB on quality assurance, and Intrasoft, which focused on software development and testing, RIHSA adapted its support to RSSB to focus on implementation planning, requirements gathering and standardization, and technical advice.

#### 1.1.1.3. Enhance and expand the existing electronic claims system

This activity was designed to provide technical support to Intrasoft to develop and test the CBHI

eCMS. During the scoping exercise, RIHSA established that Intrasoft had already developed the CBHI software features and user interfaces. Intrasoft, however, had not yet finished the customization of the functional features, as RSSB had not supplied the required codes and datasets. RIHSA addressed this gap through the analysis and data sharing approach (see activity 1.2.1.2.). RSSB expects that Intrasoft will complete customization of the CBHI medical module and eCMS by February 2022.

This activity will continue into the FY 2022 work plan. RIHSA will continue to support Intrasoft to import codification templates into the CBHI modules, complete data quality checks, and define data entry validation rules to implement the STGs. Other support areas include providing advisory and technical support for quality assurance and testing of the data import exercise and testing of the validation rules and for user acceptance testing of the CBHI medical module and eCMS.

#### 1.1.1.4. Two workshops for RSSB and CBHI district officers to monitor and use claims system

While the training of users on the new claims system will start after February 2022, when the new claims system is fully operational, a key workshop was organized with RSSB internal staff to codify the recently validated STGs using ICD-10 for diseases and customized national standard codes for medicines, medical procedures, and products and to map the codified STG disease profiles to the CBHI disease templates. The STGs are the national protocols for patient management defined by the MOH based on Rwanda's current diseases burden profile. It is focused on the most common diseases in Rwanda grouped into nine specialty-based volumes—namely, internal medicine; obstetrics and gynecology; surgery; pediatrics; ophthalmology; ear, nose, and throat (ENT); dentistry; dermatology; and mental health.

The mapping and codification exercise was a pillar software development requirement for the configuration and customization of the CBHI medical module. The medical module will capture all services rendered to a patient from registration at a health facility to the point of exit, offering the desired capability for automated billing processes and efficient claims management for the CBHI.

Additionally, the repository of the codified STGs will become universally available to all future digitalization initiatives (including the Rwanda Health Information Exchange - RHIE[4]) that will seek to normalize STGs in the implementation. As an example, the national EMR upgrade efforts will now have access to a reusable digital data set of over 900 disease conditions and the treatment profiles codified in international and national terminology standards. This resource is expected to greatly enhance the capability of digital health implementations in Rwanda.

#### 1.1.1.5. TA to improve CBHI membership and premium compliance management

RIHSA in collaboration with the RSSB/CBHI management prioritized conducting a client survey

[4] The Rwanda Health Information Exchange (RHIE) is the core system (data engine/warehouse) that is currently being developed by the MOH as part of its digital transformation road map. The RHIF will be the central system where all the other health sector systems will connect. Currently, RIHSA is a member of the Digital Health TWG set up by the MOH to lead the implementation of the digital transformation roadmap. RIHSA will specifically support training of users on the EMR billing System once the RHIE is finalized.

on current CBHI and non-CBHI members to identify and understand the limiting factors to the CBHI uptake as well as the reasons for the high default rate in premium payments. A draft survey tool has been developed and data collection consultants identified. The survey will be completed in Q1 FY 2022. Once the survey is completed, various information, education, and communication materials will be developed, and these tools will be used in community campaigns through quarterly Mutuelle Membership Days. In addition to the current efforts with the client's survey, preliminary discussions have been held with RSSB to consider enabling their membership enrolment module in the eSSS to have a function for members to save toward their annual CBHI subscription. In Q1 FY 2022, a detailed outline of the benefits and modalities for a savings module will be designed and discussed with the RSSB and the eSSS developer for consideration.

### 1.2.2. Strengthen CBHI financial sustainability

#### 1.2.2.1. TA to update CBHI sustainability analysis

CBHI's sustainability is a priority of the central government. Sustainability will mean the ability of the CBHI to continue to exist and to fulfill its mandate of ensuring that Rwandans have access to quality health services that are affordable and effective without any financial hardships. This mandate has been threatened by increasing deficit and operational challenges including delays in premium reimbursements, stagnated membership, and more recently defaults in premium payments. Consequently, a sustainability plan was commissioned by the MOH to critically assess the CBHI and propose recommendations to ensure its financial sustainability. RIHSA provided written technical feedback to the draft sustainability plan and participated in the technical validation workshop held in May 2021. In FY 2022, RIHSA plans to build upon the findings of the sustainability plan by helping RSSB to prioritize and implement the recommendations mainly in the areas of CBHI's cost containment and revenue-increasing opportunities.

#### 1.2.2.2. TA to quantify revenue-increasing opportunities

The CBHI Sustainability Plan has outlined various revenue-generating opportunities for the scheme including increased member contributions. RIHSA conducted a thorough review of the sustainability plan and technical discussions with the authors of the plan on the proposed revenue-increasing opportunities. The authors admitted that the opportunities were proposed solely in the context of the public health insurance system in Rwanda. Ideally, they should have looked at them in the context of the entire health system. In fact, it should have gone beyond the health system. For example, increasing government premium subsidies could limit the government's ability to deliver on other mandates in other sectors. Unfortunately, given the constraints of time, the plan took a somewhat limiting look at the sustainability of the CBHI and spent limited time to establish the feasibility of the proposed revenue-generating activities. In line with this, the RSSB has prioritized assessing and measuring the impact of an increased CBHI premium on members' ability to pay for their subscription and ultimately health care utilization. RIHSA, in collaboration with the CBHI management, has thus already designed tools for this assessment, and field data collection consultants have been identified. The assessment will be completed in Q1 FY 2022.

Additionally, RSSB has requested RIHSA to assess the impact of Prime Minister's Order No. 034/01 of 13/01/2020 related to CBHI scheme subsidies on CBHI financial sustainability. These

subsidies were elaborated further in the CBHI Sustainability Plan, and this assessment will be conducted in Q3 FY 2022.

### 1.2.3. Strengthen RSSB's strategic purchase of health services under CBHI

#### 1.2.3.1. TA to assess CBHI expenditures and conduct provider payment review, with consideration of impact on quality of care

The current fee-for-service PPM has posed major challenges at both the RSSB and health facility levels. With a lengthy verification process that sometimes takes up to 90 days, RSSB faces major delays in the reimbursement of services. These delays affect health facilities' cash flows, liquidity, and purchasing power, leading to shortages in medicines and supplies, which consequently affect quality-of-care delivery. It is in this regard that RSSB and MOH have embarked on a journey to reform the current PPMs and plan to implement capitation at the PHC level.

In FY 2021, RIHSA supported the ongoing efforts by the strategic purchasing sub–technical working group to reform the PPM at the PHC level by convening meetings with key stakeholders, performing secretariat functions as well as designing key documents that will guide the piloting of the capitation. RIHSA has taken the initiative to host ongoing discussions on this topic by convening key stakeholders including CHAI, the World Health Organization (WHO), and the World Bank. Beyond hosting the meetings, RIHSA is leading the development of the M&E framework and a communication strategy for the planned capitation. The drafts of both documents have been submitted to MOH and are under review. Lastly, RIHSA developed the concept note for and actively contributed to the preparation of the capitation model design workshop held from August 31 to September 3, 2021. Some of the key recommendations from the workshop include (1) adjusting the capitation rate for roaming and other factors such as geographical location of the health post and additional services that are provided by the health facilities, (2) estimating separate capitation rates for the health post and health centers, (3) enforcing the referral system (gatekeeping), (4) allowing people to choose their preferred facilities, (5) periodic adjusting of the model to reward performance, and finally (6) piloting before a national rollout.

While supporting capitation at the PHC level, RIHSA and the RSSB acknowledged a need to enhance the current discussions around CBHI strategic purchasing and PPM reform to explore Diagnosis-Related Groups (DRG), which was one of the recommendations from the sustainability plan. The CBHI Sustainability Plan estimates that Rwanda will achieve a cost reduction of about 10 percent upon the implementation of mixed PPMs. Toward this end, RIHSA, in collaboration with the RSSB and MOH, have drafted an RFP with terms of reference and have identified a consultant to assess Rwanda's readiness to implement DRG. The assessment will be completed in Q1 FY 2022. Other activities planned to be implemented in FY 2022 include facilitating the development of capitation expenditure guidelines for health facilities, providing TA for the design of a CBHI benefit package, and advocating for quality indicators to be embedded in health facilities' reimbursement policy to incentivize efforts to improve quality of healthcare services.

**Sub-objective 1.3: Increase private sector engagement**

Key highlights

- ✔ Supported and facilitated the coordination of the PSE core team meetings by documenting key meeting highlights and preparing presentations.
- ✔ Contributed to the development of the PSE Master Guide, which outlines investment processes and opportunities in the health sector.
- ✔ Organized the Maiden Health Sector Investment Fair to link health sector entrepreneurs to financial institutions.
- ✔ Participated in the joint review of the latest updated Ministerial Instruction No. 20/0003 of 23/09/2020 governing private health facilities in Rwanda. Gaps for next review were identified, and a summary of the licensing procedures was incorporated in the draft PSE Master guide.
- ✔ Supported the RHF Annual General Assembly.
- ✔ Reviewed the Private Sector Market Analysis Report and documented key investment opportunities as elaborated in the draft PSE Master Guide. Engaged the DFC on available Credit Guarantee opportunities with the aim of leveraging available DFC guarantee facilities for increased health sector lending.

### 1.3.1. Strengthen stewardship for private sector inclusive health systems

#### 1.3.1.1. Provide TA to facilitate public-private sector dialogue to discuss PSE opportunities and challenges in the health sector and strengthen overall PSE and business development capacity at the central level

**Private Sector Engagement (PSE) core team meeting**

During FY 2021, RIHSA assumed the secretarial role for the PSE core team. This included updating the team's terms of reference, coordination of monthly team meetings, documenting meeting outcomes, and provision of technical inputs into documents including the PSE master guide. The regular PSE core team meetings foster policy dialogue and increase PSE. Three PSE core team meetings were held. The first meeting took place on March 5, 2021, where MOH and key partners (RIHSA and CHAI) discussed PSE priorities and agreed to harmonize PSE activities and monitor their implementation. The second meeting was held on March 31, 2021, with a total of 21 participants from MOH and partners. During this meeting, the core team's terms of reference, which defined mandate, structure, and functionality, were reviewed and validated, and the findings of the PSE market analysis report review were discussed. The recommendations of the market analysis review barriers, including identified investment opportunities in the health sector, set out the basis for developing the PSE Master Guide. RIHSA consolidated the resolutions of the meeting, including activities to be implemented and monitored. The third meeting was held on June 8, 2021, bringing together 16 participants. This meeting discussed the draft PSE Master Guide, which was jointly developed by RIHSA and CHAI, as well as the Lab Management PPP feasibility study findings. The draft PSE Master Guide highlighted key business processes and requirements for investing in the health sector as well as investment opportunities and incentives. The Lab Management PPP model presented the potential of PPPs in laboratory services management.

During FY 2022, RIHSA will continue to support the MOH in coordinating regular PSE core team meetings and documenting the outcomes thereof.

**Regional dialogue on private sector response to the COVID-19 pandemic**

In collaboration with the Rwanda Healthcare Federation (RHF), RIHSA cohosted and sponsored a session on the response from the private sector to the COVID-19 pandemic. This session was held on the sidelines of the East Africa Healthcare Federation Annual Conference on September 9, 2021. During this workshop, private sector representatives from the seven East Africa Community member states gave insights on how the private sector was affected by the pandemic and discussed strategies adopted to mitigate the adverse effects posed by the pandemic. Key panelists during this session included Mr. Danny Mutembe (Vice Chairperson, RHF), Dr. Jeannine Condo (CEO, Center for Impact, Innovation and Capacity Building for Health Information Systems and Nutrition), Dr. Zuberi Muvunyi (Chief Medical and Operating Officer, Early Detection and Prevention Unit/EDPU Africa Ltd.), and Dr. Anastasia Nyalita (Chief Executive Officer, Kenya Healthcare Federation). Some of the key private sector interventions included investment in procurement and transportation of COVID-19 vaccines, case management, research, and community sensitization. Private sector players also noted financial distress caused by the pandemic and related lockdowns.

During FY 2022, RIHSA will continue to support policy dialogues at the central level.

#### 1.3.1.2. Provide TA to facilitate review of licensing procedures for private health sector

RIHSA reviewed the Ministerial Instruction No. 20/0003 of 23/09/2020 governing private health facilities. The instructions outlined the procedures and requirements for opening and operating a private health facility in Rwanda. Following the review, gaps were identified, discussed, and documented, including lack of a clear timeline for submission of the inspection report. This could potentially lead to delays in reporting. Additionally, the inspection team is decentralized and composed of a wide range of district officers who may not necessarily have the technical competency to document a proper report. The district team includes the DHU director, DH director, and other health professionals. A summary of the licensing procedures has been incorporated in the draft PSE Master Guide.

In FY 2022, RIHSA will continue to support the MOH to update the current ministerial instructions to address some of the gaps identified while ensuring the linkage between licensing and accreditation for better quality care provision in private health facilities.

#### 1.3.1.3. Provide TA for organizational capacity development of Rwanda Healthcare Federation (RHF)

RIHSA continued to support the organizational capacity development of the RHF to effectively advocate on behalf of its members as well as to facilitate communication between the private sector and the Government of Rwanda and ultimately to bolster a strong and organized private sector that complements the government's efforts toward a robust and well-resourced health system. Following initial meetings with RHF senior leadership to discuss the current situation, prospects, and organizational needs of RHF, RIHSA supported RHF to accomplish the following:

- Coordinate the RHF Annual General Assembly, which took place on November 27, 2020, bringing together 24 participants (7 females and 17 males) to discuss RHF prospects, elect new leadership, and strategize on how to better advocate for private health sector interests. The meeting was officiated by the minister of state in charge of PHC services, who commended RHF's role in private sector coordination and encouraged the new leadership to fast-track the official registration of RHF. As such, RIHSA supported RHF to put together all requirements for registration with the Rwanda Governance Board (RGB). RHF was able to submit its application by February 12, 2021. In addition, RIHSA supported RHF to respond to queries regarding the application and will continue to technically support the process until the registration certificate is granted to RHF.

- In addition, RIHSA facilitated RHFs organizational capacity assessment." The purpose of the assessment was primarily to (1) identify capacity gaps in the systems, functions, and practices of RHF, and (2) develop a capacity-building plan with recommendations on how to address the identified gaps. Following stakeholder meetings during the assessment and technical reviews/inputs, the following were key capacity gaps highlighted in the report: In terms of the organization's systems and functions, key gaps were identified, particularly in the governance and administrative structures,

characterized by delay in registration of the federation as a legal entity, lack of a clear organizational structure, and absence of permanent operation and administration staff at the secretariat. The organizational capacity assessment also included a draft action plan highlighting key priorities to consider in revamping RHF's organizational capacity.

During 2022, RIHSA will continue to support RHF to implement some of the organizational capacity assessment recommendations as well as review its strategic plan.

### 1.3.2. Leverage private resources for health sector financing through PPPs

#### 1.3.2.1. TA to conduct information session on existing national PPP guidelines at central level

RIHSA reviewed the national PPP guidelines and extracted a summary of key highlights that was adapted for the PPP presentation used during the DHMT training workshop. The workshop was jointly organized with MOH and the Rwanda Development Board on September 30, 2021 and was attended by 47 DHMT members and hospital managers (6 females and 41 males) from 10 districts and 14 District Hospitals. This workshop aimed at creating awareness of the national PPP guidelines among the district managers. The end of the workshop survey suggests that participants will require ongoing support and practical implementation to have a better grasp of the PPP guideline requirements and processes. The remaining 20 districts along with their corresponding DHs will be trained in Q1 FY 2022. Also, PPP guidelines specific for the health sector will be produced in FY 2022 together with the Rwanda Development Board and MOH. These will be an opportunity to further advocate for and create awareness of its implementation.

### 1.3.3. Expand private sector participation in the provision of health services

#### 1.3.3.1. Provide TA to support review of private sector market analysis to identify opportunities for private sector participation in health

RIHSA reviewed the Private Sector Market Analysis Report developed by MOH in collaboration with the WHO. RIHSA facilitated the discussion of the PSE market analysis report during the PSE core team meeting held on March 31, 2021. The report summary was presented, with a focus on prevailing barriers that impede PSE and investment in health care. The report also highlighted key recommendations, including clear stakeholder mapping and separation of stakeholder roles, establishing a one-stop center for health sector-related information, streamlining the regulatory process, and developing private sector briefs to increase awareness of investment opportunities and attract investors in the health sector, among others. The MOH then commissioned a smaller core team, composed of RIHSA and CHAI staff, to support the development of the PSE Master Guide, which highlights key health sector investment opportunities and business process mapping for health sector investments, including registration procedures and investment incentives. Throughout Q3 and Q4 FY 2021, RIHSA provided technical inputs into the PSE Master Guide, awaiting its validation and dissemination.

In FY 2022, RIHSA will support the MOH to validate and publish the PSE Master Guide.

#### 1.3.3.2. Build capacity of loan officers on health sector dynamics to boost their lending to the health sector businesses/projects

RIHSA conducted meetings with two financial institutions (Banque Populaire du Rwanda and Cogebanque) to discuss health sector lending and increase the banks' understanding of health sector financing needs. Banque Populaire du Rwanda is currently the sole beneficiary of the DCA Credit Guarantee for the health sector, and Cogebanque is in the process of finalizing a Small Medium Enterprise (SME) facility with the DFC. During these meetings, participants shared insights on some of the key gaps/challenges encountered when lending to health sector businesses, such as insufficient collateral, financial illiteracy, and failed loan repayment due to financial distress. As a result, RIHSA organized follow-up meetings and webinars bringing together both financial institutions and private sector players to demystify available financing opportunities and prevailing challenges.

#### 1.3.3.3. Create linkages between health sector players and financial institutions for increased health sector lending

With the determination to increase private sector contributions from 1.7 to 5 percent per the MOH target, boosting financial access is a timely intervention for increased health sector investments amid the COVID-19 pandemic's financial effects. Over the course of the year, RIHSA coordinated events in line with increased health sector lending through awareness of available financing opportunities for the private health sector.

