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Supply Chains 4 Community Case Management

Community Health Supply Chain Endline Evaluation

Rwanda

April – May, 2014

25th September, 2014

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Overview of Presentation

- Background
- Key Findings
  - Resupply Procedures: Training, Tools and Knowledge
  - Quality Improvement Team Process
  - District Engagement and QITs
  - Are QITs Reinforcing Correct and Consistent Use of RSPs?
- Product Availability Findings
- Scale & Institutionalization
- Recommendations

Baseline Assessment 2010

- **49% of CHWs** who manage health products had **five CCM tracer drugs** in stock on day of visit (amoxicillin, ORS, zinc, ACT 1x6, ACT 2x6)

- No Standard Resupply Procedures

- CHWs lack sufficient storage and organization for existing medicines and supplies

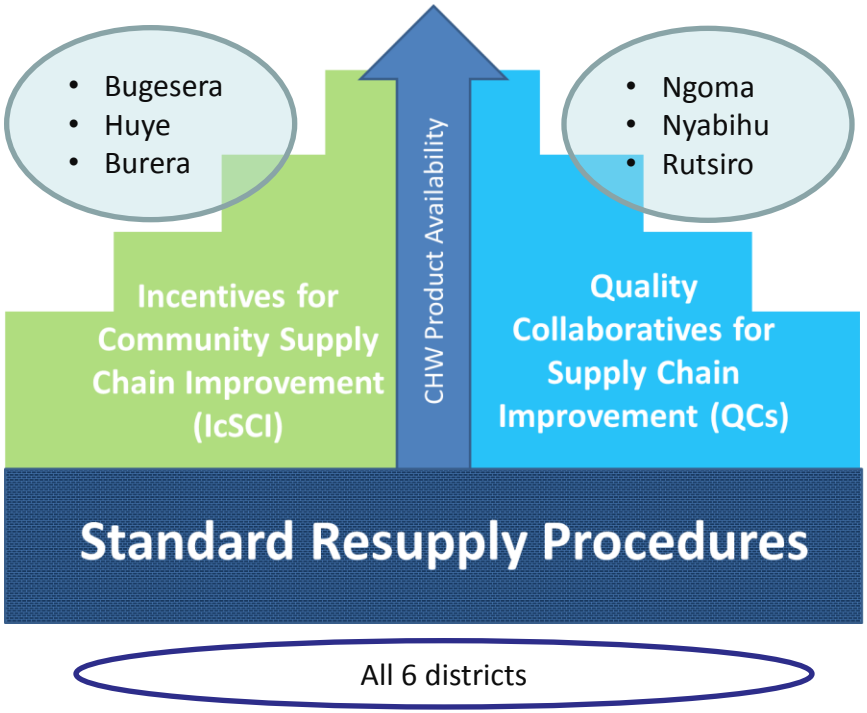
- Transportation is difficult between resupply points and CHWs

Improving Product Availability

Two Interventions to Operationalize RSPs

Foundational (cross-cutting) Intervention: **Standard Resupply Procedures (RSP)**, simple tools and procedures designed to ensure that CHWs always have enough CCM products to serve clients

IcSCI aims to strengthen RSPs by using the existing community based performance-based financing (PBF) scheme for CHWs



QCs aim to establish a network of health center-based **quality improvement teams** with shared objectives and indicators on how best to operationalize RSPs

…both with the goal of **reducing stockouts** and **improving product availability**

Midline Evaluation

QC intervention group showed significant improvement in key project indicator: availability of all 5 CCM products, compared with non-intervention group

Both intervention groups in Rwanda had **greater product availability** than the comparison group

3 key IcSCI supply chain indicators showed significant improvements in the first quarter of implementation, and maintained high performance levels over four quarters

RSPs, QITs, and **one** IcSCI **indicator** recommended for **scale up**

Changes in scale up phase:

- Allowances to CCs and district coaches stopped (Mar 2014)
- QITs: no project support/follow up after final LS in April 2013
- Learning Sessions - discontinued

Scaling Up RSP and QIT

Integrated Training on iCCM:
HCs and CCs trained on RSP & QIT tools

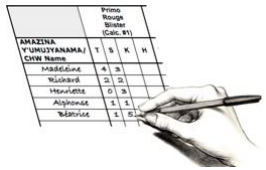
QIT Addendum:
District coaches trained on QIT meeting process

District staff hold QIT kick off meetings at HCs

District Coaching

QIT Monthly Meeting at HC:
CCs and HC staff to **reinforce use of RSPs**

CCs use **integrated supervision checklist** to collect data from CHWs

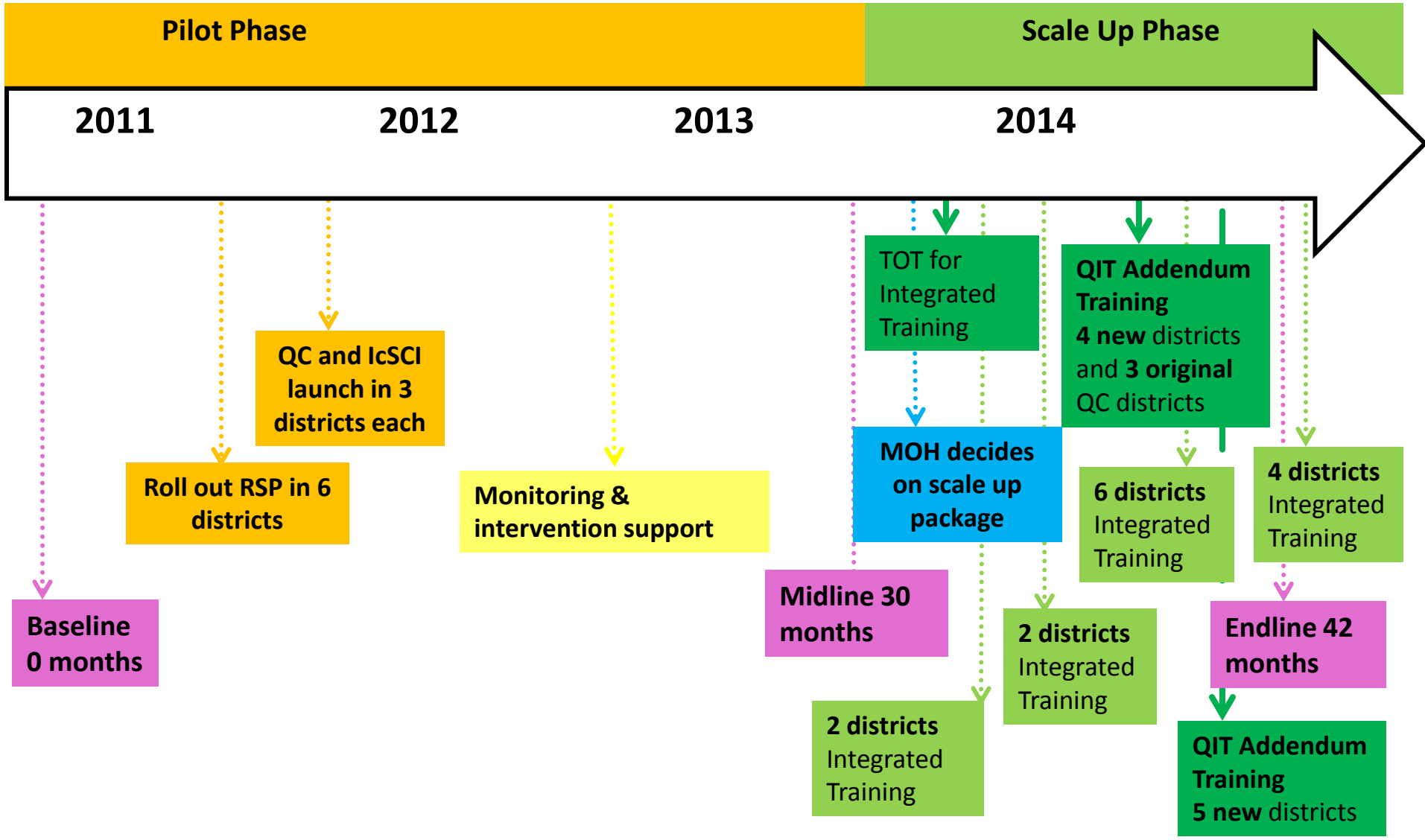


QIT develops action plan, implements, and reviews monthly progress

Monthly Resupply Process:
CC aggregates CHW data, gives to HC Pharmacist, and picks up orders for cell

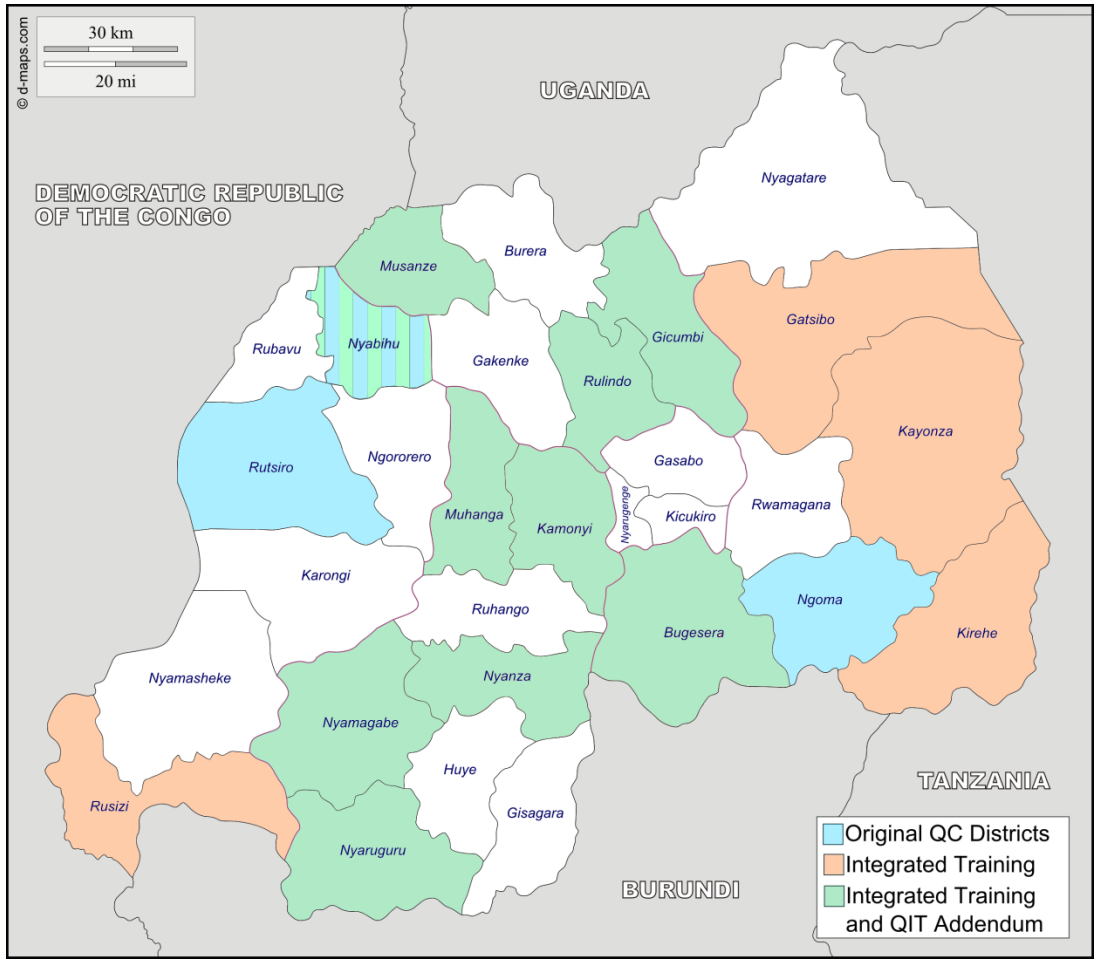
PBF indicators: CHW stock card accuracy, QIT meetings at HC (in progress)

