PRIMARY HEALTH CARE PERFORMANCE MANAGEMENT:

Key Informant Interviews Report

Bugesera and Gicumbi, Rwanda

July 17 – August 3, 2023

08/11/2023

EXECUTIVE SUMMARY

OVERVIEW

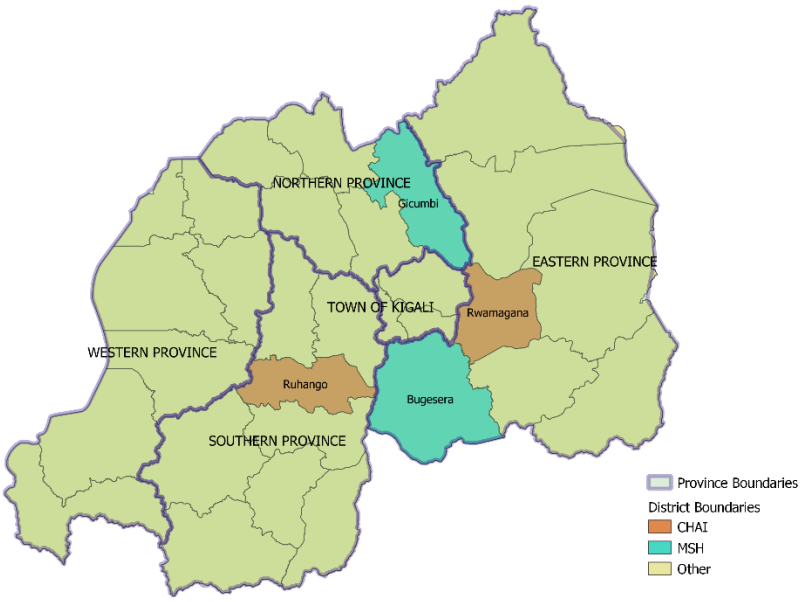
Through the Primary Health Care (PHC) Performance Management project, Management Sciences for Health (MSH) conducted key informant interviews (KIIs) in two districts in Rwanda: Bugesera and Gicumbi.[1] The Clinton Health Access Initiative is also implementing similar initiatives in two additional districts: Ruhango and Rwamagana. The objectives of the KIIs were to gather information to better understand how PHC performance is managed in each district while informing project design. In total, eight in-person KIIs were conducted in both districts (four each at the district management level and facility level). Responses were coded into six themes: management and data, financing, workers (human resources), supplies, facilities and demand.

Interviews (per district): District Hospital Director of Administration and Finance (DAF) & District Hospital Chief Budget Officer (x1),[2] District Health Management Team (DHMT) (x2), Health Centers (x2), Health Posts (x2), Community Health Worker (CHW) Cooperatives (x2).

[1] The two districts Bugesera (Eastern Province) and Gicumbi (Northern Province) were selected based on several factors including discussions with the MoH leadership, distance from Kigali, and performance according to DHMT performance matrix.

[2] However, at the time of submitting this draft, the interview with Gicubmi's District Chief Budget Officer had not yet been conducted due to their availability. Therefore key information related to financing is largely unavailable.

Figure 1. Map of selected districts



SUMMARY OF FINDINGS

During the interviews, neither district reported any considerable human resource absenteeism. Facility staff considered the standard package of services, as defined for their level of facility, available to the community. However, both Gicumbi and Bugesera reported inconsistent supportive supervision to health facilities as well as additional barriers to providing quality services -e.g., limited transportation, equipment, and staff training in Bugesera. Gicumbi demonstrated more progress in certain areas including incentives for facility staff and access to resources (i.e., electricity and water) within facilities.

Facilities in both districts stated limited ability to recruit and allocate staff, which was mostly done at the national and district level. In Bugesera, higher-level facilities reported some autonomy over use of financial management, particularly in how facility revenue is used. Performance-based financing (PBF) was considered an important factor for promoting staff retention and increasing revenue but in some cases, de-incentivized referral of more severe cases to higher levels of the health system. Although frequent meetings using data for planning, management and other purposes are conducted, both districts stated logistical and staffing challenges fulfilling reporting requirements (e.g., turnover of staff; lack of computers and internet connectivity). Nationwide distribution of pharmaceuticals and medical supplies is managed by Rwanda Medical Supply (RMS) Ltd, with reported stockouts of antibiotics and antimalarial drugs.

Key findings are summarized below:

- **Management and Data:** Both districts reported the importance of priority setting at all levels of the health system (with the exception of second-generation health posts [SGHPs]) – e.g., setting targets for service coverage, on-time reporting, and community-based health insurance (CBHI) enrollment. Data reportedly plays an important role in decision-making and informing performance management as part of routine meetings at district, facility, and the community level. Despite the availability of numerous information systems, as well as the widespread use of Rwanda Health Analytics Platform (RHAP) platform and Imihigo dashboards (for assessing and improving district performance across sectors), it was unclear whether they are all integrated and used for decision-making (beyond the DHMT) in the face of challenges such as limited number of laptops, lack of trained staff due to turnover, poor network coverage (internet and telephone), and shortages of registers to record patient/client visits.