**Maiden Health Sector Investment Fair**

In partnership with the Rwanda Healthcare Federation (RHF), RIHSA organized the Maiden Health Sector Investment Fair, held on September 29, 2021, with the objective of bringing together financial institutions (including banks and microfinance institutions) and health sector private investors (owners of health facilities like clinics, polyclinics, hospitals, laboratories, and prospective investors) to meet, discuss, and explore mutual business partnerships. The investment fair was hosted both virtually and in person at the Grand Legacy Hotel with over 53 participants and 6 banks (namely, Cogebanque, Access Bank, I&M Bank, Development Bank of Rwanda, GT Bank, and Urwego Bank) attending to showcase their products. There was a strong presence of One Family Health, one of the main private managers of health posts across the country. The local participants were predominantly members of the RHF and Rwanda Private Medical Facilities Association.


*Figure 2. Maiden Health Sector Investment Fair. Left to right, Dr. Kayitesi Kayitenkore (CEO, Kigali Dermatology Center), Dr. Nyirinkwaya Jean (Founder, La Croix du Sud Hospital), and Gunther Faber and Mark Wagstaff (One Family Health).*

These representatives of the private sector articulated the financial challenges of health care entrepreneurs to include the need for lower interest rates and more health sector–specific financing opportunities and incentives, as seen in other sectors of the economy such as agriculture. Also, the banks expressed their limited understanding of the health sector, including the investment opportunities. RIHSA has been requested by Cogebanque, I&M Bank, and Development Bank of Rwanda to support them to revise their health products or tailor products to suit the financial needs of the health sector. Some private sector investors have requested help to develop their business plans to make them creditworthy. This support will be provided in FY 2022.

#### 1.3.3.4. Provide TA to MOH to increase financing opportunities for private providers

**USAID DCA and DFC information session**

RIHSA coordinated a DCA information session on February 24, 2021, bringing together over 30 participants, including owners and proprietors of private health facilities. The goal was to create linkages between Banque Populaire du Rwanda, the beneficiaries of the DCA Credit Guarantee, and private sector actors with an aim of increasing the private health sector lending portfolio by advancing affordable loans to health sector investors as well as improving credit readiness for all stakeholders. This session also created an opportunity for dialogue on key financial constraints faced by the private sector in their pursuit of credit facilities. The information session highlighted key recommendations from private sector actors, which included considering lower interest rates, especially for existing businesses, and availing financial incentives for start-ups.

In addition, RIHSA mobilized and coordinated participants to attend the DFC town hall meeting on March 30, 2021, which aimed at increasing awareness on available DFC financing opportunities for private businesses in Rwanda's key sectors, including health. Different collaborative meetings between RIHSA and DFC representatives have taken place following the town hall and RIHSA aims to continue these collaborations in its quest to increase financing opportunities for private health providers.

Later in the year, RIHSA engaged the DFC on available financing opportunities for the private health sector to increase financing opportunities for private providers. A meeting was held to discuss prospects of the upcoming DFC facility with Cogebanque. Although this facility targets SMEs in general, RIHSA discussed the possibility of engaging the bank to prioritize SMEs in the health sector given the capital-intensive nature of health care businesses.

**Credit Guarantee webinar**

On September 17, 2021, RIHSA organized and facilitated a webinar bringing together 27 participants to discuss credit guarantees as an instrument for mobilizing private capital. Banque Populaire du Rwanda shared its experience in managing a Credit Guarantee facility and how this boosted its health sector lending portfolio. With USAID as a guarantee, the bank was able to lend approximately $1 million to four private health facilities to finance their expansion and purchase new equipment. The USAID-funded Kenya Investment Mechanism shared best practices in using credit guarantees to facilitate the expansion of finance into underserved markets. Some best practices shared include ensuring compliance to the qualifying borrower criteria, communicating clearly about credit guarantees, and emphasizing the fact that guarantees are not a substitute for collateral as generally perceived as well as documenting success stories. Common challenges raised include misconceptions that credit guarantees are interest-free despite the high interest rates imposed by financial institutions among others. The webinar recommended more Credit Guarantee opportunities for the health sector and the extension of the current DCA guarantee for full participation, especially given current active efforts of the government to mobilize more private investors to the sector.

### 1.3.3.5. Provide TA to MOH to develop guidelines / ministerial order to enforce linkage between relicensing of private health facilities and accreditation process

During FY 2021, RIHSA supported the development of an assessment toolkit that aligns licensing standards and accreditation standards for private health facilities. A workshop was organized, bringing together 15 participants, including representatives from MOH, inspectors of health facilities and districts within the City of Kigali, and private sector actors, to review the licensing assessment toolkit. In FY 2022, the toolkit will be validated and used to implement the licensing standards for private health facilities. Licensing private health facilities using the standards and assessment toolkit is a gateway to the national accreditation program. This alignment is expected to be reflected in the revised licensing guidelines / ministerial instructions to be implemented during FY 2022. The updated ministerial instructions will capture the duration of licensing and relicensing based on the accreditation level.

## OBJECTIVE 2: IMPROVE THE QUALITY OF ESSENTIAL HEALTH SERVICES

### Sub-objective 2.1: Increase the quality of essential health services

**Key highlights**

- ✔ Supported the development of a licensing inspection tool aligned with licensing standards.
- ✔ Provided technical support to the MOH in identifying and prioritizing QI support for the three DHs (Nyamata, Rutongo, Gisenyi) and one provincial hospital (Rwamagana) with poor performance in selected indicators in MNCH services—all of which are linked with the accreditation standards.
- ✔ Worked with the MOH to develop job profiles and job descriptions for hospitals and health centers according to the new organizational structure of public health facilities.
- ✔ Drafted quality indicators to be integrated into hospital staff job descriptions as part of institutionalizing QI in day-to-day staff operations and building a culture of quality in staff's minds and behavior.
- ✔ Revised the QI course, which is now available on the Human Resources for Health e-learning platform, to provide an online QI facilitation course.

#### 2.1.1. Ensure effective leadership and governance for quality at district levels

##### 2.1.1.1. Provide TA to MOH to identify high-burden sites performing poorly in selected MNCH indicators to be prioritized for QI support

MNCH is a priority component of the Rwandan MOHs strategic plan (HSSP IV 2018–24). Improving MNCH also contributes directly to the accomplishment of SDG 3, which is related to the health sector. Together with the MOH, RIHSA identified and prioritized four site hospitals—Nyamata, Rutongo, Gisenyi, and Rwamagana—with low performance with regard to key MNCH selected indicators, which are directly linked with the accreditation standards. In FY 2021, RIHSA jointly with the MOH provided facilitation sessions to Nyamata District Hospital. The sessions combined QI methods and Leadership Development Program (LDP+) approaches to enhance the hospital teams to work on the performance gaps. LDP+ is an experimental learning and performance improvement process that empowers people at all levels of an organization to learn leadership, management, and governing practices, and teaches them how to face challenges and achieve measurable results. QI methods empower staff with additional skills to identify root causes for challenges in the provision of their daily services and enable staff to apply problem-solving techniques to identify practical and feasible solutions. The facilitation sessions resulted in the following outputs:

- Identified maternal and neonatal priority areas according to key indicators with low performance.
- Established two hospital teams linked to two priority areas.

Table 2. Key indicators and priority areas

| Teams | Priority areas | Indicators with low performance |
|---|---|---|
| Team 1 (5 staff) | Maternal health care | 1. Number of maternal deaths |
| | | 2. Post cesarean infection rate |
| | | 3. Maternity bed occupancy rate |
| Team 2 (4 staff) | Neonatal health care | 1. Neonatal death |
| | | 2. Birth asphyxia rate |
| | | 3. Neonatal infection rate |

- Established baseline for hospital performance against the key indicators.
- Identified probable root causes according to the key indicators' performance.
- Developed action plan to address causes, including immediate, midterm, and long-term actions.

RIHSA will continue supporting the hospital teams to monitor the implementation of set strategies to improve their performance. In addition, in year 2, the accreditation facilitation will prioritize those hospitals with low performance in MNCH indicators by strengthening the QI structures and compliance with standards contributing to MNCH.

#### 2.1.1.2. Provide TA to central and decentralized facility levels to support implementation of new organizational structure (as per Ministerial Instruction No. 001/03 of 01/09/2020)

In reference to the Prime Minister's Instruction No. 001/03 of 01/09/2020, the Government of Rwanda, through the MOH, has revised the organizational structure of public health facilities ranging from new referral hospitals to health centers. As part of the implementation of this new organizational structure, it was important to develop job profiles for the new or revised positions to ease staff placement in health facilities. RIHSA supported MOH to develop the job profiles in close collaboration with the directorate general of corporate services and the Planning, M&E, and Health Financing Department. The RIHSA and MOH team worked on the first drafts, which were later used in a workshop at Nyamata Lapalisse Hotel on June 14 –19, 2021. The purpose of this workshop was to collect inputs and comments from various health, administrative, and finance professionals. It was attended by 12 participants, including professionals from health facilities, councils, and heads of MOH departments. As a result of this workshop, a final draft of job profiles was reviewed by both MOH and the Ministry of Public Service and Labor as part of the approval process.


*Figure 3. The opening (left) and closing (right) sessions of the workshop by Dr. Parfait Uwaliraye, Head of the Planning, M&E, and Health Financing Department, and Ndonkeye Valens, Director General of Corporates Services in the MOH.*

Since the job profiles have been approved, the next steps will be to use them as main reference documents during recruitment and placement of staff. The new organizational structure of public health facilities, ranging from new referral hospitals to health centers, may be implemented progressively for five years as funds allow.

### 2.1.2. Institutionalize sustainable quality structures

#### 2.1.2.2. Disseminate new licensing requirements for private health facilities

In 2019 the MOH developed and published private health facility licensing standards applicable to all private health facilities in Rwanda. These standards were developed based on the basic requirements for quality standards and patient safety before issuing licenses to operate a new private health facility. The first edition (2019) of these licensing standards was published but not disseminated due to a lack of inspection tools. Therefore, in FY 2021, RIHSA provided technical support to the MOH to develop a new licensing inspection tool to operationalize the standards and facilitate dissemination during the licensing inspection process. The inspectors will use the tool to assess whether new private health facilities meet licensing standards requirements and could be approved to operate.

As such, a three-day workshop was organized to review the development of the licensing inspection tool. Fifteen inspectors from central and district levels attended, including inspectors from MOH, districts of the City of Kigali (Gasabo, Kicukiro, and Nyarugenge), representatives of the private health facilities association, and RIHSA technical staff. The objective of the workshop was to review the drafted tool, integrate inputs from the users (inspectors), and finalize the tool that would be used for licensing inspection of private health facilities.


*Figure 4. The USAID/RIHSA chief Dr. Solange Hakiba of party delivers remarks to participants (left), and RIHSA staff facilitate the training (right).*

The licensing inspection tool will guide the process to assess whether new private health facilities comply with national licensing standards. That will be an entry point for private health facilities in the national accreditation program and the beginning of implementing the private health facility accreditation standards to determine whether the private health facilities are to be relicensed. For effective dissemination and implementation of the licensing standards and inspection of new private health facilities in FY 2022, RIHSA will train inspectors on the use of the tool targeting staff involved in the inspection process at the district and central levels (MOH and National Reference Laboratory).

### 2.1.2.3. Support the development of QI key performance indicators and ensure integration into staff job descriptions

RIHSA is committed to developing strategies that institutionalize continuous QI as part of Health Systems Strengthening. Building on past achievements,[5] RIHSA worked with the MOH team to develop quality indicators to be integrated into the job descriptions of hospital staff as part of institutionalizing QI in day-to-day staff operations. The quality indicators can also be used to assess adherence to standards or the achievement of quality and safety goals. As hospitals implement standards, monitoring QI indicators provides a valuable adjunct to standards-based surveys, since indicators often focus on a few key structures, processes, and outcomes that represent an overall picture of the quality of the facility. For example, monitoring of a hospital's postoperative infection rate for mothers who have had a cesarean section could provide useful information about how effectively the hospital is implementing its infection prevention and control program. Additionally, QI indicators provide information that is beneficial for planning purposes as well as ongoing monitoring for continuous improvement. It is intended that the results of the indicators demonstrate the impact of the accreditation system on the quality and safety of health care services.

### 2.1.2.4. Advocate for QI continuing professional development

The MOH has put in place systems and structures to address QI in the health system.

[5]. Past achievements include two main activities: (1) integrating performance-based financing and health care accreditation whereby QI efforts inform the incentives paid to health facilities and (2) including quality units and QI officers' positions in the revised health sector organizational structure.

Addressing QI has also included incorporating QI officers in the hospital's organizational structure and establishing an education, research, CPD, and QI unit as indicated in the Official Gazette special issue of January 9, 2020. All health professionals need to understand training in QI methods to ensure they can identify and address quality problems systematically while providing the best care to their patients. Including QI training in CPD programs will keep health professionals up to date on evidence-based approaches and best practices.

RIHSA worked together with the MOH and the Human Resources for Health Secretariat to increase strategies to institutionalize continuous QI as part of health systems strengthening. During FY 2021, RIHSA successfully advocated for integration of QI courses in health professionals' CPD programs. In this regard, a concept note was developed and presented to guide the advocacy/discussion with the professional councils. The intent was to promote the inclusion of QI training in the CPD programs of all health care professionals, to discuss course content, and to identify the roles and responsibilities of the various stakeholders involved in the CPD programs. As a result, it was agreed that the QI courses, and the surveyor training program will be included in the CPD programs. As a long-term strategy, RIHSA will explore opportunities to integrate QI courses into the service curriculum for all nurses, doctors, and pharmacists.

**Sub-objective 2.2: Strengthen the accreditation process at hospitals and health centers**

**Key highlights**

- ✔ RIHSA provided technical support to facilitate standard development and review of guidelines.
- ✔ Revised the second edition set of Rwanda Hospital Accreditation Standards to ensure compliance to the third edition of International Society for Quality in Health Care (ISQua) principles, integrated MNCH standards, and aligned with national priorities.
- ✔ Completed the surveyor-training program where 49 surveyors reached the passing score (70 percent) as required by the program and were certified, increasing the pool of surveyors from 35 to 84.
- ✔ Completed baseline assessment of 24 public health facilities, including 4 private hospitals and 20 polyclinics
- ✔ Completed the accreditation progress survey for 44 public hospitals and a baseline accreditation survey for one DH.

### 2.2.1. Provide TA for standards at all levels

#### 2.2.1.1. Facilitate development standards review guidelines

RIHSA provided technical support to facilitate standards development and review guidelines. The hospital accreditation standards currently used across 45 hospitals were first developed in 2012 and revised in 2014 as the second edition. Subsequently, six sets of standards have been developed. However, there has been no guideline to ensure a harmonized and standardized approach to development and reviews in Rwanda. RIHSA leads the development of a policy and procedure guideline that will be used to guide future standards development, revision, and modification to ensure an effective process and adherence to ISQua principles and standards development in the health sector.

The developed policy and procedure for standards development and review are underpinned by the following six ISQua principles for standards development:

1. Standards are planned, developed, and evaluated through a defined and rigorous process.
2. There is a transparent measurement or rating methodology used by organizations and surveyors to aid a consistent achievement rating.
3. Standards require assessment of the capacity and efficiency of health and social care organizations.
4. Standards include the processes to manage risk and to protect the safety of patients/service users, staff, and visitors.
5. Standards are person-centered, reflect the continuum of care, and encourage partnerships between patients/service users and professionals.
6. Standards require service organizations to evaluate, monitor, and improve the quality of services.

Flow charts to guide the process of standards development and review have been developed. A Standards Evaluation Feedback Form has also been established to be used to gather feedback regarding the contents and interpretation of the standards, as this is vital for future standards development and review. The developed guidelines will be validated by the quality and standards technical working group (TWG).

#### 2.2.1.2. Review the existing hospital standards to ensure compliance with national priorities such as national referral standards and ISQua guidelines of standards development and review

Rwanda looked at its health care accreditation system as one quality-enhancing strategy as it pursues universal health coverage. At the heart of any accreditation system lie reliable, valid, measurable, and objective standards. During the year 1, RIHSA supported the revision of the second edition of the Rwanda Hospital Accreditation Standards, which were last reviewed in 2014 and were overdue for review and update. The review of the existing hospital standards was to prepare Rwanda hospital health care standards for external evaluation and to meet international principles of standards development.

Due to COVID-19 prevention measures, RIHSA organized and conducted a five-day virtual workshop to review these standards, which otherwise would have been organized face-to-face. A task team was composed of technical persons from MOH, RIHSA, Ingobyi, and professional councils as well as surveyors from health facilities. This comprehensive team of stakeholders was actively engaged to assess how the existing hospital standards were aligned with the six IEEA principles and criteria of good standards and to identify the existing gaps in the compliance to ISQua guidelines. The identified gaps and feedback from the team informed the review. The feedback session by each team provided active discussions, and the workshop concluded with an agreement by the team requesting amendments to the existing national standards.

It was subsequently requested by MOH that newly developed Maternal; Newborn, Child, and Adolescent Healthcare Standards (MNCH standards be integrated into the hospital standards. RIHSA, Ingobyi, and MOH advocated for their integration into the hospital accreditation standards. The team also reviewed the Quality Service Delivery Standards developed by the

Ministry of Labor and integrated all missing elements into the Rwanda Hospital Accreditation Standards Third Edition. A reference document was developed to crosswalk the Rwanda Essential Hospital Accreditation Standards Third Edition and to ensure they include the Quality Service Delivery Standards from the Ministry of Public Service and Labor and share them with MOH.

RIHSA led the testing of the standards done by surveyors and facilitators in the two selected hospitals to demonstrate how the new additional and modified standards confirm that the standards can be measured in a comprehensive, reliable, and consistent manner. Further, the team made amendments based on the agreed-upon, required changes, finalized review, and submitted the Rwanda Hospital Accreditation Standards Third Edition to MOH, which is being formatted and then will proceed to dissemination. Additionally, the performance assessment toolkit was revised and aligned to the revised version of standards. This is a useful tool in the health systems to holistically assess hospitals' level of effort to meet standards and improve the quality of services provided to the population in Rwanda.

