

Trip Report: Supervision & Planning Visit:

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March 2006

This report was made possible through support provided by the US Agency for International Development, under the terms of Contract number GHS-I-00-03-00030-00, Task Order GHS-I-02-03-00030-00. The opinions expressed herein are those of the author(s) and do not necessarily reflect the views of the US Agency for International Development.

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**Rwanda HIV/PBF
PROJECT**

Trip Report

**Supervision &
Planning Visit:**

**Implementation Review
And Reporting on Jan
through March 2006**

**Revision of Project
technical Strategy**

**Performance Review &
Work Planning**

**Review of Subcontractor
Scopes of Work**

April 21-May 6, 2006

John Pollock

Background & Summary

The **Rwanda HIV Performance-Based Financing Project** was launched by MSH and its partners, Cordaid, Healthnet International-TPO, and IntraHealth in January. The initial contract with USAID is for 2 years, followed by a two-year option period, pending initial success implementing the HIV/PBF project.

The Project builds on innovative performance-based financing pilot projects in Rwanda (implemented by Cordaid, HealthNet and others) that have provided monetary and other incentives and subsidies to some health facilities in Butare and Cyangugu provinces (and other districts in the general Kigali area) to increase the delivery of specific PHC services. The Project applies the lessons learned from these projects, as well as from MSH and Partner experiences in Haiti, Cambodia, Afghanistan and elsewhere, to extend the scope of services covered to include HIV/AIDS services (including ART). A major challenge for the Project is to ensure that incentives for HIV/AIDS services do not negatively impact on primary health care services and that the lessons learned in earlier and related programs (such as QAP) are effectively integrated into the work plan.

Program priorities require adaptation of the current draft work plan in collaboration with the Ministry of Health, project partners, and other agencies operating in support of the Rwanda health system.

The structure of the HIV/PBF team is designed to integrate with ongoing efforts in PBF (*l'approche contractuelle*) being developed under the leadership of the MOH and with active support and participation of several donors and agencies. Recently, a decision was made to change a basic USAID program strategy and as a result, the HIV/PBF project will not be taking over the support of services in large numbers of health sites from currently active clinical CAs. USAID and the Rwanda MOH have supported the revision of our implantation strategy and agreed to the proposed restructuring of effort to focus on rollout of a national system for payment of output incentive payments and intensive support to performance improvement within district hospitals.

Goals for Visit

The scope of work for this trip was approved as follows:

- Finalize the revision of project implantation strategies
- Work with the team to finalize the HIV-PBF Project Quarterly Report for January through March, 2006
- Work with the project Team Leader to review work plan elements with USAID, MOH and partners and develop a work plan and budget for PEPFAR COP 06
- Assist the MSH team in conducting the regular PP&R process and complete the PP&R review with the Team Leader
- Meet with subcontracting partners to review scopes of work and approaches.

Outputs/Deliverables

Supervision report

Implementation strategy

Draft work plan for HIV/PBF Project based on collaboration with GOR, USAID, and other partners for COP 06.

Activities and Results

Finalize the revision of project implantation strategies

Meetings were held with USAID, with the team, with technical and clinical partners and with the MOH. After establishing that the agreement to eliminate the 'graduation' strategy as the mechanism for rolling out the PBF program was confirmed, the MSH team developed a revised approach for using the project resources to promote the GOR and PEPFAR program goals within the contract budget and overall SOW.

The revised plan is described in detail ANNEX 1. The two major themes are that a) MSH and its partners will support the MOH in establishing a national output incentive system that will pay premiums for achievement of targeted results on an equitable basis across districts, and b) MSH will provide direct support within a series of district hospitals (to be specified by the GOR) to improve the quality and efficiency of clinical and management systems.

Another element of the MSH role will be to provide consulting services to CA partners to assist them in meeting their program obligations with their now-expanded roles in the PBF roll-out.

Work with the team to finalize the HIV-PBF Project Quarterly Report for January through March, 2006

The Quarterly report was completed on schedule and reviewed in Cambridge prior to submission.