- **Finances:** Financial autonomy varied by health system level – e.g., the DHMT plays no role in determining the allocation of financing, but rather plays an advocacy role and is consulted during the budgeting process; health facilities can use internally generated funds for infrastructure improvements, equipment, and supplies while CHW cooperatives are responsible for managing their own revenues from income-generating activities. Some SGHPs are managed by the Society for Family Health (SFH) – a non-profit social marketing organization – and therefore use of finances are closely controlled with a proportion of revenue used for paying casual laborers. PBF represents an important source of revenue and motivation for health facilities and CHW cooperatives despite reports of payments being delayed. CHWs reportedly lose PBF financing when they refer patients to SGHPs (they are supposed to refer to health centers except in the case of emergencies in which they refer to SGHPs), Health insurance coverage is reportedly high in both districts.

- **Workers:** The allocation of doctors is determined at the national level, and the districts recruits additional nurses and staff. Facilities are not able to manage their own recruitment or allocation; however, some health facilities reported looking for short-term contractual staff during district recruitment process. Both districts reportedly faced challenges with staff retention despite the availability of financial incentives through PBF payments and other allowances. Supportive supervision was planned routinely, but both districts reported gaps in reaching lower levels, as well as transportation barriers.

- **Supplies**: Facility staff feel reported that pharmaceutical stockouts are rare, despite noting national shortages of amoxicillin and artemether-lumefantrine (AL) antimalarials. The RMS Ltd manages the procurement and distribution of all medicines and medical products in the country; written permission is required to procure from other vendors. Health facilities work directly with the RMS Ltd branch to request essential medicines and supplies via the e-LMIS. Paper-based systems (e.g. stock cards, medicine registers) are also used to manage inventory and estimate ordering needs.

- **Facilities:** Facilities were generally able to provide comprehensive services defined in their respective service packages, but DHMTs outlined a need to add services to the existing package to meet the needs of the population. HIV treatment was provided inconsistently by both districts at the facility level. Both districts had basic resources to maintain sanitation and provide quality care, but Gicumbi reported better access to pipe-borne water and electricity. The privately managed SGHP in Gicumbi offered dental and eye care services in addition to the standard health post package – these services were reportedly in high demand.

- **Demand:** Health Center caseload in Bugesera averages 150-220 cases/day and 60 deliveries/month. Gicumbi reportedly averages 80-150 cases/day and 7-15 deliveries/month. Bugesera manages a greater number of upper respiratory tract infections (URTIs), comprising 70% of Health Center cases and 60% of Health Post cases. In comparison, Gicumbi sees more dental cases, making up 40% of Health Center cases and 95% of Health Post cases. Efforts are needed across both districts to improve personal hygiene (including development of a comprehensive hygiene plan), nutrition for children under 5 (CU5), health-seeking behavior, dental, eye care, and reproductive health.

KII METHODS & APPROACH

The data gathering exercise used a non-experimental qualitative design and included KIIs and semi-structured deep dive focus group discussions (FGDs), complemented by a review of secondary data from national information systems and available district reports. Key informants for the evaluation interviews were purposively sampled based on their role in the health system at the subnational level. A similar exercise was also conducted in Ghana. The main questions this information-gathering exercise sought to answer are:

1. How is PHC performance currently managed at the district level in Ghana and Rwanda? Who are the people in the health system that have responsibility for decision-making (for human resources, supply chain, data, financing)?
2. What standards are in place? How functional are these systems in practice?
3. What are the critical PHC drivers for district level stakeholders? What information drives PHC decisions? What are the information systems that district staff are using to make decisions?

Data was collected in Bugesera and Gicumbi districts from July 17 – August 3. The project identified five stakeholder groups of interest: (1) DHMT (1 KII per district), (2) District Hospital DAF & Chief Budget Officer (1 KII, Bugesera), (3) Health Center staff (1 KII per district), (4) Health Post staff (1 KII per district), and (5) CHW supervisors (1 KII per district).

The following is a summary of preliminary qualitative findings from **Bugesera and Gicumbi districts**, organized by "glassbox" sub-heading: 1) management and data; 2) financing; 3) workers; 4) supplies; 5) facilities; and 6) demand. Additional qualitative and quantitative data (with further synthesis across districts and countries) will be completed for both Rwanda and Ghana.

