Performance Based Financing of Health Services in Rwanda: Development of a National PBF Model

Ministere de la Sante Republique du Rwanda

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Performance Based Financing of Health Services in Rwanda: Development of a National PBF Model

REPUBLIQUE DU RWANDA

MINISTERE DE LA SANTE
B.P. 84 KIGALI

DRAFT March 1

Proceedings of a three-day Workshop
16, 17 and 18 February 2006

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Background to the Work Shop

The Government of Rwanda (GOR) has made Performance Based Financing (l'Approche Contractuelle') the cornerstone of far-reaching health financing reforms.[1] Together with obligatory community health insurance schemes ('mutuelles') and a new Quality Assurance Policy,[2] Performance Based Financing (PBF) aims at increasing the effectiveness, efficiency and quality of health services.

Evidence of the efficacy of PBF in increasing the effectiveness and quality of health services whilst at the same time increasing the outputs considerably and, in some cases, even lowering the financial burden of out-of-pocket payments by patients, was obtained in two PBF schemes: one in the former Cyangugu province, set up with the help of Memisa/Cordaid, the other in the former Butare province set up with the help of Health Net International (HNI).[3] These two schemes have been ongoing since 2002. GTZ also worked on PBF schemes in Kibirizi and Byumba. A fourth scheme, started in March 2005 by the Belgian Cooperation (BTCCTB) also added to the evidence of the effectiveness of PBF to induce considerable positive changes at the Health Facility level. Currently, PBF schemes cover 137 health centers (40% of total health centers in Rwanda) and 11 District Hospitals (about 30% of total District Hospitals in Rwanda).

The GOR plans, during 2006, to roll-out PBF schemes to all Health Facilities in Rwanda; at the University Teaching Hospital level, the District Hospital level, the Health Centre level and at the Community level. Whilst the Government will finance the PBF schemes at the Teaching Hospital level and the Health Centre and the Community levels, development partners are requested to focus on PBF schemes at the District Hospital level.

Introducing PBF nationwide demands careful collaboration with various on-going events and with multiple partners;

(i) The national roll-out of PBF coincides with the implementation of far-reaching administrative reforms in which administrative boundaries have been redrawn, provinces have disappeared, districts have been remodeled and created, new district names have been introduced and a new structure for public health management is envisioned.
(ii) The World Bank has designed a scientific study to measure the impact of PBF in Rwanda. The 'roll-out' plan envisions delaying the start of PBF schemes in eight districts until March 2007.[4]
(iii) Various PBF actors use different models (HNI; Cordaid; BTCCTB), whilst some actors are planning to start PBF schemes; GOR; USAID/MSH HIV PBF project and the German Technical Cooperation (GTZ).
(iv) Obligatory health insurance schemes ('mutuelles') will be rolled out in the country during 2006.

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[1] 'Health Sector Policy' Government of Rwanda, February 2005.
[2] 'National Policy for Quality of Health Care in Rwanda', Draft 26 Jan 2006.
[3] 'Comparison of two output based schemes in Butare and Cyangugu provinces with two control provinces in Rwanda' Global Partnership on Output Based Aid, WB, MiniSante, 12 Sept 2005. 'Purchasing health packages for the poor through performance based contracting. Which changes at the district level does it require?' Soeters, R., Perrot, J et al.
[4] 'Proposed Evaluation and Roll-out plan for Performance Based Contracting Rwanda' WB, v21 Dec 2005.

To create a national PBF model, building on lessons learned from the existing models, seemed the right way forward. A work shop was planned for 16-18 February with the purpose to design a national PBF model with a common governance mechanism, a common set of indicators with set unit costs and a common verification procedure. All key PBF actors in Rwanda were invited to this workshop. The World Bank, through their consultant Bruno Meesen, participated actively.