#### 2.2.1.3. Develop a coordinated, phased plan and tools for baseline assessment of health centers, leveraging existing resources and partner collaborations

Primary Health Care standards were developed and disseminated in 2019 at the health center level. The next step was to conduct a baseline survey to establish the current compliance level of health centers to the set primary care / health center standards. Because conducting a baseline survey of 510 health centers requires a large budget and concerted efforts from different MOH partners, RIHSA supported MOH to outline a phased roadmap to conduct a baseline survey. MOH discussed the plan with partners to gain commitment while leveraging existing resources and collaboration of partners. As a result, Enabel Barame project committed to support a baseline survey of 70 health centers, while RIHSA plans to support a baseline survey of 28 health centers during Q1 FY 2022.

In addition to tools to guide interviews with health center managers, QI and infection prevention committees have been developed for the baseline survey. It was agreed that surveying 100 health centers would be representative of the 510 health centers. Findings from the baseline survey will inform the standards implementation plans while prioritizing high-impact interventions.

### 2.2.2. Strengthen capacity of local organizations to manage the accreditation process based on ISQua principles

#### 2.2.2.1. Facilitate review of RAAQH's organizational structure and the organizational development plan

RIHSA aims to strengthen the health system in Rwanda to ensure all Rwandans have access to quality health care services. One of the mandates is to review the organizational structure of RAAQH and the organizational development plan with a view to strengthening RAAQH as a local organization to manage the accreditation process and complying to ISQua External Evaluation Association (ISQua EEA) standards and criteria for organizational accreditation. Thus, the Council for Health Service Accreditation of Southern Africa (COHSASA) has reviewed the documentation provided by RAAQH to date, made recommendations, and

indicated which other documents and systems are required to meet standards of an accrediting organization. Documentation is key to demonstrating that RAAQH meets the required systems and processes in place to effectively meet the ISQua EEA. The review process, together with TA, will continue in year 2 to support the RAAQH organizational development plan.

#### 2.2.2.2. Support surveyors in training to complete their training and certification program

RIHSA has supported MOH to conduct a surveyor certification exam for the fourth cohort in training as part of the program of National Accreditation of Surveyors in training and certification. RIHSA provided logistical support and facilitation for exam setting and marking. A total of 82 of 111 (73.9 percent) expected candidates attended the certification test, and 49 (59 percent) reached the passing score. Surveyors who did not pass will be given an opportunity to retake the exams. The certification exam built on previous USAID support to MOH for the surveyors to pursue the one-year practicum and theoretical certificate course for the fourth cohort, which commenced in 2019. Having a critical mass of skilled and competent surveyors is key to the institutionalization of an accreditation approach to continuously improve quality of services. In addition, as the national program expands, covering all district and provincial hospitals and rollout to the health centers, private health facilities call for the need to increase the number of surveyors. Generating a pull of surveyors and keeping connection with surveyors who completed surveyor training are critical for smooth and expedient implementation of RIHSA activities. As a result, the number of certified surveyors increased from 34 to 83, making it more possible to conduct baseline surveys with private health facilities.

Figure 5. Surveyors attending a training session (Kigali, February 2021)

Key challenges include a one-year delay between completion of the practicum and the exam, which might have led surveyors to forget the course content, resulting in poor performance during the certification test. The delay was caused by poor support for the program from an implementing partner. In addition, the surveyors in training did not have much exposure to the survey practicum due to the shift from biannual to annual surveys, as they are required to participate in a minimum two-practicum survey training. Furthermore, some trainees were unable to attend the certification exam, as they were not available due to their respective engagement in managing COVID-19 activities. Surveyors who did not pass the test will be able to retake it.

#### 2.2.2.3. Develop online surveyor training modules for the next cohort of surveyors

The review process of the survey training modules included identifying gaps in the existing surveyor training program and converting the updated training modules to a digital platform for online training. The online training program will be used for capacity-building of surveyors who conduct surveys at health care facilities for the purpose of assessing compliance performance levels with the Rwandan accreditation standards. Developing online surveyor training modules will facilitate not only efficient delivery and management of training for new surveyors but also consistent attendance in CPD programs. In addition, having an online surveyor training

program with accompanying competency assessment tools will give RAAQH more flexibility in the program delivery and will help surveyors to engage remotely in ongoing CPD activities. During FY 2021, RIHSA reviewed the existing surveyor training program against the ISQua EEA requirements. A series of virtual meetings were held with MOH and the Human Resources for Health Secretariat to discuss changes to the existing surveyor training program and agree on the format and mode of delivery for the online activities. A virtual workshop was held to discuss the content of the online training and the surveyor competency evaluation tools with MOH, RAAQH, COHSASA, and the Human Resources for Health Secretariat. The accreditation surveyor CPD program will be completed in FY 2022.

### 2.2.3. Support accreditation in provincial and district hospitals

#### 2.2.3.1. Build capacity of hospital QI teams, especially the newly appointed QI officers to support standards implementation for all sets of standards including maternal and child health based on previous survey results/gaps identified

**a. Quality improvement facilitation as a key component of quality management**

The Government of Rwanda has appointed QI officers at health facilities who will play an important role as change agents. These officers will work closely with QI committees to identify areas of improvement, set improvement goals, provide tools, and facilitate QI initiatives while strengthening and maintaining the QI structure within health facilities.

RIHSA worked closely with the MOH, Human Resources for Health Secretariat, and professional councils to review existing training material. During a series of workshops, they agreed the content of the QI course would include five modules:

1. Fundamentals of quality improvement
2. Designing an improvement effort
3. Supporting transformation by testing changes
4. Sustaining and scaling up improvement in the health system
5. Patient safety

The modules were revised and are now available on the Human Resources for Health e-learning platform to provide both an online QI facilitation training course as well as on-site training practicums for the newly appointed QI officers. In addition, COHSASA has worked with the RIHSA team to develop training materials for the QI officers. Building the capacity of QI champions through both online and on-site training will enable the newly appointed QI officers, including health care providers of the targeted hospitals, to attend ongoing CPD programs. The Human Resources for Health Secretariat and the professional councils will allocate credits to the course as part of the CPD policy. Earning the CPD credits will be additional incentive to pursue the QI course and will be part of institutionalizing quality into the existing structures.

**b. Quality improvement facilitation to support hospital teams in standards implementation**

As part of continuous efforts to improve the quality of care in hospitals and based on findings from the accreditation surveys of hospitals, RIHSA has identified the need to provide QI facilitation to hospitals. RIHSA was requested to support the MOH in conducting QI facilitation for Gahini, Rwinkwavu, Kirehe, and Butaro DHs from May 30 to June 4, 2021. This facilitation

was conducted by certified QI facilitators from the MOH who were organized in two teams of four facilitators each. The objective of the facilitation was to provide technical support to the QI committees at each hospital as they discussed and developed strategies for addressing the quality gaps at different compliance levels identified during the previous accreditation surveys. Facilitation accomplished the following:

- QI plans to address elements missing during surveys, like operational policies, procedures, plans, documentation of inventories, and so on
- tools to monitor if clinicians are complying with treatment protocols, emergency triage guidelines, recording discharge planning, and so on
- QI action plans to implement surveyors' recommendations to enhance hospital performance

For FY 2022, RIHSA will provide facilitation of more hospitals and capacity-building of QI committees.

#### 2.2.3.2. Support accreditation progress surveys in hospitals

During FY 2021, RIHSA provided technical support regarding accreditation surveys to identify quality performance gaps and health system inefficiencies within the public health facilities. The surveys aimed at establishing the hospital performance progress toward achieving accreditation. Progressive assessments were conducted among all 44 public hospitals as was a baseline assessment for one DH. Surveys for accreditation measure hospitals' progress toward achieving hospital standards, organized in five risk areas: (1) leadership process and accountability, (2) competent and capable workforce, (3) safe environment for staff and patients, (4) clinical care of patients, and (5) QI. The main objective of each hospital is to work toward achieving three progressive levels of accreditation: Levels I, II, and III.

*Figure 6. Orientation session and certification of new accreditation surveyors (Kigali, May 2021)*

First, RIHSA conducted a one-day orientation workshop with 77 surveyors to share survey process challenges, standards interpretation issues, and survey findings across risk areas, scoring, and reporting. The orientation workshop was an opportunity for newly certified surveyors to learn from the experience of their seniors. In the workshop, MOH and RIHSA officials also awarded certificates to newly certified surveyors.

A survey manual and hospital standards performance assessment toolkit were used to ensure objectivity. Each hospital was surveyed over four days by a team of four certified surveyors. MOH notified the hospitals to be surveyed, followed by the hospitals sharing the services they

provide. The survey methodology included review of various hospital documents, administrative and medical records, interviewing QI committees, the management team, and patients, and conducting facility tours. This allowed for comprehensive and thorough observations to determine the extent to which facilities ensure environmental safety, implemented infection prevention control practices, ensured respect for patient rights (privacy, confidentiality of information), and displayed signage for directions.


*Figure 7. Hospital progress accreditation survey: preliminary findings presentation (Nyanza, June 2021)*

At the end of each survey, a feedback session was held with the hospital management teams and District Health Unit Directors to discuss findings of each health facility surveyed and draw actionable recommendations for future improvements.

In the FY 2020/21 hospital performance target set by MOH was to achieve Level II, which is met through implementation of policies, procedures, and plans. Specifically, the hospital must meet the following requirements to achieve Level II:

- Level I recognition must be achieved and maintained with an overall average score of 75 percent.
- Each risk area must attain an average score of 70 percent.
- Level I critical standards must be met at 100 percent.
- Level II critical standards must attain an overall average score of 80 percent.

Based on the 2021 accreditation progress survey assessments, the following are the key results:

- 5 out of 44 hospitals achieved their target of Level II.
- 30 hospitals achieved or maintained Level I.
- 9 hospitals did not achieve Level I.
- The new DH that underwent an accreditation baseline assessment did not achieve Level I.

The results from the accreditation process will be used to determine performance-based financing incentives for each hospital. Figure 8 suggests that all hospitals above 75 percent are likely to achieve their target for Level II in the next survey if they work on addressing their gaps. Figure 9 shows the 10 standards with the lowest scores across five risk areas.

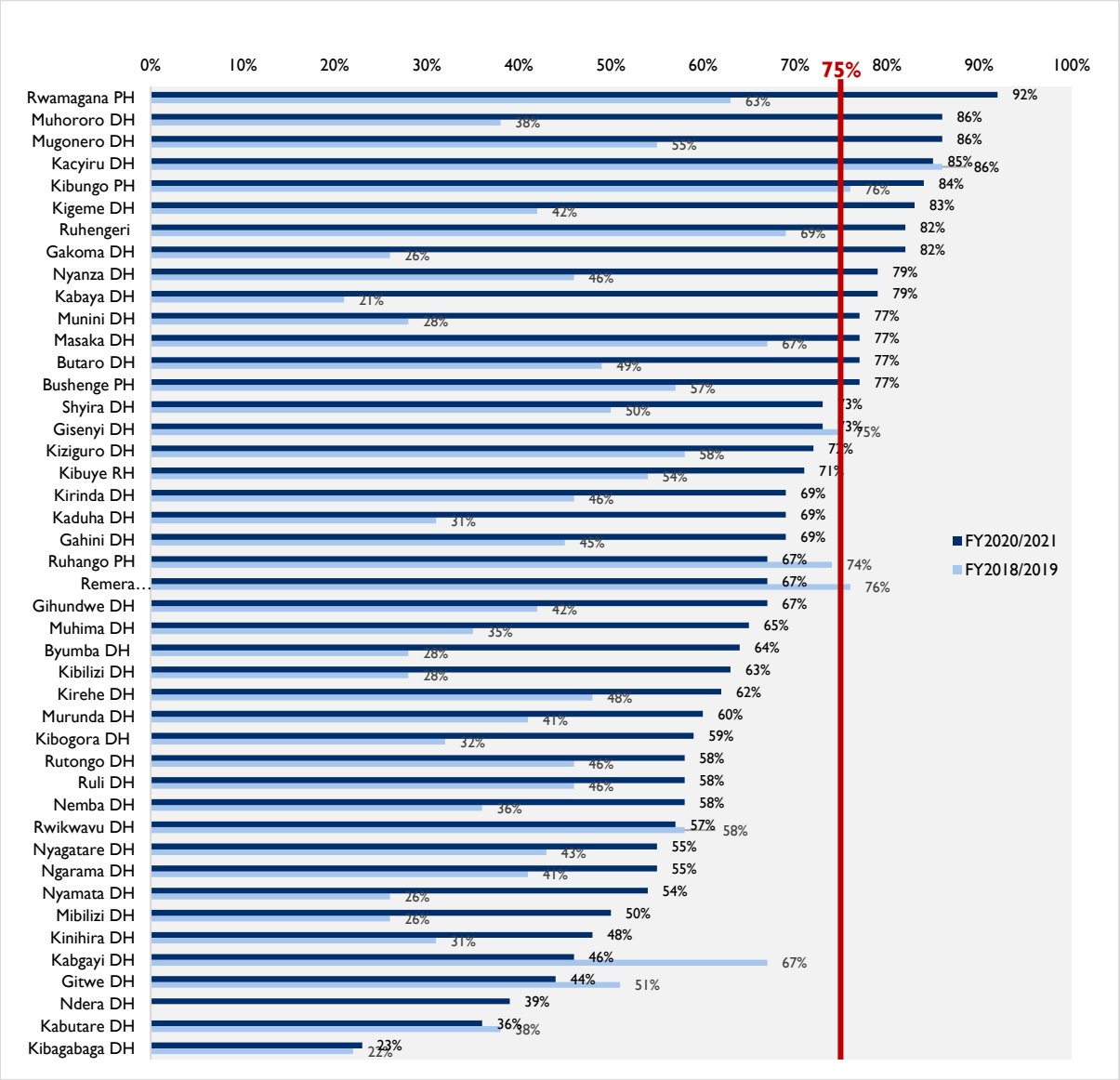

Figure 8. Level II accreditation performance for 44 public hospitals in FYs 2018/19 and 2020/21.

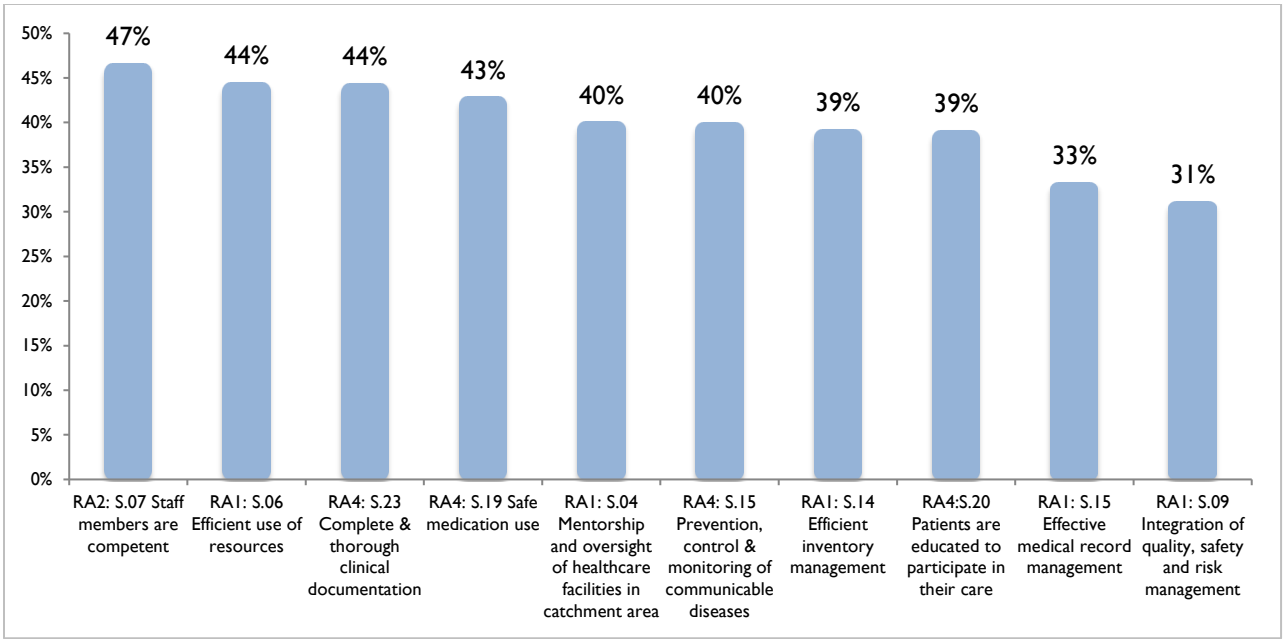

Figure 9. Ten lowest-performing standards at Level II, FY 2020/21.

**Key hospital progress survey findings**

Performance targets at Level II always require implementation of existing policies and procedures and ensuring that processes are in place for consistent and effective risk reduction. Since most public health facilities have developed the required guiding policies and procedures, plans, and other documents (achieving Level I performance), gaps can still be observed regarding communicating and building staff competencies in standard implementation of quality programs at health facilities. The following are some key observations from the FY 2021 accreditation progress survey:

- Limited leadership involvement is available to create and sustain an organizational culture that supports quality care delivery.
- In most public facilities, leadership has not been able to establish links and integration between different QI committees, such as infection prevention, health and safety, QI, and others. This has resulted in lack of collaboration regarding standard implementation.
- Hospital mentorship of health centers within catchment areas constitutes a major challenge. Hospitals lack formal plans on how they can carry out mentorship activities, and in cases where there is mentorship, there is no formal documentation.
- Safe medication use remains a big problem at many health facilities. Special focus is needed regarding management and maintenance of emergency medicine trolleys, the storage process, and monitoring of drug expiration dates, which poses a serious threat to patient safety.
- Across most health facilities, safety and risk management is a challenge. There is no culture for incident reporting or root cause analysis. It is common for hospitals to have incidents or medication errors that go unreported, and recommendations are not in place to improve the quality of care or address any upcoming risks.
- Goals and quality indicators are supposed to be a priority at most health facilities to meet the expected quality targets. It was however observed that most hospitals were not able to put in place mechanisms for monitoring the defined targets and indicators.

Improvement recommendations have been provided in individual hospital reports and the

executive summary report submitted to MOH.

### 2.2.4. Strengthen private sector engagement for accreditation and QI

#### 2.2.4.1. Conduct baseline assessment for 24 private health facilities

MOH emphasized the need to continue scaling up a standards-driven QI approach through the enrollment of polyclinics and private hospitals in the national hospital accreditation program. Thus, RIHSA provided technical support to conduct an accreditation baseline assessment for 24 private health facilities and establish the current situation of health facilities regarding compliance with Rwanda Polyclinics and Private Hospital Accreditation Standards (First Edition, November 2018). The baseline surveys helped to identify quality performance gaps and inefficiencies within the health systems in private health facilities.

