REPORT ON THE EXCHANGE VISIT OF CORDAID PARTNERS TO RWANDA

October 13-17, 2008

INTRODUCTION

0.1. Background

CORDAID is a Non Government Organisation from the Netherlands committed to innovative health financing systems so as to improve access to health care. It has been intervening in Rwanda after the 1994 genocide. In the same time, CORDAID undertook actions in health financing field in other countries, such as Tanzania, Uganda and Zambia. In all those countries, including Rwanda, one system (whatsoever the name) of funding health actions was adopted by the donor, CORDAID: performance-based financing.

This is an approach to health financing 'that shifts attention from inputs to outputs, and eventually outcomes, in health services.'[1] The key principle is to address weaknesses by linking payment to the outputs or results delivered. The advantage of this way of working is to improve incentives and accountability, while expanding opportunities for mobilising private financing. The idea was rather successfully implemented in Rwanda.

As several partner organisations involved in the PBF programme in Tanzania, Uganda and Zambia have expressed the need to share ideas and experience with partners in other countries, an exchange visit to Rwanda was organised.

That visit was co-organised by Cordaid and Health, Development & Performance (HDP), one of CORDAID's partners in Rwanda. It led the Tanzania and Zambia representatives to visit the PBF pilot project in Nyamasheke and Rusizi Districts. It also planned for the conference held in Kigali from 16th to 17th October, 2008 on Performance Based Finance.

[1] http://www.pbfrwanda.org.rw/, Rwanda:Performance-Based Financing in Health, 12/12/2008, p.105.

0.2. Objectives

The visit targeted the following objectives:

- To improve understanding of the PBF concept;
- To improve knowledge about the issues involved in practical implementation of PBF;
- To improve understanding of the way care quality could be addressed in a PBF system;
- To improve understanding of the community role in PBF.

0.3. Scheduled activities

During that exchange visit, the following activities were scheduled:

- Visits to health facilities;
- Visits to Government officials, fund holders and technical assistants involved in PBF;
- Presentations of outcomes of the recent multi-country review;
- Presentations summarising the design of PBF in Rwanda, Tanzania and Zambia;
- Discussions about the strengths and weaknesses of PBF;
- Discussions about the impact of PBF on health facilities and health workers.

0.4. Participants' profile

Participants came from the Netherlands as CORDAID's representatives. Their role was to coordinate the technical aspect of the exchange visit. From Tanzania and Zambia, participants were representatives of their respective ministries of health and members of civil society. The Rwandan delegation was made of HDP representative.

0.5. Methodology

To make the exchange visit a success, the methodology used had three aspects. First, there was a study tour for those who were to discover what is going on in the implementation of PBF in Rwanda. They were given the situation and achievements so far.

After the study tour, presentations were made about the functioning of the programme. One was about the pilot project in Nyamasheke and Rusizi, the rest was about countries situation. Achievements, as well as strengths and weaknesses were described.

Discussions were the third element of the adopted methodology. This was certainly not the least important activity of the agenda, since the aim of the whole programme was to share experiences, so as to enable the participants be aware of possibilities and ways of positive change.

PART I: VISIT TO EX-CYANGUGU

1.1. Field visit

The whole group of participants left Kigali to spend the night at Rusizi City on 13th October, 2008. The following morning, the group was split into two sub-groups. One went to Nyamasheke District, and the other one went to Rusizi District.

Both sub-groups saw decentralised authorities, service provider and beneficiaries at community level. As health centres are by Government or Faith based organisations belongings, the group managed to meet both sides. So, one sub-group met Government institutions in Nyamasheke District, but the other sub-group saw Faith based organisations' hospitals and health centres.

1.2. Presentation of the pilot project in Ex-Cyangugu

1.2.1. Introduction

Cordaid Rwanda, Memisa at that time, started its operations as an implementing agency in Rwanda in august 1994. Until early 2000, all actions were focused on rehabilitation of infrastructures and more generally on reconstruction of a district health system. The experience in that field showed that despite the heavy investment done in the rehabilitation phase, health indicators only slightly improved

Two studies were conducted (October 2000 and January 2002) to examine the reasons why there was a low utilisation of health services. Main conclusion from both studies was the discrepancy between size of the inputs and the resulting outputs

The major recommendation from both studies was to change the health services financing system in order to make more money available at the health facility level.