Timeline for QC Implementation & Scale Up



Partnering for Scale

- Scale up status:
  - 14 of 30 districts have received RSPs through the integrated training
  - 12 districts had received the full package of RSPs and QIT training
- Scale up has been led by MOH and supported by a number of partners – World Relief, Concern, UNICEF, RFHP, i+Solutions, SC4CCM

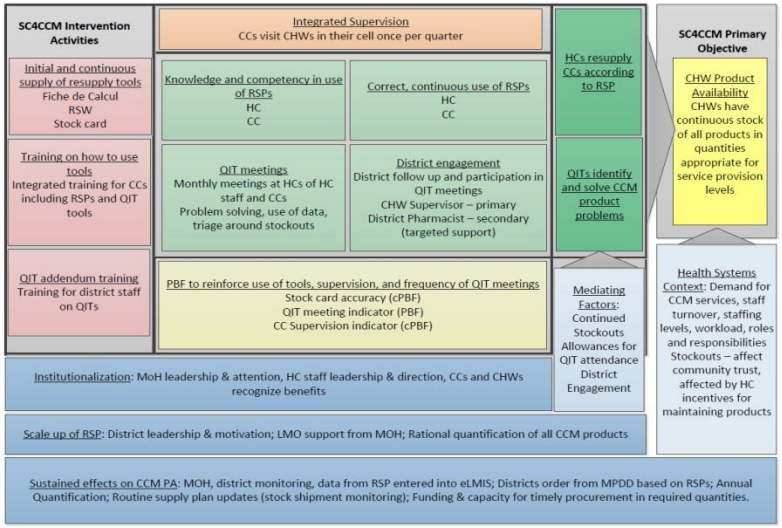


Endline Survey Methodology
(April-May 2014)

- The endline collected evidence on two concepts central to the project's objectives: **scalability** and **sustainability**
- Employed **mixed methods**
  - Quantitative: Logistics Indicators Assessment Tool (LIAT) in 3 original QC districts only (Ngoma, Rutsiro, Nyabihu)
  - Qualitative: Case Study Approach, 2 original districts (Ngoma, Nyabihu) and 2 new scale up districts (Nyaruguru, Rulindo)
- Collected stock data for 6 commodities:
  1. Amoxicillin 125mg tablets
  2. ORS sachets
  3. Zinc 10mg tablets
  4. Primo Yellow
  5. Primo Red
  6. RDTs

Key Findings

Results organized using a Program Theory



A program theory helps us understand what activities were critical and important to invest in to achieve benefits of RSPs and improved product availability

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RSPs - Training, Tools, and Knowledge

- **HC staff and CCs are trained and have RSP tools**
- **HC staff know how to use RSPs**

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RSPs: Critical Elements

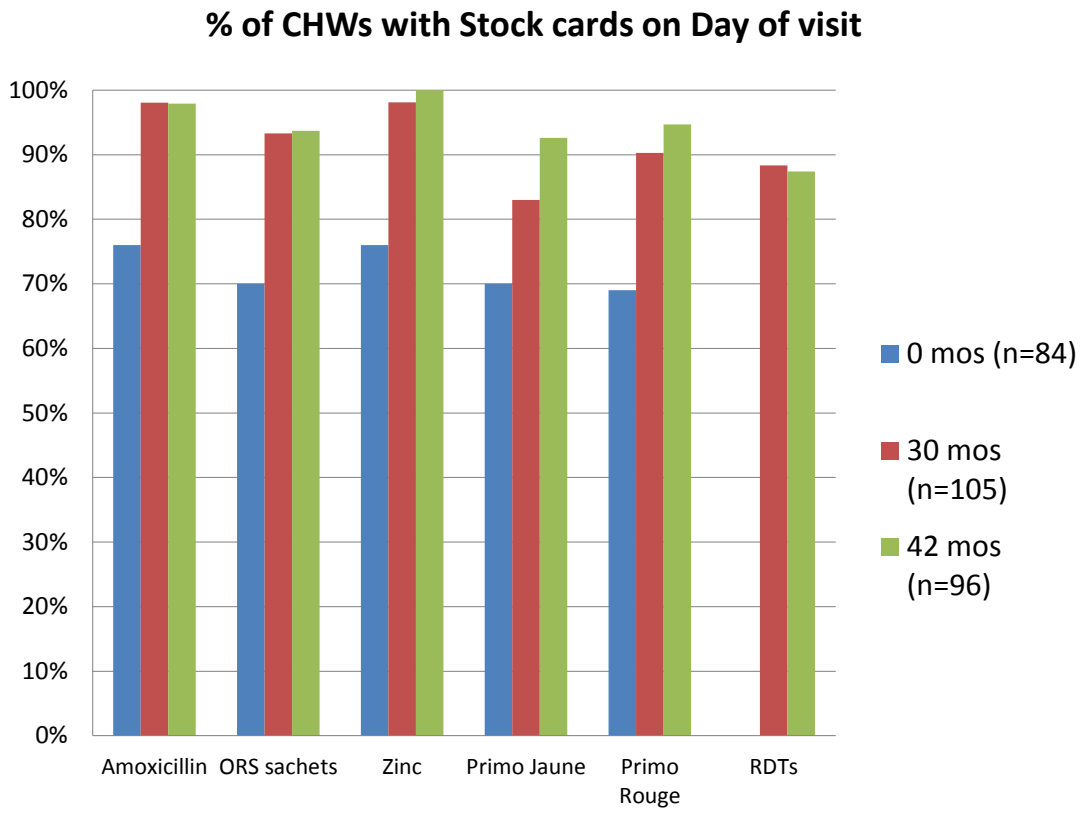
Cell Coordinators are the key players.
Three tools: stock card, resupply worksheet, "magic" resupply calculator

- **Cell level**: CHWs bring their **stock cards** and meet at Cell Coordinator's (CC) house or other convenient venue to report each month
  - CCs use each CHW stock card, **magic calculator** to determine how much resupply required, enter on **resupply worksheet**

- **HC level**: CHWs and CC attend HC monthly meeting
  - CCs give HC Pharmacy Managers resupply worksheet
  - HC use resupply worksheet to prepare orders for all CHWs, give to CCs
  - CC distributes quantities to CHWs,
    either at meeting or afterwards

Stock Card Availability

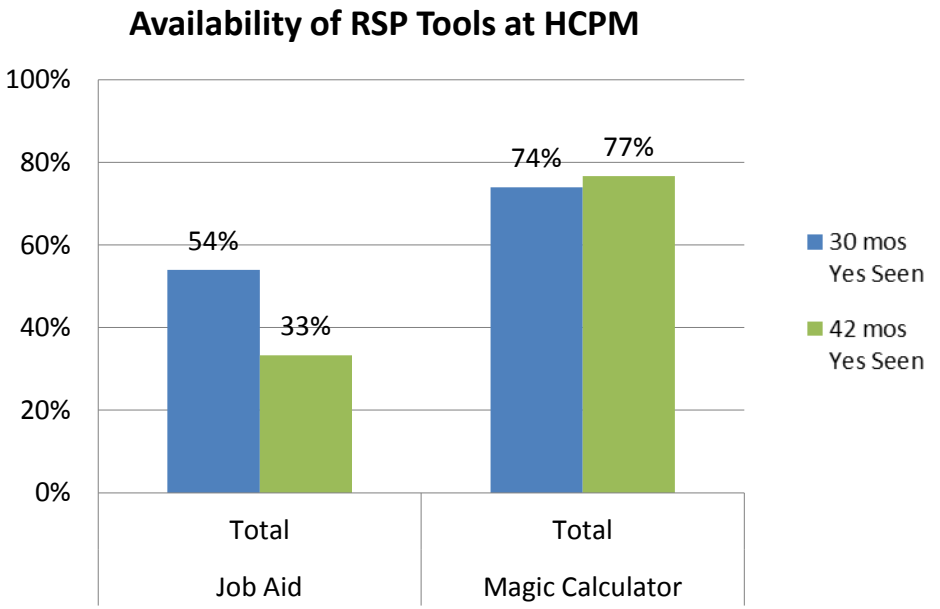
At endline, CHW stock card availability remained high compared to ML indicating high availability of the foundational tool for the resupply system

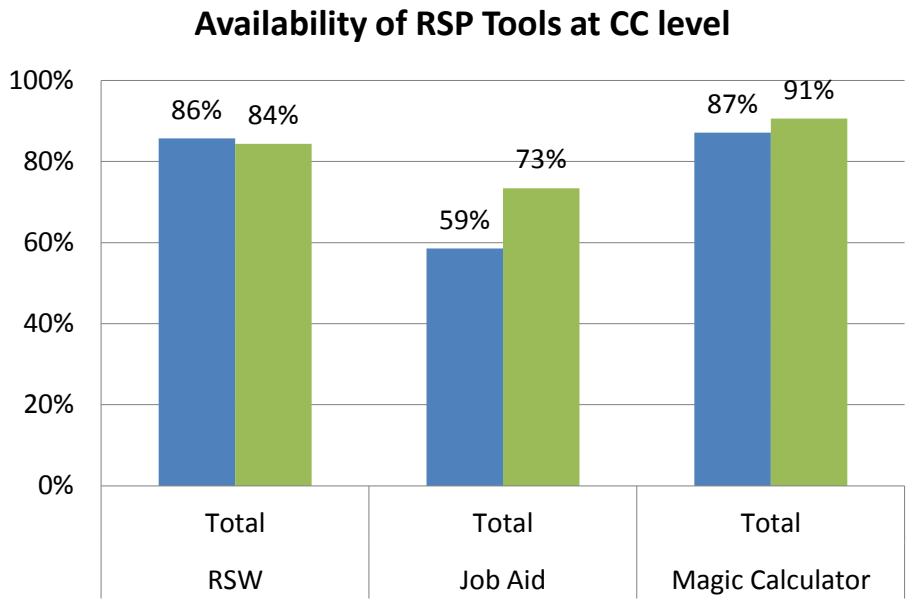


At EL, 77% of CHWs had stock cards for all 6 products on DOV (compared to 75% at ML)

RSP Tool Availability

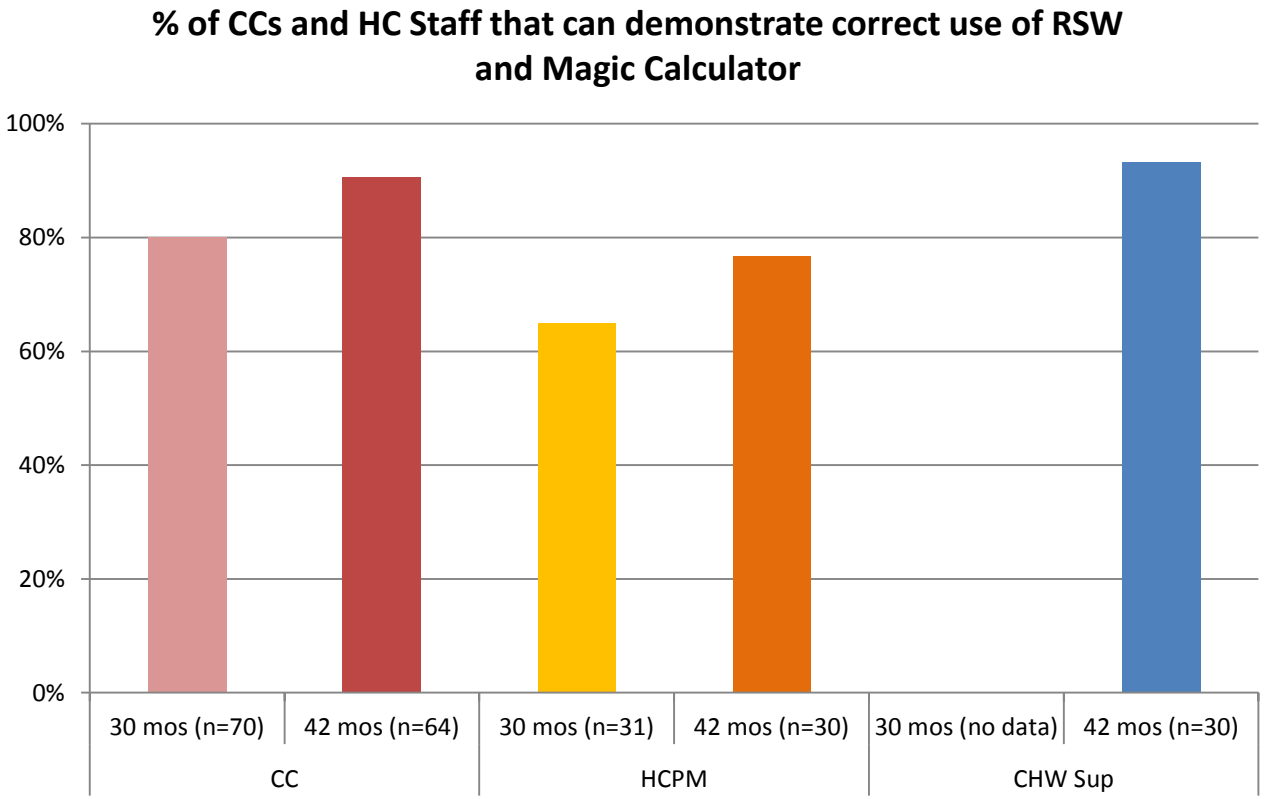
At endline, tool availability was similar to or higher than at ML with the exception of the job aid at the health centers