Figure 10 shows that the overall performance regarding accreditation standards implementation was very low. None of the surveyed private health facilities achieved Level I recognition (85 percent average score). Legacy clinics scored the highest, while 19 facilities scored less than 20 percent. The survey also showed that some facilities lacked accreditation support committees—specifically, QI and infection prevention committees. Leaders of health facilities were encouraged to invest resources and efforts to ensure the availability of the required standards documents, develop a QI plan to close the performance gaps identified during the baseline survey, and subsequently begin implementing an accreditation program. Although some required activities or procedures have been implemented, they could not be scored or considered as meeting the required level of compliance based on the guiding documentation. These policies and procedures, the administrative manual, the operational plan, the overall training plan, protocols, clinical guidelines, the QI plan, and the customer care program were not available for most of the health facilities. In PY2, RHISA will support private health facilities to teach them how to share information, learning, experiences, and best practices to facilitate the development of standard implementation improvement plans.

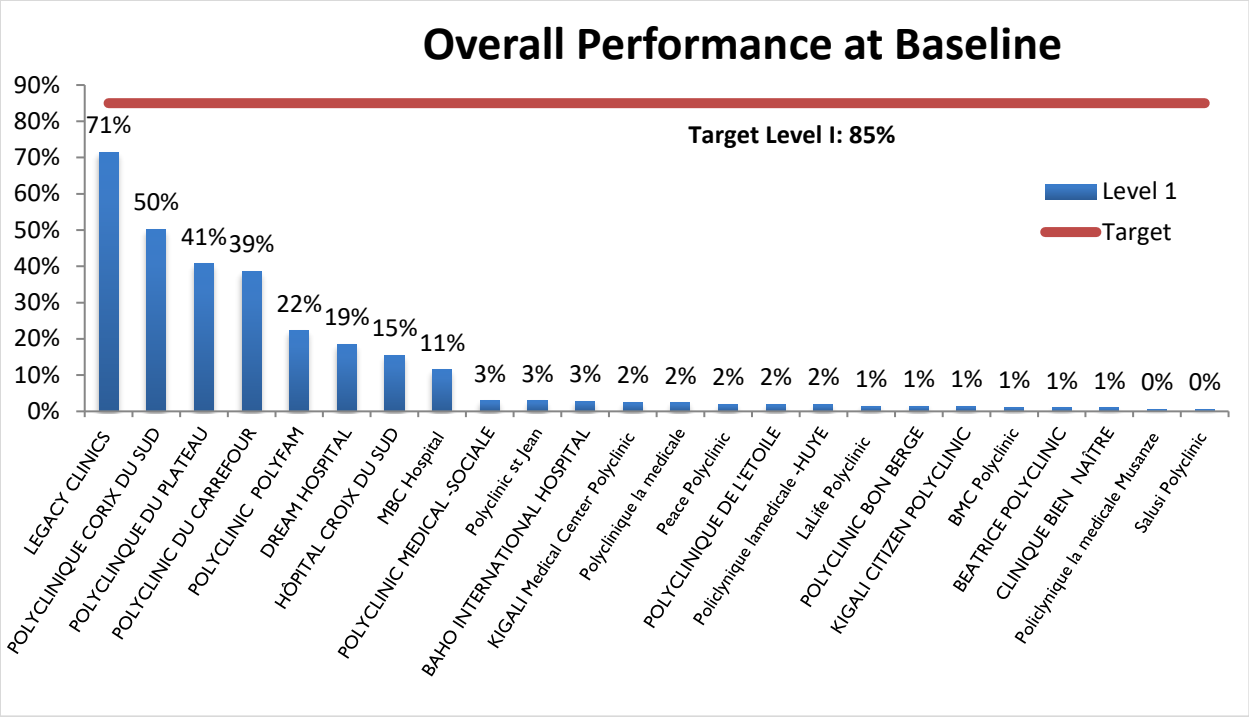


Figure 10. Summary of results of accreditation baseline survey for 24 private health facilities.

#### 2.2.4.2. Information sessions with both public and private sector networks to share health care accreditation survey findings

Information sharing was organized to compare findings from hospital progress surveys in FYs 2018/19 and 2020/21 and discuss how to improve performance in 2022. These sessions took advantage of the three innovative twinning workshops organized by RIHSA, which brought together the DHMTs, including the director of health, the health promotion and disease prevention officer, and the district M&E Officer; the Director General of each district hospital, the Chief Nursing Officer, and the QI Coordinators. Each workshop brought together 10 districts (Gakenke, Nyagatare, Rulindo, Ngoma, Karongi, Gasabo, Bugesera, Kamonyi, Kirehe, and Kayonza). Workshops took place in Musanze on September 29 and October 6, 2021, and in Huye on October 13, 2021. The findings from the survey on hospital accreditation progress were presented, focusing on the hospitals in 10 districts. The presentation summarized the overall scores, the risks area analysis, and the recommendations to various stakeholders.

The following points from the participants' feedback summarize the outcome of the sessions:

1. The awareness and commitment of district health authorities were perceived as major factors for better future performance, as the health care accreditation progress will be part of the district performance contract.
2. Weaker hospital accreditation performers forged twinning mechanisms with higher accreditation hospitals.
3. Hospitals requested support for a more systematic training program for some technical areas such as fire safety and resuscitation techniques.
4. Technical support was requested for sustained in-hospital accreditation facilitation.
5. Resistance to change from some hospitals' leaders could still be perceived by some participants, though not most.

   Compliance with the 75 standards was achievable at Level III provided there is a

mindset change, as summarized by one hospital director general.


*Figure 11. A representative from RIHSA presents findings to DHMTs and hospital managers regarding the 2021 accreditation process survey conducted in 45 public hospitals.*

**Sub Objective 2.3: Improve data use for quality and governance**

**Key highlights**

- ✔ Supported the MOH and RBC to adapt the RHAP TWG governance structure. This included appointment of new leadership, clarification of RHAP TWG functioning (roles and responsibilities, communication, meetings, decisions, and so on), and introduction of RIHSA stakeholders and scope of work.
- ✔ Created RHAP data quality dashboards that display facility-level data quality and service delivery gaps. The dashboards were presented to the RHAP TWG for validation and will be shared monthly with RBC moving forward for follow-up and remedial actions at the health facility.
- ✔ Conducted a situation analysis comparing public and private health facility routine reporting and data use. Findings and recommendations of the assessment were shared with MOH and RBC for improvement of private health facility reporting and data use.
- ✔ Held first of two twinning launch workshops to kick off and set the foundation for the twinning activity.
- ✔ Established essential partnerships with the MOH and the MINALOC to obtain buy-in and support from key government leaders through a series of virtual and face-to-face codesign sessions.

Improving the quality of essential health services requires a robust, adaptable, and resilient health system with adequate tools to use data for measurement of health sector performance

and achievement of quality goals. During year 1, the RIHSA focused on identifying data use cases, supporting existing data quality assurance efforts, mapping and assessing of data sources (including accreditation, IFMIS, and ISHYIGA for potential integration into the RHAP, and developing a roadmap for the long-term sustainability of the platform and a rollout strategy for decentralization to districts and hospitals.

### 2.3.1. Strengthen development of Rwanda Health Analytics Platform

#### 2.3.1.1. Adapt RHAP governance structures (e.g., Technical Working Group (TWG and steering committee) (SC) and work collaboratively with government partners to identify, scope, and prioritize critical data triangulation use cases

RIHSA supported the strengthening of the RHAP, a platform intended to consolidate data from multiple fragmented information systems in the health sector under a single unified workspace for analysis. This platform is expected to significantly enhance situational awareness and disease surveillance and to provide decision-makers with the actionable analytics needed to coordinate responses in a data-driven way. To ensure smooth implementation, support, and strategic use of RHAP, the RBC created an internal RHAP TWG to oversee the platform and its implementation. The TWG is expected to closely monitor the progress and challenges in the use of the platform, to bridge communication between core users and implementing partners, and to oversee the introduction of new initiatives, policy guidelines, and programs.

Since RIHSA is working to strengthen RHAP use at both the central and decentralized levels, as well as the recent restructuring of RBC and MOH, it was necessary to adapt the governance structure of the RHAP TWG to reflect these changes. For this reason, RIHSA worked with the team from the new division of Research Innovation and Data Science (RIDS) to revise the TWG terms of reference and present the changes to the RHAP TWG for validation. The revised terms of reference planned to roll out RHAP to districts and hospitals, to integrate new data sources and private sector data into the platform, and to develop a roadmap for the long-term sustainability of RHAP. In addition, the revised terms of reference also clarified the structure and functioning of the RHAP TWG, including governance structure, roles and responsibilities, communication, and frequency of meetings. The adapted RHAP TWG terms of reference were finalized and validated for use.

RIHSA will continue to support functioning of the RHAP TWG by providing the RBC TWG with TA in organizing monthly meetings, by documenting decisions, and by following up on their implementation.

#### 2.3.1.2. Conduct initial organizational change assessments including organizational readiness, technical readiness, and data source availability assessments

In order to address the challenge of multiple stand-alone/siloed data systems, RBC had previously worked on integration of several data systems into the RHAP. Building on these existing successful integrations, RIHSA plans to strengthen the platform through several interventions, including integrating additional data sources into the platform. These may include accreditation data, health financing data, and private sector data, among others. It is in this context that RIHSA conducted the initial organizational change assessments on data source availability as well as the organizational and technical readiness of key institutions that could potentially contribute data for integration into the platform. The identified institutions and data sources included MINECOFIN (IFMIS), RAAQH (accreditation survey data), and ISHYIGA.

Findings of the assessment were used to determine feasibility and importance of integrating the data sources into RHAP for cross-program analytics.

The identified data sources would all generate important use cases for informing decision-making in the health sector if integrated. The recommended order of priority for integration would begin with accreditation survey data, followed by IFMIS and then ISHYIGA.

#### 2.3.1.5. Scope two data sources critical to the prioritized use cases for integration into RHAP

Following the findings from the initial organizational readiness assessment described under sub activity 2.3.1.2, two data sources were identified as having the highest priority use cases. These were selected for integration scoping (accreditation survey data and the IFMIS). As such, RIHSA performed integration scoping of the selected data sources to determine the most appropriate integration approach and requirements for successful integration. This was done through interviews with representatives of the target organizations—MINECOFIN for IFMIS and RAAQH accreditation survey data—and review of relevant documentation such as IFMIS quality assurance reports and accreditation executive summary reports. The gathered information included the organizations' data workflow, data collection processes, data quality challenges, issues and risks, data access/sharing policies, credentials and user support, system modeling, and use cases.

**Table 3 . Key findings**

| Aspect | IFMIS | RAAQH |
|---|---|---|
| Organizational Structure | Well-structured with all standard functions of a business. IFMIS is maintained by a professional team under MINECOFIN. | A small organization, with only 3 staff. having only "essential staff". Most of the time other IT functions of the business are outsourced when needed. |
| Data Sources | IFMIS gets data from different public sector services and covers financial expenditure and budget at different levels. Currently working on getting data from the private sector. It has two main data sources (Expenditures and Revenues) | RAAQH gets data from Accreditation assessments conducted every 6 months in public hospitals. Currently the exercise is going to be extended to Private facilities. |
| Data Collection and Data Quality Gaps | The IFMIS team does not focus on enforcing data quality, their mandate is to avail a platform which allows data collection and sharing. Most of the data quality issues are raised by end users or data consumers. IFMIS hires external professional firms to run QA assessments periodically. The recent QA assessment did not find any issue which can impact integration. | Mainly manual and paper-based process during data collection. No standard tool to collect data. Data cleaning and analysis is conducted offline. No system to consolidate all historical data.<br><br>No external QA assessment conducted. |
| Data Hosting | Have an internal data hosting policy. IFMIS | No policy on hosting or data |

| | | |
|---|---|---|
| Policies | currently has two hosting sites. | sharing. |
| Shared Resources/Tools | All tools or shared resources such as administrative hierarchy, facility registry or other codification are internally created and administered. | All tools or shared resources such as administrative hierarchy, facility registry is not customized and not centralized. |
| Reporting Frequency | Each report has its own reporting requirements. IFMIS has periodic (daily, weekly, monthly, quarterly,... ) and non-periodic reports (ad hoc, ...) | The reporting is based on the accreditation compliance assessment exercise which is conducted once annually. |
| Target Audience | Public sector | Health Facilities in the Public sector. Planning to expand the exercise to Private health facilities. |
| Integration with 3rd Party Interfaces | IFMIS currently has an API, runs integrations and does both pull and push operations.<br>For each API integration, the API can get customized to the needs of the partner. | Data completely stored offline and no integration interfaces with other systems. |
| Availability of Technical Team Supporting the System | There is a technical team in charge of system development and maintenance, infrastructure management and capacity building. For all tech issues, the team uses a ticketing service to manage all support requests. There is also a team to support other business aspects of the Platform. | No technical support available. |
| Challenges | Occasional mismatch between IFMIS and other external systems (facility registry, Ministry restructuring also affect data structure)<br><br>Updating institution codes impacts historical data.<br><br>Need for capacity building of low-level staff | A completely offline and manual process<br><br>A high probability to introduce data quality errors while transitioning from one stage to another. |
| General | IFMIS operates in a standard fashion, its integration efforts are clear. | Currently RAAQH is looking at setting up a tool which will be used to collect, store, and share accreditation data online. All historical data are available in excel/csv formats. |
| Integration Way Forward | Use of an API to share data with RHAP. An official request from the Ministry of Health to MINECOFIN is required. | There are prerequisites to fulfil<br>• decide on how future assessments or data collection will be handled<br>• data structure and sharing mechanism to be defined<br>• way forward for historical data<br><br>The above will provide clarity on |

| | | |
|---|---|---|
| | | how RAAQH data can be integrated in RHAP.<br><br>A potential mechanism is to do an integration of processed spreadsheets. |

From a technical perspective, the integration readiness of IFMIS was at 95 percent, whereas accreditation data were at 60 percent (percentage determined based on API availability, level of support, and potential risks that might affect the process). Integrating accreditation data would require a manual process, while IFMIS integration would be facilitated by the system API. For integration, next steps would involve mobilization of resources, integration of data source, identification of priority use cases, generation of relevant analytics, capacity-building of target user groups, and ongoing user engagement /support.

#### 2.3.1.7. For data sources already available in RHAP, provide TWG with a monthly data quality report and support documentation of data quality discussions and initial remediation

To improve health outcomes, the use of routine health data is essential for identification of gaps in the availability, utilization, and quality of health services. It follows that the data must be of reliable quality so as to objectively measure the quality of health services. Following efforts made by the MOH, RBC and partners like USAID over the years, public health facilities currently have remarkable reporting rates (over 99 percent) and timeliness (over 93 percent) in the national Health Management Information System (HMIS). However, despite the high reporting rates, data gaps and data quality issues continue as some of these reports are submitted with missing values, data inconsistencies, and outliers that may negatively affect the decision-making process. It is in this context that the RIHSA generated data quality reports through RHAP that will be used to flag and share data inconsistencies with the relevant RBC programs and prompt data quality discussions as well as remedial actions.

The data quality dashboards are based on analysis of consistency along the health service provision cascades. This involves comparison between the number of individuals eligible for a given service (in accordance with clinical guidelines) and those who received the service. RIHSA worked with RBC to identify the most commonly evaluated data validation checks conducted by the various health programs.

The team thus far has generated RHAP data dashboards for reproductive, MNCH, and malaria indicators and will continue to add dashboards for other program areas in collaboration with RBC. The data validation rules used for the consistency checks are displayed in the dashboard to guide users with interpretation. Data quality issues identified included mismatches between the number of target service beneficiaries and actual service beneficiaries. The dashboards also allow the user to filter results by district, facility, and month as needed between October 2020 and August 2021.

RIHSA will continue to share data quality dashboards with MOH and RBC for further follow-up at the health facility level. Access to these dashboards will be based on user access rights and permissions as prescribed by the RBC RHAP focal point. Other avenues that will be used to share this information include the following:

- TWG monthly meetings
- exported PDF versions of the dashboard shared via email
- scheduled automated reports (automated reports created in RHAP and sent out by the system at predefined intervals to platform users)

#### 2.3.1.8. For the two new data sources scoped for integration, provide data quality SWOT assessment based on integration scoping activities

As part of the integration scoping exercise for the two data sources selected for integration (accreditation survey data and the IFMIS), RIHSA also conducted a Strengths, Weaknesses, Opportunities, and Threats (SWOT) assessment of the data sources. This SWOT exercise was aimed at identifying ways to build on their existing strengths and opportunities while addressing their weaknesses and threats, thereby ensuring better cross-program analytics and generation of holistic information to decision-makers after the data sources are integrated into RHAP.

This exercise involved interviews with representatives from the two organizations—MINECOFIN (IFMIS) and RAAQH (accreditation)—as well as review of relevant documents. During the interviews, the IFMIS coordinator provided a demo of the financial system, and the representative of RAAQH provided an overview of accreditation data collection, analysis, and dissemination. For IFMIS there is a need to improve the automation of data quality assurance processes and report generation, the ability for users to run their own analytics and generate visualization as needed, and the standardization of registries. As for the accreditation survey data, the main recommendation was to automate data collection and promote use of the findings for improvement of service quality and safety at the hospital level.

RIHSA will take these findings into account during the next steps, which include integration into RHAP, capacity-building of target users, and defining a partnership framework for collaboration and data sharing between stakeholder institutions.