Work with the project Team Leader to review work plan elements with USAID, MOH and partners and develop a work plan and budget for PEPFAR COP 06

The work plan was reviewed in relation to the new roll out strategy and the HIV/PBF team completed a new project work plan in time for the regular due date for the PEPFAR COP 06 planning process. The elements of this work plan have been reviewed with the Director of DSS (Dr. Rusa) and have his full support. He has already taken the lead in presenting and explaining this approach in two broadly attended meetings that included multiple partners. The draft work plan file is now being reviewed by the USG team and, after any needed revisions, will be presented to the GOR for discussion and approval as part of the routine PEPFAR planning and implementation process (in May and early June).

Assist the MSH team in conducting the regular PP&R process and complete the PP&R review with the Team Leader

The MSHH PP&R process is well under way in Rwanda. The review with the team leader (including conferral with USAID, the MOH, the leader of another MSH Project team, and senior members of the HIV/PBF Project team). A Joint RPM+/ HIV-PBF project staff session was held to review the purposes and process of the MSH performance management system with the goal of completing the reviews by May 12.

Meet with subcontracting partners to review scopes of work and approaches.

Meetings were held with Intrahealth, Cordaid, and Healthnet staff to review roles and clarify approaches for moving forward together. Intrahealth is still in the process of recruiting the full-time HCD professional that we agreed on in January, they are actively discussing with Healthnet the assignment of their main Rwanda-based staff member to the project as a full-time regional coordinator in the South, and the Cordaid team is actively working with us under the established MOU provisions. The issues that CORDAID has expressed with the USG requirement for an anti-prostitution policy continues to make a full sub-contract impossible. The strategy for assuring collaboration and progress toward common goals was reviewed and clarified.

HIV-PBF Project Support to National Performance Output System

Phases 0 (13 Districts) and 1(10 Districts)

and

Support to Selected District Hospitals

HIV-PBF Project Support to

National Performance Output System

- System tracks a clearly defined set of PHC and HIV/AIDS indicators and progress toward specific targets
- HIV-PBF project supports MOH in selection and confirmation of focus indicators
- HIV-PBF project supports MOH in defining the level of output payments for each indicator target
- HIV-PBF project supports MOH in design and implementation of M&E System to track outputs
- Service Results are reported by Health Centers and District Hospitals (through Districts) to MOH Monitoring system

HIV-PBF Project Support to

National Performance Output System

- HIV-PBF Project signs contracts with Districts to support data reporting and pay for outputs that meet targets.
- Payments are approved by MOH to be made to Districts for distribution to Health centers and Hospitals based on achievement of targets
- M&E system triggers routine process for validation of reported service data (Quantity & Quality)
- M&E system is inclusive of **all stakeholders**, It is guided by M&E manager with TA from HIV-PBF, but is NOT a unit to be staffed separately from health delivery system

HIV-PBF Project Support to

National Performance Output System

- Key element is to assure that all output payments (incentives) come from national system. Other partners pay for performance, but do not offer output premium payments.
- All Phase 0 and Phase1 Districts are eligible to participate.

HIV-PBF Project Support to Selected District Hospitals

- Selected District Hospitals receive support from the HIV-PBF project through arrangements to improve Management Performance (Finance, Management, Human Resources, etc) and Service Delivery results.
- Targets for improvement will be agreed to by Hospital Managers and District leaders.
- The HIV-PBF project will provide TA and input support as required to meet program goals.
- Major equipment, and operating costs will continue to be paid through existing arrangements with Donors and cooperating Agencies/
- Incentive payments for reaching performance targets will be paid through the National Performance Output System.

Kigali, 24 April 2006

Issue:

The HIV/PBF Project SOW can be redesigned to accelerate roll out of HIV/AIDS services, improve equity and enhance quality.

Background:

Payment for health care services on an input basis in Rwanda does not necessarily guarantee performance in terms of access to and quality of those services. Service support funds (subsidies) maintain provider salaries and other recurrent costs, but do not hold providers or managers directly accountable for performance (results). The PBF model in use in Rwanda now pays premium amounts for specific services – and so does pay for results – but can be enhanced to increase the incentives to Managers and Providers to expand service provision and improve its quality.

Given that the USG and GOR expect that technical assistance and financial support to services will be provided within each district by a single Collaborating Agency, the opportunity is clearly presented to redefine the HIV/PBF project approach to support the GOR in establishing a national program to promote access to high quality services without disrupting processes already under way.