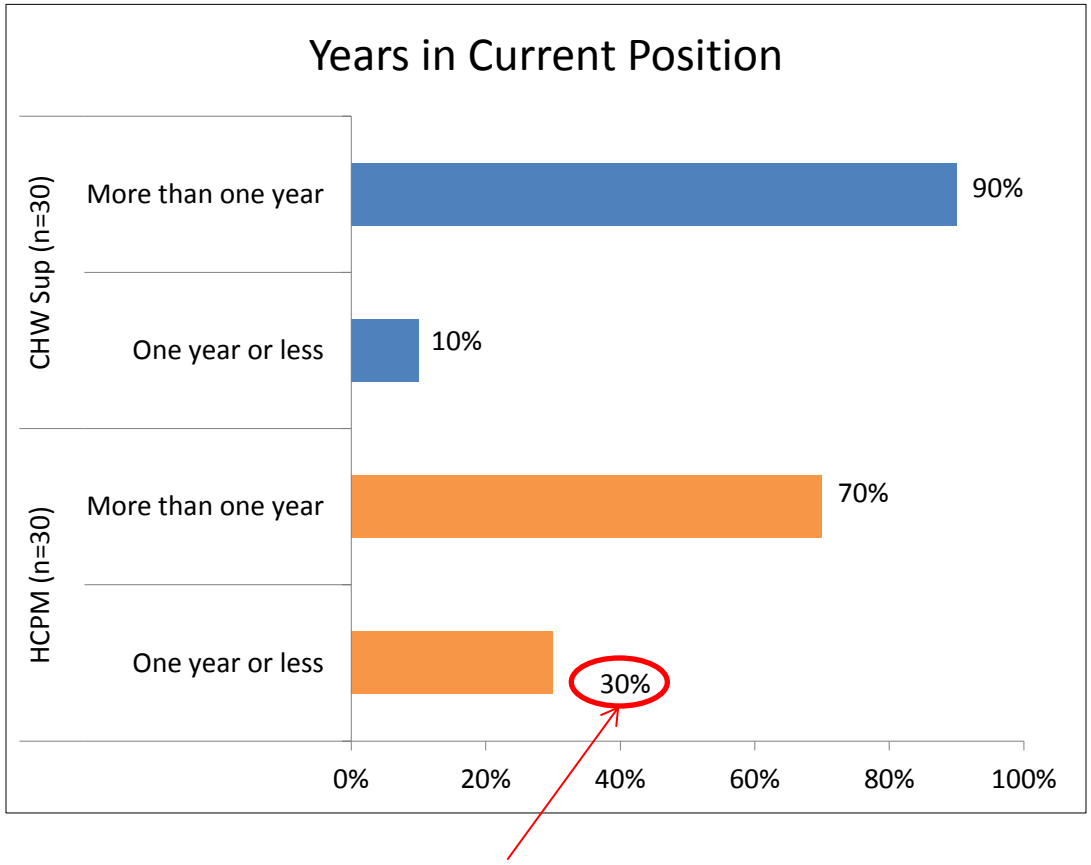
RSP Knowledge and Training

CCs and HC staff had sufficient and accurate knowledge on how to use the RSPs. This suggests that integrated training is just as effective for transferring knowledge as stand-alone RSP training



Staff Turn Over and Implications for RSP

Staff turnover or absences did not negatively impact use of RSPs, likely as a result of the simple design and ease of use of the procedures



"……if the pharmacist isn't here, and I am also not here, ***in my absence the other staff are able to distribute medicine "because the requisition is so clear"****. Before if I wasn't at the health center it was a problem because no one else knew how to requisition medicines…."*
- HC staff, original district

At EL fewer HC staff and CC had received training on RSPs compared to ML, likely due to high turnover in the past year, and incomplete integrated training coverage in all districts

Perceived Benefits of RSPs

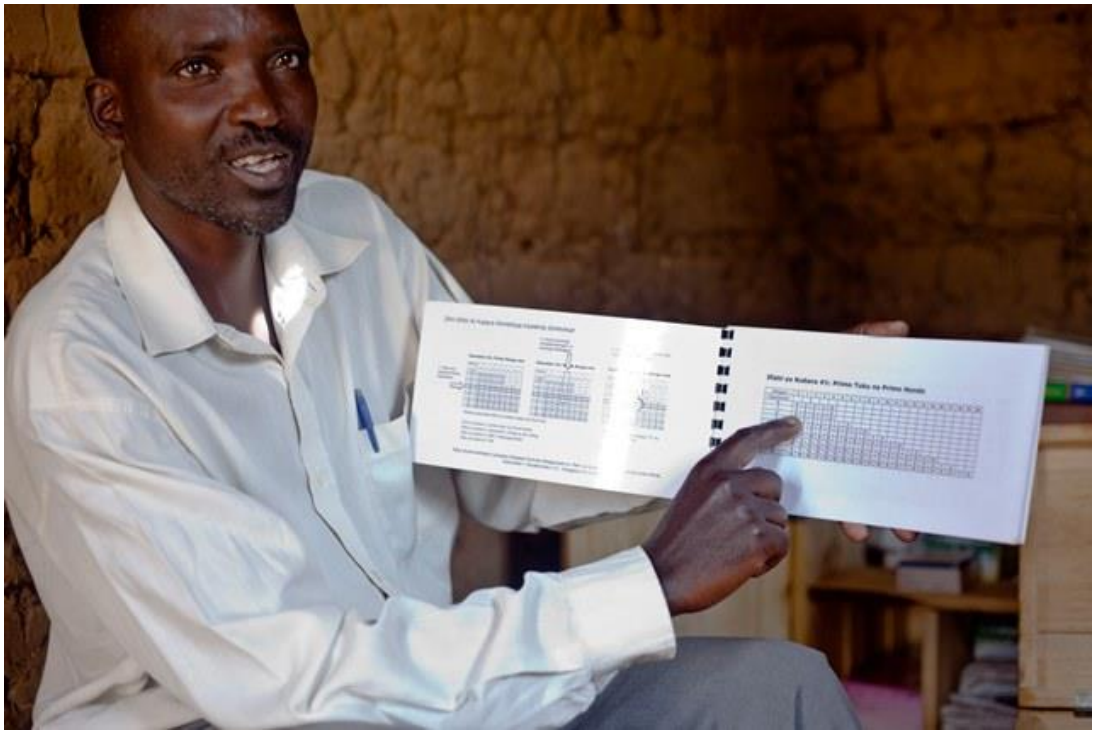
HC staff, CCs and CHWs all identified many benefits associated with RSPs

- Provides organization and structure, clarity on roles & responsibilities
- Improved transparency and accountability
- Efficiency - time saving and reduced work load
- Informed decision-making
- Better stock management/ redistribution
- Improved collaboration
- Improved access to health care

Summary

- RSPs as designed are simple, easy to use and **knowledge levels on usability** remain **high** among health workers
- RSP tool availability remained high
- Health workers at all levels recognize the benefits of RSPs; **RSPs have streamlined and increased efficiency in the resupply process**, improved stock management, collaboration, transparency and accountability
- **Training on RSPs through the integrated training is sufficient to transfer knowledge on requisition and resupply to HC staff and CCs**

Question & Answers?
Discussion



Health Center QIT team members: CHW Supervisors from HC level, Pharmacy Store Managers, Data Manager and Cell Coordinators (generally 7-10 CCs per HC)

Monthly QIT Cycle

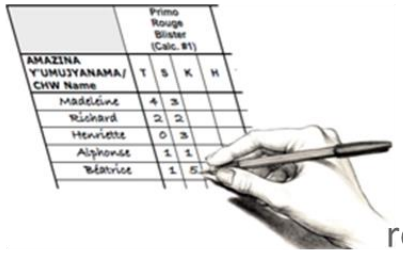
District Coaching

QIT Monthly Meeting at HC: CCs and HC staff

QIT develops action plan and reviews monthly progress

QIT implements action plan through supervision, monthly HC meeting with CHWs

CCs visit CHWs and collect data on common SC problems



Tools:

- Tally sheet
- Decision matrix
- Why-why analysis
- SMART objective
- Action plan

The purpose of QITs is to use data and a regular process to reinforce use of RSPs, using supervision checklists as the main data source

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QIT Process

How are QITs performing in original districts compared to new scale up districts?

- Are QITs meeting regularly?
- Do they have good attendance?
- Are they using data?
- Are they following the QIT process?

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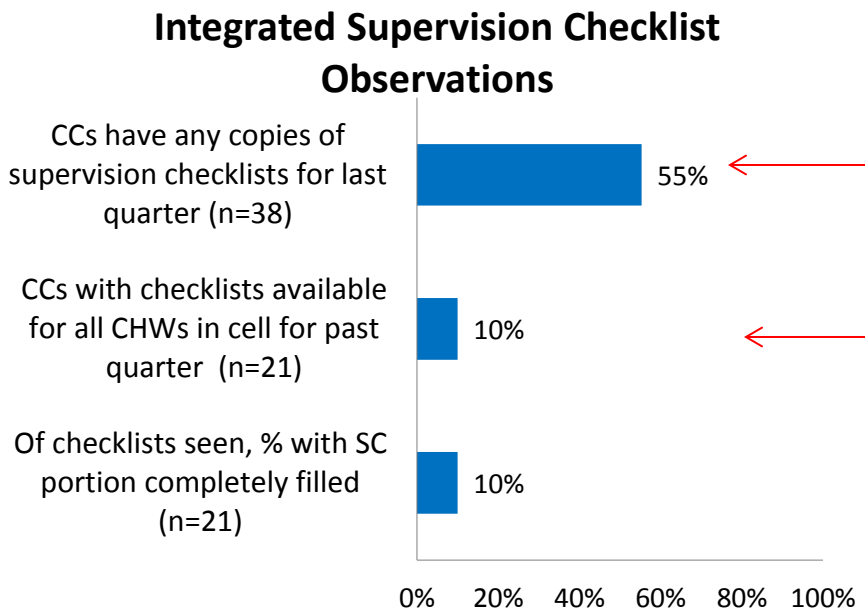
Integrated Supervision & Data for QITs

Of 3 original districts surveyed in LIAT, very few (10%) CCs could show that they had the right data that could be used for QIT process and meetings