**Table 4. IFMIS strengths, weaknesses, opportunities, and threats**

| Strengths | Weakness |
|---|---|
| **Technical/Integration**<br>1. Availability of Application Programming Interface (APIs)<br>2. Ability to customize APIs to partner requirements<br><br>**Data Quality**<br>1. Conduct periodic Data Quality Assessments (DQA)<br>2. Follow industry best DQ practices<br><br>**Data Use**<br>1. Ability to satisfy all stakeholders' reporting needs<br>2. System has dashboards customized by IFMIS team based on user needs | **Technical/Integration**<br>1. Lack of consultative approach in development of standards and tools (e.g. Registries, …)<br>2. No API for sharing data with the public<br><br>**Data Quality**<br>1. IFMIS team only focuses on high level factors affecting data quality, the end users are primarily responsible for actually ensuring data quality<br>2. DQA is not automated<br>3. Use external support for DQA assessment<br>4. Too much manual effort required to manage the reporting flow<br>5. No resources to explore data and uncover insights for different stakeholders |

| | |
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| | 6. Using too much custom and manual process in report generation<br><br>**Data Use**<br>1. Only focusing on routine reporting not on data use<br>2. Inability for users to run analytics and generate visualization in the system<br>3. No data use strategy<br>4. Limited generation and dissemination of data analytics<br>5. Offline analysis, most analysis is conducted outside the system |
| **Opportunities** | **Threats** |
| **Technical/Integration**<br>1. Several integrations not yet explored. Only few sectors exploring data exchange with IFMIS<br>2. Can feed so inform many public health policy models<br>3. Serves as the only public sector financial platform<br><br>**Data Quality**<br>1. DQ automation is limited<br><br>**Data Use**<br>1. Contains many insights that are not yet explored | **Technical/Integration**<br>1. Low resources: Insufficient staff to maintain and support all aspects of the platform<br>2. Integration request would require a written request from the Minister of Health to the Finance Minister of State.<br><br>**Data Quality**<br>1. Internally, DQ is not a priority among IFMIS team members<br>2. DQ errors might get<br><br>**Data Use**<br>1. Limited feedback mechanism between IFMIS team and end users or their constitution. |

#### 2.3.1.9. Conduct comprehensive assessment of private sector data availability in and outside of RHAP that includes a gap analysis and analyzes the discrepancy between metrics available in the public and private data sets

Over recent years, the MOH has made efforts to facilitate partnerships between public and private health care providers to ensure greater participation of the private sector in the provision of health care services and improved access to care using services offered by the private health facilities. However, despite the large proportion of the population seeking health care in private health facilities, efforts to support improved data management, reporting, and data use have historically focused more on public health facilities. As a result, private health facility reporting has been inconsistent and inadequate. This, in turn, leaves decision-makers with inadequate information that underrepresents the contribution of private health facilities. During FY 2021, RIHSA worked in collaboration with MOH to conduct a gap analysis to assess private health facility data availability, quality, and use. The key informants included the MOH director of the Health Policies and Regulation Unit and the MOH director of the Monitoring and Evaluation Unit. The main objective of this activity was to identify key areas of support for improving private health facility data availability, quality, and use through RHAP to ensure more comprehensive health care tracking across the public and private sectors.

The assessment involved interviews with representatives of private health facilities (the executive secretary of the Rwanda Private Medical Facilities Association) and public health facilities (the aforementioned MOH officials), a desk review of documents relating to private health facility data, and verification of public and private health facility reporting rates and timeliness in the HMIS. Findings showed that despite the significant contribution of private health facilities in providing health care services to the Rwandan population, their reporting compliance and data use were significantly lower than those of public health facilities.

Some recommendations shared with MOH to improve private health facility reporting and data use included the following:

- Mandatory registration of all new private health facilities in the HMIS prior to provision of a license to operate and reporting requirements associated with biannual license renewal aimed at motivating consistent reporting by private health facilities (considering both the timeliness and completeness of reports).
- Routine DQA and capacity-building of private health facility staff by the MOH M&E team on HMIS reporting and data quality assurance.
- Inclusion of data generated by private health facilities in central and decentralized health data analytics. This includes information products such as data bulletins, data dashboards, data presentations, and other platforms.
- Inclusion of private health facility representatives in any existing data quality and data dissemination forums.

#### 2.3.1.11. Conduct technical capacity assessment and ownership preferences survey with health information systems teams at the MOH and RBC

Although RHAP has already helped to integrate data from multiple information systems for analysis, there is still no plan for the gradual transition of roles and responsibilities from the Zenysis team to MOH and RBC. It is for this reason that the RIHSA worked with RBC/RIDS to launch a survey aimed at assessing the available technical capacity in these institutions to assume system management of the platform as well as the preferred ownership model of MOH and RBC. This is essential for better ownership and long-term sustainability of RHAP in Rwanda.

The assessment approach involved an online survey to gather information on four major aspects: personnel availability, ownership/sustainability model preferences (targeting managers), system maintenance and skills, and RHAP user management (targeting MOH and RBC technicians). The main findings were presented to MOH and RBC and showed the need for capacity-building of technicians on general system management to enable them to perform maintenance tasks for RHAP as well as other similar platforms. Regarding preferred ownership models, the managers decided there is a need for further discussion between MOH and RBC to agree on the preferred model. During Q1 FY 2022, RIHSA plans to build the capacity of MOH and RBC teams on system management and administration to ensure the sustainability of RHAP and similar data systems.

#### 2.3.1.12. Collaboratively develop a sustainability plan with TWG that aligns with the Rwanda Digital Health Care Transformation Roadmap

Since August 2018, RBC has been addressing the issue of siloed systems by integrating selected data systems into the RHAP. The platform has so far successfully integrated some routine public health data, allowing analysts at MOH and RBC to run queries from the different

systems, uncover insights, and enhance the health systems. Given the added value of having an integration and analytics platform for the health sector, MOH and RBC would like to have a long-term sustainability plan to ensure continuity of the project as well as alignment with the Rwanda Digital Health Care Transformation Roadmap without encountering technical and financial interruptions.

As a first step toward identifying the preferred sustainability path, RIHSA developed and shared four high-level models with MOH and RBC. This was done through a sustainability survey described under activity 2.3.1.11 as well as a TWG meeting. The four models presented included the following:

1. Full handoff. This consists of transferring all technical and financial responsibilities from Zenysis to MOH and RBC.
2. Local implementer handoff. In this model, MOH and RBC transfer the technical responsibilities for system maintenance and user support to a third-party local partner.
3. Partnership with Zenysis. This consists of contracting Zenysis to maintain the software and integrations under specific terms based on the scope and complexity of integrated systems.
4. Hybrid model. This model consists of combining the above models. The particular conditions governing this option can be set by all stakeholders. In this model, Zenysis would build innovative front-end tools that enable MOH/RBC to perform maintenance functions while continuing to provide capacity-building and user support.

After presenting the models to the RBC/RIDS division manager and the MOH director of M&E, it was decided there was a need for further discussion between MOH and RBC to agree on the preferred model. RIHSA team developed and shared a high-level plan and timeline for each model pending the decision by MOH and RBC. After a specific sustainability model is selected, a more detailed plan that includes resource mobilization (costing) will be developed for the model.

### 2.3.2. Strengthen data use at central, district, and facility levels

#### 2.3.2.2. Provide technical support in the HSSP IV midterm review

RIHSA supported the MOH to conduct the Mid-term review of the 4th Health Sector Strategic Plan (HSSP IV) through the recruitment of a local consultant to conduct the Mid-term review. The project developed the terms of reference, and they were approved by MOH. Following this approval, RIHSA conducted the selection process in close collaboration with the MOH. The local consultant was hired, and the Mid-term review kicked off in the Q4 PY1. RIHSA has been actively involved in the HSSP IV Midterm review core technical team and has provided technical inputs on the Midterm review, particularly on the financial analysis workstream. The preliminary findings show positive performance in some key indicators. For instance, Total Health Expenditure (THE) increased by 41.4% (from RWF 461b in 2017/18 to RWF 652b in 2019-20, total health expenditure per person also increased in the period from 38,167 RWF (43USD) to 51,526 RFW (56 USD)). This increase in per capita expenditure represents a positive trend towards the recommended per capita spending for developing countries, which is pegged at $90 per capita. There was as significant drop in Out of Pocket (OOP) expenditure as a share of THE from 4.9% in 2017-18 to 4.5% in 2019-20. However, the domestic share to total health expenditure (THE) remained unchanged, from 59% in 2017-18 to 58% in 2019-20, While the decrease in OOP to THE is positive, it doesn’t say much in terms of how it impacts household

income. It is recommended that efforts should be made in the future to gather data that will allow comparison of the OOP with household income. This will help determine households' risk for catastrophic expenditure on health.

During PY2, the project will continue to support the MOH to finalize the Mid-term review, including coordination of stakeholder interviews, participation in key informant interviews, and providing technical feedback on draft reports.

#### 2.3.2.3. Conduct technical feasibility, sustainability, and ownership assessments, and present potential options for medium- and long-term support for HSS-MAG software

Health worker motivation is crucial for the retention of health workers as well as the performance of the entire health system. In response to this need, the MOH and partners established the Health Sector Staff Mutual Aid Group (HSS-MAG), a savings and credit scheme that aims to enhance health workers' motivation by supporting their savings and access to affordable credit. The newly formed HSS-MAG encountered challenges with manual data management during day-to-day operations and expressed the need for an electronic system to ensure improved record keeping and efficiency.

It was in this context that RIHSA supported the HSS-MAG team with the software procurement and deployment process and development of terms of reference for key HSS-MAG technical staff as well as their recruitment and plans for long-term sustainability of the software.

The RIHSA will continue to provide technical support to the HSS-MAG team mainly around mentoring the newly recruited IT lead on key aspects of HSS-MAG software implementation, supporting the team to monitor technical deliverables of the software vendor and providing ongoing guidance on key technical aspects of the project as needed.

#### 2.3.2.4. Collaborate with Ingobyi to assess data triangulation priorities and requirements at the decentralized level

The RHAP has served to provide useful health analytics within RBC programs at the central level. However, in addition to supporting data use efforts at the central level, the RIHSA plans to roll out use of the platform to the district and hospital levels to empower data-driven decision-making at the decentralized level. In preparation for the decentralization of RHAP, RIHSA worked with the Ingobyi Activity to identify district- and facility-level target users, analysis priorities, and user metrics to measure user success. The analysis priorities identified will guide the development of customized district level dashboards prior to conducting cascade trainings from the central to the district level.

The preparation for the decentralization of RHAP was conducted through a serie of virtual and in-person joint working sessions between RIHSA and the Ingobyi Activity's monitoring, evaluation, and learning (MEL) team, which includes district-based analysts who interact directly with district- and hospital-level target users. Analysis priorities included both national-level priority indicators (HSSP IV) and key performance indicators prioritized at the district and hospital levels. Identified RHAP district-level analysis (triangulation) priorities target users and their capacity/roles. Key metrics for measuring user success were presented to the RHAP TWG and are now ready for use.

Based on the high number of target users identified, it would be more feasible to conduct the rollout exercise over years 2 and 3 of the RIHSA project, especially as year 1 of the project was marred by the COVID-19 pandemic and its associated Government of Rwanda restrictions measure.

#### 2.3.2.5. Convene a two-day stakeholder workshop in partnership with Ingobyi to collaboratively develop data triangulation dashboards and roll out strategy

In order to foster synergy between RIHSA and USAID/Ingobyi, RIHSA held a session with USAID/Ingobyi MEL team in Rubavu district and presented a draft of RHAP training manual and tools for discussion and feedback. Feedback was incorporated into the draft training manual and tools. Rollout of the system is expected to facilitate data-driven decision-making at decentralized levels by providing analytics and insights from previously fragmented information systems. Materials developed included an RHAP training manual for decision-makers and analysts, training materials, data dashboards, and a timeline for RHAP rollout to decentralized levels. The rollout will be conducted through a cascade of trainings followed by ongoing remote mentorship to ensure sustainable use of the platform by the new users.

RHAP rollout activities planned for year 2 include the following:

1. a workshop to develop data triangulation dashboards based on priority analytics identified during Q1 FY 2022;
2. training of trainers (MOH and RBC trainers);
3. training of decision-makers on dashboard interpretation and evidence-based decision-making (district directors of health and hospital directors);
4. training of analysts on RHAP analytics and dashboard development (hospital data managers); and
5. ongoing RHAP user engagement interventions aimed at building a data use culture at both the central and district levels.

#### 2.3.2.6. Hire local consultant to support the initiation of the twinning approach

RIHSA hired a local consultant and fully onboarded him to support the twinning activity. The twinning activity plan was harmonized with the project work plan and the MEL plan. Subsequently, RIHSA started designing the twinning workshop and adapting the coaching structure with input from DHMTs.

#### 2.3.2.7. Design twinning workshop and adapt coaching structure with input from District Health Management Teams (DHMTs)

Twinning fosters mutual learning, growth, and organizational development. RIHSA's approach to twinning fosters peer-to-peer learning and cultivates a culture of organizational learning to strengthen data use at the district level to inform decision-making. This approach brought together DHMTs to forge a dynamic and sustainable twinning partnerships network such that mutual learning and local ownership over both the twinning relationships and the methodology yield improved district-level data use that informs and improves health sector decision-making.

To facilitate twinning, RIHSA closely collaborates with MOH stakeholders to leverage existing structures and networks within Rwanda's health system, build dynamic relationships among

Rwanda's 30 DHMTs, and improve peer-to-peer learning and data demand and use for decision-making at the district level. A twinning activity concept note was developed to outline the twinning approach, identify the MOH's needs, and ensure complementarity with other USAID projects such as the USAID Ingobyi Activity. The concept note was shared with and presented to the MOH team for input and comments. The approach started with codesigning interventions with MOH and DHMT stakeholders. Through the codesign process, RIHSA took the WHO's twinning model and adapted it to develop the Six Cs of Twinning (Collaboration, Connection, Cooperation, Commitment, Capacity, and Coaching).

RIHSA conducted a virtual codesign meeting with MOH and DHMTs. During this workshop, participants designed the twinning workshop and started discussions on adapting the coaching structure after the twinning workshops, which are ongoing. During the codesign meeting, the MOH asked RIHSA to conduct an orientation meeting with MINALOC for district leadership, including mayors and vice mayors. In total, 31 participants (12 males and 19 females) attended this meeting.

#### 2.3.2.8. Deliver two twinning workshops reaching a total of 20 districts and 60 DHMT members (three per district)

Following the vice mayor's orientation meeting held on September 17, 2021, RIHSA organized and conducted two twinning workshops. The first was held on September 27–29, 2021, bringing together 30 participants from 10 districts *(Gakenke, Nyagatare, Rulindo, Ngoma, Karongi, Gasabo, Bugesera, Kamonyi, Kirehe, and Kayonza).* The second workshop took place on October 4–6, 2021, bringing together 30 participants from 10 districts *(Gicumbi, Gatsibo, Burera, Nyarugenge, Rwamagana, Ngororero, Muhanga, Ruhango, Huye, and Nyanza)*. The workshops helped districts lay a foundation for the twinning activity, including identifying and prioritizing key data use-related challenges and issues each DHMT would like to focus on and strengthen through the partnership. In total, 60 participants (47 men and 13 women) attended both workshops. The remaining twinning workshop for 10 districts will be held in Q1 FY 2022. Following the three twinning workshops for all 30 districts, RIHSA will continue to support the twined districts focusing on in-person and remote coaching, as well as implementing and tracking DHMT data use strengthening plans in Q1 of PY2. RIHSA will conduct initial coaching sessions in November and December 2021, which will include finalizing twinning partnerships between districts and designing DHMT data use strengthening plans.

Tracking implementation of the DHMT data use strengthening plans will begin in Q2 FY 2022. To conduct remote coaching and monitoring, RIHSA will use virtual means, including a WhatsApp peer-to-peer discussion group and WebEx. This learning community will also include virtual gatherings that include "ask the expert" sessions and group knowledge sharing.

# SECTION 3. CROSS CUTTING ISSUES

## 3.1. Monitoring and evaluation

The USAID-RIHSA MEL system focuses extensively on strengthening the M&E of the RIHSA task order, tracking progress in implementation of project activities and results indicators against expected targets for data-driven decision-making, and managing all operations according to the MEL plan.

**Key highlights**

- ✔ Revised a comprehensive Activity Monitoring Evaluation and Learning Plan (AMELP) that includes 34 key performance indicators and performance indicator reference sheets. The plan was approved by USAID on May 5, 2021.
- ✔ Developed monitoring tools and templates for data collection and reporting, and continually shared performance monitoring findings with relevant RIHSA staff, including recommendations for better programming and decision-making.
- ✔ Organized and coordinated a USAID quarterly site visit.
- ✔ RIHSA is in the process of negotiating a contract and terms of reference with a local consulting firm to conduct the rapid baseline and progress assessment for year 1.
- ✔ Organized an orientation meeting between RIHSA staff and subcontractors. The meeting aimed to enhance the partners' capacity in communication, branding, and documentation of RIHSA's activity deliverables and achievements in accordance with USAID branding and marking standards.
- ✔ Produced and printed communication material (pull-up banners and project signage).
- ✔ Worked with Ingobyi to develop a consolidated M&E framework that will be used to measure collaboration performance.

## 3.2. Development of an AMELP

The Activity Monitoring Evaluation and Learning Plan (AMELP) is a guiding document for how RIHSA monitors, evaluates, and learns from its activity implementation and results to enhance its efficiency, effectiveness, and impact. Furthermore, the plan responds to the activities, deliverables, indicators, targets, results, and objectives for the project. It is a living document that should be referred to and updated on a regular basis to reflect changes in RIHSA'S strategy and ongoing tasks. In Q2 FY 2021, the RIHSA team finalized the review and update of the FY 2021 AMELP, including the revision of indicators and learning plan to align with the activity's implementation and a robust MEL system. As per the FY 2021 work plan, the following revisions were made:

- All 34 key performance indicators were revised to effectively measure the progress in project implementation. The revised sections include the precise definition, unit of measure, data collection methodology, reporting frequency, target, and responsible person.

- RIHSA is hiring a consultant to document the impact of CLA implementation and respond to six learning questions adapted from the OHS Health Systems Strengthening Learning Agenda. Addressing these learning questions will guide a self-reflection on the performance and effectiveness of activity interventions in achieving the results as articulated in RIHSA's results framework.
- Key indicators were selected to be reported in USAID's Development Information Solution (DIS), and annual and quarterly targets, numerators, and denominators were determined and uploaded into DIS for efficient reporting, data tracking, and continuous improvement of project coordination with USAID Missions.

To finalize revision of the AMELP, the RIHSA organized a series of meetings with technical leads to ensure that all program staff and partners were actively involved in and accountable for development and implementation of the planned activities. The AMELP update was approved by USAID on May 5, 2021. In Q4 FY 2021, RIHSA will update the AMELP as per the approved FY 2022 work plan, organize a training workshop for program teams on the update of AMELP, and improve their understanding of key performance indicators, their targets, and performance M&E approach.