1.2.2. How does the ex-Cyangugu Province PBF work?

The PBF in Cyangugu takes place in the following decentralisation environment. The main principle is to separate functions, regulation, service provision and financing.

The organizational structure is as follows:

- HF makes its business plan;
- If the plan is convincing it will lead to a contract between the fund holder and the HF;
- HMIS monthly reports are sent to ECD and Fund holder;
- ECD plans its monitoring and supervision and produce a report on the qualitative aspects of the services every three months (they also have a PBF contract with the fund holder for this activity);
- Fund holder organizes his monitoring (with close attention on subsidized indicators) based on the HMIS report received and produces an invoice which it pays monthly;
- The community based organizations contracted by the fund holder, get samples of the verifications to be done in the community (cycle of three months) and produce a report (verifying patient contacts and documenting client satisfaction on the services);
- When no abnormalities are detected, payment is done, however when irregularities are documented, the relevant clause in the contract that stipulates sanctions is applied;
- If indicators are improving as indicated in the business plan, the contract is renewed;
- One separate quarterly meeting with all service providers, with all community based organizations and with the local health and administrative authorities.

1.2.3. CORDAID's role

In PBF Cyangugu, Cordaid Rwanda plays the role of fund holder. First, it coordinates and puts together (basket) all subsidies from different partners, fund holders and Government. Second, it pays subsidies based on performance to individual Health facilities.

The payment mode is as follows:

- Every month based on the quantity produced by HF and verified by FH
- Every quarter quality bonus based on the evaluation of ECD and local associations

1.2.4. Who are the service providers?

The **service providers are the following:**

- Health centres (public or private) recognized in the HMIS (public and NGO/faith based);
- Private dispensaries (with authorization from the health district team) subcontracted by those HC;
- District hospitals (public and NGO/faith based.

1.2.5. Monitoring and Evaluation

Monitoring exists at three levels:

- Monitoring and supervision of the PMA and PCA by **Health district team** which leads after three months to a quality bonus in favour of HF;
- Monitoring on health indicators subsidised by the fund holder;
- Monitoring in the community among clients who used services for the confirmation of the figures which fund holder collected.

Evaluation is ensured by the Ministry in charge of Health represented in this case by the decentralised structures.

1.2.6. Contracts

In PBF Cyangugu, the fund holder, CORDAID, had contracts with twenty-six health centres, four district hospitals and four ECD. The Health facilities had on their turn about nineteen sub-contracts with private dispensaries

1.2.7. Strengths and weaknesses

1.2.7.1. Strengths

- Much improved levels of output and use of input;
- Staff behaviour changed with more commitment to their jobs;
- Out of pocket expenditure of patients decreased considerably;
- More money made available at the health facility level and used for staff bonuses and other recurrent expenditures;
- Government of Rwanda adopted this strategy in its national health policy and consequently fund it national wide.

1.2.7.2. Weaknesses

- Lack of funding to cover the whole PMA and PCA
- Poor linkage between performance based financing using external funds and community health financing schemes;
- The coordination of activities between partners can be improved;
- Lack of quality insurance system.

1.2.8. How to proceed?

- All PBF initiatives should work closely with local authorities in order to reinforce its sustainability;
- All PBF initiatives should find how to work together with the health insurance ("mutuelles") or community health insurance) in their intervention areas;
- Increase emphasis on quality service.

1.2.9. PBF expansion in Rwanda

- PBF is a national strategy since 2005;
- The Government of Rwanda is investing in the health sector sing this mechanism from 2005;
- The roll out plan of PBF on the national level is implemented since 2006;
- Three level of implementation exists for the present scheme of PBF in the country: PBF on hospital level, health centre level and community level.

1.3. Presentation of HDP

1.3.1. Name

HDP is an abbreviation from "**H**ealth **D**evelopment & **P**erformance". This name matches with the sector in which the programme intervenes, namely that of health only. As for development, it targets improving services and changing mindset.

1.3.2. Historical background

HDP is a local Non Government Organisation whose founders are ex-CORDAID workers. Just after the Genocide, the NGO called MEMISA intervened in the Rwandan health sector with a humanitarian assistance objective. MEMISA's rehabilitation phase started in 1996 and ended in 2000. Then CORDAID (this Non Government Organisation was a union of three organisations and one of them was MEMISA) took over with a focus on the development phase, with more focus on health financing sector. HDP was founded in 2006 by the CORDAID local staff so as to continue actions started by CORDAID.

