

REPUBLIC OF RWANDA



**MINISTRY OF HEALTH
PO BOX 84 KIGALI**

**PERFORMANCE BASED FINANCING PROCEDURE
SUPPLEMENTAL MANUAL FOR HEALTH CENTERS
SUPPORTED UNDER THE
STUNTING PREVENTION AND REDUCTION PROJECT (SPRP)**

September, 2018

Foreword

Since the year 2000, Rwanda has made remarkable progress in all sectors of development and specifically in the health sector, which was demonstrated by achieving most of the Millennium Development Goals (MDGs). The Performance Based Financing (PBF) approach institutionalized in Rwanda since 2008 has contributed a lot to achieve the health related to MDGs by boosting the utilization of health services and quality. We expect this to continually be improved in order to achieve Universal Health Coverage (UHC) and the Sustainable Development Goals (SDGs).

During the last decade, the PBF strategy has strongly contributed to increase productivity and efficiency in the management of health services. For the sustainable implementation of this strategy, the Ministry of health has defined a comprehensive PBF framework package with guidance for each level, such as PBF procedure manuals, payments process, contracts with decentralized levels and control mechanisms of PBF system.

One of the major challenges faced by the policies and decision makers is to ensure sufficient and quality health services provision to respond to the increasing demand by the users and sustain the high level of performance reached. In order to confront these challenges, Rwanda will continue to implement a number of reforms through decentralization and the establishment of performance contracts between His Excellency, the President of the Republic of Rwanda and the decentralized administrative authorities (Imihigo) in different areas including health sector.

The PBF system is dynamic and its implementation regulations and procedures merit to be reviewed regularly. For the last three years, considerable improvements have been undertaken, such as the link of PBF and accreditation systems at the hospital level and the review of Health Center PBF indicators to include non-communicable diseases. That is why MOH avails this new version 2018 of PBF procedure manual to help users to comply with PBF principles and take into account all modifications introduced in the PBF Scheme.

We urge all health centers of 13 districts with Stunting Prevention and Reduction Project (SPRP) to comply with this guiding document in order to ensure our health system is performing well and achieving to the global and national objectives.


Dr. Diane GASHUMBA
Minister of Health



Contents

CHAPTER I: INTRODUCTION	2
1.1 Background.....	2
1.2 Historical development of PBF in Rwanda	3
CHAPTER II: RWANDA HEALTH SYSTEM ORGANISATION.....	5
2.1 PBF contributions to health sector achievements	7
2.1.1 Quality, demand and accessibility of health care.....	7
2.1.2 Human resources.....	7
2.1.3 Health financing.....	7
2.1.4 Health sector successes	7
CHAPTER III: PBF DEFINITION OF CONCEPTS AND PRINCIPLES	8
3.1 Definitions of concepts	8
3.2 PBF Principles	9
3.2.1 The Separation of Functions	9
CHAPTER IV: PERFORMANCE BASED FINANCING EVALUATION	16
4.1 PBF indicators.....	16
4.2 Performance evaluation process	16
4.2.1 Evaluators Profile.....	16
4.2.2 Sampling methodology	16
4.2.3 Process of quarterly evaluation of quantitative indicators	17
4.2.4 Qualitative indicators evaluation Process	18
4.2.5 Documentation.....	18
4.2.6 Monitoring and evaluation of the PBF model.....	18
4.2.7 PBF Data System	19
4.2.7.1. PBF Data entry at District Level.....	19
4.2.7.2. PBF data base management at Central Level	19
CHAPTER V: PBF BUDGET AND PAYMENT FOR HEALTH CENTERS	20
5.1 Sources of Funds.....	20
5.2 Determination of unit cost for quantitative indicators:	20
5.3 Billing and Payment Process of PBF indicators	21
5.4 Production, validation and transmission of Quarterly Final Invoices.....	22
5.5 Timeline of transmission and payment of the PBF invoice	23
5.6 Staff performance evaluation and PBF Payment.....	24
CHAPTER VI: PBF SYSTEM MONITORING AND DATA COUNTER VERIFICATION.....	26
8.1 PBF System Monitoring	26
8.2 PBF data counter verification	26

ACRONYMS

BNR	: Banque National du Rwanda
BTC	: Belgium Technical Cooperation
CDC-CoAg	: Center for Diseases Control and Prevention Cooperative Agreement
CHUB	: Centre Hospitalier Universitaire de Butare
CHUK	: Centre Hospitalier Universitaire de Kigali
CMHS	: College of Medicine and Health Sciences
CHWs	: Community Health Workers
DAHR	: Director of Administration and Human Resources
DF	: Director of Finance
DG/PHFIS	: Directorate General of Planning Health Financing and Information System
DH	: District Hospital
DHS	: Demographic and Health Survey
DHMT	: District Health Management Team
DSC	: District Steering Committee
DT	: Drop Thick
EDPRS	: Economic Development and Poverty reduction Strategy
EHCP	: Essential Health Care Package
FBO	: Faith Based Organization
GoR	: Government of Rwanda
HC	: Health center
HF	: Health Facilities
HMIS	: Health Management Information system
HIV/AIDS	: Human Immunodeficiency Virus/ Acquired Immunodeficiency Syndrome
M&E	: Monitoring and Evaluation
MINECOFIN	: Ministry of Finance and Economic Planning
MoH	: Ministry of Health
MPA	: Minimum Package of activities
NGO	: Non-Governmental Organization
NISR	: National Institute of Statistics Rwanda
OPD	: Outpatient Day
PBF	: Performance Based Financing
PBI	: Performance Based Incentives
PH	: Provincial hospital
PS	: Permanent Secretary
RBC	: Rwanda Bio-medical Center
RH	: Referral Hospital
RSSB	: Rwanda Social Security Board
SPIU	: Single Project Implementation Unit
SPRP	: Stunting Prevention and Reduction Project
TB	: Tuberculosis
UTH	: University Teaching Hospital

CHAPTER I: INTRODUCTION

1.1 Background

Over the past two decades, the Government of Rwanda has aimed at increasing access to quality health services for improved health outcomes for the entire Rwandan population. Initiated as a pilot project in 2001, Performance Based Financing (PBF) is an output health financing mechanism aimed at providing health workers and their respective health facilities monetary incentives when they achieve specified qualitative and quantitative performance indicators. Later in 2006, PBF was scaled-up as a national framework at many levels of service delivery from health center to MoH Central level. In 2008 the community PBF took place as strategy to sustain CHWs system.

PBF implementation entails 3 main functions, namely performance contracting, assessment and payment. The Ministry of Health undertakes the overall strategic stewardship and sets policies and procedure to guide the implementation of the PBF strategy. Within the PBF system, there are two types of performance contracts. The health facility performance contracts are established and defines performance targets health facilities must meet in order to receive the motivational incentive payment. The Ministry of Health establishes facility performance contracts for the referral, provincial, district hospitals and District steering committee. The individual performance contracts on the other hand is established between the management committee of the health facility and the employee, and defines the agreed bonus to be paid to the employee for satisfactory achievement.