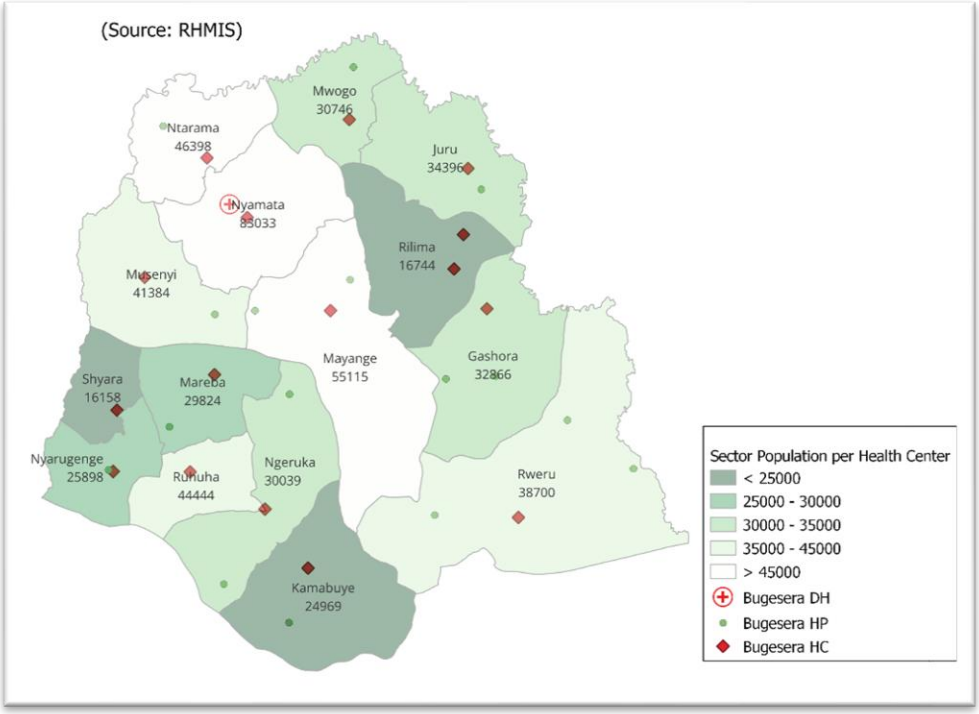
PRELIMINARY FINDINGS: BUGESERA

Table 1. District Snapshot, Bugesera

Criteria	Bugesera
Total Population	561,606
Land Area	1,33788 km^2
Communities	92
Facilities	
District Hospitals	1
Health Centers	15
Health Posts	16
Prison Dispensaries	1
Health Workers	
Doctors	38
Nurses	244

Midwives	42
CHWs	2,251

Figure 2. Population per Health Center, Bugesera (2020)



1) MANAGEMENT & DATA

The KIIs with the DHMT, health facility staff, and CHW cooperative focused on how districts and facilities use data to plan and prioritize; a landscape of planning meetings and structures; decision-making processes, and how performance targets are set.

- **Nearly all levels of the health system reported setting performance targets** – e.g., on-time reporting, supervision of CHWs and facilities (by district staff), attaining certain health indicators (family planning and antenatal care coverage), reductions in stockouts of medicines and supplies, and compliance with public financial management procedures. CHW cooperatives also set targets for CBHI enrollment and revenue (e.g., expand revenue based on their wheat growing income-generating activity). Village leaders also contribute to setting performance targets (e.g., increasing the rate of completion for ANC4 for pregnant women). However, the SGHP reported that there are no set performance targets ("SFH asks SGHP staff to deliver to their best.").

- **Needs assessments are conducted periodically**, with frequency depending on the level of the health system, to assess needs for human resources, infrastructure development, equipment, and capacity building. At the district level, these needs are then communicated to the District Management and ministries on what is required to be budgeted for.

- In addition to its use of the Imihigo dashboards (aimed at accelerating the achievements of government development programs and priorities), the district also provided a demonstration of the RHAP platform which could play a critical role in facilitating PHC performance management. However, **it was unclear how data dashboards have been used for decision-making in the health sector and at which level of the health system they are used and at what frequency**.

- All levels of the health system reported **challenges to ensuring timely and quality data reporting**: limited number of laptops, lack of trained staff due to turnover, poor network coverage (internet and telephone), lack of registers to record patients/clients.

- In Bugesera, there are a **number of meetings to use and share data for performance management that are held at the district, facility and CHW cooperative level** (Table 2)**.**

Table 2. Meetings with consistent data use (Bugesera)