1.3.3. Mission, vision and objectives

1.3.3.1. Mission

The mission of HDP asbl is in line with Cordaid's intervention in Rwanda: working for the country development through support to health sector in the three sides of the triangle, which stand for the different actors of the sector: the technical network (Ministry of Health, Partners, Hospitals, Health

Centres, Health care providers) the administrative procedure (District, Sector, Cell) and the population.

HDP's interaction with those different partners is achieved through activities conducted by its three operational sections: health centres, Training centres and Projects cell.

1.3.3.2. Vision

HDP's vision targets:

- Building the population's capacity to get together and undertake health actions, to introduce Enhancement of service quality community-based health insurance mechanisms and put in place income generating projects initiatives;
- Building the population's capacity to express the way they appreciate received services;
- Capacity building for supported administrative and health structures staff;
- Enhancement of staff performance of supported administrative and health structures ;
- Enhancement quality of services provided by supported administrative and health structures.

1.3.3.3. Objectives for 2008-2009

a) HDP's general objectives are the following:

- To make HDP operational and financially autonomous;
- To go on with the action initiated by CORDAID/Rwanda by integration and implementation of its activities within HDP.

b) HDP's specific objectives are the following:

For health centre:

- To make the health centre operational and financially autonomous;
- To ensure health security cover;
- To make available a minimum complete package of curative and preventive activities of good quality;

- To integrate the health centre into the national PBF system and into the "mutuelles de santé" system.

For the Training Centre

- To make the Training Centre operational and financially autonomous;
- To make available a didactic package on PBF, on the "mutuelles", quality insurance and HIV/AIDS.

For the Projects Cell

- To make the Projects Cell operational and financially autonomous;
- To go on providing technical assistance to districts in the Western Province within the framework of PBF and elsewhere in the country, of "mutuelles de santé" and community participation.

1.3.4. Subsidies

HDP funding sources vary in accordance with approved projects by donors and implementing agency.

PART II: COUNTRY PRESENTATIONS

2.1. Rwanda presentation

2.1.1. Objectives of the PBF

The **overall objective** is to improve the health status of the Rwandan population, and the **specific objectives** are the following:

- To improve the accessibility of the population to the health care services;
- To motivate the health personnel;
- To insure financial equity between the different districts;
- To improve the quality of health care;
- To reinforce the management of the health units and insure the autonomy of those structures.

2.1.2. The target

- The indicators related to the MDG's: Infant and maternal health, HIV/AIDS and Malaria
- MPA: Minimum package of activities at H.C. level.
- CPA: Complementary package of activities at D.H.

2.1.3. Strategies

- To remunerate the outputs;
- To consider the quality of services deliveries: supervisions and controls;
- To manage the contract;
- To monitor the functioning of the District Steering Committee (Piloting committee);
- To produce the management tools;
- To train the staff at different levels.

2.1.4. Monitoring and Evaluation System

- At H.C level: Done by the DH team and USF monthly for both quantity and quality;

- At DH: peer review system (Hospitals clusters in a group of 4. Three evaluate the 4th);
- The score is given to the institution which affects the financial flow and the top up to be allocated to the personnel during the quarter.

2.1.5. Payment of the personnel

- Indice value for 100%: 215
- Performance of the structure: 80%
- Revenue of staff: 215X80%X Indice
- The staff members must do all possible to improve their cotation so that they increase their revenue.

2.1.6. Tools currently used

- Health centres bunch of indicators
- Health centres evaluation standards;
- Evaluation standards of HIV sites indicators;
- Evaluation standards of HD by peers;
- Website for managing data and bills.

2.1.7. Conclusion

- The PBF is a dynamic approach
- The health personnel are motivated and are innovative on how to improve their performance.
- The management of health structures is being consolidated.

2.2. Tanzania presentation

This presentation was done on 16th October 2008 in Kigali, Rwanda, by the delegation from Tanzania.

2.2.1. Background

- There is little progress made in the reduction of maternal and new born mortality ratio over the past decade.