District Hospitals (DH) and Provincial Hospitals in Rwanda constitute the secondary level of service delivery, and manage referred cases from the primary health care level (health center). At hospital Level the PBF system has been mainly concerned with measuring and improving quality of health services delivery. Performance analysis of the impact of PBF at the district hospitals has reported improvement of various health sector indicators including increased utilization of health services. The utilization of maternal and child health services also increased significantly in PBF facilities than controls.

Although initiated as a quantity improvement program in 2012, hospital accreditation system offers goals and strategies that are complementary to and synergistic with the PBF program in a number of ways. Both aim at improving health facilities' performance, and both assume that performance is, to some extent, controlled by intrinsic and extrinsic motivational factors relevant to the health service providers and managers. Also, both programs involve a third party to collect data and verify achievement of performance objectives against set targets or defined standards. To strengthen the complementarity of both programs, major reform in 2014 involved the linkage between PBF and accreditation at the provincial and district hospital levels. The linkage aimed at avoiding duplication of efforts in implementing the two programs and as such, to promote and achieve greater efficiency. The linkage involved developing and orienting health providers on the new instruments and tools for self-assessment and external assessment of quality of care, based on clear and measurable indicators. This supplemental procedure manual describes how the current PBF framework at health center level has been adapted to incorporate the PBF scheme for the SPRP. Chapter one provides a brief introduction, background and PBF historical developments. The second chapter describes the contribution of PBF to the Rwanda health sector achievements. The third chapter provides the definition of concepts and principles of the performance based financing scheme. The fourth chapter describes the performance based financing evaluation mechanism.

The subsequent sections are grouped around the three following PBF functions and implementation model: PBF Budget and payments, PBF audits, and performance contracting.

The selected PBF indicators under the SPRP are intended to boost the productivity and performance of Health facilities in 13 selected districts. These health centers will be held accountable and incentivized to provide these interventions through the national PBF program. The project will support health facilities with training, information technologies, and logistical support from the national level. To this end, support will be provided for the design and roll out of new information technologies (i.e. two-way messaging system, tablets) and interactive systems for tracking every pregnant woman and child, ensuring prompt identification of growth faltering and effective response at the facility and household levels. This PBF supplemental manual summarizes the proposed indicators; unit costs; weights; source of data; and verification/ counter verification procedures, along with a financial analysis of the impact of the incremental revenues for participating facilities.

Under the Stunting Prevention and Reduction Project (SPRP), 13 Districts were selected for the PBF scheme aimed at incentivizing interventions to improve the nutritional status of mothers and children under 5 years of age. The districts were selected based on 3 criteria: prevalence of stunting, poverty level and status food security. The selected districts are Nyabihu, Ngororero, Karongi, Rubavu, Rutsiro, Rusizi, Nyamagabe, Huye, Nyaruguru, Ruhango, Gakenke, Kayonza, and Bugesera.

1.2 Historical development of PBF in Rwanda

Performance Based Financing started in Rwanda as early as 2001. Several factors led to its introduction. Firstly, NGOs working in Rwanda at the time felt that although they paid health workers a 'bonus' salary supplement, the health services outputs produced at their facilities were stagnating and, in some cases, even deteriorating. Another reason was that innovative experiences from other contexts, such as a pilot health services contracting scheme in Cambodia, proved to be very successful at achieving quality improvements and other significant results in areas seen by the health authorities and development partners in Rwanda as critically important. This experience was adapted and applied in Rwanda through a number of individual initiatives. In 2001, the NGO Memisa/Cordaid started a PBF scheme in Cyangugu (Western Province) while HealthNet International (HNI) started one in Butare (Southern province). In 2005, the Belgian Technical Cooperation (BTC) also started a PBF scheme at health centers and district hospitals in Kigali City, Kigali Ngali and Kabgayi Health District. These piloting experience which particularly focused on quality of health care services delivery confirmed PBF effectiveness as a mechanism to achieve significant improvements in quality of services but also in increasing the volume of services delivered.

These models applied by NGOs although with different set-ups, proved that performance-based incentives when well designed and managed are successfully producing sought after results in Rwanda and in 2006, the MoH decided to roll out PBF in all health facilities throughout the country for quantity and qualitative selected indicators improvements.

From 2006 to 2013 the District hospitals were assessed quarterly by teams from the MoH central level and peer evaluators selected from other district hospitals staff. PBF payments were contingent on the evaluation scores assessed (60% central level team assessment and 40% for the peer evaluation). Despite high PBF score, there were persistent concerns about the quality of services delivered. This mostly emanated from the fact the PBF

performance indicators at the time were not providing an accurate measurement of performance. A more comprehensive and deeper assessment of the quality of services was needed. Following the establishment of accreditation program for the DH's in 2014, the PBF and accreditation system were linked. They started with five provincial hospitals, and the roll out to all hospitals occurred in 2016.

CHAPTER II: RWANDA HEALTH SYSTEM ORGANISATION

Rwanda health system and administrative structure are linked. The system has three levels as shown in figure 1 below:

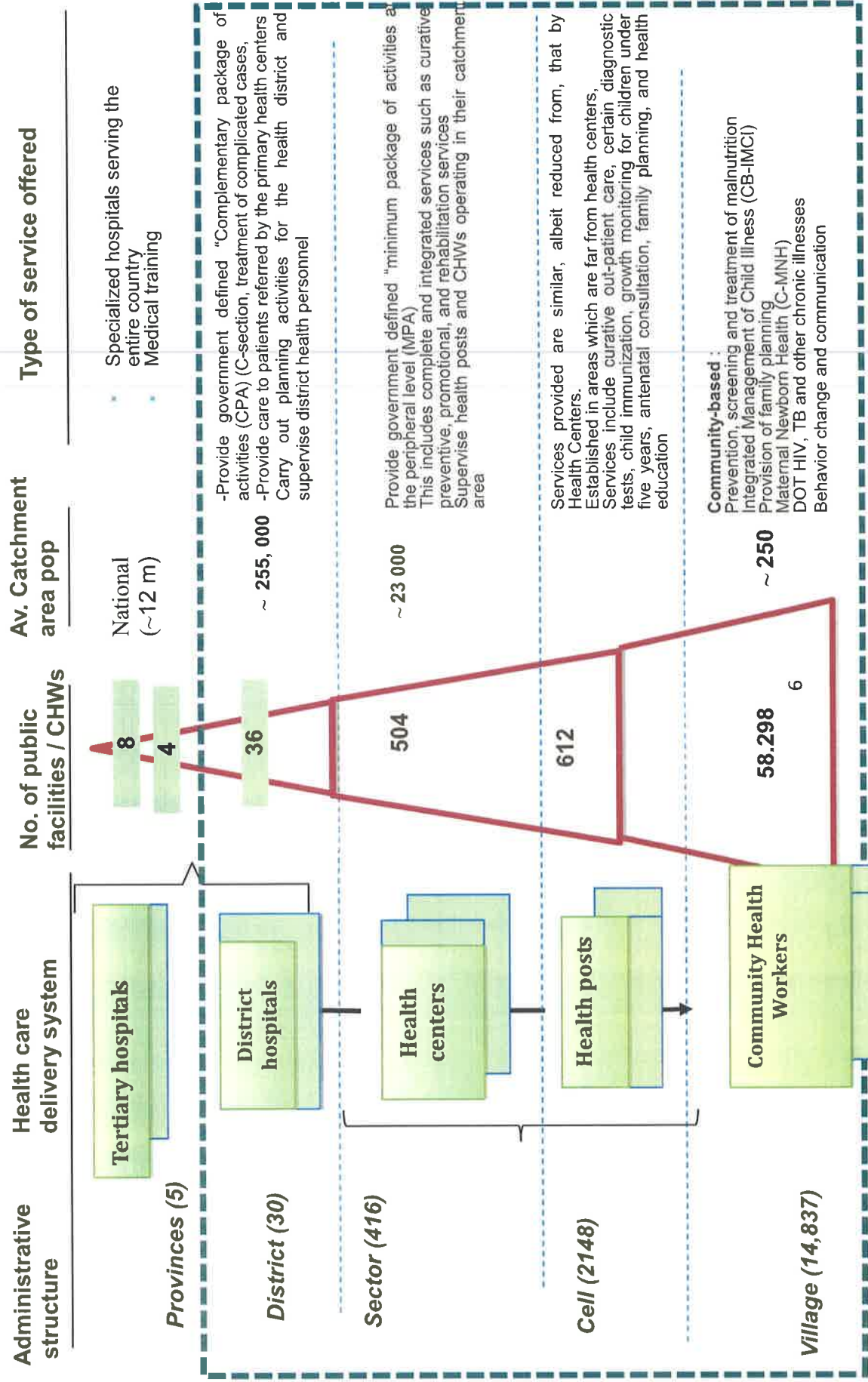
- The central level has the responsibility for policy making, overall monitoring and evaluation, capacity building and resources mobilization.
- The peripheral level with districts hospitals and health centers has the mission of delivering health services.
- The community level main purpose is focused on promotional, rehabilitative and some curative health activities.

The PBF framework is implemented across the Rwanda health system and at each administrative level corresponds a category of health facility. Community PBF (C_PBF) is implemented at the village level through the trained community health workers (CHW) operational within each community. Health posts are located at the cell level and due to their public private partnership status they are not integrated into the PBF system. Health Center PBF is implemented at the sector's level health center while district, provincial and referral hospitals are implementing the district hospital PBF model (recently linked with accreditation). Central level and the referral teaching hospitals are implementing the central level PBF model.

Figure 1: Rwanda Health System



Rwanda's Health System



84% of burden of disease addressed at this level (primary health care)

2.1 PBF contributions to health sector achievements

2.1.1 Quality, demand and accessibility of health care

The focus is to improve the quality of health-care services, including the management of health facilities, while continuing to expand geographical and financial accessibility (NST1 2018-2024). PBF as a tool introduced positive competition among health facilities and fostered an environment where health care providers could take initiatives aimed at improving quality of services and advocate for their health facility to increase the utilization of services and thus the income generated, and indirectly their own incentives.

2.1.2 Human resources

A shortage of qualified health workforce sector is one of the biggest challenges facing the government. In order to fill the gaps, the Government has invested significant resources in the training of health professionals.

Human Resources for Health (HRH) is the backbone of the health system and very critical to its performance. The introduction of PBF in the Rwandan health system was an innovation to improve the quality of services and to retain the qualified staff.

2.1.3 Health financing

The Government budget allocation to health has increased in recent years. As a share of the national budget, health budget has increased from 4.2% in 1996 to 16% in 2015. Of this, about 60% of Government budget are allocated to the decentralized level. The Government has a social insurance scheme to make services available to the communities (CBHI). This scheme mostly serves the poor and has been very successful.

The PBF reward to the HFs has been decreasing over the past five years due to the decrease of development partners funds, while the Government fund is increasing every fiscal year from 2015-2016 to 2017-2018. The SPRP will provide additional resources for PBF specific to health centers in 13 districts incentivizing performance on indicators related to preventing and reducing stunting.

2.1.4 Health sector successes

There have been very significant improvements in the health sector. The Government campaign for HIV/AIDS has yielded a downward trend in the prevalence of the disease (3%) and stabilize it over the past 15 years. Addressing maternal and child health challenges have contributed to reducing maternal and child mortality and increased the quality of life. The life expectancy increased from 42 years in 1996 to 64.4 years in 2012 (Census 2012). They observed an increase in preventive care for under five years' children. However, while the burden of infectious disease is decreasing, there is a significant increase of Non-Communicable Diseases (Cancers, Heart diseases, Diabetics, Respiratory diseases, kidney and renal diseases) and only moderate progress in reducing chronic malnutrition.

CHAPTER III: PBF DEFINITION OF CONCEPTS AND PRINCIPLES

This section first provides the definition of the most common PBF-related concepts and terms, followed by sub-sections on key PBF principles as they are applied at the health centers level.

3.1 Definitions of concepts

Accreditation: According to International Organization for Standardization (ISO), accreditation is a procedure by which an authoritative body gives formal recognition that a body or person is certified to carry out specific tasks.

Contract: An agreement with specific terms between two or more persons or entities in which there is a promise to do something in return for a valuable benefit such as a payment in some form. In addition to the above, the existence of a contract requires finding the following factual elements: a time when performance must be made, terms and conditions for performance, and performance definition (criteria)

The PBF contract can be entered into at different levels, between different partners and under different modalities (Sector - Health Centers, Sector – PBF Sector Steering Committee, Sector- Cooperative of CHWs, and Health Centers – Staff.).

Indicator: a performance measure which is objectively verifiable. In the context of the contractual approach through PBF, there are quantitative indicators (found in service delivery units) and qualitative indicators (an act/procedure/service which is properly executed /offered according to established quality standards).

Motivation: An emotional state which pushes someone to act so as to attain a goal or results. Intrinsic motivation of health workers is related to dynamic aspects such as moral values or duty or attachment to the mission and goals of the employer organization. Extrinsic motivation is related to practical aspects such as monetary incentives. PBF incentives motivate individual staff to work toward achieving the organization’s goals in order to obtain the additional compensation or other motivational reward when goals are achieved. Health staff motivation in PBF is thus aligned to performance in the production of services.

Performance: The accomplishment of a given set of tasks measured against preset known standards. The required performance for PBF is that of health staff who must be “performing, active, innovative and competitive” to get better quantitative and qualitative results.