Level	Meetings and scope
Districts	• Monthly coordination meetings that bring together the district, district hospital, health facilities, and partners. • DHMT quarterly meetings: each unit is given time to express challenges faced by his/her unit, and then resolutions are shared generally. Analyzed data (derived from the HMIS) is shared; health and service delivery indicators are extensively discussed. The District Health Unit in collaboration with district hospital M&E staff prepare updates on health sector funding, human resource status and management, and equipment. Detailed presentations and reports are made noting gaps and challenges. • Social cluster semester meetings. • Annual general meeting which is held at the start of the fiscal year during which the DHMT and stakeholders work on priority setting and a list of projects/activities that aim to be completed.
Health facilities	• Monthly management meetings. • Bi-annual planning meetings are mainly held twice a year (before the fiscal year begins in May and mid-term review that is carried out in December). Priorities are derived from the needs assessment reports from the community, health center staff and district hospital. Follow up is made through monthly management meetings and community outreach.
CHW cooperatives	• Monthly and quarterly CHW coordination meetings to review health indicators. In advance, the health center data manager generates information on the status of all indicators in their catchment area and shares it with C-EHO for discussions and actions during meeting. • A report of issues and suggestions generated from weekly meetings and monthly communal work is submitted to the health center for discussion and elevated to district administration as needed. Citizen Voice Action

	meetings are another opportunity for community members to raise concerns and ideas. • Also reportedly convene whenever it deems necessary – e.g., for urgent preparations to manage pandemics or carry out vaccination exercises. • CHWs also use Rapid SMS to notify decision makers on availability of medicines and malaria treatment.

- Facilities reported completing a number of different data reports:
    - Health center: health services report (monthly), financial report (monthly), HR status updates (occasional), equipment status (occasional).
    - Health post: general services report (submitted through HMIS and e-FICHE) and other reports on services that are asked by the district management
    - CHWs: general report on services at community level, submitted monthly to the health center.

Included in **Error! Reference source not found.** is a summary of sub-national information system use based on data mapping conducted by MSH (applicable to both districts).

Table 3. Information system use

Data type	Data Collection Approach	System Name	Reporting Frequency	Data Use
Health service statistics, finances, HR, tracer drugs, vaccinations, program indicators (HIV, TB, Malaria, non-communicable diseases (NCDs), etc..)	Data are recorded on paper service registers and stock cards, then tallied monthly onto monthly report forms which are entered into District Health Information System (DHIS2) by facility data managers.	Rwanda Health Management and Information System (RHMIS)	Monthly	Calculating performance indicators, monitoring stock levels, disease surveillance
CHW activity monitoring, tracer drugs, deaths in the community.	Data are recorded on integrated management of childhood illness (IMCI) forms and a series of paper registers, then tallied each month on a CHW monthly report form that is entered into DHIS2 by health center CHW coordinator and Data Manager	Système d'information sanitaire des communautés/CHW information system (SISCom)	Monthly	Estimating community level burden of disease, tracking commodities, monitoring CHW performance and CHW cooperative activity.

Epidemic prone disease incidence	24 epidemic prone diseases are summarized on a weekly basis with priority disease reported on an immediate (daily basis).	Electronic Infectious Disease Surveillance Report (eIDSR)	Weekly Immediate	Disease surveillance and response
CHW event reporting (community-based family planning distribution, nutrition screening, IMCI, post-natal visits, pre-natal visits, deaths in the community)	CHWs report all contacts with clients in their communities	RapidSMS	Immediate	Data are used to track individual CHW performance – including # of clients seen, home visits made, stock of medicines.
Stock variables for all medicines and consumables supplied by the District Pharmacies (stockout days, beginning stock, distribution, loss/transfer, stock remaining.	Data are maintained on paper stock cards then daily (or monthly) distribution and remaining stock are entered into the electronic logistic management information system (eLMIS) along with orders	eLMIS	Daily or Monthly (as required for orders)	Data are used at District Pharmacy and National level to determine re-supply amounts and quantification.
Maternal and child death audits	Staff from district hospitals and health centers investigate maternal and <5-year deaths	DHIS2 death audit module	Immediate	Used to determine if deaths were avoidable and take actions to improve case management
Data warehouse and visualization platform that synchronizes data from RHMIS, SISCom, and other data sources. Also analyses imported data sets to identify outliers and alert district staff of potential data errors.	Data are automatically pulled from different data sources using APIs or by exchanging excel spreadsheet downloads.	RHAP	Most updates are monthly after the end of the reporting period ends	Used by health facilities and DHMTs to monitor health facility performance and to respond to ad hoc queries. Standard dashboards have been created for DHMTs, district hospital and health center.

2) FINANCING

Primarily discussed with the District Chief Budget Officer, detailed questions were asked on decision-making authority, budget and expenditures, planning and budgeting process, budget execution/funding flows, payment mechanisms, and health insurance. The DHMT and DAF were also asked about the district financing process. To obtain the perspectives of health facility staff and CHW cooperatives, questions about decision making and budget execution were asked from their perspective as well.