Only 55% of CCs had any copies on DOV

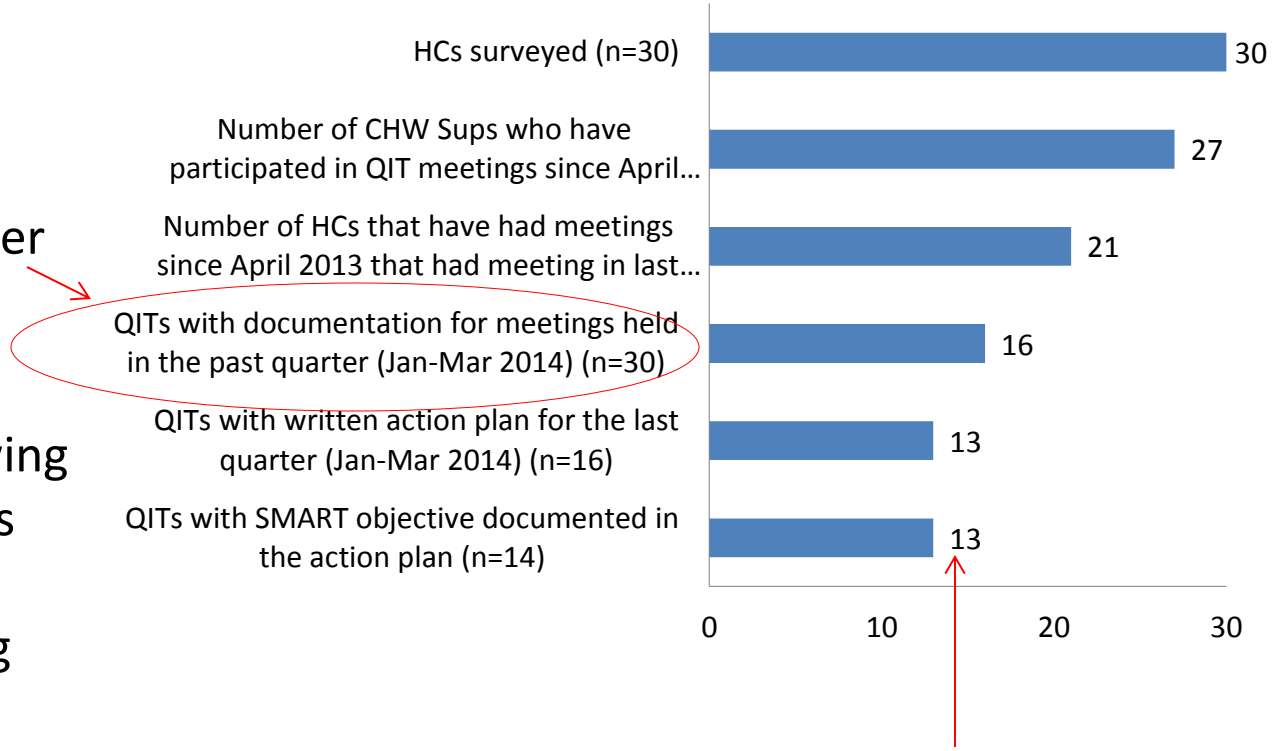
Only **10%** of CCs had copies for all CHWs in the past quarter

"We have been provided with integrated supervision checklist we use for our regular supervision, and we received 1 day training about its use. Some of us started using the checklist in January and others in March after the training." – Cell Coordinator, original district

QIT Meeting Frequency & Action Plans

Among HCs surveyed in 3 original districts, QIT meetings appear to have been infrequent, but when they happened, participation was high (excluding coaches) and most are setting objectives and developing an action plan

- **53%** of HCs had documentation of a QIT meeting in the past quarter
- **52%** of CHW Supervisors had documentation showing all expected QIT members (excluding coaches) attended the last meeting



- 13 of 16 HCs having a QIT meeting in the past quarter, had a **written action plan** and a **SMART objective**

Scale Up Districts: QIT Tools & Process

The case study showed that QITs have yet to be well-established in new scale up districts. While HCs in new scale up districts were interested in QITs, implementation of the correct process and content was inconsistent

- **Incomplete/outdated tools**
- **Problem prioritization and solving not evidence based.**
- **Action plan and feedback loop may be incomplete.** From observations, it was unclear if action plans were used to track performance and assess the changes made by the activities in the action plan (critical feedback for QIT effectiveness)

High appreciation and interest in QITs:

"QIT meeting is good, it helps us working together and we help each other and we discuss on how we can improve our work and what you don't understand you ask your colleague to orient you how to do it." – Cell Coordinator, new scale up district

Perceived Barriers to Supervision & QITs

CCs and HC staff identified similar barriers to regular supervision and QIT meetings, namely heavy workload and the additional burden of time and travel required.

"There are a lot of changes because they don't do much supervision, and that's because they don't get money. They also have other responsibilities—they have to treat their own patients. And now, they have the supervision checklist as well. So it can be a real handicap to the QIT meetings. A CC will have 68 CHWs and will only visit 20 of them. We can't extrapolate the results from the 20 CHWs and generalize to all 68" – CHW Supervisor, original district

The role of local leadership: a HC continuing to hold QITs

In this original HC, because the QIT process was well established previously and benefits realized and appreciated by the team, motivation was high for continuing QIT meetings even without allowances. Leadership at the HC level enabled this to happen.

"How were you able to continue without allowances while others haven't?"

"The main reason is us. We saw that the QIT meetings helped us a lot. When the CCs do supervision, we can catch all the problems. We also do supervision and see many problems. So we said, 'why do we have these problems?' We said, 'let's have QIT meetings so we can solve these problems together'. So ***we included the QIT meetings into the description of our tasks,*** *and we encourage the CCs, tell them how we can help them and how they can help us. Encouragement is necessary, and we have to do follow-up because they are volunteers and they don't get any compensation. But in the end, it's not impossible to have CCs work hard without getting payment. It's a saying that we have here, sono anori. It means someone who can work hard for the good of everyone, for the good of the country without expecting anything…it's based on patriotism."* – CHW Supervisor, original district

QIT Benefits

Respondents at all levels in both original and scale-up districts identified many benefits that they associated with QITs. They especially appreciated improved collaboration and communication with higher levels of the health system and mentioned feeling more valued, more connected to HC

- Analysis and focus on CHW problems, helps CCs identify where problems are in their cells
- Utilizes supervision data
- Allows for discussion of problem with staff at other levels
- Increases collaboration among staff at different levels
- Allows for solutions by team members based on their roles
- Provides regular time for problems to be brought by CCs
- Establishes a timeline/accountability for problem solving

QIT Summary

- Very limited evidence of districts reaching HCs to “kick off” QITs, explain the meeting process and reinforce use of data and tools
- QIT meetings infrequent in all districts
  - In original districts, long history with process so when meetings happen participation is high and process well understood and followed
  - In scale districts, high awareness and interest but not enough experience so inconsistent implementation (content, lack of uniformity of tools)
- Less data available from supervision, and used in meetings
- QIT meetings are widely perceived to be beneficial in **problem solving,** finding **local solutions** and **improving trust and collaboration**
- In one original district, integrated training and letter from MOH were effective at **restarting** QITs

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District Engagement and QITs

- Three district coaches were trained (CHW Supervisor, District Pharmacist, and Data Manager)
- Coaches were critical to **"kicking off" the QITs** with the material they learned during the QIT addendum
- One district coach would **initiate QIT meetings at each HC** to introduce the concept and go over how to hold a QIT meeting
- Coaches would provide **follow up support** to ensure meetings were **scheduled** and **attend one meeting per quarter**

REPUBULIKA Y'U RWANDA

UBUNWE - UMURIMO - GUKUNDA IGIHUGU

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Initiating QIT Meetings

Starting up QIT meetings takes focused initiative on the part of both HC staff and district staff.

Even the district coaches who understood their vital role in QITs delayed in holding "kick off" meetings because of competing priorities and limited time

"…if the HC Supervisor has that good will and organize that meeting we can attend in it because we know how it's important to have it for example even if there are some problems I can be able to solve myself, they are some others which I can't solve alone and these needs to be discussed in the QIT meeting and with deep analysis and find solutions." – Cell Coordinator, original district

"Have you received QIT training?"
"Yes, we received training about QIT in January 2014, and we continued with CCs in January to March. After 3 months, I asked HC to start QIT meetings, some started and others delayed but I call them. We have 16 HC, ¾ did QIT meeting. I estimate 12 HC did, and only 4 didn't yet. I'm not sure if they did."
- District CHW Supervisor, scale up district

District Staff Support of QITs

Lack of participation of District Pharmacist in QITs limits the ability to address some product availability issues that are outside the purview of the District CHW Supervisor and District Data Manger

- Only **6/16** (**38%**) HCs with documentation from a QIT meeting showed evidence of participation from district staff in the last quarter
- In scale up districts **District CHW Supervisors** were more involved with and aware of QITs; District Data Managers were less involved; there was **no indication that District Pharmacists** had attended any QIT meeting
- District staff stated that they faced **scheduling conflicts and time constraints** to attending QITs as well as doing regular supervision to the HCs

"We tried to re-launch in February but were very busy with other activities. We've been talking about how to get the meetings started again. We have a plan to restart at the beginning of June. We have a meeting next week to discuss this issue." – District Pharmacy Manager, original district

Summary of District Involvement in QITs

- District engagement with **initiating or re-starting QITs** was also **minimal**; motivation to **follow up seems insufficient**
- Where district engagement was seen it was usually the District CHW Supervisor; **lack of District Pharmacist engagements** limits ability to influence product availability
- Time, scheduling conflict and competing priorities identified as **barriers** to district level physical presence at the meetings
- **Evidence from 2 new districts show that training is sufficient to impart knowledge about QITs, but making QITs work effectively is not possible without follow up support from the district**

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Are QITs Reinforcing Correct and Consistent Use of RSPs?

QITs were established to reinforce RSP practices through the identification of performance goals and problem solving.

- CHWs complete stock cards accurately?
- CCs complete and submit RSW to HC?
- HCPMs complete stock cards and resupply CCs based on order quantities on the RSW (based on last month's consumption and SOH)

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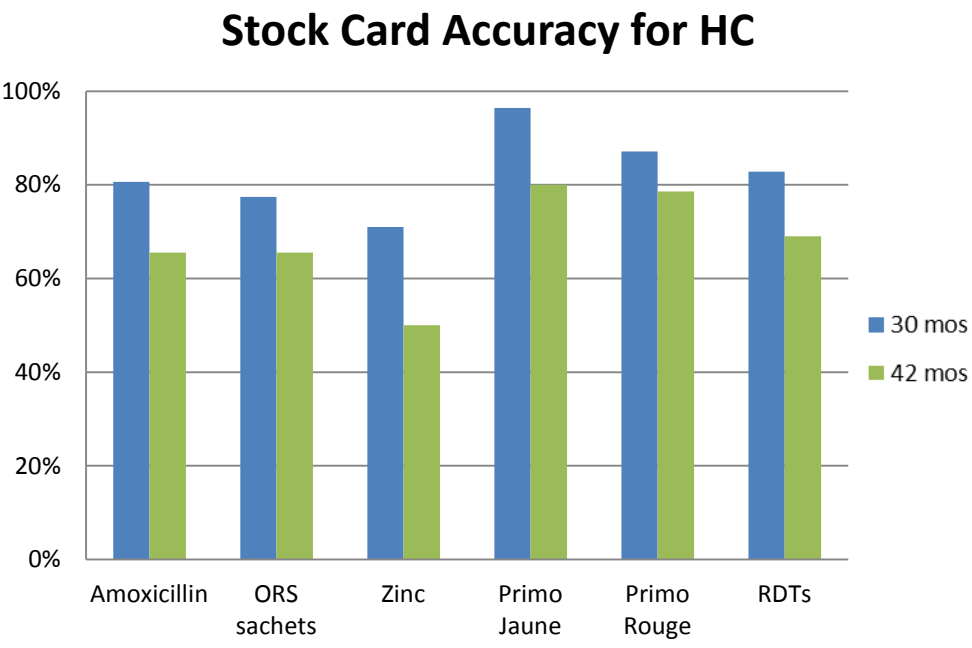
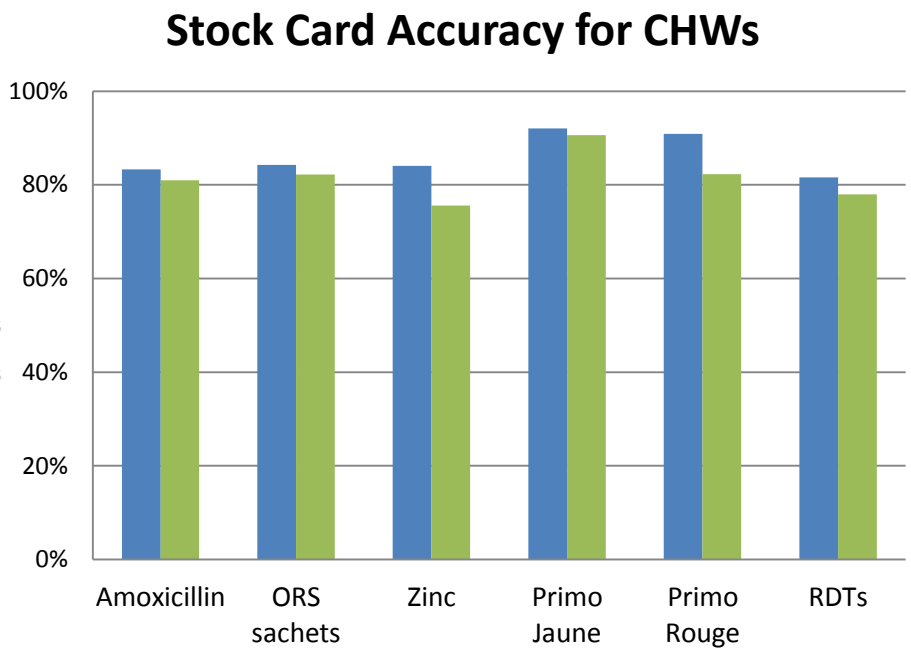
HC and CHW Stock Card Accuracy