Performance-based financing: PBF refers to the transfer of money or material goods to health facilities and providers after predefined results have been achieved such as health services that meet protocols and standards. The incentives are received at regular intervals based upon verified results.

PBF implementation can be summarized into three basic steps:

1. The “purchaser” (usually a ministry of finance and partners) and the “provider” (a health facilities). Ministry of Health establishes a contract that defines provider performance targets and the amount of payment it will receive from the purchaser for achieving those targets.

2. Results in attaining performance targets are verified on a regular basis by an independent agency.
3. Based on verification, the provider receives payment according to the level at which they achieved agreed-upon targets.

Provider/Vendor: The entity that implements strategies and activities that will improve the volume and quality of services in view of producing results meeting or surpassing the targets or goals agreed-upon according to the terms/conditions of the contract established with the purchaser (buyer). The PBF vendors also vary according to the level of the contract; the ultimate vendor in the PBF process is the service provider.

Purchase: Acquiring something, a good or a service against payment. PBF procurement entails a certain number of results at health centers meeting defined targets for selected indicators.

Purchaser: The entity that sets targets and buys the produced results in a given catchment area according to the terms and conditions of the contract established with the provider. In the PBF system, the purchaser (buyer) can be different depending on the level of the contract.

Quality: A trait which attaches more or less value to a product. The quality of care provided to the population and purchased under PBF involves compliance with set norms and standards for health care delivery. Technical quality control is achieved through quarterly quality supervision and evaluation.

Regulation(s): The act of ensuring proper operation of a complex system (like a health system) by setting rules, norms and standards, and monitoring and enforcing their adherence. Regulations are rules made by a Government or other authority in order to control the way something is done or the way people behave. For the health sector this role is delegated to the Ministry of Health which sets policies and standards, and to the district authority at the decentralized level.

Verifier: An intermediary controller between the purchaser and the provider who verifies adherence to norms, standards, rules and regulations. An individual or entity that verifies the accuracy of reported data and ensures that services are actually provided.

3.2 PBF Principles

The PBF approach is based on 3 principles:

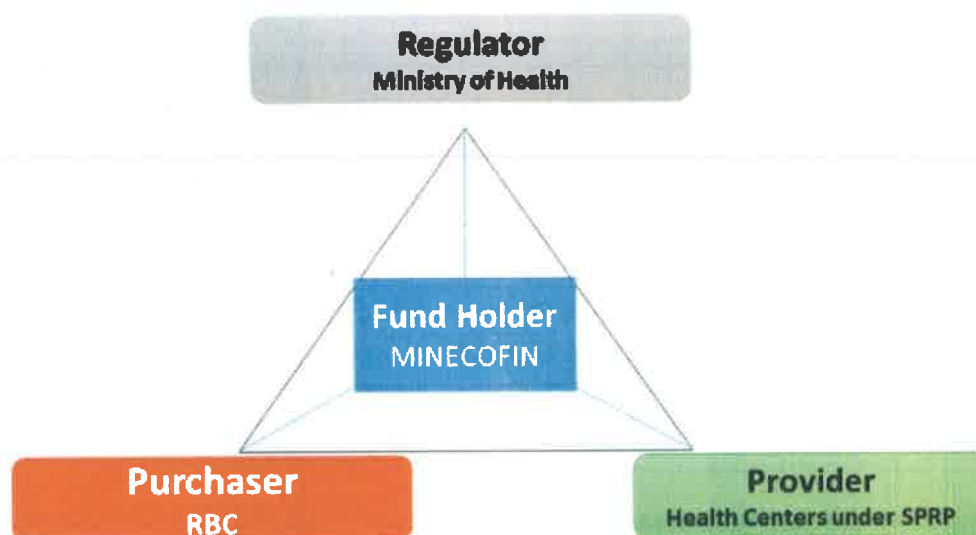
- The separations of functions
- The contractual approach
- The indicators to be purchased

3.2.1 The Separation of Functions

This section describes the institutional setup in PBF implementation ensuring separation of functions, roles and responsibilities. Separation of functions is paramount to effectively and efficiently implement the PBF strategy and to avoid conflict of interest. These imperatives require that the regulator, the fund holder or the purchaser and the provider all be different from one another.

Figure 2 below shows the functions and respective institutions involved in PBF implementation at health center level. MOH is the regulator and sets policies and procedures. The providers are health centers delivering health services to the population whereas the purchaser is Rwanda Biomedical Center (RBC).

Figure 2: Separation of Functions in Health Center



3.2.1.1 The regulator - Ministry of Health

The overall management of the PBF is the responsibility of the MoH. MoH is the regulator with main functions including; regulation (setting the policies, norms and procedures), supervision/facilitation of the PBF implementation strategy, resource mobilization and resource allocation. Different departments within the MoH are involved in implementing the PBF strategy and Accreditation program in Health Facilities, respectively Directorate general in charge of planning, health financing and information system (DG/PHFIS) and Directorate General of Clinical and Public Health Services.

The roles of MoH in PBF Strategy and implementation of Accreditation Program include:

- Regulation
 - Set goals and targets (qualitative and quantitative) pursued by the PBF and ensuring that they fit into the overall Government policy to ensure the integration and implementation of the link PBF-Accreditation strategy. Participate in the review, develop and update PBF/accreditation tools and indicators.

- Develop an assessment PBF/ accreditation tool kit, policy, procedures and select a list of standards, services to be purchased through PBF and identifying the resources needed.
- Supervision/Facilitation
 - Enforce regulations and contracts,
 - Develop and periodically review the PBF model of various structures and evaluation grids (including the selection of indicators and their respective amounts);
 - Manage, monitor and analyze PBF Data generated from the PBF Data base;
 - Accept or reject the consolidated invoice for payment submitted by hospitals;
 - Designing, coordinating and monitoring the PBF models at all levels.
 - Provide technical support to the PBF implementers and functioning of the DHMT/DSC.
 - Harmonize PBF system with all involved partners to ensure the coordination.
 - Advocate for PBF sustainability.
 - Plan and conduct PBF system audit and PBF Data counter verification and Dissemination of results.
 - Conduct annual accreditation Assessment at hospitals levels.
- Resource mobilization
 - Advocacy to GoR and Partners on increasing PBF budget of hospitals.

3.2.1.2 The Purchaser

The Rwanda Biomedical Center is the purchaser of performance results of Health Centers as shown in the figure below.

Figure 3: Purchaser for Health Centers PBF



3.2.1.3 Roles of the Committees (Central and Decentralized level)

3.2.1.3.1 Central/ National level

Various committees at the national level support PBF implementation at the hospital level. These include the National Accreditation Steering committees and the National PBF Steering committee.

National Accreditation Steering committee

This is a sub-committee of the Quality Improvement Technical Working Group. The roles and responsibilities of this committee include:

- Oversee and coordinate the national accreditation program
- Manage the hospital accreditation assessment process
- Present the results to the accreditation to the national health authorities, the hospital themselves and all stakeholders
- Conduct training of the providers on how to improve their performance
- Maintain and update accreditation standards.