Intervention by the MSH HIV-PBF project:

The HIV/PBF team can, for specifically identified sites that need service support, provide both technical assistance and support much like had been originally envisaged.

One major difference is related to the budget available per site; whilst originally the USG and MSH had envisaged that the MSH project would ‘graduate’ sites managed by CA’s to PBF, recently a decision has been taken to have CA’s continue to provide TA to their sites whilst the MSH PBF project would focus on output financing only. Whilst originally, the budget computed for each sites, computed from the average cost of ‘managing’ an established site by CA’s (at around \$35K per site per year), was around \$35K per year, MSH will now restrict itself to pay for outputs only, with an **indicative budget of about \$11K per year per site**. This will free up about \$24K per site per year of ‘input financing’. These freed up funds in combination with any potential non-HIV funds will be used for output (incentives) financing for 5 district hospitals and partnership with the MOH in establishing a national incentive plan.

Whilst the exact magnitude of the recurrent costs at the Health Facility level to provide HIV/AIDS services will need to be computed still (work on this component is in progress), early data suggest that, at the Health Centre level, 100% of the recurrent costs-bar drugs and consumables- could be financed through Output based financing (within a PBF budget for HIV/AIDS services per site of approximately \$11K per year).

Additionally, if funds are available to support non-HIV/AIDS services, those elements could be included.

We propose, in line with our current SOW/contract to work in:

- I. Gicumbi District: 9 Intrahealth sites by Sept 05, 11 by Sep 07. There are two GF sites that can be added leading to a total expected sites in which PBF for HIV/AIDS services are implemented: **13 sites by Sept 07**

- II. Rubavu District: 3 MCAP sites (plus 2 GF plus 1 UNICEF site): Cordaid TA for assisting the Gov for PBF for general services in addition to the TA under our sub-agreement. This would lead to **6 sites by Sept 07**
- III. Rutsiro District: 5 MCAP sites (plus 2 GF): Cordaid TA for Gov PBF in addition to the TA under our sub-agreement. This would lead to **7 sites by Sept 07**
- IV. Ngororero District: 4 MCAP sites (plus 6 GF and 1 UNICEF site): Cordaid TA for Gov PBF in addition to the TA under our sub-agreement. This would lead to **11 sites by Sept 07**
- V. Nyaruguru District: 4 IMPACT/FHI sites (plus 4 GF): HNI TA for Gov PBF in addition to the TA under our sub-agreement. This would lead to **8 sites by Sept 07**
- VI. Nyanza District: 1 IMPACT/FHI site: HNI TA for Gov PBF in addition to the TA under our sub-agreement. This would lead to **1 site by Sept 07**.

In total, by Sept 07, we would provide PBF for HIV/AIDS services in a **total of 46 sites in six Rwandan Districts plus the impact of supporting the national incentives system.**

It is important to point out that these six districts are all in the WB ‘phase 1’ areas and that the remaining WB ‘phase 1’ areas are taken care of by the BTCCTB project, therefore, being entirely in line with the Minisante its roll-out plans. An outstanding issue is the introduction of PBF activities by CA’s in areas ‘managed’ by the BTCCTB. TA by MSH will be provided to those CA’s who want to introduce PBF for HIV/AIDS services in BTCCTB areas.

In addition, in these six districts, in partnership with the local health authorities, Cordaid and HNI we propose to write contracts with (a) the District Hospitals in six districts to carry out the medical supervisory activities, based on performance, of the quality of general service which include HIV/AIDS services and (b) the Unite Sante et Famille of the Town Hall (Mairie) to do the ‘control/verification’ function. A rough costing for such contracts indicates that an amount of about \$25K for each contract amounting to an **estimated total of \$50K per district per year** would be involved. This amount includes an aspect of input financing to provide these administrative units with means to exercise its functions. In later years, a considerably lesser budget would be necessary to pay for these administrative functions. CA’s presence and continued activities in HIV/AIDS in the districts will provide for the TA necessary to facilitate the medical supervisory teams to ensure Quality of HIV/AIDS services.