### 3.3. Activity monitoring

**Project Monitoring Tools**

To ensure that the project tasks and activities are leading toward the intended project objectives and are being implemented in accordance with agreed-upon standards, RIHSA developed monitoring tools and templates for data collection, reporting, and performance monitoring. Findings are continually shared to relevant RIHSA staff during planning and review meetings to take actionable recommendations for better programming and decision-making. The following tools were developed:

- **Indicator performance tracking table (IPTT)** to help the program regularly (annually, quarterly, monthly) determine the indicators that are on track (performance above 90 percent), moderately performing (75–89 percent), or off track (less than 75 percent).
- **Event report tool** for tracking and ensuring a consistent record of various capacity building activities (trainings, workshops, and meetings) organized and facilitated by the RIHSA.
- **Reporting template** to produce an activity progress report (quarterly and annually) with quality, meaningful, and useful monitoring data for decision-making.
- **Weekly coordination meeting** to discuss a quick off/on project activity implementation and the agenda for the coming week to capture the necessary data and continue having internal access to information at all levels.

The MEL team organized an orientation meeting with RIHSA staff and subcontractors to ensure a proper understanding of developed tools. In addition, a data quality assurance framework was developed to ensure accuracy, validity, and timeliness of data generated for reporting and management.

**Data quality assessment**

Data quality assessment (DQA) is an important way for USAID to spot-check the quality of performance monitoring information collected and publicly reported by USAID-funded activities. It ensures that USAID Missions and projects are aware of the strengths and weaknesses of the data, as determined by applying the five data quality standards, and the extent to which data integrity can be trusted to influence management decisions.

In FY 2021, RIHSA facilitated DQA for eight indicators (three THRIVE PAD, two PPP, and three custom) in the form of a virtual discussion meeting between RIHSA staff and the assessment team. The DQA checklist was used to guide the discussions, which looked at quality, data collection instruments, data collection method, database management, and actual data collected for each indicator. During the discussions, the assessment team provided immediate feedback and explained how data for each indicator are collected and managed.

### 3.4. Organize and facilitate USAID site visit

In FY 2021, RIHSA, accompanied by USAID Contract Officer Representative (COR) conducted virtual or in-person site visits to monitor the progress on project activities implementation. These site visits are part of a systemic approach to health care quality management that includes institutionalizing, monitoring, and measuring quality services. The following are highlighted site visits conducted in FY 2021:

- In Q1 FY 2021, the site visit was conducted virtually due to COVID-19 restriction measures. In total, 10 people (RIHSA's COR from USAID, two DHU staff from Kicukiro and Gasabo, one staff from MOH, one staff from RBC National Reference Laboratory, one staff representative of the Rwanda Private Medical Facilities Association, and four staff of RIHSA) participated in the evaluation of licensing standards and the inspection tool that was developed. During the visit, USAID had an opportunity to meet and ask RIHSA team members, stakeholders, and beneficiaries about the intended impact of RIHSA on health systems strengthening performance in Rwanda. The inspectors, who were from the central and decentralized levels, expressed their views on how useful the new inspection tool, which was developed based on the licensing standards, is and how well it covers essential elements.

- In Q2 FY 2021, RIHSA visite Polyclinique de l'Etoile. The purpose of visit was to present the results from an accreditation baseline survey conducted in 24 private health facilities to assess quality standards compliance levels. The site visit was conducted in a mixed approach (both virtual and physical) in accordance with COVID-19 pandemic preventive measures. One participant from MOH and one participant from RIHSA's COR from USAID attended virtually, while 15 participants (6 RIHSA staff members and 10 Polyclinic de l' Etoile staff members) physically participated in the visit.

- In Q3 FY 2021, four DHs (Masaka, Byumba, Nyanza, and Kacyiru) were visited. The site visit was in line with RIHSA's support to the MOH in conducting the progressive accreditation surveys for district, provincial, and referral hospitals in Rwanda. Specifically, the site visit was used to present the preliminary findings of the progressive accreditation surveys and to give hospital leaders and staff an opportunity to discuss

surveyors' feedback and recommendations. The site visit was attended by the task order contracting officer's representative from USAID, RIHSA staff, surveyors, health facility leaders, staff, and district authorities.

### 3.5. Conducting a rapid baseline and progress assessment for year 1

In FY 2021, RIHSA started the process of negotiating a contract and terms of reference with a local consulting firm to conduct the rapid baseline and progress assessment for year 1. This assessment will take place in Q2 FY 2022 and it will provide missing baseline data for 15 out of 34 activity indicators that did not have baseline data.

### 3.6. RIHSA communication strategy

To ensure that RIHSA's reports, communications materials, deliverables, and other project documents comply with USAID branding and marking standards, that all staff and subcontractors are aware of RIHSA's communication strategy, and that impactful communication materials are developed and shared, the RIHSA MEL and Communication team held a one-day orientation virtual meeting in FY 2021 for all RIHSA staff and subcontractors. During this meeting, participants were given an overview of the communication strategy, including its objectives, key messages, and target audiences. MEL also made clear its focus on compliance, which includes providing USAID credit in all verbal, textual, and visual outreach and communication materials and activities as well as complying with photography rules.

In additional, RIHSA designed and printed the communication materials that would be continuously used to promote the visibility of RIHSA in public events. This effort ensured that RIHSA's activities would be visible and well branded and that the appropriate materials would be available in a usable and digestible format and in compliance with USAID branding and marking standards. These materials include the pull-up banner and project signage (see annex 5).

Furthermore, in FY 2021, RIHSA created social media accounts on Twitter and LinkedIn and organized media coverage for different activities to share activity information with the wider public. This is an effective way of listening to and engaging stakeholders and beneficiaries:

- 30 tweets and LinkedIn posts received over 5,6789 tweet impressions and likes (the number of times a tweet appears to users in either their timeline or search results).
- Media coverage of the Maiden Rwanda Health Sector Investment fair,[6] linking health sector entrepreneurs/investors to financial institutions, was robust. Two online articles in a local language (Imirasire.com and kigalitoday.com) were published, highlighting the investors' challenges, the lessons learned, and recommendations in accessing finance.

### 3.7. Gender integration

In FY 2021, RIHSA developed a Gender Equality and Social Inclusion Strategy and Integrated

[6]. Held on September 29, 2021, with the objective of bringing together financial institutions (including banks and microfinance institutions) and health sector private investors (including owners of health facilities such as clinics, polyclinics, hospitals, and laboratories, as well as prospective investors/entrepreneurs) to meet, discuss, and explore mutual business partnerships as well as share experiences in accessing finance.

Work Plan. The strategy and work plan were designed (1) to support the Government of Rwanda to integrate gender equality into strategies to increase domestic financing for health, strengthen CBHI, and increase PSE, and (2) to strengthen the health system to deliver inclusive, quality, and sustainable health services at the national, facility, and community levels. The integrated work plan outlined a set of activities to be conducted to ensure gender equality and social inclusion are integrated into RIHSA activities, including but not limited to development of the training manual and delivery of the training on gender and health system strengthening.

RIHSA held an orientation meeting with all staff to share insights on USAID's gender equality, female empowerment, and social inclusion policy and its objective to promote gender equality and social inclusion throughout all activities by mainstreaming gender equality and female empowerment into RIHSA's overall goals and objectives. For example, in trainings, meetings, and workshops, facilitators encourage both male and female participants to participate equally, as well as provide additional space for breastfeeding mothers and caretakers who attend project meetings/workshops with their babies to allow for breastfeeding between training/workshop sessions.

# SECTION 4. COLLABORATION, LEARNING, AND ADAPTING (CLA)

Collaboration, learning, and adapting (CLA) plan is an important component of the RIHSA AMELP. It ensures that new learning, innovations, and performance information inform project implementation, policy formulation, and strategy development. It also facilitates coordination, collaboration, and exchange of knowledge internally and with external stakeholders, contributing to overall project learning objectives.

A CLA approach was implemented by RIHSA and its partners to ensure project success; identify synergies to increase technical effectiveness, cost-effectiveness, and reach; and share knowledge about which approaches and interventions work. This was applied through a collaborative process of consultations, work planning, and adaptive management.

## 4.1. Collaboration

In FY 2021, RIHSA engaged various stakeholders including the Government of Rwanda, implementing partners, the private sector, non-governmental organizations (NGOs), and other development partners through a variety of means to provide expertise, input, and feedback, as well as share information internally and with consortiums and learning networks.

- ***Consultative meetings with key stakeholders.*** RIHSA held several consultative meetings with stakeholders during the FY 2021 planning period and implementation process to gain consensus on priorities for strengthening health systems and to identify areas of synergy and collaboration (Table 3).

**Table 3. Agreements between key stakeholders during FY 2021 planning**

| Stakeholder | Agreement |
|---|---|
| USAID | Ensured alignment of RIHSA activities with USAID/Rwanda's Country Development Cooperation Strategy 2020–25 |
| MOH & MINECOFIN | Prioritized health system strengthening activities based on national priorities |
| RSSB | Established priorities related to strengthening, sustainability, and efficient management of CBHI |
| USAID Ingobyi Activity | Elaborated areas of collaboration and synergies and mitigated duplication of efforts. As such, both projects developed and started implementing a collaboration framework. |

- ***Collaborating on PPM reform at the PHC level.*** The MOH has begun a journey to reform the current fee-for-service PPM to capitation PPM at the PHC level. MOH and RSSB appointed a technical team comprising different development partners to conduct a thorough evidence-based assessment and develop technical documents that will guide this new reform. In this regard, RIHSA convened different collaborative meetings with CHAI and WHO to discuss and draft recommendations for MOH and RSSB regarding the reforms and to develop critical documents that will inform the pilot phase including (1) the M&E framework, (2) the legal framework, and (3) the communication strategy.
- ***Collaborating on PSE.*** CHAI collaborated in the development of a PSE joint work plan that would guide the MOH and relevant stakeholders' engagement within the private sector. Consequently, this collaboration led to the development of a PSE Master Guide

that outlines potential investment opportunities in the health sector targeting potential private sector investors. The first draft of this document has been circulated for feedback from different development partners and is set to be validated in FY 2022.

### 4.2. Learning questions

**Objective 1: Increased Financial Protection**

***Learning Question 1: What are the interventions that are contributing the most to increasing health finance / domestic resources for health that will support Rwanda's self-reliance in the public health sector?***

- The CBHI is one of the most powerful domestic health financing tools that the GOR has used to ensure that people working in the informal sector have access to high-quality health care without facing financial hardship. In efforts to ensure long-time sustainability of this scheme, RIHSA has contributed to the technical revisions of the CBHI Sustainability Plan draft report and participated in its validation. Following its validation RIHSA plans to assist RSSB in the prioritization and implementation of the recommendations, primarily in the areas of CBHI's cost containment and revenue-increasing opportunities, which will lead to increased self-reliance and long-term financial sustainability of this important scheme for the country's health sector.
- In line with the CBHI sustainability and in efforts to mobilize more funds for the scheme through increased membership and ultimately more premium contributions. RIHSA has prioritized conducting a client survey on current CBHI and non-CBHI members in partnership with the RSSB/CBHI management to identify and understand the limiting factors to CBHI uptake as well as the reasons for the high default rate in premium payments. Data collecting consultants have been recruited and a draft survey form has been produced and the study is set to begin in Q1 FY2022.
- Supporting the strategic purchasing sub–technical working group's efforts to reform the PPM at the primary health care level by convening meetings with key stakeholders, performing secretariat functions, and providing technical contributions to designing key documents that will guide the capitation piloting such as the M&E framework, capitation design, and communication strategy.
- With limited resources available in the health sector, effective, efficient and accountable use of these scarce resources is vertical to Rwanda's increased domestic resource mobilization and self-reliance. RIHSA supported this effort by adopting a bottom-up approach in training decentralized level staff on effective Public Financial Management. The training workshops started at the lowest level, by training health center accountants (488) and district hospital accountants along with their reporting managers (29 district NBA accountants). These training were complemented by high-level training of the District Health Management teams (the first batch of 10 districts composed of 47 DHMTs were trained in PY1) who are the ultimate decision makers on health matters within the district. This bottom-up approach will ensure proper use of the IFMIS system and will create accountability at decentralized levels, leading to effective, efficient, and accountable use of the available resources.
- An important aspect in increasing domestic resources is understanding the clear flow of these resources through the system. RIHSA has contributed to this clear understanding by supporting data collection and reporting of Health Resources Tracking Tool (HRTT) data for three fiscal years (FYs 2017/18, 2018/19, and 2019/20) from health sector players, including government and non-governmental agencies, submitted their health expenditure data. This effort will allow the government to understand the clear flow of resources which will in turn lead to effective resource mobilization and proper allocation.
- Lastly, leveraging the private sector is key to increasing domestic resources. The HSSP IV aims to increase private sector contribution to the national GDP from 1.7% to 5%. RIHSA has supported increased private sector contributions through the development of the PSE Master Guide, which outlines investment processes and opportunities in the health sector, facilitation of private sector dialogues targeting private health sector entrepreneurs and financial institutions, to discuss available financing opportunities, bottlenecks, and possible solutions to increase health sector lending. Other sessions included Development Credit Authority (DCA)

information session, a U.S. International Development Finance Corporation (DFC) town hall, a webinar on Credit Guarantees, and an investment fair.

***Learning Question 2: What are the contributions of system thinking approaches and tools to changes in health system outcomes?***

- For the transfer of knowledge, RIHSA is organizing a coaching approach customized to support for DHMTs and hospital teams using in-person and remote formal and informal coaching sessions to twinned districts to support their district-level and institutional objectives, monitor and review the progress of achievements of milestones, and provide technical support. RIHSA is preparing technical briefs and documents on best practices for twinning approach at national and/or regional conferences.
- In accordance with the collaboration approach aimed at ensuring synergy between co-recipients of USG funds, RIHSA is working in collaboration with other USAID partners to roll out RHAP to decentralized levels (districts and hospitals). This tool aims to cultivate the culture of data use which will lead to system-wide evidence-based interventions and policies. By enforcing this culture of data use, there will be more targeted approaches that will lead to positive health outcomes.
- Stakeholder engagement continues to be one of the crucial ways to bring about lasting change within a health system. This is at the heart of RIHSA's support to the ongoing support to the Provider Payment Mechanism (PPM) reforms and private sector engagement. RIHSA has taken the lead role of bringing together all the development partners (WHO, CHAI, Enabel, World Bank) supporting this ongoing reform. This approach is contributing to less fragmentation in DPs' support to the government (Ministry of Health and RSSB). Convening these partners for technical discussions means that the support we are providing to the government partners is more unified and efficient leading to a strong consensus among DPs and has led to resource optimization. Beyond this role of bringing DPs together, RIHSA has particularly contributed to the 3 main streams of the PPM reform work, namely the model design, the Monitoring and Evaluation framework and communication strategy.

**Learning Question *3: What conditions or factors successfully facilitate the institutionalization and/or implementation at scale of HSS good practices that might increase the likelihood of improving health system outcomes, and why? What are lessons learned regarding planning for sustainability and achieving results at scale?***

- The CBHI Sustainability Plan has mobilized interest and commitment from the MOH and partners to implement various reforms including alternative Provider Payment Mechanisms (PPMs), and the CBHI benefit package design. The efforts so far in designing capitation for Primary Healthcare and the outcome of the Ministerial Instructions for CBHI benefit package (N° 20/7017 of 31/08/2021) will go a long way to help the CBHI plan for its financial sustainability and thus protect the gains made in ensuring the population of Rwanda access essential healthcare at affordable rates. RIHSA as the secretariat of the Capacitation design is facilitating the process to endure that the MOH and RSSB's timeline of rolling out the capitation by July 2022 is met. This will address the cash flow challenges of health facilities as well as help the RSSB contain the increasing cost of claims administration.
- COVID-19 has demonstrated that some activities can be implemented effectively and in a cost-efficient manner using virtual tools. For instance, through online meetings, the PSE Core technical team was able to put together a Master Guide for Private Sector Investments in the Health Sector and is expected to be disseminated in PY2. The guide provides an overview of the investment opportunities, priorities, attributes, and processes in the Rwanda's health system. Also, RIHSA worked together with MOH to design and implement 2 online courses: Rwanda Accreditation Survey training and Quality Improvement training for facilitators. These online courses are a first step towards decentralizing technical training/capacity development for health practitioners across the country.

- RIHSA's support to the review of the Dual Clinical Practice Policy as well as development of tools for assessment of health facilities' readiness to implement the policy is one of the strategies to improve health facilities income, staff retention, and check resources leakages from public facilities.

**Learning Question *4: What are effective and sustainable mechanisms or processes that enable the participation of private sector, civil society, and public organizations in developing locally led solutions to improve high-performing health care, especially for poor and vulnerable populations? What enables the effective participation or leadership of marginalized populations themselves in the development and implementation of these solutions? Under what conditions is this participation different?***

- Collaborative stakeholder working Groups and Sessions: The creation of the Private Sector Core technical team which is represented by stakeholders from the Ministry of Health, Private Sector and development partners provides a collaborative space for all the voices, expertise and know-how of key players to be mobilized towards the common objective of ensuring a strong and dynamic health system that supports the needs of the population. Also, we made sure that the various workshops organized involved all the relevant stakeholders in the design, planning and preparation phases and these and ensured active participation and ownership from all the participants. For instance, the Capitation Workshop held in September2021, brought together representations from both the decentralized and centralized levels, and helped to have a firsthand insight into the experiences of facilities at the community levels. The field visits that were often organized as part of these workshops further highlight the challenges and objectives of the various interventions.
- Regular Information sessions with stakeholders across the country (workshops and meetings) which were sometimes enabled by virtual meeting platforms provide an opportunity for people of diverse backgrounds to learn and contribute meaningfully to current topics and discussions. The webinar on Credit Guarantee and the "Maiden Rwanda Health Sector Investment Fair on September 29th, 2021", for instance, saw a sizeable number of people from the private sector joining from different geographical locations and benefiting from the discussions and information sessions.