National PBF Steering committee

This is a sub-committee of the Planning, Health Financing and Information System (PHFIS) Technical Working Group. The roles and responsibilities of this committee include:

- Designing, coordinating and monitoring of PBF System (Clinical and Community);
- Revision of PBF indicators and targets.
- Follow-up of PBF payment at Health Facilities;
- Analysis of PBF Data;
- Conduct PBF Data counter verification;
- Disbursement of funds needed to pay for PBF indicators;
- Empower Local Government (District) in the implementation of PBF Strategy and guidelines;
- Oversight and coordination of PBF District level steering committees.
- Coordination of partners supporting PBF programs.

The Ministry of Health can set ad hoc indicators according to the emergency and priorities to be considered for PBF payment.

3.2.1.3.2 Decentralized level

The District Health Management Team chaired by the Vice Mayor in charge of Social Affairs delegates to the district PBF steering committee the responsibility to drive and implement PBF activities within the district (*Annex1*).

The members of the district PBF steering committee are:

1. Director of health unit; (Chairperson)
2. Hospital Director General; (Co-Chairperson)
3. Health Promotion officer who acts as the focal person of the steering committee;
4. Planning and M&E officer at the hospital;
5. PBF officer at the hospital;
6. RSSB officer at district level;
7. Community health officer at the hospital
8. Director of Pharmacy at district;
9. Representative of public health facilities;
10. Representative of sector steering committees
11. Representative of development partners supporting health activities within the district;
12. Representative from NGOs implementing community health programs.

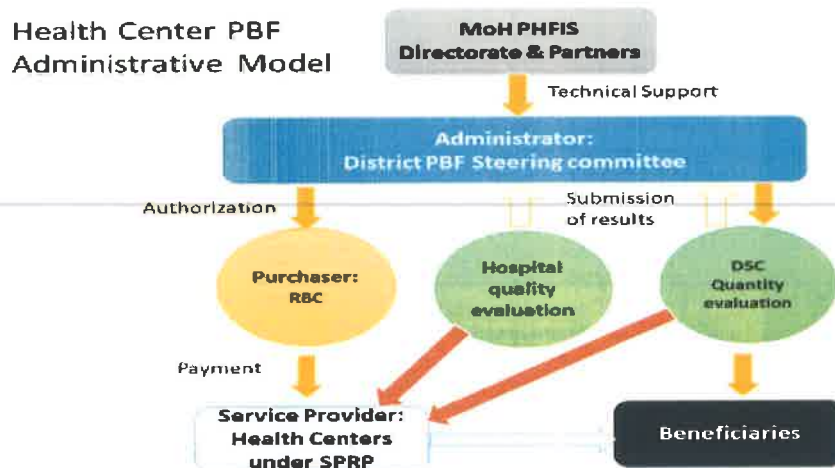
The District Steering Committee (DSC) coordinates hospitals and health centers PBF activities at the decentralized level. Currently this committee is merged with the District Health Management Team (DHMT)

The PBF District Steering Committee (DSC)/DHMT members, roles and responsibilities are:

- To operationalize the PBF strategy at local level;
- To Conduct verification of PBF quantitative and qualitative indicators;
- To ensure that PBF data entry in PBF Database is made on time;
- To ensure that the preparation meeting of DSC was well held and PBF Data was verified;
- To hold a meeting once a quarter to discuss and address health issues within the district and validate PBF data from providers;
- Sharing information among members regarding the opportunities and challenges they face in the implementation and their own contribution to PBF;
- Proposal of decisions by consensus on the actions necessary to implement these recommendations, including Conflict resolution or any penalties;
- Daily management of the PBF database and District HMIS data;
- Monitoring and supervision of the financial mechanism based on performance at the community level (coaching of the sector's steering committee);
- Carry out data counter verification exercise in case of errors or frauds.
- To submit on timely fashion, the report including minute and PBF invoices to the central level;
- To ensure that the staff at health facilities was evaluated and PBF payment was done according to individual performance;
- To Evaluate PBF Sector Steering Committee;
- To discuss on Community PBF activities.
- To ensure that all PBF transfers to health facilities and Community from central level are received on the accounts of beneficiaries.

- To make quarterly feedback report to central level for all PBF transfers and PBF payment to beneficiaries according to their individual performance.
- Formulation and review of the strategy for improving the quality of care in health facilities;

Figure 4: Health Centers under SPRP PBF administrative model- Summary of the institutions and their roles.



3.2.1.4 The provider

As earlier defined the provider is the entity that implements strategies and activities that will improve the volume and quality of services in view of producing results meeting or surpassing the targets or goals agreed-upon according to the terms and conditions of the contract established with the purchaser (buyer). The role of provider is played by all Health Centers taking part in the PBF system in the 13 SPRP districts.

The Contractual approach

In Rwanda, the PBF contract is signed between the provider and the purchaser. Here the providers are Health Centers and the purchaser is the Rwanda Biomedical Center.

3.2.1.5 Importance of contracts

The PBF contract allows the concerned parties to have clarity on their respective commitments, obligations, roles and responsibilities, as well as on a time when performance must be made, terms and conditions for performance and performance definition (criteria). The parties who sign the PBF contract are committed to respect its clauses. The provider has committed to provide quality health services meeting or surpassing the targets or goals agreed-upon according to the terms and conditions of the contract established with the purchaser, while the purchaser have the obligation to provide the motivation funds for the level of achievement attained (for both qualitative and quantitative indicators).

PBF contracting approach should aim to avoid conflict of interest through rigorous respect of the principles of separation of functions.

3.2.1.6 Types of contracts

There are three types of PBF contracts in Health Center:

- **District Steering Committee contract:** This contract is signed between Ministry of health (represented by District) and District Steering Committee (DSC) for commitment of implementation of PBF strategy at decentralized level. The DSC is expected to manage PBF data entry and verify the quantity and quality of PBF performance indicators at health centers on a quarterly basis. The Director of the Health Unit is Chairperson and the co-chairperson is DG of Hospital.
- **Health Center contract:** This contract is signed between District, in collaboration with the sector, and Health Center. The content of this PBF contract is the description of the commitment at each level (district, hospital and health) under SPRP interventions. The health center is expected to deliver services to the population according to established standards.
- **Individual Performance contract:** This contract is signed between health center and its employees. The contract describes expectation for performance and the process of individual evaluation and PBF payment.

CHAPTER IV: PERFORMANCE BASED FINANCING EVALUATION

4.1 PBF indicators

The Health Centers in the Rwandan health system provide curative, preventives, and promotional health activities. The performance-based financing covers the indicators related to stunting prevention and reduction in order to increase the quality and quantity of the overall package in health centers of 13 districts under SPRP.