In our 3 original districts, HC and CHW stock card accuracy declined slightly at EL for all products, however CHW stock card accuracy levels better than HC

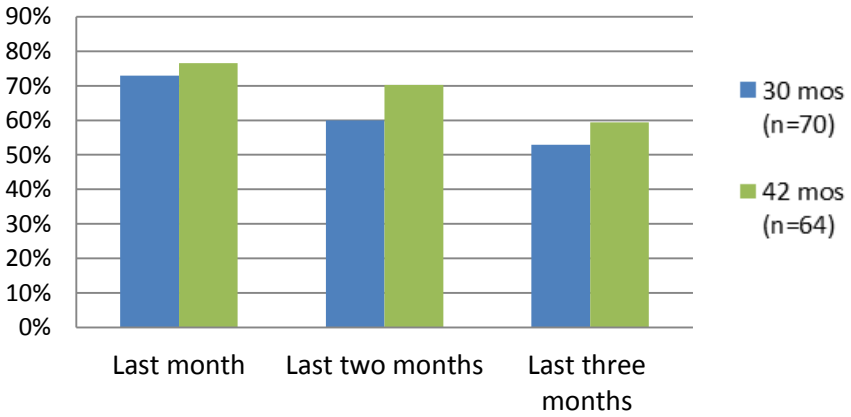




Availability and Submission of Resupply Worksheets (Reporting Rate)

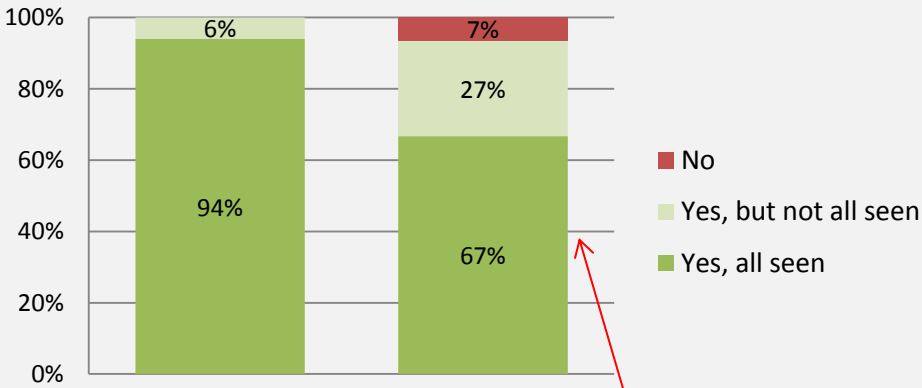
- Reporting and documentation of RSWs at CC level has improved
- But, records of RSWs at HC level have declined, suggesting a gap in information flow to districts, undermining resupply decisions

% of CCs with RSWs available for past 1, 2, and 3 months



75% of the RSWs observed for the last three months were complete (had an entry for every binome in the cell)

HCPM with RSWs submitted by CCs at last HC monthly meeting

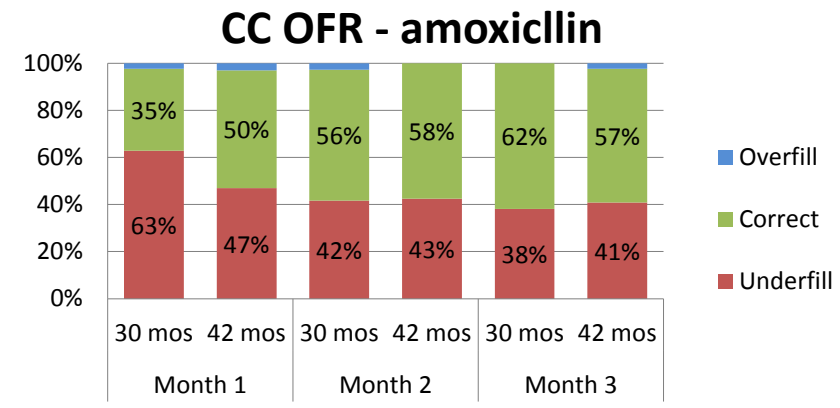


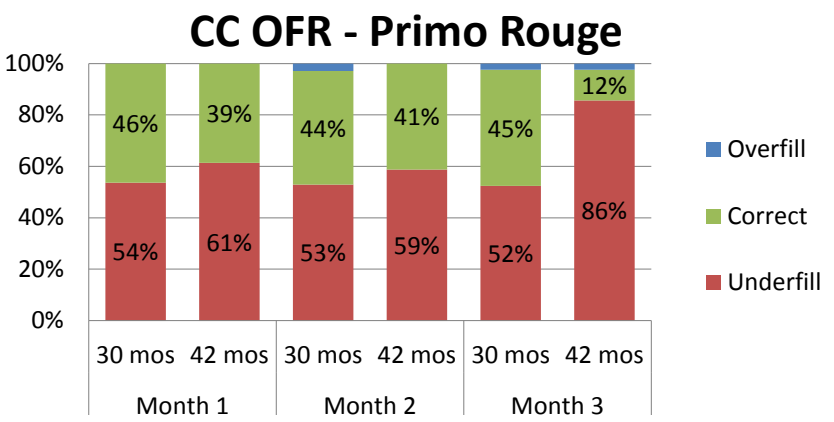
30 mos (n=31)

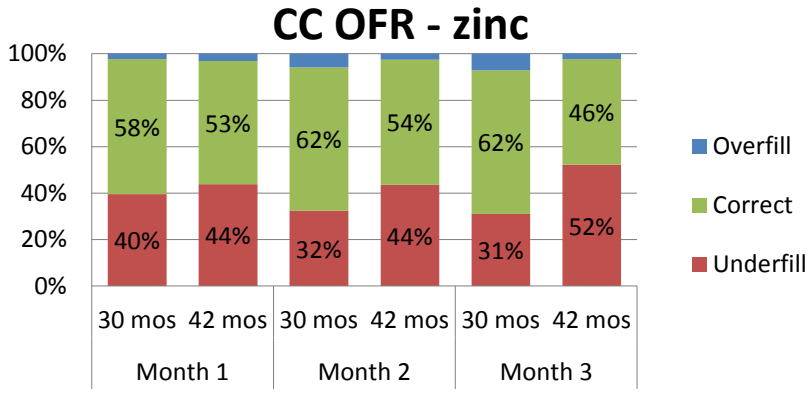
42 mos (n=30)

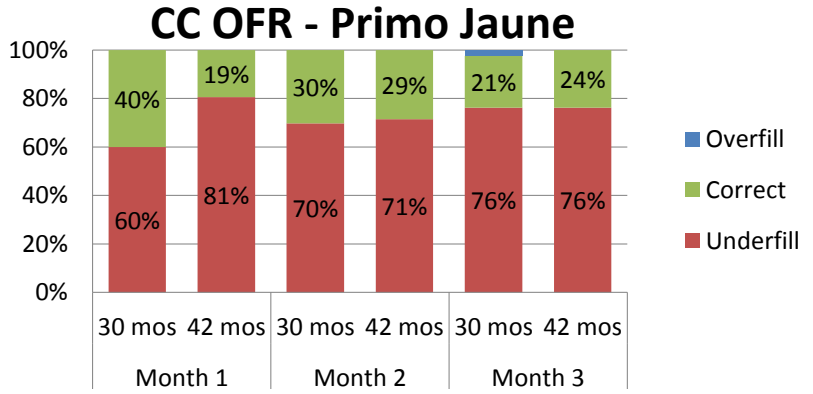
RSW availability at HC has declined

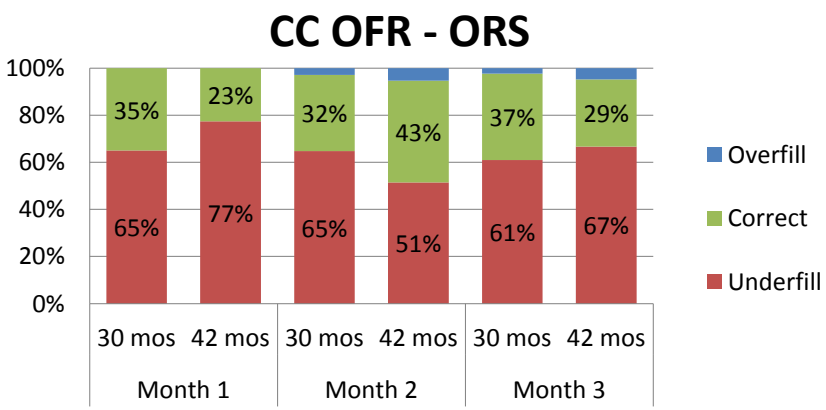
CC Order Fill Rate improved or unchanged from ML