***Learning Question 5: What are key behavioral outcomes that indicate a functioning, integrated health system? In what ways can integrated health system strengthening approaches explicitly include social and behavior change?***

- By adopting a comprehensive training approach to the Integrated Financial Management Information System (IFMIS), we were able to ensure that the accountants capture all the daily transactional data into the systems and the district management team periodically supervise the quality of the data entry process to ensure that they are up to date. Prior to the training, the district managers did not know what type of analytical information to expect from the IFMIS and the accountants had limited knowledge about how to use the system for their planning and budgeting.
- In addition to RIHSA hand-on technical support to the development of the new CBHI systems (which will be part of the new RSSB electronic Social Security System - eSSS), the project is ensuring that the systems are aligned and interoperable with relevant systems including facilities Electronic Medical records (EMRs) and IFMIS. A concrete activity in this respect is the codification of the Standard Treatment Guidelines in accordance with international standards. Thes codes will be available to other players of the health system. By defining and setting standards, future systems will find it easier to integrate with the existing systems and data exchange between systems will be streamlined for better analysis and informed decision making.

**Objective 2: Improved Quality of Essential Health Services**

***Learning Question 6: What are the most promising approaches at national and sub-national levels to maximize the use of data or tools to increase data-informed decision making to improve quality of essential health services? What measurement tools, approaches, and data sources, from HSS or other fields, are most helpful in understanding interrelationships and interactions, and estimating impact of HSS interventions on health system outcomes and priority health outcomes?***

Currently the most promising approach/tool for maximizing the use of data in the health sector is the Rwanda Health Analytics Platform (RHAP). It integrates data from most routine health data collection systems under one workspace for comprehensive analytics. Its easy-to-use features allow users to conduct a vast number of simple and advanced analytics and to generate customized data dashboard comprised of their own priority performance indicators. Since it includes all health outcomes currently tracked through routine data, it can be used to estimate the impact of HSS interventions on these outcomes.

- To improve data use for quality and governance, RIHSA on monthly basis provides to relevant stakeholders with data quality reports and support the documentation of data quality discussions and initial remediation steps. This continuous activity aims to ensure that decision-making is based on accurate data.
- In data for decision making, RIHSA organized a stakeholders' workshop to outline critical questions and data analysis use cases for the new and existing RHAP data sources and develop analytics aimed at promoting data use by decision makers at central and district level.

**List of Annexes**

The subsequent pages will serve as a presentation of the following annexes:

- **Annex 1: Indicators.** This chart presents all indicators tracked on a quarterly, biannual, or annual basis, along with the targets, achievements for FY 2021, and explanation for deviations.
- **Annex 2: Financial Report.** This financial report is a presentation of cumulative and annual expenditures for budget direct and indirect costs, balance and budget realignments, and significant variances.
- **Annex 3: Success Stories and Photos**
- **Annex 4: RIHSA Communication Materials**

## Annex 1: Table of Indicators

The RIHSA AMELP tracks a total of 34 indicators. The chart below shows progress toward targets.

| Indicator | Methodology | Baseline and data source | Target FY 2021 | Actuals/results FY 2021 | Comments |
|---|---|---|---|---|---|
| **Objective 1: Increased financial protection** | | | | | |
| 1. Percentage of national health budget executed with Government of Rwanda resources ***[THRIVE PAD indicator]*** | *Numerator*: Domestic Health Budget<br><br>*Denominator*: Total Health Budget | 51%<br>2020<br>HRTT report | 51% | 57.6%*<br><br>(2019-2020) Domestic Health Expenditure as percentage of the Total Health Expenditure<br><br>* Proxy result | Due to lack of budget data, expenditure data was used as proxy. (Data source: HRTT 2019-2020 preliminary results)<br><br>Domestic Health Expenditure: RWF 375,585,563,162<br><br>Total Health Expenditures: RWF 652,484,033,252 |
| 2. National health budget as a proportion of total Government of Rwanda budget | *Numerator*: Domestic Health Budget<br><br>*Denominator*: Total Government Budget | 15.8%<br><br>2020<br>HRTT report | 16% | 7.6% *<br><br>Government health budget as a percentage of Total Government Budget<br><br>* Proxy result | Due to lack of budget data from the private sector and other non-state actors, only the government health budget was used for this estimation.<br>See the following data source: https://www.minecofin.gov.rw/fileadmin/user_upload/Minecofin/Publications/REPORTS/National_Budget/Budget_Execution_Reports/2020-2021_Budget_Execution_Reports/Quarter_IV/Budget-Execution_COFOG_15082021.pdf). |
| 3. Percentage of finance staff from public health facilities trained in using Integrated Financial Management Information System (IFMIS) | *Numerator*: Number of Finance staff in public health facilities trained in using the IFMS.<br><br>*Denominator*: Total targeted number of | 57%<br>(172 staff)<br><br>2020<br>IFMIS training reports | 69%<br>(207 staff) | 267%<br>(552 Staff)<br><br>2021<br>IFMIS training reports | In FY 2021, number of finance staff trained in using IFMIS (552) is 167% higher than the annual target (207); this was in response to the urgent need to reduce the incidence and reoccurrence of unreported or misreported spending and income relating to NBAs, particularly health centers. |

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| | finance staff in project reporting year. | | | | 552 accountants from health centers, DHs, and administrative districts (NBA accountants) across the country were trained, including:<br>• 35 DH Accountants<br>• 488 Health Center Accountants<br>• 29 NBA Accountants |
| 4. Proportion of district hospitals with business plans developed | | 86%<br>2020<br>Health facility annual reports | 92 %<br>(3 Specialized hospitals) | 86%<br><br>2020<br>Health facility annual reports | In FY 2021, the development of hospital business plans was not done, due to COVID-19 restrictions that limited physical interaction with the hospitals to identify IGAs and subsequent hands-on support to develop and implement the business plans.<br><br>Furthermore, given that IGAs are relatively new to the Rwandan health system, we had prioritized to develop the IGA guidelines first to help provide the structure for the implementation IGAs. Efforts toward development of the IGA guidelines has been initiated and will be concluded in PY2. The business plans development will follow and aligned to the guidelines. |
| 5. Number of Income Generating Activities (IGAs implemented in public health facilities based on the developed IGA guidelines | | 0<br>Health facility annual reports | 7 | 0 | As a prerequisite to implementation, development of IGA guidelines was prioritized for FY 2021.The implementation of IGAs was affected by COVID- 19 travel restrictions in In FY 2021. Nonetheless, a consulting team is in place to develop the IGA case studies and guidelines. Once the guidelines are finalized, 8 hospitals will be supported to develop IGA business plans. |

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| 6. Number of health facilities reporting the total health spending through Health Resource Tracking Tool (HRTT) | | TBD<br><br>Health Resources Tracking Output report | 50 | 561<br><br>2019/2020 HRTT Report preliminary results | The baseline was not established at the beginning of the project because the HRTT system was last used in 2016/2017, which is 3 years before the launch of RIHSA. The 50 targeted facilitates assumed that all hospitals were already reporting to the HRTT. However, in 2021 when RIHSA supported the MOH to manually collect the HRTT data for FYs 2017/18, 2018/19, and 2019/20, it was realized that all eligible public facilities were reporting their HRTT related data through the IFMIS. Since use of the IFMIS is mandatory, the compliance rate was therefore very high. |
| 7. Number of health facilities/institutions staff trained in data entry and use of HRTT | | TBD<br>Health Resources Tracking Output report | 50 | 10<br><br>2021 RIHSA Training record | Ten (10) data coordinators/analysts were trained to support the MOH to manually collect the HRTT data for FYs 2017/18, 2018/19, and 2019/20. |
| 8. Percentage of population enrolled in CBHI (CBHI coverage) ***[THRIVE PAD indicator]*** | *Numerator:* Total number of CBHI members<br><br>*Denominator:* Total population eligible for CBHI enrolment | 79.6%<br>2019/20<br>RSSB/ CBHI Enrolment Report | 80% | 85.9%<br><br>2020/21 RSSB Draft Annual report | |
| 9. Percentage of people enrolled in USAID-assisted financial protection schemes in area(s) receiving USAID assistance ***[PPR Indicator, HL5]*** | *Numerator:* Number of people enrolled in financial protection<br><br>*Denominator:* Total population in USAID supported area | 79.6%<br>2019/20<br>RSSB/ CBHI Enrolment Report | 80% | 85.9%<br><br>2020/21 RSSB Draft Annual report | |
| 10. Percentage of CBHI premium compliance | *Numerator:* Number of CBHI members who paid 100% of CBHI Premium<br><br>*Denominator:* Total number of CBHI members expected to pay CBHI premium | TBD<br>Records from 3MS | 95% | 85.9 %<br><br>2020/21 RSSB Draft Annual report | |

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| 11. Percentage of public health facilities (provincial and district hospitals) using the most updated CBHI claim management system | | 0%<br>2020<br>Health facility records on use of CBHI claim management system | 33% | 0% | The RSSB new electronic Social Security System (eSSS), which will include the CBHI claims management system, is planned to be completed in February 2022 |
| 12. Percentage of targeted health facilities using digital tools for financial transactions | | 8.6%<br>2019/20<br>CBHI records | 25% | 93.89%<br><br>2021 IFMIS Report | Digital tool refers to the use of IFMIS for financial transaction. As of FY 2021, the following is a breakdown of the facilities trained to use the IFMIS:<br>• 35 DH out of 48 hospitals (72.9%)<br>• 488 health centers out of 509 (95.87%) |
| 13. Percentage of eligible health facility officers trained in the use CBHI systems | | 0%<br>2020<br>RIHSA training records | 40% | 0% | These trainings had to be rescheduled for PY2 because the RSSB new electronic Social Security System (eSSS), which will include the CBHI systems, is planned to be completed in February 2022. The trainings will be conducted once the system is launched. |
| 14. Number of public-private partnerships facilitated or strengthened with USG support for improved management of health services | | 4<br><br>2020<br>Records from MOH, RIHSA records | 50 | 4<br><br>2020<br>Records from MOH, RIHSA records | In FY 2021, the focus was on clarifying the national PPP guidelines to stakeholders, which took the form of information workshops with DHMTs and District Hospital Managers. Also, to enable further PPPs, the PSE investment master guide was developed highlighting the investment opportunities and priorities of the sector. Facilitation of PPPs to improve Health services is planned in FY 2022 |
| 15. Number of private health sector stakeholders that received USG support | | TBD | 50 | 46<br><br>2021<br>RIHSA records | In FY 2021, the RIHSA hosted four financial access information sessions to discuss existing financing opportunities and potential solutions to increase health sector lending. These sessions include: the Development Credit Authority (DCA) information session, a U.S. International Development Finance Corporation (DFC) town hall, a webinar on credit guarantees, and an Investment Fair.<br><br>In total, those sessions brought together 7 financial |

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| | | | | | institutions (banks) and 15 private health sector entrepreneurs/stakeholders (private clinics and polyclinics, RHF, RPMFA).<br><br>In addition, RIHSA has conducted accreditation baseline assessments for 24 private health facilities, which were then enrolled in the national accreditation program. |
| 16. Number of public and private health sector stakeholders who received information on existing national PPP guidelines | | TBD | 50 | 47<br><br>2021<br>RIHSA records | In FY 2021, 47 Participants from 10 districts[7] were trained during PY1. These included Director General of Hospital, Director of Accounting & Finance (DAF) from the hospital, Director of Health Unit at district level and Director of Accounting & Finance (DAF) from the district. The information session was facilitated by a Public Private Partnerships (PPP) Analyst from Rwanda Development Board. During FY 2022, focus will be put on information sessions at central level and developing health sector-specific partnership guidelines. |
| **Objective 2: Improved quality of essential health services** | | | | | |
| 17. Citizen level satisfaction rate with health services ***[THRIVE PAD indicator]*** | *Numerator*: Points awarded on Annual Citizen Report Card<br>*Denominator*: Total points available | 70.8%<br>2018<br>Annual Citizen Report Card | 75% | 73.7%<br><br>2021<br>Citizen Report Card | Citizen Report Card 2021 has revealed an increase in citizen level satisfaction rate with health services. |
| 18. Overall facility utilization rate in areas implementing quality improvement supported by USAID ***[PPR Indicator, HL6]*** | *Numerator*: Total number of annual outpatient department visits in area implementing QI supported by USAID<br><br>*Denominator*: Total number of people residing in the project catchment areas | 1.51<br><br>2019-2020<br>DHIS2/HMIS | 1.6 | 1.46<br><br>2020/21<br>Health sector performance report | The observed decrease in overall utilization rate of Health services is due to COVID-19 restrictions. The improvement of COVID-19 situation nationally decrease is expected to improve facility utilization rates in FY2022. In addition, during FY2022, RIHSA plans to continue supporting improved CBHI membership and extend QI initiatives to health centers. |

[7] Gakenke, Nyagatare, Rulindo, Ngoma, Karongi, Gasabo, Kayonza, Kamonyi, Bugezera, and Kirehe

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| | where QI was implemented last year supported by USAID | | | | |
| 19. Proportion of births taking place in health facilities pursuing national accreditation program, including health centers | | 40%<br>Statistical yearbook 2019 | 50% | 45%<br><br>2021 DHIS2/HMIS | RIHSA is planning to enroll health centers in the accreditation process so that the coverage data increase. |
| 20. Number of district health management teams (DHMTs) / District Health Units (DHUs functional as per DHMT/DHU guidelines ***[THRIVE PAD indicator]*** | | 0<br>2020 DHMT/DHU records, RIHSA records | 20 | 17<br><br>2021 DHMT/DHU records, RIHSA records | Some DHMT meetings were not held due to COVID-19 restrictions for physical gathering. |
| 21. Number of provincial/district health committees members trained in oversight and management of public health facilities | | TBD | 60 | 0 | The Provincial/District Health Committee is a body in charge for auditing, monitoring, and evaluating a hospital's activities, administration and financial management. Its members were appointed by MOH in July 2021. RIHSA in collaboration with MOH is finalizing the Health Facilities Procedures Manuel which will serve as training manual for the appointed Health Committee Members planned in FY2022.<br><br>The training of the members of Health Committees are not yet started all over the country. Ministerial Order No. 38 of 30/11/2020 establishing a health committee was published in July, and MOH appointed focal personal to support establishment of DHC. Therefore, there is no planned activity in FY 2022 related to training of DHC. |
| 22. Percentage of health facilities (hospitals) that are using quality standards for quality improvements (including hospitals under the accreditation program) | **Numerator:** Number of health facilities (hospitals and health centers) that implement quality standards with a quality | Hospital: 86%<br>Health facility records on QI | 96% (5 more hospital) | 60%<br><br>2021 Health facility records on QI | Initially RIHSA planned to conduct the progress accreditation assessment in 47 Public Hospitals and baseline for 28 Health centers in FY 2021. Hospital progress Accreditation survey was done in 44 Hospitals and baseline survey for Gatunda District |

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| ***[THRIVE PAD indicator]*** | improvement plan in place.<br><br>**Denominator:** Total number of health facilities enrolled in the accreditation program | | | | Hospital. Due to COVID restrictions, the baseline assessment for HCs was postponed to FY2022. |
| 23. Percentage of health facilities (health centers) that are using quality standards for quality improvements (including hospitals under the accreditation program) ***[THRIVE PAD indicator]*** | | 0<br>2020<br>Health facility records on QI | 5.5%<br>(28 health centers) | 0% | The activity will be conducted in FY 2022. |
| 24. Independent accreditation body in place and functional | | 0<br>2020<br>MOH annual report | 1 | 0 | COHSASA is conducting an RAAQH organizational capacity assessment to identify gaps to meet standards for a local accreditation organization. |
| 25. Number of district hospitals that have achieved Level I of the national accreditation process | | Level I: 28<br>Accreditation Report)<br>2018–19<br>Health facility accreditation database | 36 | 30<br><br>2021<br>Health facility accreditation database | During PY1, RIHSA provided technical support regarding accreditation survey to identify quality performance gaps within the healthcare system. Progressive assessment was conducted in 44 Hospitals and the target set by MOH was to maintain level I and to reach level II. However, five hospitals achieved the target, 30 hospitals maintained or achieved Level I and 4 hospitals did not achieve Level I. The involvement of Hospital Leadership in creating sustainable culture is still limited and this is the major reason of under achievement for the 4 District Hospitals which did not achieve the level I.<br><br>RIHSA will continue to facilitate Hospitals in accreditation process through monitoring and measuring the progress performance for the identified gaps during previous assessment. |

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| 26. Number of district hospitals that have achieved Level II of the national accreditation process | | Level II: 2<br>2018–19<br>Health facility accreditation database | 4 | 3<br><br>2021<br>Health facility accreditation database | In FY 2022, RIHSA will continue to provide technical support to the DHs that did not reach Level II through the twinning activity. |
| 27. Number of provincial and new referral hospitals that have achieved Level II of the national accreditation process | | 0<br>2020<br>Health facility accreditation database | 4 | 2<br><br>2021<br>Health facility accreditation database | In FY 2022, RIHSA will continue to provide technical support to the provincial and new referral hospitals that did not reach Level II through the twinning activity. |
| 28. Number of provincial and new referral hospitals that have achieved Level III of the national accreditation process | | 0<br>2020<br>Health facility accreditation database | 3 | 0<br><br>2021<br>Health facility accreditation database | This year (2021)'s hospital target was to achieve Level II as per MOH guidance, which is met through implementation of policies and procedures and plans. Currently, the Quality Improvement Facilitators together with the hospital teams are working on the major gaps and addressing the identified weaknesses in FY 2022; there are expectations that many Hospitals will achieve level III of accreditation. |
| 29. Percentage of private facilities (hospitals and polyclinics) that have achieved Level I of the accreditation process | | 0%<br>Health facility accreditation database | 0% | 0%<br><br>2021<br>Health facility accreditation database | In PY1, RIHSA supported setting up the baseline of where private facilities are with regards to compliance with accreditation standards. In PY2, it is expected to conduct progress surveys and measure the level of efforts achieved by the private facilities. |
| 30. Number of private facilities (hospitals and polyclinics) enrolled in national accreditation program | | TBD<br>Health facility accreditation database | 24 | 24<br><br>2021<br>Health facility accreditation database | Data from Q2 report. In FY 2022, the following activity is planned: dissemination of baseline survey findings for 24 private facilities and sharing of experiences. |