4.2 Performance evaluation process

The PBF evaluation tool is available at district and hospital level both in soft and hard copies.

This procedure manual describes the evaluators profile and sampling methodology,

4.2.1 Evaluators Profile

In order to ensure good quality of data and results of monthly statements and quarterly quality evaluations, the profile and criteria required of evaluators were defined. The District PBF steering committee must consider compliance with indications and defined profiles.

a) Choice of the evaluator of the quarterly quantitative evaluation

The Steering Committee is responsible for evaluating quantitative indicators as defined in the "Terms of Reference" of the Steering Committee. The evaluators will be selected from the steering committee members from the hospital: data manager, PBF Supervisor and Planning and M&E officer

b) Choice of the evaluators for quarterly evaluation

The Hospital is responsible for the choice of evaluators from staff of the hospital; the team must be permanently and clearly identified. The quality evaluation team should be multidisciplinary and well trained. The list of evaluators must be presented and approved by the steering committee.

4.2.2 Sampling methodology

The PBF evaluation cannot cover all the cases observed in a health center, a sampling mechanism is defined for cases to be selected, on which comments and analyses will be provided. The choice of cases to be evaluated follows a probabilistic method.

a) Document review

The number of records to choose or the sample size is a maximum of 15 cases. For activities whose beneficiaries do not exceed 15 cases, the evaluator examines all.

b) Choice of the cases:

The random method is used to select the cases to analyze. The method applied to conduct systematic random sampling is to calculate the pitch of the sample (k) by dividing the total number of cases (N) by the number of cases to select (15) and rounding to the nearest unit.

To determine the first record to get from the register, the evaluator draws a random number between 1 and (k) which becomes the first record. Then, the evaluator adds (k) to pick the next folder and so on. If the assessor does not find the selected case, he replaces it with the following case.

For example: a health center has 75 FP consultations traced from the register. The number of cases to choose from register to apply the quality validation criteria is 15cases. Sampling area or space (k) = $75/15 = 5$. The assessor chooses a random number between 1 and 5 (eg 5). The proposed figure represents the first record. From Record 5, every fifth record is chosen until we reach the number of 15 records (eg, the second record is 10, the third is 15, and so on).

c) Direct observation

The number of cases to observe for each activity is indicated in the grid (specifically the quality grid). If during an assessment visit the required number of cases is not found, we must return to this activity during the next visit to assess the remaining cases in order to comply with the requirement.

d) Sampling to find the number of children under 2 whose height are correctly measured and recorded at the health center.

Number of cases to choose

The number of cases to choose or the sample is 15 cases. For activities whose benefits are lower in 15 cases, the evaluator examines all. Once a year, the central level will examine a larger sample that will be used to calculate the bonus for each health center.

4.2.3 Process of quarterly evaluation of quantitative indicators

a) Self-evaluation

To ensure the reliability of data and promote the self-evaluation process, the staff of health center conduct quarterly self-evaluation. This self-evaluation is presented to the evaluation team during the evaluation visit and the data are compared and discussed in case of discrepancy.

b) Evaluation Schedule

The Quantitative verification is done on a quarterly basis for Stunting Prevention and Reduction indicators.

c) Conducting the evaluation

The evaluation team is composed of at least 2 people to ensure the transparency of results from evaluation. Evaluators work with the head of the health center or the head of services being evaluated.

At the end of the evaluation, the collected data are compared with data from the self-evaluation, discussed and agreed with names and signatures of the evaluators and the head of the health center (or her/his representative). A copy of the evaluation results is given and kept by the health center. The original copy of the evaluation is sent to the focal person of the district PBF steering committee. For quality evaluation in health centers of 13 districts under SPRP, we will use the same quality assessment tool used at the national level. The billing of the quarter is multiplied by the result of the quarterly quality score.

4.2.4 Qualitative indicators evaluation Process

a) Evaluation Schedule

The evaluation of qualitative indicators is done once a quarter by the team from the hospital, for the indicators performed quarterly and for each of the selected activities. In order to avoid congestion in health centers because of the PBF evaluation visit, the average proportion of services evaluated in a quarter in a health center should not be higher than 50% of total services.

b) Conducting the evaluation

Steps below are defined in the evaluation process of qualitative indicators.

The evaluation is done using unannounced visits to the health center;

The visit for the evaluation of the activity is scheduled according to the days the activity is conducted;

The evaluator works with the responsible person performing the activity (for the observation of cases) or with the duty manager or his representative (for the documentary section);

At the end of the evaluation, the evaluating team takes time to give feedback of findings to the staff of health center.

The district steering committee submits PBF quarterly report including invoices and meeting minutes to the district Executive Secretary for validation and the report is then sent by the district Mayor to the Permanent Secretary of Ministry of Health and copy to Directorate General of Planning, Health Financing, and Information System.

4.2.5 Documentation

The health center has the responsibility to ensure the availability and accessibility of all data and documentation received from MOH such as norms, standards, flowcharts, protocols, and guidelines. This documentation should be available permanently for the health center staff and to the evaluation team during their visits.

4.2.6 Monitoring and evaluation of the PBF model

In summary of the above description of the performance evaluation system, the monitoring and evaluation of the PBF approach consist of three components:

The 1st component is the quantitative monitoring of indicators by the District Health Unit (DHU).

The 2nd component is the evaluation of the quality of health services in health center. This evaluation is conducted by the hospital's team and uses the national PBF evaluation tool.

The 3rd component is the validation of quantitative and qualitative evaluation by the district PBF DSC before approval by the Executive Secretary of the district and the transmission by the mayor to the MOH.

4.2.7 PBF Data System

The national PBF scheme uses the following web site: hmis.moh.gov.rw/pbfrwanda/dhis2 a database accessible online. This website offers the public general information about the PBF in Rwanda. The purpose of the PBF data entry system is to enable the PBF District Steering Committee to enter data on quarterly evaluations. These data are then compiled to prepare a quarterly PBF payment based on pre-established tariffs.

4.2.7.1. PBF Data entry at District Level

Each district has its name "user" and password; this user name and password are kept by the district. The data entry takes place at the decentralized level (District).

Once the data are entered into the database, the system produces a variety of outputs:

- Quarterly PBF payment vouchers, by bank and by district
- Health Facilities specific reports for a given period.
- Table of indicator values to be used in pivot tables for ad hoc analysis.

4.2.7.2. PBF data base management at Central Level

The PBF data base www.hmis.moh.gov.rw/pbfrwanda/dhis is managed by MoH/Central level. The main responsibilities at this level are the following:

- Adding or modifying indicators,
- Adding or modifying tariffs,
- Adding or modifying account number,
- Adding health facilities that need to be paid
- Changing and adding Managing users.

CHAPTER V: PBF BUDGET AND PAYMENT FOR HEALTH CENTERS

5.1 Sources of Funds

The Stunting Prevention and Reduction Project is funded by the World Bank. Health centers in thirteen (13) districts supported by SPRP can contribute to improving quality of services through the motivation of their staff. There are 223 health centers in the 13 districts, and the level of quarterly PBF transfers will be according to their performance on the PBF indicators.