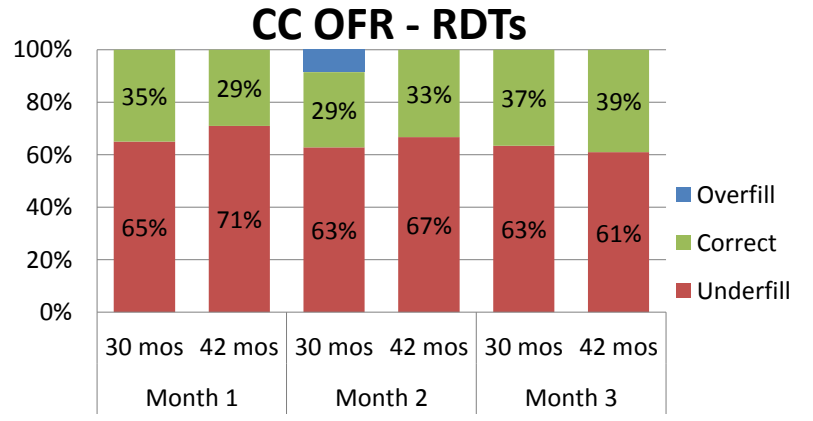






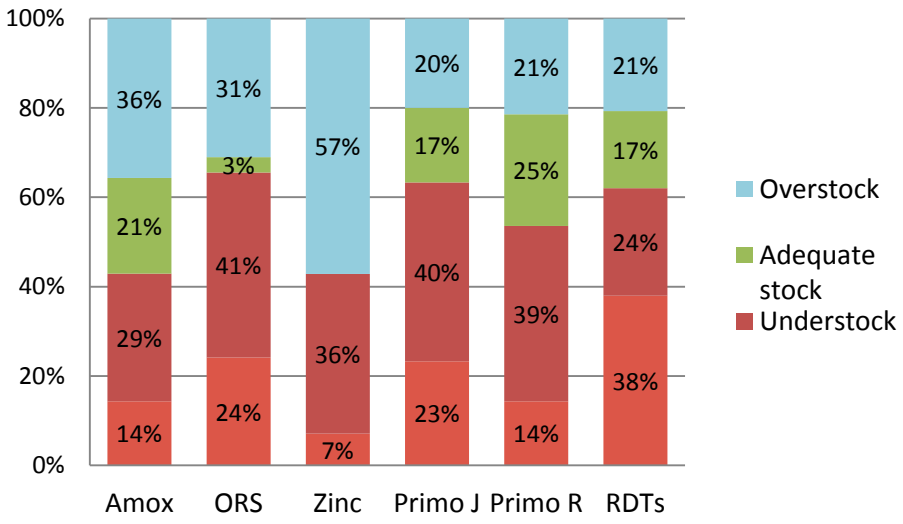


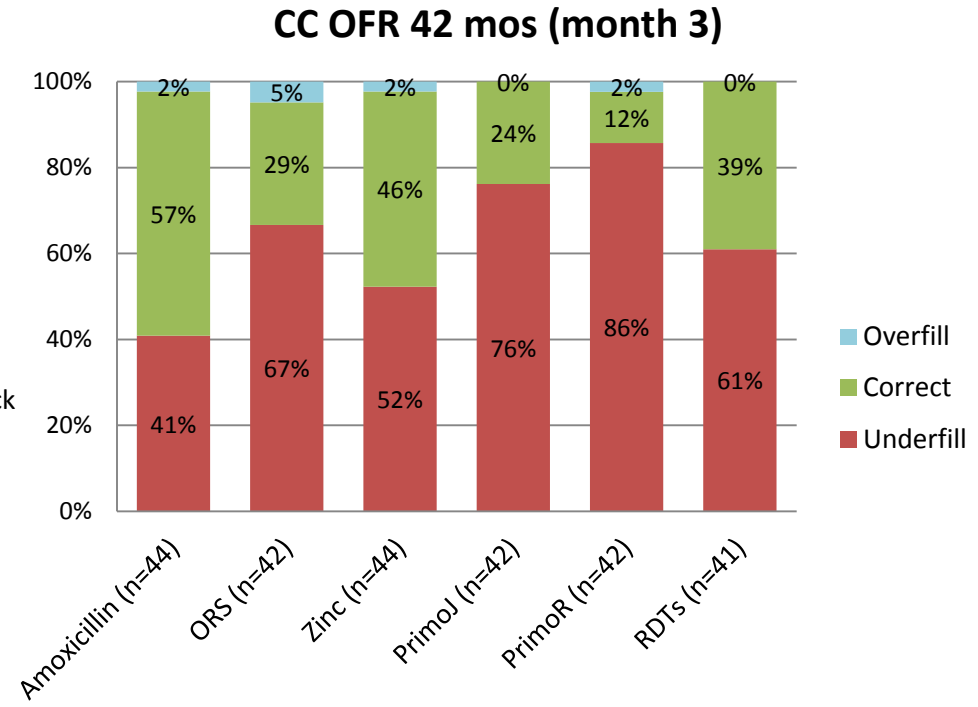




Comparing HC Stock Status to CC OFR

OFR for ALL products at CC, mirrors trends of stockouts and low stocks observed at the HCs. 43% - 65% of HCs were understocked or stocked out for every product





Over 40% of CCs were under-filled

*"If I don't have enough medicines, **I distribute what I have to the CCs who live far from the HC, and I tell the CCs and CHW who live closer to refer their patients to the HC.**"* - HC Pharmacist, scale up district

Reasons Given for Undersupplying CCs

- Low or no stocks at the HC in both old and new districts
- Misunderstanding of the purpose of RSP tools, despite correct knowledge of how to complete the RSW
- CCs did not see the positive effects of using the RSW when they are under or not supplied by the HC
- Concern around expiration dates (don't want to distribute products that will expire soon)
- Perception that **HC incentive (indicator)** encourages HCs to hold onto stock even if they can't use the iCCM product at that level

Risk of undermining RSPs

" I can tell you that because of this stock out of products at the HC, we have been discouraged to complete the RSWs." Cell Coordinator, scale up district

Summary: RSPs Affected by QIT Limitations

- Despite good understanding of resupply practices there is **a lack of consistency in correct use of RSPs**
- **Case study findings confirm that reinforcement and support from QITs are needed** to ensure consistent and correct use of the RSPs (training alone is insufficient)
- Slow uptake of QIT meetings has hampered reinforcement
- Almost 30% decline in HCs with RSWs available at 42 months points to a **gap in community level logistics information flow from HC to district levels**, potentially undermining district resupply decisions
- **Low levels of district engagement in QITs provides little opportunity for districts to identify this and other potential bottlenecks that impede product availability**

Question & Answers?
Discussion

SC4CCM

Supply Chains 4 Community Case Management

Product Availability Findings

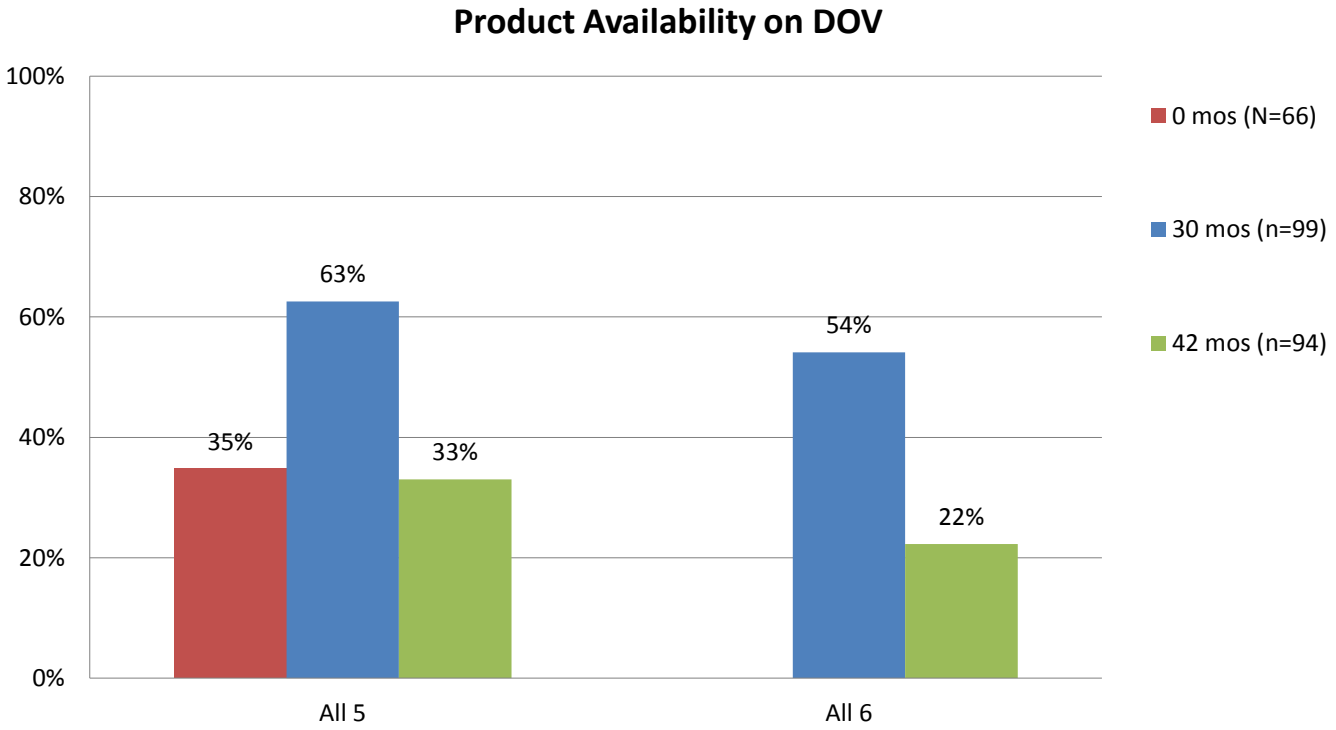
- **CHW product availability across 5 CCM products, by district**
- **CHW product availability for individual products**
- **CHW Stock Status**
- **CHW Stockouts**
- **HC Product Availability**

JSI

JSI Research & Training Institute, Inc.

CHW Product Availability

In 3 intervention districts, significant reduction in % of CHWs with All5 and All6 Product Availability since ML