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| 31. Number of health staff/managers trained to manage the national accreditation system/quality improvement QI | | 34 accreditation surveyors<br>0 QI trainers<br>24 QI Facilitators<br>RIHSA project training records | 84,<br>0,<br>44 | 84<br>0<br>0 | 84 accreditation surveyors trained<br>QI facilitators and QI trainers were not trained. |
| 32. Percentage of health facilities using data dashboards for key indicators in RHAP<br>***[THRIVE PAD indicator]*** | *Numerator*: Number of health facilities (hospitals) with data dashboards in place for key indicators using the RHAP<br>*Denominator*: Total number of hospitals with dashboards created with access to RHAP | TBD<br>2020<br>Health facility records on QI | 24% | 0 | RHAP is currently used at central level only, USAID-RIHSA had planned to conduct cascade trainings to rollout RHAP to hospitals and districts during year one but the trainings were postponed to year two due to COVID-19 prevention restrictive measures limiting gathering of people. |
| 33. Percentage of District Health Unit (DHU members onboarded with dashboards and data use processes | | TBD<br>2020<br>Health facility records, RIHSA training records | 20% | 0 | RHAP is currently used at central level only, USAID-RIHSA had planned to conduct cascade trainings to rollout RHAP to hospitals and districts during year one, but the trainings were postponed to year two due to COVID-19 prevention restrictive measures limiting gathering of people. |
| 34. Number of people trained in health system strengthening– (HSS) related activities | Number of health facilities staff trained in data entry and use of HRTT, finance staff trained in IFMIS, Provincial/District Health committees trained in Oversight and management of public health facilities, and health staff/manager trained to manage national accreditation system. | TBD<br>2020 | 445 | 646 | RIHSA increased the number of trainees to include additional HCs staff bringing the total trainees to 646 and this was to respond to urgent needs. |

**Annex 2: Financial Report**

| Financial Table 1: Cumulative Expenditure | | | | |
|---|---|---|---|---|
| **BUDGET COST CATEGORY** | **TOTAL BUDGET ($)** | **CUMULATIVE EXPENDITURE ($)** | **BALANCE REMAINING ($)** | **COMMENTS (BUDGET REALIGNMENT, SIGNIFICANT VARIANCES, ETC.)** |
| Direct Costs | 8,050,063 | 1,550,652 | 6,499,411 | |
| Indirect Cost | 1,344,923 | 391,630 | 953,293 | |
| Fixed Fee | 469,749 | 97,114 | 372,635 | |
| **TOTAL PROJECT EXPENDITURES** | **9,864,735** | **2,039,397** | **7,825,338** | |
| CUMULATIVE OBLIGATED AMOUNT | | 4,668,000 | | |
| UNDISBURSED AMOUNT | | 2,628,603 | | |
| NUMBER OF MONTHS TO SPEND UNDISBURSED AMOUNT | | 7 | | |

| Financial Table 2: Annual Expenditure | | | |
|---|---|---|---|
| **BUDGET COST CATEGORY** | **PLANNED FY 2021 EXPENDITURE ($)** | **ACTUAL FY 2021 EXPENDITURE ($)** | **COMMENTS (EXPLAIN SIGNIFICANT VARIANCES ETC.)** |
| Salaries and wages | 1,468,489 | **601,263** | The project experienced some delays in the recruitment and onboarding of staff during start-up, particularly regarding the health financing director, data use/HMIS specialist, and M&E and communications associate, who all joined in 2021. Some staff salaries following recruitment have come in below the budgeted rate for their respective position. Additionally, following the resignation of the MEL manager, there was a gap in this position until a replacement was onboarded. *Note: Some fringe costs included under this budget line item in the work plan budget are recorded as actual expenditure under the Overhead (Fringe) line item.* |
| Consultant | 79,843 | **2,202** | Consultancy assignment discussions and negotiations took longer than anticipated. Some of the reasons for extended procurement timelines included refining the SOW to align with the expected outcomes, discussion with stakeholders to agree on scope and objectives of these assignments, and |

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| | | | time taken for selected consultants to submit required documentation. Some payments have been delayed as initial deliverable submissions have required feedback and resubmission by consultants before payment is made on final products. In addition, there were some challenges in initiating assignments for consultants associated with COVID-19 restrictions in place at various times throughout the year. |
| Travel & transportation | 72,673 | **19,223** | The underspend is mainly attributed to movement restrictions put in place by the Government of Rwanda as part of curbing the spread of the COVID-19 virus. These involved total lockdowns in some areas as well as prohibitions placed on physical gatherings that led to nontravel even after lockdown measures were lifted. Such travel measures involved prohibiting movements across different districts, thus hindering some of the earlier planned travels for project activities to such areas. Planned in-country visits to Rwanda by headquarters-based staff have not been possible so far due to restrictions and risks associated with COVID-19. |
| Allowances | - | **-** | n/a |
| Other direct costs | 489,744 | **97,966** | There was underspend associated with reduced expenditures in costs items such as vehicle fuel and maintenance expenses due to measures that were put in place to curb the spread of COVID-19. With staff spending a large portion of the year teleworking, there was reduced spending on office expendables and stationery as well as other activity-related expenditures. |
| Overhead (including Palladium NICRA and Fringe) | 722,405 | **496,534** | Overall lower spend resulted in lower overheads compared to the work plan budget. |
| Equipment | - | **-** | n/a |
| Training | 135,448 | **145,604** | This variance is because of four rounds of HRTT and IFMIS trainings series facilitated by RIHSA for the district accountants and NBA accountants in the Q3 and Q4 of this year. These trainings were fast-tracked to ensure a more rapid implementation following relaxation of some of the COVID-19 measures put in place by the Government of Rwanda that prevented physical meetings. |

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| Subcontracts (includes subcontractors overhead/NICRA) | 563,261 | **358,118** | The underspend is due to earlier delays in issuing subcontracts to Research Triangle Institute International, COHSASA, RAAQH, and Zenysis Technologies. There were extended negotiations with subcontractors that aimed at refining deliverables. There also was a need to ensure cost reasonableness for FY 2021 activities, as well as clarifying compliance requirements with subcontractors. |
| Fixed Fee | 176,593 | **97,114** | Overall lower spend resulted in lower fee billing compared to the work plan budget. |
| **TOTAL EXPENDITURES** | **3,708,455** | **1,818,026** | |

## Annex 3: Success Stories and Photos

### 1. ACCREDITATION—Private Health Facilities' Strengths and Weaknesses

Quality assurance is a critical component of well-performing health systems. Having access to health care is not enough: patients who visit the health facilities—whether a hospital, a health center, a clinic, or another health care venue, private or public—need to be confident and have faith that they will receive health care that is safe, efficacious, and consistent with the latest clinical evidence. Therefore, done properly, accreditation can be a powerful tool to offer that assurance, and for health facilities, it offers a sustainable strategy to improve the quality of their health services. The primary goal of accreditation is to ensure that the health facilities not only perform evidence-based practices but also focus on the access, affordability, efficiency, quality, and effectiveness of health care. Different studies have shown that accreditation promotes capacity-building, increases staff satisfaction, and improves health outcomes of patients.

A part of RIHSA's mandate is to strengthen the accreditation process at hospitals and health centers (subobjective 2.2) through PSE for accreditation and QI. In Q2, the project worked closely with the MOH to conduct the accreditation baseline assessment of private health facilities to assess the current situation of health facilities' compliance toward the Rwanda Polyclinics and Private Hospital Accreditation Standards (First Edition, November 2018). Five risk areas have been assessed, comprising a total of 71 standards. A total of three certified surveyors conducted a three-day assessment for six targeted private health facilities located in Kigali (two in Gasabo, two in Kicukiro, and two in Nyarugenge). The survey aimed to identify quality performance gaps and inefficiencies within the health systems in private health facilities. The performance assessment toolkit for private health facilities was used to assist the team of surveyors in performing the survey process consistently, efficiently, and effectively.

**Finding synthesis**

Polyclinique de l' Etoile, located in Gasabo District, Remera Sector, Rukili I Cell, was one of six private health facilities assessed. In a systematic presentation of the assessment findings for each aspect of the facility's operations, the participants had the opportunity to discuss the implications for successful implementation and how accreditation may drive QI.

Dr. Birahira William, Director of Polyclinique de l'Etoile, responding to various identified challenges.

Generally, the assessment findings revealed the following as strengths: increased staff engagement and communication, staff capacity-building, positive changes in the health care organizational culture, identification of improvement areas, enhanced patient safety, public recognition, market advantage, and enhanced leadership and staff awareness of continuous QI.

"*We are grateful for this activity. It really woke us up. Previously we had a myth that accreditation is only for the public health facilities. From today we are going to make an effort—educate, train, and communicate our staffs how to develop and follow operational policy and procedures as required.*" —Dr. Birahira William, Director of Polyclinique de l' Etoile

The identified weaknesses included excessive staff workload, organizational resistance to change, lack of awareness, inadequate resources, insufficient staff training and support regarding continuous QI, and lack of performance outcome measures. Guiding documents such as policies, procedures, protocols, and operational plans to describe the expected quality of care/services to be provided were not developed, and the standards that were disseminated a year ago had not yet been used.

*"Particularly there is a need of financial and technical collaboration of all private health facilities with the support of MOH and its partner to establish harmonized policies, procedures, and other required documents that guide in health care services and activities provision."* —Dr. Birahira William, Director of Polyclinique de l' Etoile


Accreditation programs should be supported as tools to help identify the internal opportunities, strengths, and weaknesses within health facilities, with the intention of improving the quality of health care services. The results of this assessment will be used by the assessed facilities to develop interventions that will continuously improve the quality of services. RIHSA will continue to provide technical support to the facilities in QI planning and capacity-building in QI, as well as assessing and prioritizing training needs, to strengthen the national accreditation system. RIHSA will also organize information sessions to support private health facilities in having a better understanding of standards requirements, respond to any issues pertaining to standards interpretation, share planning tools for standards implementation, and provide guidance.

## 2. TWINNING ACTIVITY—Improve Data Use for Governance and Decision-Making

RIHSA and MOH collaborated to codesign a district-level twinning activity that builds on current Government of Rwanda strategies and efforts to improve data use for governance and decision-making. RIHSA adapted a preexisting twinning model that fits the Rwandan context by twinning high- and low-performing DHMTs based on Imihigo performance, as well as operational knowledge, resources, and skills that affect the use of quality

data for decision-making.

The twinning activity's goal is to foster peer-to-peer learning and knowledge sharing by creating a dynamic network of supportive relationships among districts. The twinning approach was inspired by WHO's Twinning Partnerships for Improvement, which is a "'doing while learning' model in which the collaboration, co-development, and sharing of knowledge are key elements." The approach started with codesigning interventions with MOH and DHMT stakeholders. Through the codesign process, RIHSA adapted WHO's twinning model to develop the "Six Cs of Twinning" (Collaboration, Connection, Cooperation, Commitment, Capacity, and Coaching).

On September 27–29, 2021, RIHSA held the first of three planned twinning workshops (activity 2.3.10), with district-level stakeholders (directors of the Health Unit; data managers; and the planning, M&E, and district health promotion and diseases prevention officer) from 10 DHMT districts in attendance (Gakenke, Nyagatare, Rulindo, Ngoma, Karongi, Gasabo, Bugesera, Kamonyi, Kirehe, and Kayonza). The purpose of this twinning workshop was to bring the districts together to lay the groundwork for the twinning activity, which included identifying and prioritizing key data use-related challenges and issues that each DHMT would like to focus on and strengthen through the twinning partnership. There were 30 people in total (27 men and 3 women).

Gaston Ntabana, the Director of Health, Kamonyi District, is one of the 30 participants who attended the workshop. Before Ntabana attended the workshop, he did not know much about twinning and thought it would be like other workshops.

"*I found this twinning approach as a great opportunity for districts to share information on what everyone is doing and learn from others who are performing well in areas where you are struggling to perform. Often, you would find everyone locked up in their corner, fighting hard to overcome the challenges they are facing in their district, sometimes finding it difficult for you to cope with and sometimes bringing frustration and feel that probably you are not capable of anything. But I see twinning as a solution that will help us (as districts) to learn from each other and to create a network of learning and sharing of experience, which will improve performance for all of us."* —Gaston Ntabana, Director of Health, Kamonyi District

Following the workshop, Gaston and the other participants committed to using the twinning activity to improve their decision-making processes and subsequently strengthen the quality of health services in their districts.

*Twinning workshop, Fatima Hotel, Musanze*

The workshop provided staff from districts with opportunities to share and learn from one another, which will help DHMTs in improving how they collect, manage, and use high-quality data to make decisions that lead to better health outcomes for their communities.


## 3. PRIVATE SECTOR ENGAGEMENT

USAID RIHSA is determined to increase PSE through strengthening stewardship for private sector inclusive health systems. Through biannual public-private dialogue meetings at the national level, RIHSA intends to build the organizational capacity of the private sector to actively participate in policy dialogue with its public sector counterparts. As such, the project engaged the RHF as the premier private health sector body that plays a pivotal role in PSE in Rwanda. RHF's goal is to advocate for the interests of the private health sector and promote access to affordable, equitable, and quality health services for the population in Rwanda. The RHF brings together nonstate actors in the health care space including, but not limited to, health professionals' associations, NGOs, and faith-based organizations.

Through consultative meetings with RHF senior leadership, RIHSA assessed RHF's organizational capacity needs with an aim of aligning interventions and TA for organizational capacity development of RHF. The needs assessment revealed that RHF faces significant organizational capacity gaps that require immediate attention. Some of these gaps included streamlining the legal status in line with the Rwanda Governance Board guidelines governing NGOs. RIHSA supported RHF to identify and prioritize the necessary steps toward strengthening its organizational capacity and be in a better position to effectively advocate on behalf of private providers. RIHSA therefore supported RHF to organize a meeting that brought together RHF founding and prospective members including health professionals' associations, NGOs, and faith-based organizations in the health care space.

*Figure SEQ Figure * ARABIC 6. Members of RHF who attended the General Assembly*

This meeting was officiated by the minister of state in charge of PHC services and attended by RIHSA chief of party. The meeting was an opportunity for participants to exchange ideas on how to foster better public-private collaboration toward achieving national health priorities and Sustainable Development Goals. The meeting was also an avenue for increased transparency, communication, and alignment between private-sector and national guidelines and health priorities. It was also an opportunity for RHF to reorganize its structures, conduct a general assembly, and elect new leadership. In his remarks, the minister of state in charge of PHC services, Hon. Lt. Col. Dr. Tharcisse Mpunga, highlighted that the private health sector has a lot to offer and that its sustainable involvement in building the health sector is needed in several areas. He also pledged that the MOH will actively engage RHF through quarterly meetings organized by the PSE core team chaired by MOH.

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*"Today, we have been able to elect a new and strong committee with people who are energetic and willing to advance the federation's agenda. We are thankful to RIHSA for the technical and financial support that enabled this meeting to happen. Thanks to RIHSA for initiating this partnership."* —Hon. Lt. Col. Dr. Tharcisse Mpunga, Minister of State in Charge of PHC Services

RIHSA will continue strengthening RHF's organizational capacity to ensure that the private health sector is better organized and equipped not only to promote increased PSE in policy reforms but also to increase private investments in the health sector through PPPs.

**Annex 4: RIHSA communication materials**

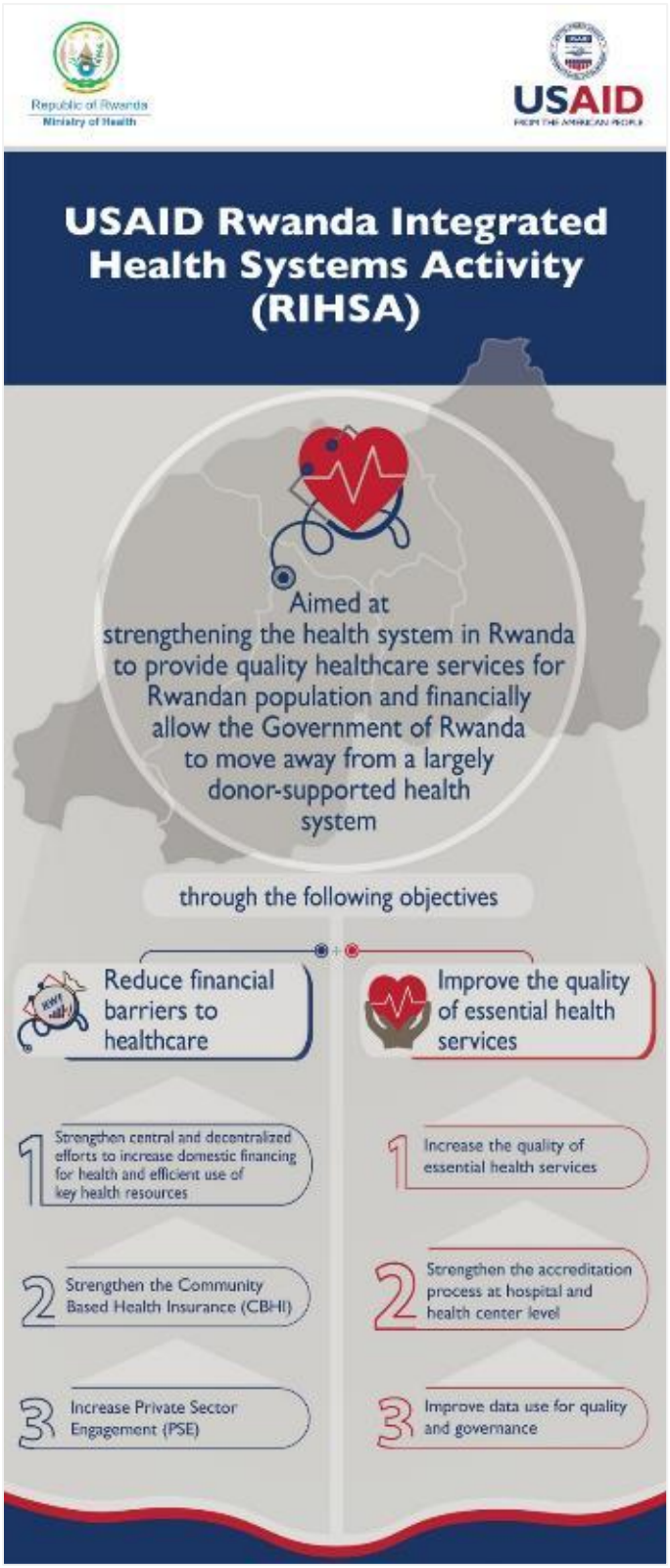



Figure 12. Pull-up banner stand (*left*) and office and car signage (*right*).