- **Financial autonomy and influence in the budgeting process vary by facility type and health system level.**
    - Decisions on budgeting and the allocation of funding at the district level are led by the district budgeting team. The **DHMT plays no role in determining the allocation of financing**, but rather plays an advocacy role and is consulted during the budgeting process. The budget cycle occurs every three years and is preceded by a session focused on harmonizing district priorities and is coordinated by Ministry of Economic Planning and Finance (MINECOFIN). The district reported that in the previous fiscal year it spent 96% of its annual budget.
    - However, **district hospitals and health centers have autonomy on the use of internally generated funds** (e.g., for infrastructure improvements, equipment, supplies) while also having their own bank accounts. Hospital and health center finance teams draft budgets based on annual action plans of activities, with funds allocated to each activity as per priority and available/projected budget. **There is no specific budget line item for PHC or secondary care.**
    - **SGHPs report some constraints related to financial autonomy.** Finances are managed by the SFH and all revenues and transactions pass through the SFH account. Prior to the launch of SGHPs (before July 2022), the Nurse Head managed the facility finances. Under the agreement between SFH and the owners of SGHPs, there are some funds included in the account which they use to pay casual laborers.
    - CHW cooperatives have their own bank account and are responsible for managing their revenues from projects as well as earmarked funds from the Ministry of Health (MoH), PBF, and training fees.

- **Sources of financing also vary by health facility type and health system level**:
    - DHMTs report three sources of funding: 1) earmarked transfers by MoH and MINECOFIN (staff salaries, implementation of construction projects, maintenance fees for the district hospital); 2) Partners (CDC, Global Fund, and SFH) offer salaries and budgets for equipment and maintenance; 3) Revenues (including from taxes and internally generated funds from services provided by health facilities). The district does not receive PBF funding, which only goes to health facilities.
    - Health centers: user fees for select services (HIV and TB services provided free-of-charge), CBHI reimbursement, and PBF.
    - CHW cooperatives receive quarterly allowances through PBF based on their performance as well as earmarked annual funds to invest in income generating activities.

- District hospitals report **insufficient budget/funding as a general challenge**. If funding is inadequate, the district hospital either waits for the next fiscal year or allocates its own funds (from revenue).

- The district reports that **more than 80% of patients subscribe to CBHI which promotes access to more affordable services and reduced out-of-pocket payments**, even to the most vulnerable members of the community. Employees of public and private sectors are enrolled in the Rwandaise d'Assurance Maladie (RAMA) scheme; military members in the military medical insurance (MMI) scheme; and private insurance.

3) WORKERS

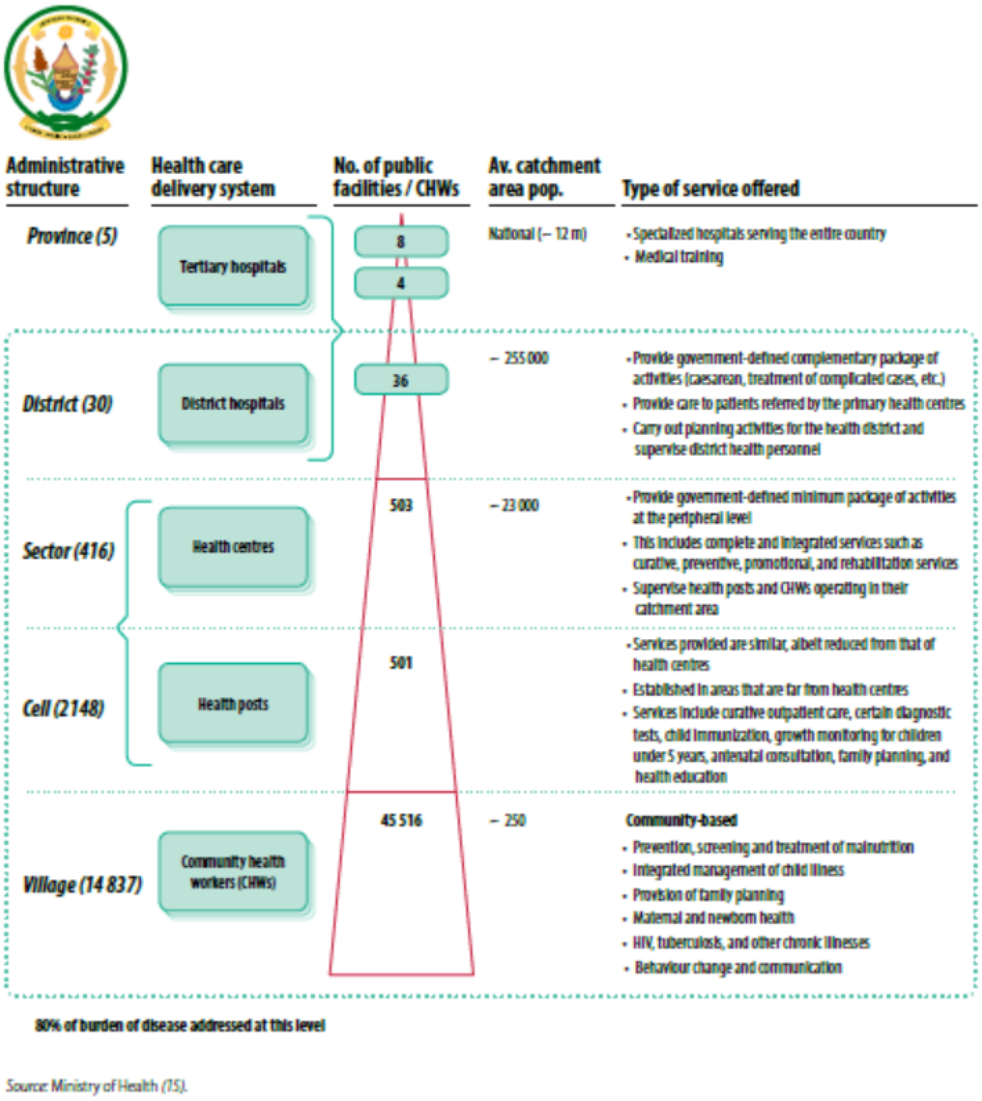
DHMTs were asked a number of questions about how human resources were managed including how supportive supervision, recruitment and selection, deployment, retention and motivation are managed at the district level as well as how much decision-making authority they have around HR issues. Health facility and CHW cooperative staff were asked about the functionality of human resource processes in their contexts.