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Workshop Objectives and Methodology

1. To Determine the main Objectives for a National Performance Based Financing model for Rwanda
   - Methodology: advance reading, create main objectives of a national PBF model through the 'Prioritization Process Using Delphi Technique' (see annex 3)

2. To Create a list of desirable attributes for a national PBF model for Rwanda
   - Methodology: advance reading, create a list of desirable attributes of a national PBF model through the 'Prioritization Process Using Delphi Technique'

3. To Agree on a National Model, or Models, to be used in Rwanda
   - Methodology: use of the Six Thinking Hats™ decision making technique (see annex 7)

4. To Determine Site Goals, Deliverables and Indicators to be used in PBF Contracts
   - Methodology: Group work and report back to plenary; use of the Six Thinking Hats™ decision making technique

5. To Design a Monitoring and Evaluation System for use in PBF Contracts
   - Methodology: as above under 3

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Proceedings

Objectives of the National PBF Model using Delphi:

Notwithstanding the first time use of Delphi among participants (see annex 3), the method led to a remarkable level of consensus among the panel of experts (see annex 4). Two runs were made. Remarks on the objective 'to improve health' were that it was so all-encompassing, true and non-refutable that it should not have figured on the straw man criteria list in the first place. Improving Health is rather a national policy objective or an overarching goal/objective for any health scheme or health financing method. The objectives were therefore reformulated in a plenary (see under 'national PBF model').

Attributes of the National PBF Model using Delphi:

A straw man criteria list was formulated by requesting all participants to assist by listing individually the ten most important criteria/attributes that defined a performance based financing model according to themselves. A panel of experts made two runs on the list of attributes, that were grouped under criteria that had been tagged 'contracts', 'monitoring' and 'regulation' type attributes. Again, a remarkable level of consensus surfaced among the panel of experts, results of the Delphi are available in annex 5. Attributes with fairly large standard deviations were noted although not discussed in depth. Quite significant differences in opinion would later emerge in the run-up to the use of the six-thinking hats decision making technique. The Delphi exercise took longer than expected: most of the first day of the workshop.

Group work on three thematic areas:

Three thematic groups worked for four hours on their topic, guided by 'working group guidance sheets' (see annex 6). This exercise filled the second day of the work shop, which was a half day only.

The third day of the work shop, a second half day, started with presentations of the groups (see annexes 10-12).

The Regulation group brought up an important issue, which still needs to be finalized:

- The issue relates to the financing of the whole PBF package of indicators, rather than only part of it (in the case of budget constraints or a donor with a specific disease orientation such as HIV/AIDS). This issue would apply to District Hospitals only if plans of MiniSante materialize, i.e. that Gov will take care of the PBF schemes at the health centre and community levels and donors would be requested to focus on District Hospitals.
- <u>Three scenario's were delineated (see annex 10) which could focus the discussion after this work shop</u>.

The Monitoring and Evaluation group proposed two core functions related to PBF for the Mairie (Town Hall) in which would be housed the newly appointed unit responsible for public health in the district (Unité Santé et Famille):

- Verification of Outputs (PBF indicators) at the District Hospital, Health Centre and Community levels
- Financial audit of District Hospitals and Health Centres

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The use of performance based contracting between a district-level PBF steering committee 'comite de pilotage' and the Unite Santé et Famille/Mairie to perform these functions is, quite likely, a necessity rather than a possibility as the verification process would need at least two and maybe more full-time additional staff. Contracting would allow this unit to employ additional staff to perform these functions; the performance based nature of the contracts would ensure that the functions would be carried out in a timely and satisfactory manner.

Regular (medical) supervision of health centres was conceived as an activity, using performance based contracting, originating from the District Hospital. Quality assurance was envisioned as each health facility having individual quality assurance teams. Medical audit and accreditation of District Hospitals was envisioned as an activity originating from the University Teaching Hospitals.