- Road map for accelerating reduction of maternal , new born and child deaths is in place

- Through better motivation and explicit attention to results, **Pay for Performance [P4P] is one** of the strategy expected to ensure that health workers and their supervisors are Motivated, actively seek ways to increase coverage and quality of service including address local service delivery constraints

2.2.2. Implementation

- Feasibility study was done between October 2007 and February 2008. It came up with proposed design for consideration;

- The P4P proposal was interpreted in the context of Tanzania LGAs , and the Basket financing modalities;

- The DPs agreed to increase the funding level of per capita from 0.75 US $ to 1.0 US $ with a condition of introducing P4P in the service provision, using the increase 0.25 US $;

- The government summarised the P4P approved documents and made a circular to all LGAs, and RAS to factor in the CCHPs, HCs, Dispensary plans an activity P4P – to finance Bonus payments to levels mentioned in the documents.

- All LGAs – CCHPs 2008/09 have activities to operationalise P4P.

- National coordination unit under DPP established

- Ministry of Health and Social Welfare has developed Health Centres & Dispensary planning templates and the P4P activities have been included

- RHMTs similarly have factored P4P activities in their plans and those of Regional Hospitals.

- Payments:- It is proposed to be done twice a year. Midyear and end of FY.

Amount for Payments:-

- Dispensary: 1 million per year
- Health Centre: 3 million per year
- Hospital: 9 million per year
- Regional Hospital: 10 million per year
- CHMT: 3 million per year
- RHMT: 3 million per year.

Performance Indicators

- Immunizations DPTHb 3 - 85%;
- Deliveries in health facilities – 65%;
- IPT for pregnant women – report;
- Quarterly HIMS reports – timely and accurate.

2.2.3. Roles of Partners

- Include Result Based Bonus Scheme in their budgets;
- Facilitate the Development of implementation guidelines;
- Facilitate Monitoring and Evaluation.

2.2.4. Role of Ministry of Health and Social Welfare

- Develop implementation Guidelines;
- Facilitate implementation;
- Track Progress;
- Share and disseminate best practices;
- Undertake annual assessment;
- In collaboration with PMORALG award bonuses to Regions;
- Revise the model for subsequent years.

2.2.5. Role of RHMTs

- Supervise CHMTs;
- Provide Technical Support to districts;
- Prepare reports and submit timely;
- Award bonuses to CHMTs.

2.2.6. Roles of CHMTs

- Conduct Supportive Supervision to Hospitals, Health centres and dispensaries;
- Conduct annual biannual P4P assessment;
- Award bonuses to facilities.

2.2.7. Clients

- Direct clients: Health workers in Hospitals, health centres, dispensaries, CHMTs and RHMTs
- Indirect clients: Consumers of health services.

2.2.8. Key activities and time line

- Developing implementation guidelines in October 2008;

- Orientation on the implementation guidelines to national facilitators, regions and districts through zones in phased approach in November 2008;

- Orientation of facility in-charges &other staff [November – December 2008 +]

- Monitoring activities
    - Supportive supervision [January – May 2009]
    - Monthly reporting [*January – June 2009]

- Awarding of bonuses to facilities, CHMT and RHMT
    - Assessments[Facilities- June, 2009]
      [CHMTs and RHMTs – June, 2009]
    - Awarding [Facilities - June 09]
      [CHMTs& RHMTs - July/August 09]

- National Performance report 08/09 September 09

2.3. Zambia presentation

2.3.1. Introduction

The following elements show the Zambian Health System, after the Health Reforms initiated in 1992:

- **Health Vision:** ***"...provide the people of Zambia with equity of access to cost-effective, quality healthcare as close to the family as possible…";***
- **Three-Tier decentralized system of Planning & Implementation;**
- **Input funding through Sector Wide Approach (SWAp);**
- **Basic Health Care Package of Interventions;**
- **Community Involvement in Health Service Delivery.**

2.3.2. Selected Health and Socio-economic Indicators

Infant Mortality Rate per 1000 live births	79	95	70
Child Mortality Rate per 1000 live births	120	168	119
Maternal Mortality Rate per 100,000 live births	20.1	729	449
Fully Immunised Children Under 1 Year (%)	73%	76%	87%
HIV/AIDS prevalence (15-49yrs)	23%	15.6%	14.3%
Life Expectancy at Birth (Years)	46.9	43	41
Incidence of Poverty (%)	70%	68%	64%

2.3.3. How to finance health services

Financing health services is characterized by the following:

- Augment input funding with PBF;

- Sustain the recent gains and further reduce the indicators towards attainment of MDGs;
- Enhance equity and pro-poor focus by providing more support to low performing districts;
- Child and Maternal Health indicators can be further improved through scale-up of incentive schemes i.e. PBF, Rural Retention schemes, infrastructure development.