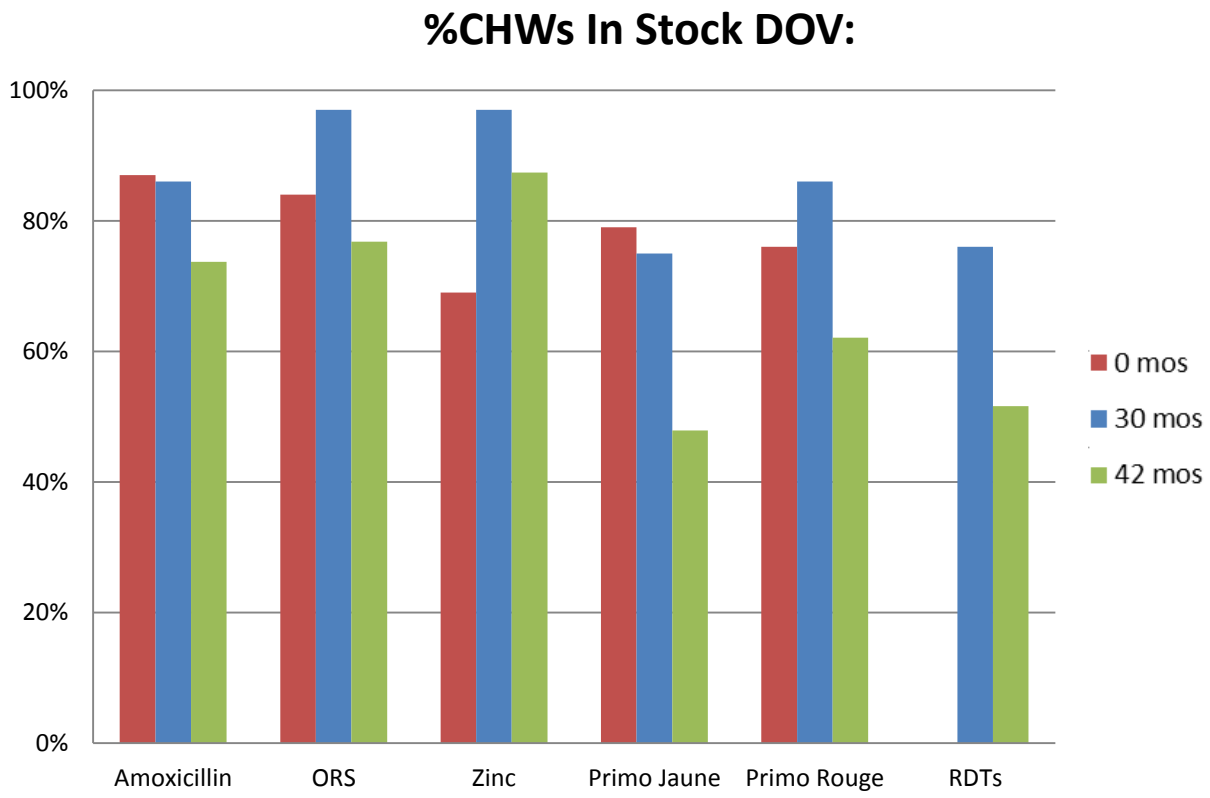


*** All 6: Amoxicillin, ORS, Zinc, Primo Rouge, Primo Jaune, RDTs*

**** No RDTs included in All 5*

CHW Product Availability

Individual product availability with CHWs declined for all products at EL

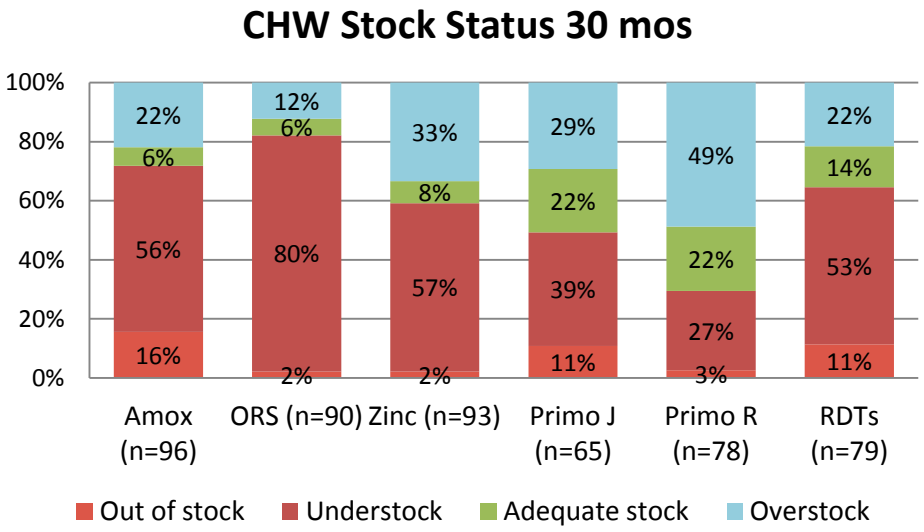


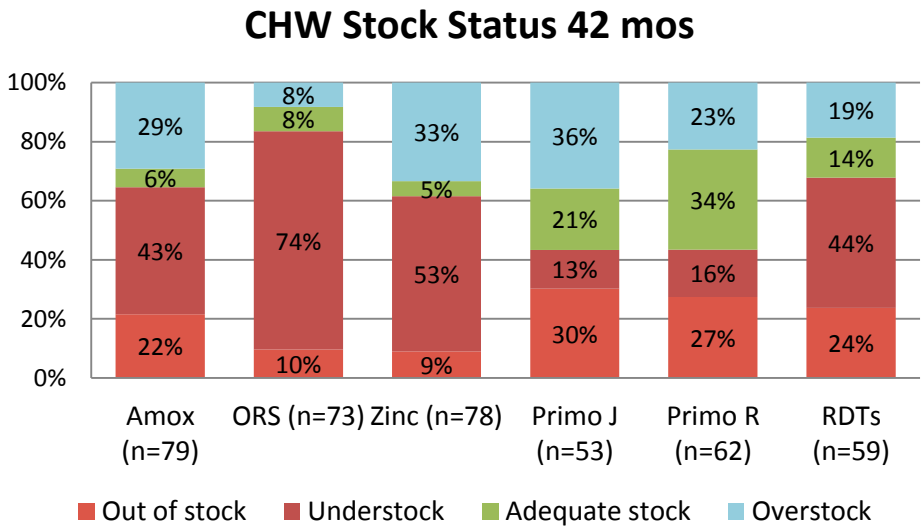
*0 months (n=71 to 84), 30 months (n=102 to 105), 42 months (n=94 to 95), variation based on CHWs who manage products

**RDTs not included for BL because of low number of CHWs who managed

CHW Stock Status

Increase in stockouts at EL for all products at CHW level; similar levels of adequate and overstocks at ML and EL



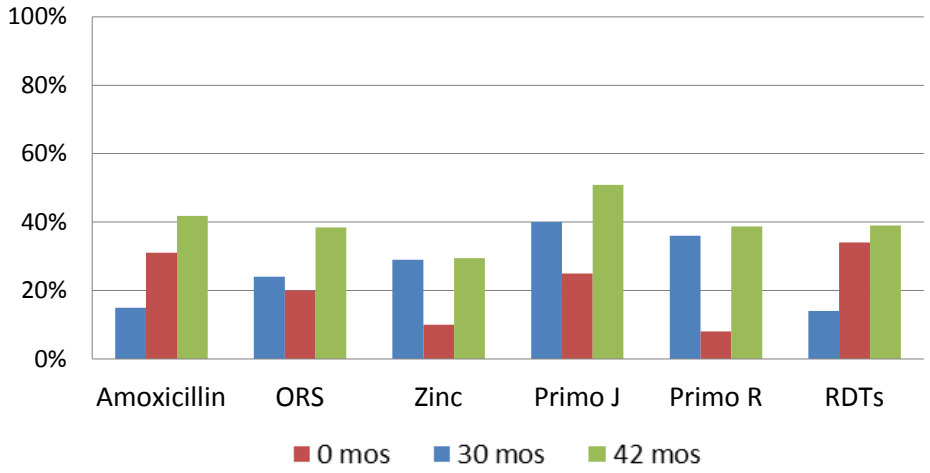


Significant increase in stockouts for zinc, ORS, Primo J, and Primo R from ML to EL ($p < 0.05$)

CHW Stockouts

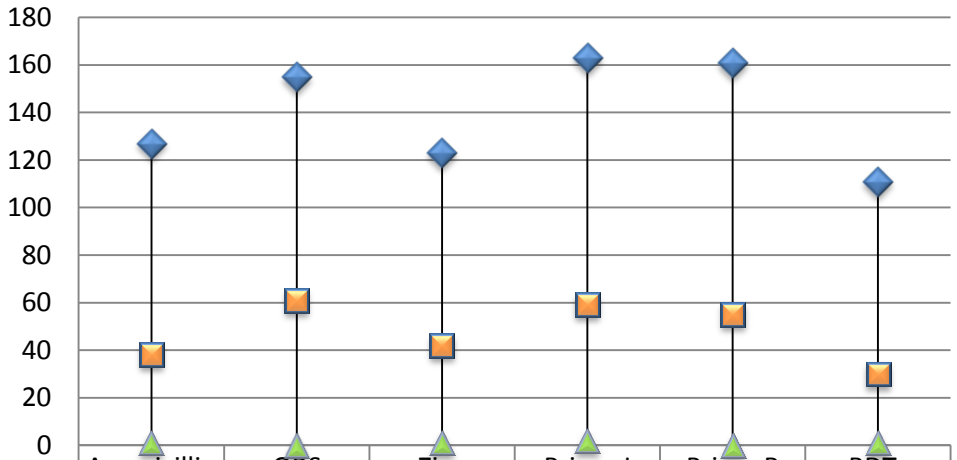
Stock out rates were below 50% but prolonged. On average, CHWs were stocked out for 1-2 months of the 6 month period for all products

% CHWs with stockouts in last 6 months



Six month stockout rates increased for all products at EL compared to ML. Over the same period, **stockouts lasted on average 30-61 days**

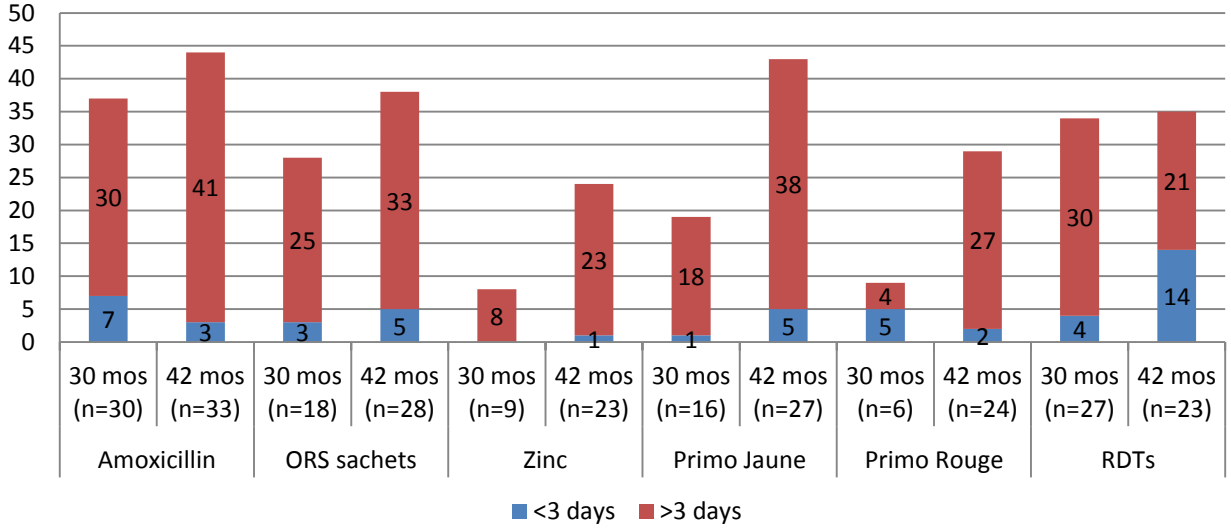
Mean # of days and range of stock out at CHWs in last 6 months



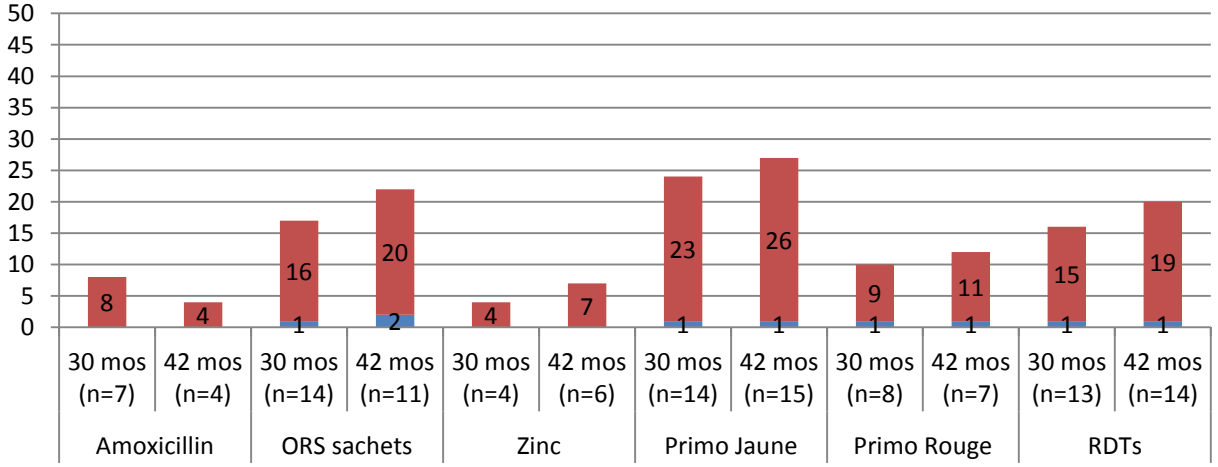
	Amoxicillin (obs=33)	ORS (obs=28)	Zinc (obs=23)	Primo J (obs=27)	Primo R (obs=24)	RDTs (obs=23)
Mean	38	61	42	59	55	30
High	127	155	123	163	161	111
Low	1	0	1	2	0	1

Number and Duration of Stockouts

Number of CHW stockouts over past six months lasting > and < than 3 days, 5 CCM products



Number of HC stockouts over past six months lasting > and < than 3 days, 5 CCM products

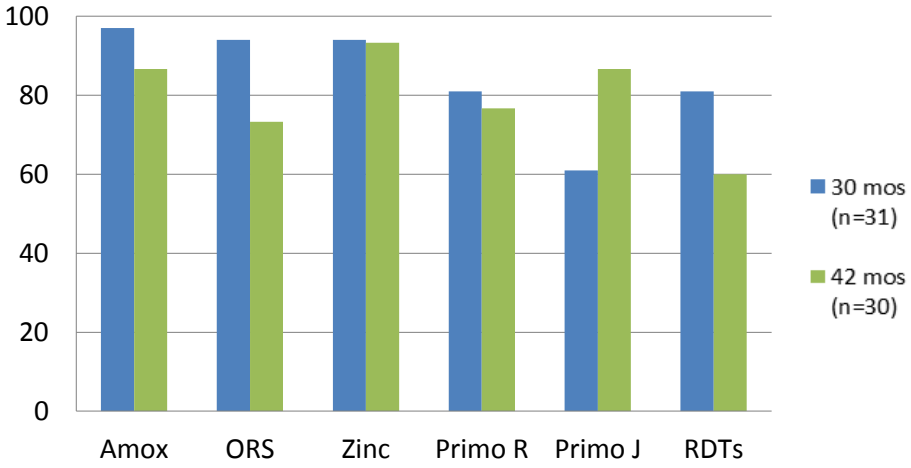


Majority of stock outs at HC and CHW level are longer than 3 days implying that HCs are unable to resolve CHW stock outs because they have low stocks themselves