- Staff reported **no cases of absenteeism** at all levels. PBF was widely reported as an incentive for retention, but **PBF payments were often delayed** and staff reported that the district rarely covers accommodation, transport, and other allowances.

- **Recruitment is done at the central and district levels** – the MoH appoints doctors and the DHMT recruits nurses and other auxiliary staff. The staff are deployed to health centers and hospitals – the DHMT can move staff between facilities depending on need. Due to geographical challenges within the district, recruitment is often delayed, and **staff are not allocated sufficient accommodations** near facilities.

- The DHMT facilitates **quarterly supportive supervision** using the MoH tool to assess if protocols are observed, medicine and vaccine storage, and waste management for health facilities and CHWs. However, **not all facilities are reached** during supervision – for example, one SGHP reported that the DHMT rarely comes to them for supervision, and likewise CHW supervision is not part of the facility's role. Figure 3 provides an overview of the health system and supervision structure.

Figure 3. Health system overview and supervision structure



Source: Ministry of Health (15).

4) SUPPLIES

The KIIs with DHMT, health facility, and CHW cooperative staff focused on understanding how service delivery points can maintain supply of essential medicines, supplies, and equipment to deliver their prescribed package of PHC services and asked questions about commodity forecasting, stockouts of key commodities, and the availability of equipment and supplies.

- Facilities registered essential medicine stockouts of **amoxicillin** and **artemether-lumefantrine** (Coartem) antimalarials. Despite this, facility staff feel that medication **stockouts are generally rare**.

- **Health facilities at all levels work directly with the pharmacy stock manager to request essential medicines and supplies via the e-LMIS.** The pharmacy stock manager is based at the district hospital and health center levels; s/he is responsible for submitted a list of required commodities/products to the RMS Ltd branch based at the district. Medical supplies are trucked directly to facilities, and CHWs must transport their own supplies from there.
- When drugs or supplies are unavailable from RMS Ltd, **facilities must request written permission** to purchase from other wholesalers in Kigali (e.g. KIPHARMA, Madiasol). After an official request is made by health facilities, RMS Ltd headquarter grants non-objection to purchase from outside its branches.
- In addition to the e-LMIS, paper-based systems are utilized at every level. **Stock cards** are completed at all levels, and CHWs also complete **medicine registers** which are used to estimate needs and use rapid SMS to request additional stock from health facilities.

5) FACILITIES

The KIIs with health facility staff, hospital staff and CHWs focused on understanding what package of PHC services are offered at each level (according to the Essential Health Package (EHP) services), the ability of service delivery points to deliver on these services (equipment, amenities, power, water), and population health management (including network design, referral systems, and perceived quality of care).

- **Facilities are aware of and able to provide their defined package of services,** and **services are mostly integrated**. However, respondents at all levels noted that **facilities lack the ability or equipment to design their service package** to match community needs. For example, health posts flagged that they were **not able to provide HIV testing or materials**, even though the community requires these services (i.e., health post staff had to travel to the nearby health center to get prophylaxis for a newborn). On the other hand, the privately-run SGHP added dental and eye care services that are not part of the service package for health posts. Currently, there are three levels of health posts: Ist generation (offers minimum package), and different levels of second generation. Some additionally provide s maternity, laboratory and circumcision and others additionally provide maternity, circumcision, laboratory, dental, and ophthalmology). The decision on what type of health post to consturct is based on a join assessment made by MoH, DHMT, and district hospital.

- **Facilities are open 24 hours a day** but face barriers such as **lack of adequate equipment, staff shortages and limited space to accommodate patients.** Access to power and piped water systems is inconsistent, although internet access and cell service was reportedly improving.

- Health Centers and Health Posts have **limited options for transportation** (vehicles, bicycles or motorbikes) which impacts their ability to pick up supplies and complete other logistical operations including supportive supervision. **Ambulances are available** for emergency transportation from district and provincial hospitals.