2.3.4. What is Results Based Financing or "RBF"?

Results Based Financing (RBF) is *"Transfer of money or material goods conditional on taking a measurable health related action or achieving a predetermined performance target",* that is, from the Centre for Global Development working Group on Performance Based Incentives. **Financial risk** is the assumed driver of change.

2.3.5. Overall objectives of the RBF in Zambia

The overall objectives of the results-based financing in Zambia are the following:

- Increase coverage of key interventions that contribute to reducing maternal and child mortality;
- Contribute to changing the policy & implementation framework in Zambia from a focus on inputs & processes to a focus on performance & impact.

2.3.6. How will RBF contribute to improved maternal and child health?

The results-based financing contributes to improve maternal and child health by:

- Motivating health workers and their supervisors;
- Helping to build capacity at community, health centre, district, and central levels;
- Strengthening the systems needed to deliver quality services;
- Rewarding innovation and results.

2.3.7. The "All Important" Details

- US $15 million grant won by the GRZ through a competitive process;
- Additional US $ 1 million dollar impact evaluation to measure progress and results;
- Funding will flow through the district basket;
- Facilities and district teams will be rewarded (with money) for increasing utilisation of key services by women and children;
- Performance will be measured against a set of pre-agreed indicators collected by the HMIS.

2.3.8. Operational Design

- Pilot will cover 9 districts; one in each province of Zambia
- Performance contracts between health facilities and DHMT
- Performance contracts between DHMT and MoH

2.3.9. Performance Targets

- % increase in institutional deliveries;
- %increase in postnatal visits within 6 days of delivery by health centre staff (delivery at home or in facility);
- % increase in full immunization of children under 1 (target depends on baseline);
- % increase in pregnant women receiving 3 doses of IPT;
- Contraceptive prevalence rate;
- % pregnant women received Iron supplements at antenatal care;
- % houses with bed net properly set up;
- % children taking Vitamin A administered by CHW.

2.3.10. Katete Pre-Pilot to inform design

2.3.10.1. Payment Model

Katete has been randomly divided into two groups:

- Group A: **target-based**- performance rewarded against a set-of pre-agree targets. Example: reward if 70% of children under 1 are fully immunized.

- Group B: **fee-for-service**- payment of a fee for each unit of a service provided. Example: pay x for each fully immunised child.

2.3.10.2. Data Quality

- Builds on existing HMIS. Each month, facility reports to district. Each quarter, district reports to centre;
- Assess strengths and weaknesses;
- Develop a plan to strengthen data quality;
- Use District Management Tool to monitor progress and identify potential data entry errors.

2.3.10.3. Data Validation

- Evaluate proposed approach to externally validate reported data at both district and facility level;
- Independent entity contracted to examine random sample of reported results. Households interviewed to verify;
- Penalties for discrepancies.

2.3.10.4. Capacity Building

- Provide tools to district team to help manage results in the district;
- Establish new systems and strengthen existing ones, such as financial management, which enables facilities to open bank accounts and manage funds, and technical assistance. In this case, DHMTs will provide strategic assistance to help low performing facilities improve.

2.3.10.5. Timeline

- October 15, 2008: roll-out of Katete pre-pilot
- January 15, 2009: roll-out of pilot in Zambia
- Pilot will run for 3 years.

The pre-pilot will inform the design and implementation of the pilot.

2.3.11. Design elements and implementation considerations

- Agree on **indicators**: Small number is best;
- Agree on **targets:** Relative to own baseline;
- Agree on **reward** (or penalty) linked to attainment of target;
- Agree on way to **measure and validate;**
- **Regulatory role** and **Fund holder;**
- Agree on **Institutional framework** while sustaining what is currently working;
- Capacity Building and more investments for low performing districts;
- Huge amount of money available through basket funding as compared to PBF;
- Sustainability of the PBF.