The issue of a 'third party agency' was put forward. Although it was recognized that the district level 'comite de pilotage' formed a powerful institutional framework for PBF, the group defined the need for a 'measuring stick', to determine if Outputs were real and whether Ghost patients occurred. The results of these can be incorporated into payments for performance. The following three options were proposed:

- The 'Cyangugu type': quarterly patient follow-up surveys through performance based contracting with grass root level organizations (the surveys include assessments of patient satisfaction, level of out-of-pocket payments and so on)
- The 'Butare type': six-monthly patient follow-up surveys by the National School of Public Health
- The 'Collaborative Approach type': based on the MSH Haiti model in which, six-monthly, all health facilities in a district are visited by teams, composed of members of e.g. other steering committees, actors involved in PBF from the national level, CAAC staff etc, using a standardized tool. This tool could do different things, for instance (i) verify patient records, with the possibility to do follow-up surveys in the community if deemed necessary; (ii) determine the level of structural quality of health facilities (building, staff, equipment etc) and (iii) observe processes. Results could be translated into composite scores.

The plenary did not manage to discuss this proposition due to extensive discussions following the 'Contract and Indicator' group presentation. Therefore:

- <u>The 'third party agency' is still an outstanding issue and need to be taken forward after the work shop</u>.

The 'Contract and Indicator' group worked for a prolonged episode of time (see annex 11). This group, quite independently of the 'M&E' group, came to the same institutional framework: that of using a district level 'comite de pilotage' as the district level overarching PBF governance mechanism. This, in fact, is the administrative arrangement of an existing Rwandan PBF scheme: the 'Butare model'. The 'comite de pilotage' model was accepted.

The presentation of the indicators and the ensuing discussions led to fundamental differences between groups and individuals adhering to the various existing PBF schemes. The group attempted to apply the six thinking hats to these differences.

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The use of the 'six thinking hats' decision making technique:

The use of the 'six thinking hats' decision making technique requires a group (i) agreeing on using the method after having been explained the method, (ii) a clear definition of a problem and (iii) discipline.

The 'blue hat' was used as an attempt to define the problem: its use is important to identify:

- Why we are here
- What we are thinking about
- The definition of the situation (or problem)
- Alternative definitions
- What we want to achieve
- Where we want to end up
- The background to the thinking, and
- A plan for the sequence of hats to be used

A one-and a halve hour discussion on the exact definition of the problem ensued. The problem, which remained unresolved that day, was as follows:

1. BTCCTB insisted to combine the verification of performance outputs with the process of regular, monthly medical supervision. Their line of reasoning was that as medically qualified personnel had to be used for the verification of performance outputs that this, for reasons of efficiency, could and should be combined with the medical supervision (of Quality). Their system in fact has been designed with this purpose in mind: medical supervisors from the District Health Teams count the quantity of acts and then verify the quantity of indicators related to 'quality' of processes. The combined score of their composite indicator determines the remuneration for that particular indicator. In fact, each of their indicators has a principal 'quantitative measure' with a set (of two to four) of 'qualities' that need to be met 100% for the quantity to be certified as 100%. Their stance was that a Quantitative Performance measure could and should be combined with various Quantified Quality measures.
2. Cordaid, Butare/HNI and the WB consultant were on the opposite fence: they insisted that verification of performance outputs (the counting of acts) was a separate activity from the, quite complex, assessment of the quality processes. In their minds the function of verifying outputs should be separate from the function of medical supervision using national checklists to determine the adherence to national guidelines. This could be framed as the paradigm of 'separation of functions': the separation of the function of counting the outputs (that would be remunerated) of the function of determining the adherence to national guidelines (the act of verifying the adherence to a set of activities would be remunerated also).

The consensus:

The above problem was re-discussed on Monday 20th Feb in more or less the same forum. Finally, an agreement was reached to accept the paradigm of 'separation of functions' for the National PBF model. Indicators for the health centre level, which had been formulated by the 'Contract and Indicator' group were discussed, adapted and agreed upon in a plenary session.

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The National PBF Model

Objectives

« La stratégie de financement basée sur la performance s'inscrit dans le cadre des politiques nationales de santé et de réduction de la pauvreté. Son objectif principal est de contribuer au mieux aux objectifs fixés par ces politiques générales.