5.2 Determination of unit cost for quantitative indicators:

The quantitative indicators unit cost allocation to each indicator varies from one to the other. The MoH in collaboration with RBC programs decides on the unit cost considering key criteria, such as coverage (if the indicator has low achievement, the money is allocated accordingly so that it goes up; if it has reached higher level, it is given less money accordingly).

The following steps are used to select and determine the unit cost according to the availability of funds which should be rationally allocated by taking into account the value or the weight of every indicator:

- ✓ Setting up the current production (baseline) related to each indicator considering the data of previous years using data from HMIS.
- ✓ Finding out the variance noted at least between two previous years during implementation of PBF program. $(\text{Current production} - \text{Previous production}) / \text{Previous production}$. The variance may be negative or positive.
- ✓ The projected production is calculated by applying the variance to the current indicator production as illustrated in the following formula $P_n = [(P_0 + P_0 * r)]$
 - P_n = Projected production
 - P_0 = Current production
 - r = Variance or average variation of years
- ✓ Weighting; the weight of each PBF indicator is calculated based on national and program priority, level of effort required to perform and achieve the indicator, possible bottlenecks to be encountered and level of achievement for existing indicators. This exercise is conducted by a panel of people who propose individual weights for each indicator and the average is calculated and adopted. This exercise is conducted periodically based on program needs and evolution.
- ✓ Costing; after determining the weight for each indicator, a formula to link this weight is calculated in order to come up with the unit cost. Below is the formula: $(\text{unit cost for indicator 2} = \text{unit cost of indicator 1 (UC1)} \times \text{weight of indicator 2 (W2)} \div \text{weight$

of indicator 1 (W1), example; $UC1 * W2 / W1$). Note that the first unit cost can be adjusted to affect all the others depending on the total available budget.

- ✓ Ex: The weight of the first indicator is 250,
- ✓ The weight of the second indicator is 1500.
- ✓ If the 250 = 1 that means 1500 = 6 (Rule of three)
- ✓ $250 = 1$ and $1500 = 1500 * 1 / 250 = 6$

Table 3: Determination of unit cost for SPRP quantitative indicators

	INDICATORS	Expected Production	Rel weight rwf	Relative weight %	Unit cost	Total budget
1	Number of newborn who attend all 4 PNC visits	118,337	6000	13%	1120	132,537,657
2	Number of pregnant women who received full course (90+ days) of iron folic acid tablets	118,337	1000	2%	187	22,089,610
3	Number of pregnant women with 4 standard ANC visits (check in the register of ANC)	57,356	6000	13%	1120	64,238,753
4	Number of children under 2 who received FBF (cat1 and 2 Ubudehe).	57,425	2000	4%	373	21,438,667
5	Number of feedback messages sent by HC to CHWs for follow-up on children at risk for stunting	292,234	2000	4%	373	109,100,693
6	Number of CHWs who received a Quarterly supervision visit from HC	26,016	5000	11%	933	24,281,600
7	Number of children under 2 whose height are correctly measured and recorded at the health facility.	57,425	5000	11%	933	53,596,667
8	Number of infants breastfed within one hour of birth	127,946	4000	9%	747	95,533,327
9	Health facility has no stock out of Zinc for diarrhea treatment	888.00	2000	4%	373	331,520
10	Number of pregnant women screened for anemia	57,425	4000	9%	747	42,877,333
11	Number of new users of modern contraceptives	43,333	6000	13%	1120	48,532,960
	Total		43000	100%		614,558,786

5.3 Billing and Payment Process of PBF indicators

The quarterly payment is calculated for PBF indicators and related quantitative output for the period as well as the overall quality of services obtained by the site where these indicators have been produced.

The provisional billing system is done monthly: the district PBF steering committee through its team of evaluators checks the quantitative data reported by the health center every month. This is done through the review of records.

The total validated amount of each indicator multiplied by the unit cost of the indicator will be taken into account for provisional billing. The nomenclature “provisional” comes from the fact that this total amount will be applied to the quality of services obtained in order to determine the final invoice of the Health Center.

The provisional invoice will be sent to the focal point of the steering committee for data entry.

Final invoice Health Center

This is a consolidation of quarterly results obtained through the quarterly invoice multiplied by the result of the quarterly quality score (in percentage). Performance payment formula = Σ (#validated Production * Unit Cost) *% Quality Score.

5.4 Production, validation and transmission of Quarterly Final Invoices

5.4.1. Preparatory meeting

The preparatory meeting is organized for data analysis and provide advice to the PBF district steering committee meeting. This technical meeting is composed by officers from Hospital such as: in charge of PBF, in charge of Planning and M&E, Health Community officer and data manager. The head of this meeting is one of the members of District Steering Committee delegated by the Chair.

If any doubtful data is discovered during the validation, the steering committee may be asked to conduct a brief counter verification before validation.

5.4.2 District Steering Committee

The PBF database offers the ability to produce quarterly invoices, "consolidated bills." After PBF data entry by evaluators and data analysis in preparatory meeting, the PBF invoices of all health facilities in the catchment area of the district are printed and presented to the quarterly meeting of District Steering Committee. These quarterly invoices are validated, approved and signed by the Executive Secretary of the district.

The signed invoices are sent to the Permanent Secretary of Ministry of Health with copy to DG/PHFIS for payment. The Ministry of Health will make a compilation of the invoices and prepare a list of beneficiaries (Health Centers), then a payment order is prepared and submitted to the Rwanda Biomedical Center which effects the payment to the health centers through the National Bank of Rwanda. When the financing proceeds come from externally financed sources, funds are deposited into account agreed and replenished as per modalities agreed with DPs

The Ministry of Health (central level) in case of wrong or abnormal data approved by the district PBF steering committee can conduct a verification exercise to ensure the accuracy of data. The penalties are applied where the data are found wrong. The penalties are specified in the contract between the purchaser and the provider.

5.5 Timeline of transmission and payment of the PBF invoice

A document describing all the procedures and steps of the operation of the PBF database and data entry is available for PBF stakeholders. The table below shows the process and timeframe of elaboration, approval, and payment of PBF invoices from the assessment and approval by the district PBF steering committee to the transfer of funds to the health facilities banks accounts.