Finally, the MSH PBF team will work with the Minisante to assist to develop its PBF system for the District Hospital level (treating DHs as sites); budget freed through moving away from its ‘input financing’ component, could be diverted to finance PBF at the District Hospital level. A rough cost estimate, based on real costs from Cordaid’s District Hospital PBF system, point at a budget requirement of **approximately \$100K per District Hospital per year.**

The project can also proceed as originally planned to work with the GOR/Minisante to enhance capacity to manage HIV/PBF. This area of activity was designed to be primarily one of capacity building. A useful change would be to carry out the capacity building in the context of establishing a national system for aligning performance incentives with GOR (and USG) policy and performance goals for the health system. The approach would link the Monitoring and Evaluation system with a frame work for payment of performance incentives (rewards) for desired performance and establishing consequences (disincentives) for non-performance.

The institutional development elements (Systems, Training, and Leadership development) would, in principle, go ahead as planned.

The incentive system would require establishing a national approach to Monitoring and Evaluation. Much of this is still in a very early stage of development.

The HIV/PBF project team would partner with the GOR/Minisante to link a framework of results targets to the performance of each Hospital, District Administrative Unit and individual health facilities. The team will establish a table of performance incentive payments that will be made to Hospitals, District Administrative Units and individual Health Facilities for achieving the desired thresholds for quantity (access) and quality of services. This system could also establish consequences for significant performance failures.

Because the incentive payment mechanism would reward results, managers will have a reason to examine the way they manage resources, organize services, and the way they motivate and supervise staff. MSH together with its partners Cordaid and HNI will provide TA to the district health authorities and the hospital managers to optimize performance.

The incentive promise can transform routines into strategies for results (improving quality of care and efficiency). Positive innovations will appear locally in the system that can be identified in the M&E and modeled elsewhere.

Basically, MSH's proposal is to link payment for performance for HIV/AIDS services to other services as detailed in Rwanda's Minimal and Complementary Packages of Health Services. A system will be designed to ensure that payments for the Quantity of Services by HIV/AIDS services will be influenced by the documented Quality of Services (which include HIV/AIDS services), through regular medical supervisory activities. The exact weight of the influence of the Quality of Services will be designed in close collaboration with partners in the field and the PBF department of the Minisante.

Measurement of Performance Indicators:

Monitoring and Evaluation that the MSH HIV-PBF Team will work with the Minisante to implement will consist of the following four components:

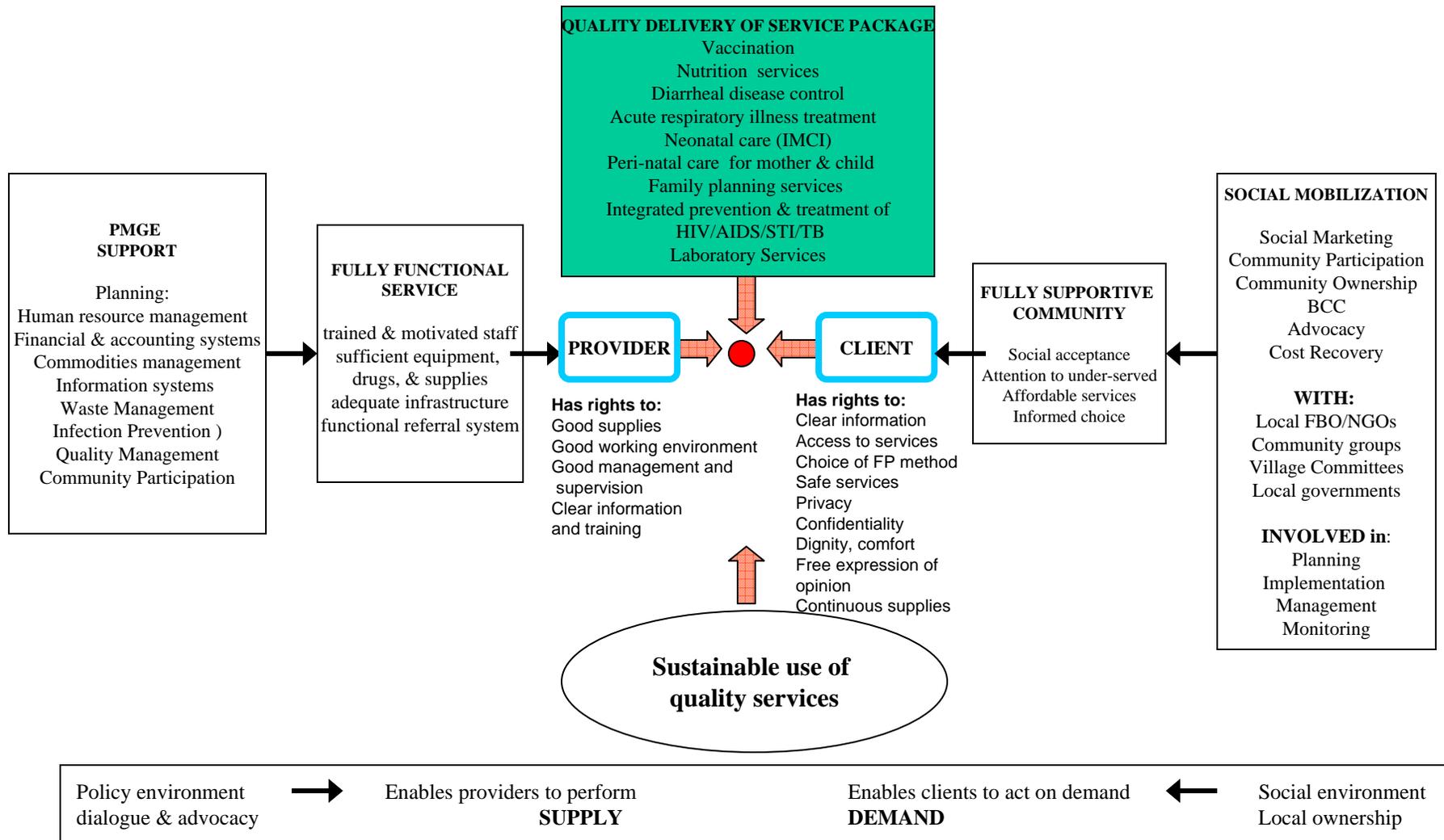
1. The first component will be a performance/results framework based on a contract with the 'Equipe Cadre de l'Hôpital' to do medical supervision. This supervision will use a tool adapted from Cordaid's program. Deliverables could be the timely submission of reports related to supervision of 13 activities over a period of three months. A composite score will be extracted for each HC. Activities to be supervised will include HIV/AIDS. Scores for the clinics will be compared and a 'Quality' bonus will be computed and added/subtracted from the quarterly payments to the HC. MSH will assist the Minisante to assure that the M&E system will both ensure that the deliverables have been met and that the services were of acceptably high quality. (Spot-checks in the field and, possibly, joint supervisory activities will form part of the introduction of this component.)
2. The second component will be a results framework with incentives to be paid through a performance based contract with the 'Unité Santé et Famille' of the Town Hall (Mairie). Again, the mechanism could be worked out to engage the Minisante