En ce qui concerne les centres de santé, la stratégie de financement basé sur la performance poursuit l'objectif spécifique d'augmenter l'utilisation par la population de services de base de qualité. Elle poursuit cette fin en renforçant les incitations financières pour les équipes des centres de santé et en augmentant leurs droits décisionnels sur l'organisation de leurs propres opérations. »

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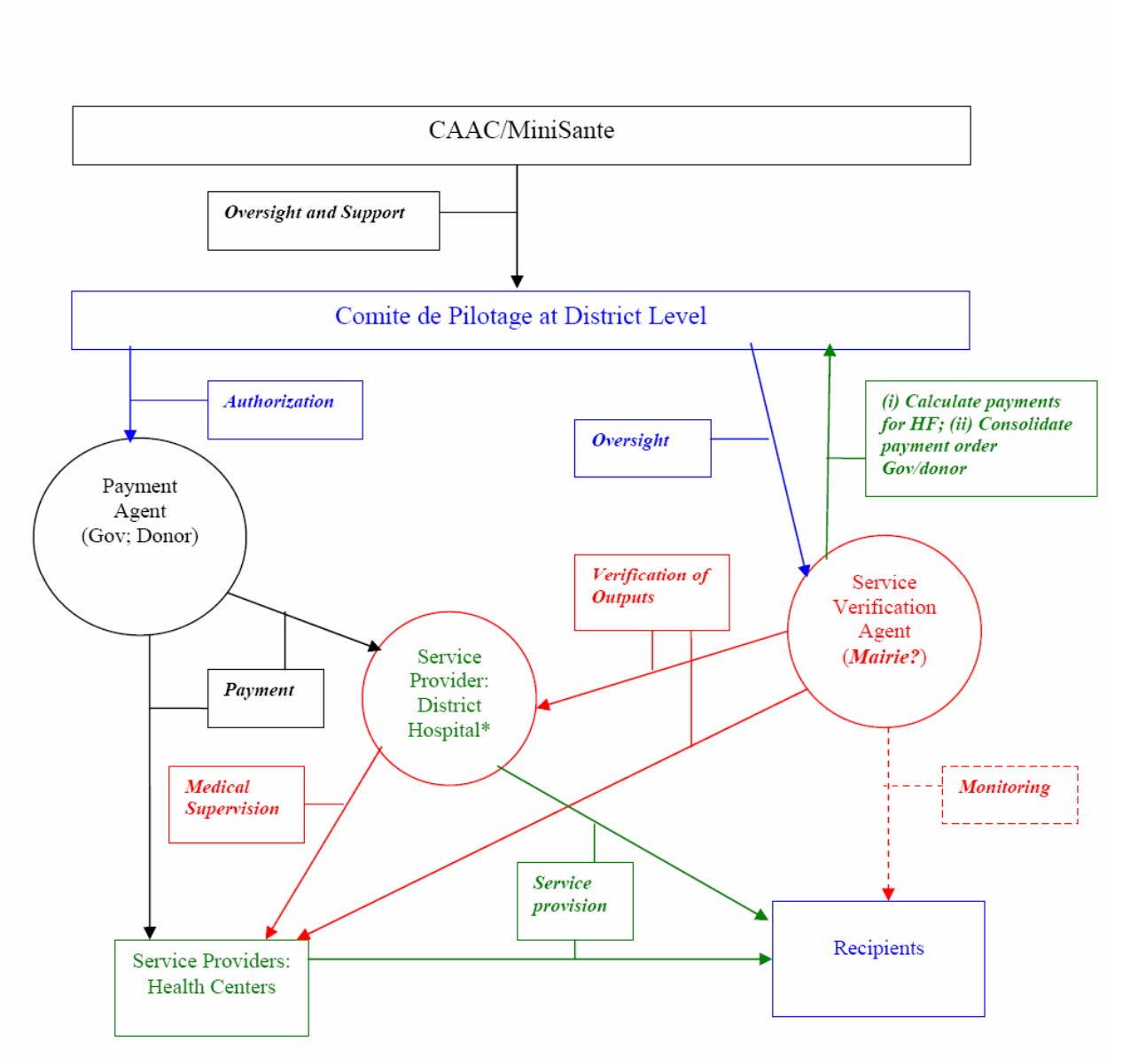
The national PBF Model administrative structure for District Hospital and Health Centres[5]



*DH team will be responsible for routine supervision of Health Centres for Quality of Care using standardized national supervisory checklists.