- A **referral network is in place** – CHWs can refer to health posts and health centers for cases outside their ability. However, CHWs generally **lose a portion of their PBF when they refer cases to health posts** and are therefore reluctant to do so. The district is working to revise this to ensure that CHWs get PBFs when referred to the health post.

6) DEMAND

The KIIs with health facility and CHW cooperative staff asked questions about how communities are engaged in priority setting and planning for PHC services, how facilities plan to meet demand, and to understand overall processes for enhancing patient satisfaction with services. Questions for the DHMT dove deeper into understanding the procurement process and distribution system.

- More efforts are needed to improve promotion and community education around **personal hygiene** and **nutrition, especially for CU5**. Change of health-seeking behavior, dental care, and reproductive care were also cited as key areas for improvement.

- **Quality of community health services is routinely monitored** through registers to record data, digital systems to keep and share data with higher institutions, reports, and periodic monthly and quarterly meetings with staff and stakeholders.

- Patients are offered a **variety of platforms to share feedback and concerns** with facilities, including: (1) **Weekly community meetings** (inteko z'abaturage); (2) **Monthly communal work** (umuganda), (3) **Citizen Voice Action** (Ijwi ry'Umuturage), a gathering of 27 members that brings together cell and village leaders, youth and women representatives, school heads, health facility representative, and CHWs; (4) **Suggestion boxes**; (5) **Radio talks;** (6) Discussions with hospital **Heads of Units**, (7) Participation in **needs assessment** exercises, (8) Invitations to extended District Council **budget review** meetings. Feedback received in these forums is consolidated and used to improve service delivery at the community level.

PRELIMINARY FINDINGS: GICUMBI

Table 4. District Snapshot, Gicumbi

Criteria	Gicumbi
Total Population	457,374
Land Area	829 km^2
Communities/Villages	158
Facilities	
District Hospitals	1
Health Centers	21
Health Posts	20
Prison clinics	1
Health Workers	
Doctors	31
Nurses	337
Midwives	54
CHWs	2,520

1) MANAGEMENT & DATA

- **Performance target setting and needs assessments:**
  - The DHMT carries out a needs assessment every year before the district planning sessions begin. Teams reach out to CHWs during meetings and general community gatherings.
  - Health centers conduct needs assessments annually before the start of every fiscal year (February); the exercise is always carried out holistically to assess needs for human resources, equipment, training, etc.
  - CHW cooperatives set performance targets related to service delivery, CBHI enrollment, and planned revenue. e.g., the interviewed CHW cooperative indicated targets for boosting low CBHI enrollment and increasing pneumonia treatment of children. Needs assessments consist of damaged and missing equipment.

- **Reports submitted (organized by health system level):**
  - District: Health indicators status (monthly), supervision reports (quarterly), human resources (bi-annual)
  - Health centers: Health services report (monthly), financial report (monthly), human resource status updates (occasional), equipment status (occasional). Health center reports contain all activities done in relation to health services. The Data Manager enters this data into the HMIS while the cashier does the same with financial statements in the FMIS.
  - SGHP: Level 2 Health Posts submit general services report, through HMIS and e-FICHE. Staff enter data for all services and operations carried out, in e-FICHE (a digital system)

designed by SFH. Then, the latter generates summarized data needed in planning sessions. If need be, SGHP staff are asked to provide additional information for smooth planning. The e-FICHE system also bills CBHI electronically for services provided.

- CHW cooperatives: general report on services at community level, submitted monthly (on the 26th). CHW cooperative leaders at the cell level compile village reports that include a summary of services provided, PBF indicator status, as well as damaged and missing equipment. All these are tabled during CHWs meetings for discussions and decision making. At the village level, four CHWs meet and consolidate data then submit to cell level for validation before it is submitted to the health center.

- **Reported challenges related to data reporting**: limited internet and telephone network coverage, few laptops, staff turnover in health facilities.

Table 5. Meetings with consistent data use (Gicumbi)

Level	Meetings and scope
Districts	• Monthly coordination meetings that bring together district, Byumba HD, HFs and partners. • DHMT quarterly meetings. DHMT staff are given time to express challenges faced by his/her unit, and then resolutions are shared to other members of the health systems by the representatives of each group that participated in the meeting. • Social cluster semester meetings
Health facilities	• Weekly and monthly data validation meetings, coordinated by the Byumba district hospital M&E team. The meeting agenda is proposed by the health center management and approved by stakeholders. Summarized data is printed and shared during the course of meetings for discussions. • Biannual planning meetings (before the fiscal year begins in June and mid-term review that is carried out in December). Priorities are derived from the needs assessment reports from the community, health center staff and district hospital. Follow up is made through monthly management meetings and community outreach.
CHW cooperatives	• Monthly and quarterly CHWs coordination meetings • Regular community meetings, monthly group work, and Citizen Voice Action meetings are opportunities for community members to raise concerns and ideas related to health. • Also use Rapid SMS to communicate stockouts and malaria treatment.