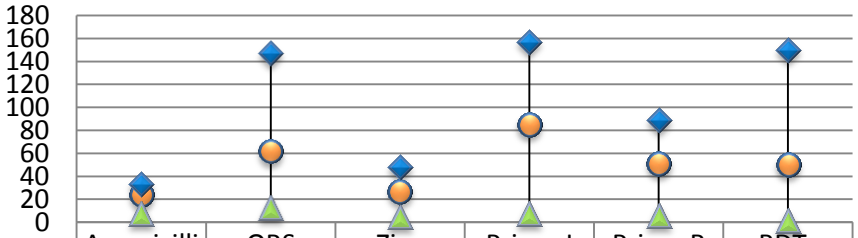
HC Product Availability

- Decline in HC product availability for all products except Primo J at EL
- Stock out rates were below 50% but prolonged. On average, HCs stocked out for 1-3 months of the 6 month period for all products

% HCs in stock on DOV



Mean # of days stocked out at HCs in last 6 months and range



	Amoxicillin (obs=4)	ORS (obs=11)	Zinc (obs=6)	Primo J (obs=15)	Primo R (obs=7)	RDTs (obs=14)
Mean	24	62	27	85	51	50
High	33	147	48	157	89	150
Low	8	13	5	8	6	2

Stockouts over six months at HCs lasted on **average 24-85 days**, longest for Primo J

Are RSPs Affected by Product Availability?

HC staff and CCs recognized the benefit of streamlined process of RSP for product availability, but noted that this benefit is less important if products are stocked out at and cannot be provided by CHWs.

"I can tell you that because of this stock out of products at the HC, we have been discouraged to complete the RSWs." – Cell Coordinator, scale up district

PA challenges at the CHW level seem less affected by incorrect RSP practices; they are more likely to be affected by SC practices at higher levels or national-level PA challenges.

"Do you see differences in product availability when you compare the situation before and after the introduction of the RSP?" "*The difference is that if there is any problem with the supply of medication in the community, it is now known. When the CCs do supervision, they notice problems. Can this new system affect product availability itself? It depends on the availability of the products at the district pharmacy—sometimes, we run out of products. It is a general problem that is well known. When this happens, we can't do anything but cross our arms and wait until the central level (CAMERWA) gives us products. "But the true difference now is that the problems are known—and this knowledge, in turn, makes finding their solutions easier."* - District CHW Supervisor, scale up district

Differing Perceptions of Source of Problem

Disconnects were observed between levels of the system and perceptions of product availability; highlights the need for better data visibility across levels

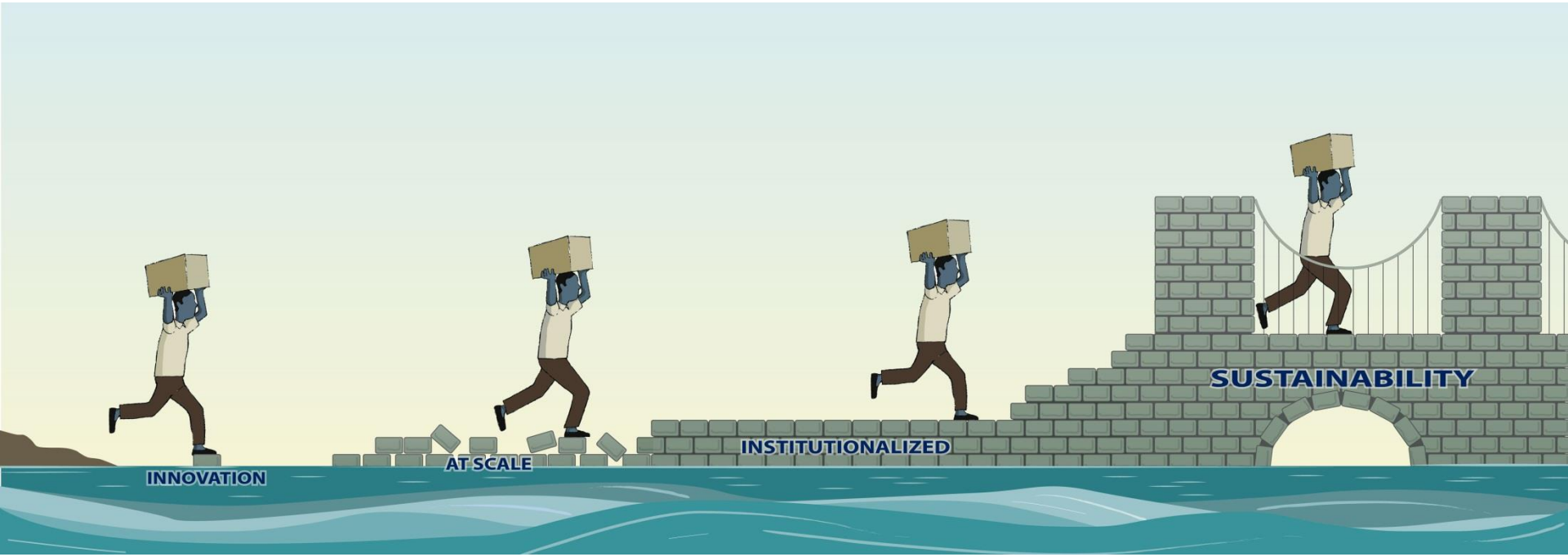
District	HC
"Actually, throughout the last few years, there's been an evolution in product availability. It's been very positive because now, there are no stockouts at the district pharmacy and in the HCs. What I can't confirm is the situation at the community level. If there are problems with product availability at the community level, it's a problem with the liaison between CHWs and the HCs." – District Pharmacist, original district	*"There are problems with medicines, often RDTs, we often have many problems with RDTs as this is a malaria zone… Well now we have problems with RDTs. It's not a stock out, but CHWs only have a few in stock."* – HC CHW Supervisor, original district
"Yes, there are no stock outs. And even as the procedure is managed the number of expiries has decreased. For quantities that are not very much needed, they order few. Now there are no stock outs, and no expiries." – District Pharmacist, scale up district	*"We don't have Amoxicillin at the HC. I asked the district pharmacist last week and he told us that he didn't have any. There are no Primos at the district either. We follow up with the district pharmacist…he told us to come back at the end of the month*."- HC Pharmacy Manager, scale up district

Summary on PA

- CHW stockouts are prolonged, primarily reflective of product availability related challenges at HCs rather than issues between CHW-HC
- Disconnects between perceptions of PA were noted between HC and district and higher levels, with districts seemingly unaware of PA challenges at HC levels
- Challenges with PA affect the use of RSPs; when stock levels were consistently insufficient to fill orders, there was a tendency to stop using RSPs
- **Decline in PA noted at endline for all 6 products at CHW level, likely due to QITs not performing effectively and PA challenges at higher levels**

Question & Answers?
Discussion

Scale, Institutionalization



Achievements in Scaling RSPs, QITs

- ✓ CHD successfully advocating with partners to support scale up
- ✓ TOTs completed, a total of 20 master trainers on integrated training; 10 on QIT addendum
- ✓ Integrated training completed in 14 out of 30 districts
- ✓ QIT addendum training completed in 12 out of 14 districts that have received integrated training
- ✓ UNFPA funding available for a further 2-3 districts on integrated training
- ✓ Indicators in progress to be added to PBF system
  - Stock card accuracy – SIS Com
  - CC supervision visits to CHWs – SIS Com
  - QIT meeting indicator - HMIS

Gaps in Scaling RSPs, QITs

- Funding required to complete Integrated training in 15-16 districts and QIT addendum training in 18
- Resources and a plan required for printing tools annually
- Follow up with all new districts to prevent delayed initiation of QITs (rolling out QIT addendum to HCs) and to increase QIT engagement and follow up in ensuring QIT meetings happen and use correct processes

Institutionalization of RSP into Existing Structures

- ✓ RSPs included as a standard component in National iCCM Integrated training package
  - Supervision checklist includes community SC component and all RSP tools provided as part of integrated training
- ✓ In districts that have received the training, RSP has become institutionalized as the accepted, standard approach through which CHWs are resupplied by HCs
  - Process is integrated into regular cell meetings, monthly meetings and tools available and used by CHW, CC and HC levels
- ✓ During eLMIS rollout, training is being provided on how HCs should add data from RSWs to eLMIS

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Institutionalization: QITs as a Standard Practice

- QIT meetings, process and district engagement are not yet a standard practice
  - Awareness and appreciation of QITs is high in districts and HCs that have received the integrated training, but case study data shows that QIT kick off meetings have not happened at most HCs
  - District engagement – especially support by District Pharmacist – is hampered by workload and competing priorities but their involvement is critical to addressing issues of effective information flow at HC and solving problems related to higher level product availability

Anticipated Risks

- Product Availability
  - Disconnects in information about stock levels at different levels have the potential to undermine RSP use and QITs
- LMO
  - Coordination across supply chain and programmatic units
- Maintaining momentum for scaling up districts and tools
  - Ensuring funding for scale up to additional 14 -16 districts
  - Ensuring MOH Budget allocation for QIT and RSP tools
- Limited follow up, prioritization and coordination for QITs by district and central level

Opportunities

- ✓ eLMIS
  - Enables increased data visibility at higher levels to better monitor supplies at community level and identify sources of bottlenecks
  - Provides SC data that can be used by District Pharmacy to support QITs
- ✓ PBF indicators
  - CC supervision to promote supervision of CHWs
  - Stock card accuracy to encourage accurate data for RSPs
  - QIT meeting indicator to encourage frequency of meetings
- ✓ Community Supply Chain Strategic Plan – drafted to outline roles needed to institutionalize community supply chain practices
- ✓ National Supply Chain Strategic Plan – includes community level practices

RSPs and QITs: Progressing Towards Scale & Institutionalization

- Continue to use the current integrated approach to train on RSPs as it produces the same levels of competency
- Consider incorporating QIT addendum into integrated training curriculum
- Budget for supplying and re-supplying the most up-to-date RSP and QIT tools as an explicit part of scale-up
- Finalize process for inclusion of new PBF indicators to motivate staff at all levels, promote supervision, and regularity and consistency of QIT meetings
- Develop performance monitoring plan to follow up on CC supervision visits, implementation of RSPs, and QIT meetings after integrated training delivery
- Encourage regular participation of district coaches in the QIT meetings so that QIT meetings can happen regularly for at least 9-12 months
- Formalize roles for central and district support of RSP/QIT implementation under the new MOH/RBC structure.

Developing Recommendations

- Group 1: Tools & Training
- Group 2: QITs at the Health Center
- Group 3: QITs and District Engagement
- Group 4: Product Availability

Instruction for Small Group Work

- Divide up into small groups
  - Group 1: Bugesera, Ngoma, Kirehe, Kayonza
  - Group 2: Gatsibo, Kamonyi, Muhanga, Nyamagabe
  - Group 3: Nyaruguru, Rusizi, Rutsiro, Nyabihu
  - Group 4: Musanze, Rulindo, Gicumbi, Nyanza
- Assign one person as notetaker who can type up recommendations on computer
- Assign one person to present (5 mins per group to present)

Be ready to report back in 15 mins!

Murakoze!

"With RSP, we have dignity in our cell and villages because the community knows we have products in stock to provide health care to their children." **– CC, original district**