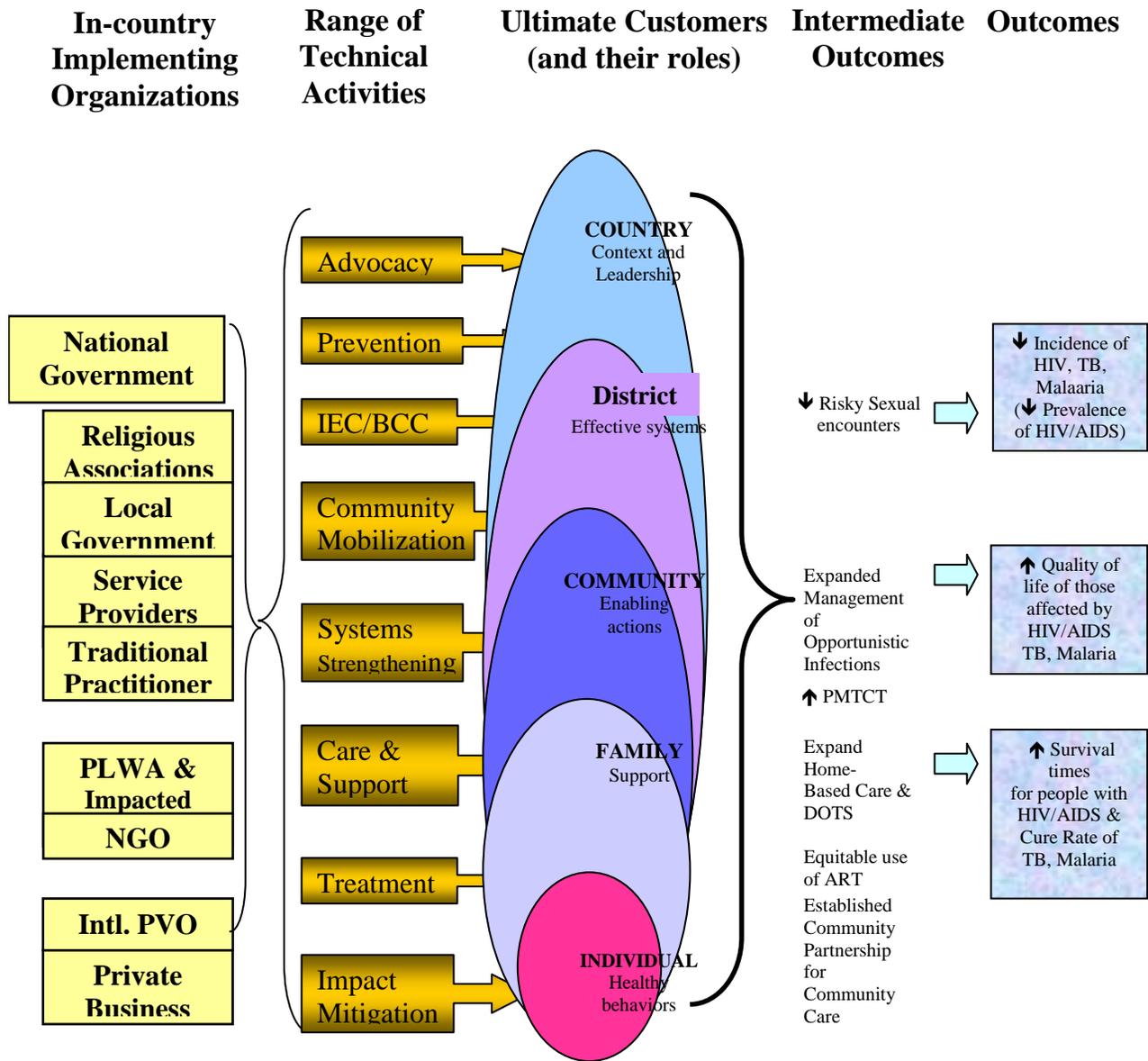
as a party to the agreement. This contract will involve the timely submission of reports of control/verification activities. The frequency could be once per quarter. Deliverables will be monitored by the MSH team; joint controlling activities will form part of the introduction of this component. [*Service support and TA will be a separate function in this component...not part of the MSH arrangement with the MOH*] The Virtual Leadership Development (VLDP) intervention is appropriate here.

3. The third component will be monitoring of the general Quality of services using an adapted version of the SDMA (Again with the MOH and engaging teams of stakeholders). Both a baseline and regular, possibly six-monthly, perhaps annually, assessments will be made. A possibility to contract out the assessments to the National Public Health School will be studied. An electronic version, to facilitate data input and comparison, will be designed by MSH (LL). Specific bonuses could be devised to reward quality enhancing innovations that can be replicated elsewhere. The actual cost of this component will need to be computed still. The Collaborative Approach will be used as well, for experience sharing and peer review process gathering HCs and conducting this QA exercise between DHs. MSH can propose to use the *MOST* in DHs as MOH would like to have each of them develop an annual action plan to improve their performance.
4. The fourth component will be formed by the six-monthly 'verification' activities carried out by the National Public Health School, contracted by the WB to monitor/verify the results from the PBF activities. These surveys will include HIV/AIDS services. The WB/Minisante will pay for this activity, but the HIV PBF project will be able to lean on its results.

JP/GF/OF/KK

FULLY FUNCTIONAL SERVICE DELIVERY POINT





The project must meet Emergency Plan targets

National Performance Output System

- National Performance Network Pays for Results