2) FINANCING

At the time of submitting this draft, the interview with Gicubmi's District Chief Budget Officer had not yet been conducted and therefore key information related to financing is unavailable.

- **Funding sources come the following sources:**
  - **Earmarked transfers by MoH and Ministry of Economic Planning and Finance**; these include staff salaries and implementation of construction projects.
  - **Partners** like CDC, Global Fund, and SFH. They offer salaries and budgets for equipment and maintenance.
  - **Internally generated funds** from fees for services provided by health facilities.
  - CBHI and other insurance reimbursements.
  - **PBF** (only for district hospital, health center and CHW cooperatives).

- **District budget allocations were reportedly low** for health promotion and prevention needs.

3) WORKERS

- Recruitment is initiated by the MoPSL (for doctors) and completed in conjunction with the DHMT (for nurses and other staff). Clinical staff at health posts are designated by health centers in collaboration with district hospital and district administration. At the health post level, SFH leads recruitment for SGHPs. **The DHMT did not note challenges with recruitment, but staff at the health center level reported retention issues** due to low salaries and PBFs in small catchment areas and staff reluctance to work in certain rural geographic areas. Few staffing gaps exist in the current organogram.

- **Decisions about staff allocation are made at the administrative district level.** DHMT may resolve to move staff from one HF to another based on the identified gap/need, but the decision is made by the appointing authority (i.e. District or MoH) depending on the cadre of staff.

- Like Bugesera, facilities in Gicumbi report **no staff absenteeism**. However, **Gicumbi reported more incentives**, including more frequent provision of accommodations as well as MoH, district hospital and SFH-facilitated trainings for career advancement, and did not mention delays in issuing PBF incentives payments.

- The DHMT plans **quarterly supportive supervision to visit CHWs and health centers** using an MoH checklist. Supervision assesses service delivery, HR management, equipment, availability of medicines and medical products, environmental hygiene and sanitation, health indicators and reporting. However, as in Bugesera, **not all CHW cooperatives are reached** through supervision each year.

4) SUPPLIES

- Procurement and delivery of supplies for CHWs follows a similar process to Bugesera. The CHW committee compiles order requests and submits them to C-EHO. Health centers collaborate with the pharmacy stock manager to request medicines and supplies through the e-LMIS and RMS Ltd branch delivers them by truck. However, interviewees highlighted the **lack of transport for supplies**, with health center staff having to take supplies to the nearest collection point.

- Explicit permission must be sought for any products that cannot be procured through RMS Ltd. The **e-LMIS, stock cards, and medicine registers** are utilized to estimate the need for medications and supplies. The

responsibility for ordering essential commodities is under the **RMS Ltd Branch Manager** who manages the District Pharmacy and is a DHMT member. Procurement training is provided annually.

- **Stock-outs occur rarely** in Gicumbi, although the national shortage of AL antimalarials and amoxicillin were mentioned. Patients receive medications from the **SGHP dispensing service** and with payment covered through various health insurance schemes (CBHI, RAMA, MMI).

5) FACILITIES

- **Most services in the EHP are provided**, although at the health post level, respondents suggest integrating **NCDs screening and management, IMCI , and treatment for communicable diseases screening**. Health posts in Gicumbi are actively doing HIV testing and prevention, which contradicts findings in Bugesera.

- Facilities **generally do not list access to care as an issue** – most are open 24 hours a day, and state that CHWs are able to provide comprehensive community-based care. However, some facilities **lack certain equipment** (i.e. weighing scales) and **space for clients**.

- Facilities report **consistent access to resources** to provide care and maintain sanitation – electricity, pipe-borne water and waste disposals are generally available and widely used, as are access to fast internet and ambulances for emergency transport.

- The **network is in place** for CHWs to refer to health posts and health centers, and for health centers to refer to the district hospital. As in Bugesera, CHWs face barriers to referrals, **mainly the loss of PBF if they refer**.

6) DEMAND

- Staff cited similar gaps in health promotion as in Bugesera, including the need for improved education on **nutrition, reproductive health**, and specialized care including **eye and dental care**. Proper hygiene was again cited as a high priority, including the need to develop a **comprehensive plan** to tackle this issue.

- Community feedback platforms in Gicumbi were also similar to Bugesera, with discussion of weekly community meetings and monthly communal work as the primary routes of information sharing. Responders noted that CHWs participate in periodic meetings, but **the conversation is generally steered by health center staff and local leadership**. SFH field teams responsible for quality assurance also receive direct feedback from clients and local leaders during facility visits.

- Interviewees expanded on use of **Ishingiro community radio** as a feedback mechanism, in which DHMT members hold radio talks that are open to public discussion. This serves as an additional platform for communities to **share ideas on PHC services, financing and governance**.