2.4. CORDAID

2.4.1. Why Performance Based Financing

- Complexity of health systems
  - Central steering not possible
  - Decentralization - output
- Investments in health systems do not bring the expected results in terms of:
  - Equity (subsidy on fees)
  - Efficiency (spend money as effective as possible)

2.4.2. Literature study

- Studies in Grate Lakes Region, Afghanistan and Haiti have shown that PBF works in terms of:
  - Staff motivation
  - Increased accessibility (utilization, coverage and fees)
- Further research on impact necessary

2.4.3. PBF principles

- Contracting

- Decentralisation
- Autonomy with monitoring on output
- Separation of responsibilities (purchaser – provider) with a referee
- Community participation
- Context specific
- Commitment of providers, high level MoH and other stakeholders is crucial. Capacity building is essential.

2.4.4. Tanzania approach

- Pilot because
  - Positive experiences in Rwanda/Cambodia
  - More emphasis on outcome of funding
- 5 dioceses
- 5 indicators
  - IPD, OPD, Deliveries, VCT and drug stock outs
- 0,5 US $ per capita
- 50% fixed and 50% based on performance
  - US $42,000 for hospitals (5% -10%)
  - US $14,000 for health centres
  - US $7,000 for dispensaries (20% - 30%)
- Criteria for spending funds
- Verification
- Funding through diocesan health offices.

2.4.5. Zambia approach

- 4 indicators
  - IPD, Deliveries, VCT and drug stock outs
- 3 dioceses
- US $ 0,60 per capita
- Start January 2007 and 2008
- Verification not yet done
- Funding through diocesan health offices

2.4.6. Congo and Burundi approach

- Local fund holder (priorities/indicators, verification and capacity building)
- Involves public as well as faith based facilities
- Higher funding levels due to EU funding
- Contracts with health facilities
- 15 indicators, including referrals, deliveries, OPD, ANC, immunisation

2.4.7. Outcome of evaluation

- Hard to attribute increase in utilization to P4P
  - HR crisis
  - National programmes (VCT; Malaria)
  - Failing information systems but recording has improved
- P4P has an impact on staff motivation through increased involvement in decision making (impact higher in lower level units)
- Many challenges when it comes to system design

Burundi/Congo vs Tanzania/Zambia

Clearer results in Congo/Burundi, due to:

- Amount of funding
- More autonomy
- Capacity building and technical assistance
- Contracting including business plan
- Starting point

2.4.8. Challenges

- *Choice of indicators:*
  - More attention for preventive care
  - VCT not a good indicator
  - Catchment population as a denominator
  - Include quality.

- *Gap between performance and bonus*

  - Payments not in time
  - Bonus is seen as entitlement
  - Bonus too small.

- *Participation*
  - Community
  - Facilities
  - Other stakeholders
  - Local Government.

- *Also related to capacity (DHO/facilities)*
  - HRM, financial management, general management
  - Planning (business plans, CCHP)
  - Toolkit for introduction.

- *Make sure lessons learnt are shared*
  - Involve stakeholders
  - Institutionalize knowledge sharing
  - International knowledge sharing.
  -
- *Verification:*
  - Community involvement
  - Quantity **and** Quality (only supervision checklist available)
  - More efficient.

- Ownership and autonomy facilities
- Improve registration (HMIS)
- Quality assurance system (Tanzania)
- Decreasing effect of staff motivation.

- *Role of different stakeholders*
  - The fund holder
  - CORDAID: building capacity / advocating / sharing experiences with other countries
  - CSSC/CHAZ: facilitating PPP
  - MoH

PART III: RESOLUTIONS

By the end of the exchange visit, participants came to an agreement. They had realized that sharing experience was a positive practice. They found that it was a way to help one another, which would enable everyone to progress. They promised to go on that way, especially because the performance-based financing is a learning process.

Participating countries in the conference are not going to copy the Rwandan system as it is. They will instead implement it basing themselves on different realities on the ground, because, for example, hospitals and health care centres have the legal autonomy allowing them to sign contracts.

CONCLUSION

The performance-based financing is not only a payment means. It is also a strategy to change mentality. It is due to go beyond assistance and reach reality of creativity. According to participants, and it is a matter of fact, the idea is to be adapted to every country, taking into account local realities, notably the cultural ones and the socio-economic context.