Table 6: Timeline of transmission and payment of the PBF invoice in 13 districts under SPRP

Step	Activity/Task Process	Duration and deadline	Responsibility	Data Source/ Tools/Templates
1.	Conduct PBF evaluation and enter Health Centers data in PBF database	Quantity: The month following the quarterly assessed	District	<ul style="list-style-type: none"> Quarterly reports of District Steering Committee PBF Assessment tool of HC PBF assessment result Terms of reference PBF Database PBF Budget
		Quality: Quarterly	Hospital	
2.	Organize a meeting to validate the results and PBF invoices	At least 2 days before the date of PBF invoice transmission	District Steering Committee	
3.	Submit quarterly report of PBF District Steering Committee including minutes and PBF invoices (SPRP) to MoH through Mayor.	1 day <ul style="list-style-type: none"> January-March: 25th April April-June: 10th Aug July-Sept: 10th Nov Oct-Dec: 10th Feb 	Districts	
4.	Prepare summary PBF invoice	3 days; Within 10 working days after reception of quarterly report from Districts	Clinical PBF Officer/ MoH	
5.	Review summary PBF invoice	1 day; Within 10 working days after reception of quarterly report from Districts	Health Financing Specialist	
6.	Review summary PBF invoice	3 days; Within 10 working days after reception of quarterly report from Districts	DGPHFIS/MOH	
7.	Proceed with payment of PBF to health centers for SPRP	Submission of PBF Payment bills to DF for verification: <ul style="list-style-type: none"> Jan – Mar: 10th May Apr – June: 25th Aug 	DF/ MOH	

		<ul style="list-style-type: none"> • July – Sept:25th Nov • Oct – Dec:25th Feb 		
		Submission of PBF payment to RBC: <ul style="list-style-type: none"> • Jan – Mar: 15th May • Apr – June:30th Aug • July – Sept:30th Nov • Oct – Dec:30th Feb 	RBC	

Note 1: From the total PBF payment received quarterly by the health center, an amount corresponding to 10% of the total payment must be reserved for the functioning of the health center. The rest of the payment will be distributed to the individual employees according to their individual performance.

Note 2: PBF funds management follows the same rules as those governing public finance management in Rwanda; the health center manager is responsible for the management and reporting of all public funds including PBF. For audit purpose, the internal auditor of the district/province will carry out regularly the audit exercise to ensure that all public funds received and used by the health center including PBF were properly managed according to the finance regulations.

5.6 Staff performance evaluation and PBF Payment

5.6.1. Staff performance evaluation

PBF at Health Center level is governed by a performance contract signed between the employee and the institution. The contract specifies the obligation of the employee and employer, the modalities of payment and the period of evaluation. In addition to the contract, the employee signs Key Performance Indicators (KPIs) with his immediate supervisor. The KPIs hard copies signed at the beginning of the month will be used for evaluation in the agreed upon period. They include basic indicators and strategic interventions measurement indicators based on the action plan of the Health Center.

The individual performance evaluation is done on monthly basis and conducted by the immediate supervisor of the employee according to the organizational structure. It is preceded by the employee's self-evaluation. The PBF evaluation is executed in accordance with the schedule described below.

- Self-evaluation of each employee on the service provided takes place before the 1st calendar day of the month following the evaluated Month;
- Evaluation of the employee by the immediate supervisor takes place before the 3rd calendar days of the month following the evaluated month;
- A consolidated report is generated by the Administration and Human Resources Unit and final results are transmitted to the Chief Budget Manager before the 5th calendar days of the month following the evaluated month.

Payment of PBF is based on the grade/marks of the assessed staff as follows;

1. If the grade of the employee is $\geq 80\%$, the employee receives 100% of their due PBF allowance; therefore, being granted the total amount according to his/her index.
2. If the grade of the employee is < 80 up to 60%, the employee's PBF allowance will be calculated in proportion to the score obtained.
3. If the overall grade of the employee is $< 60\%$, the employee's PBF allowance will not be granted.

Evaluation Tools: Evaluation of an employee's individual performance at health center level is assessed using the evaluation grid that examines each employee's performance at the workplace.

5.7.2 Individual PBF Payment

The individual PBF payment is carried out every month based on individual performance score obtained applied to the overall score of HC.

For example, if a health center X has obtained 90% of PBF evaluation and an employee Y of that health center obtained 80% from his performance evaluation, that employee will get motivation payment equivalent to 80% of 90 (meaning $80\% \times 90 = 72\%$).

The score of the performance of the Head of Health Center for the calculation of individual monthly PBF is determined by the overall score of the Health Center of last quality quarterly evaluation.

The individual Performance score obtained is considered for the PBF payment of the following month.

During the official leave (annual leave, mission abroad, maternity leave, sick leave) and the employee has no activities performed to be evaluated within the month, the employee is paid the individual motivation (PBF) based on the average of his three (3) previous monthly performance score. This is applied for a leave that does not exceed three months' calendar. If the score of the evaluated staff is $\geq 80\%$: he/she will get all 100% of his due performance allowance, and he/she will be granted the total amount according to his/her index.

- If the score of the evaluated staff lies between 79-60%: the allowance will be calculated in proportion to the obtained score.
- If the overall grade of the staff is $< 60\%$: the performance allowance will not be granted.

If an employee leaves a health facility after being evaluated for a period of work but before receiving the PBF payment for his individual performance for that period, he/she should receive his payment once the funds are available.

In case of non-satisfaction of the results of the individual performance, the staff can appeal to the Management Committee of the health center.

CHAPTER VI: PBF SYSTEM MONITORING AND DATA COUNTER VERIFICATION

8.1 PBF System Monitoring

The main objective for conducting PBF system monitoring is to determine the level of compliance with the implementation of PBF conceptual framework and to provide recommendations to improve PBF System. The specific objectives are follows:

- To check the existence of updated PBF contracts between HC and Sector
- To ensure that PBF transfers have been received to the IIFs' accounts on time;
- To ensure that PBF received were paid to staff
- To verify if there are no ghost clients reported in HC documents;

8.2 PBF data counter verification

The Ministry of Health is responsible for counter verification of quantitative data at health facility level. The process is ensuring accuracy of PBF data validated by district, comparing it with data reported by HMIS reports, and other different registers and files at the facility.

The Ministry of Health or external agency conducts bi-annual counter verification exercise of health facilities data to ensure the level accuracy. The exercise is done by selecting HFs with doubtful data identified during the data analysis or the selection is done randomly. The counter verification objectives are:

- To verify whether the data reported in PBF database by Health Centers are similar to data from PBF evaluation grids.
To verify whether the quantitative data from the registers and other documents and the quantitative data from PBF database are similar.

For any discrepancy identified during the PBF data counter verification exercise, the extra amount received by HF due to false data is deducted for coming PBF payment and other corrective measures will be determined by Ministry of Health.

ANNEXES

Annex 1: Project location and target beneficiaries:

N	Name of District	Nber of HCs	Nber of Hospital
1	Nyabihu	15	1
2	Ngororero	15	2
3	Karongi	22	3
4	Rubavu	13	1
5	Rutsiro	17	1
6	Rusizi	19	2
7	Nyamagabe	19	2
8	Huye,	18	1
9	Nyaruguru	16	1
10	Ruhango,	15	2
11	Gakenke,	23	2
12	Kayonza,	15	2
13	Bugesera	16	1
	Total	223	21