[5] The model is based on 'Contracting for public services, output based aid and its applications'. Brook P.J., Smith S.M., The World Bank, 2001. Figure 1, p111.

The national PBF Model administrative structure Community Based Health Program[6]

[The administrative arrangements need to be discussed still. Monies for the community based PBF scheme will be sent by the MINALOC straight to the Mairie. Health Centres will be closely involved in the type of activities and the medical supervision of those activities, of the community health workers. Outstanding issues are how to arrange the performance payments for the community health workers, and how to do the Verification.]

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[6] Ibid.

Regulation/Governance and Administration

- The recipients: the users of health services. Mutuelles were recognized to have important potential for the users of health services as a way to express their opinions. Mutuelles (obligatory health insurance schemes to be started throughout the country during 2006) have potential to be involved at both the 'comite de pilotage' at district level and during eventual patient follow-up surveys in the community.
- Service providers will have performance contracts with the comite de pilotage, with the contracting unit being the health facility. Health facility management committees could have contracts with individual providers which restate their job descriptions and which would give a tool to the management committees to, eventually, distribute performance bonuses on perceived level of effort. The DH will have a performance contract with the comite de pilotage to carry out medical supervision of health centres.
- The service verification agent could be the Unité Santé et Famille of the Marie. A clear decision on where to locate this function has not been taken yet. This unit will (i) verify the performance outputs of the DH, the health centers [and the community health workers]. Performance based contracting could be used between the comite de pilotage and the Unite Santé et Famille to facilitate this unit to carry out this new task. (ii) Calculate payments for DH, health centres and community health workers based on the verification process, (iii) consolidate the payment order for the health facilities on request of the comite de pilotage.
- Financial Audit of health facility accounts will be done by the Mairie.
- The comite de pilotage: a multilateral formalized body tasked with the governance of all PBF related activities at the district level. Quarterly meetings are held in which the result of the verification processes of the health facilities and community health workers are discussed and a go ahead is given to the payment order drawn up by the Mairie. The comite de pilotage is intended as an interim measure to enable relative rapid scale up and roll-out of the PBF nationwide. Over time their function will be institutionalized in a more final governance mechanism.
- Minecofin and donors: pay for performance into the bank accounts of the [(Mairie and the) if the Mairie/ Unité Santé et Famille will be chosen to do the verification of outputs of the district health system then, in that case, a performance contract between the Committee de Pilotage and the Unité Santé et Famille could be devised. This performance contract would enable this unit to employ additional staff and to carry out its functions smoothly] health facilities after receiving the payment order that has been approved by the comite de pilotage.
- CAAC/MiniSante: have a supportive and an oversight role related to the district steering committees. Policy and regulatory issues, guidance on the model, compilation of figures etc all are done at the central level.

Monitoring/Verification and Medical Supervision

- Verification of performance outputs will be done by the Unité Santé et Famille of the Marie.
- Medical Supervision and accreditation of the District Hospital will be done from the University Teaching Hospitals.

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- Medical Supervision of health centers will be done through the District Hospital.
- Medical Supervision of the community health workers will be done by the health center.

PBF Indicators at the District Hospital level:

The PBF model for District Hospitals needs to be designed. There was consensus that such a PBF model would not necessarily be along the same performance measures as those of health centres or community health workers. The BTCCTB performance based financing scheme for District Hospitals was put forward as a promising model on which to build upon. The BTCCTB district hospital PBF scheme is predominantly axed on measuring processes and administrative procedures. The group decided to continue developing such a national model for district hospitals in the PBF taskforce.

- Develop a PBF model for Rwandan District Hospitals

PBF Indicators at the Health Centre level

The following indicators were discussed and agreed:

No	*PBF Indicator*	*Index*[7]
1	New Curative Case from within the health centre catchment area	100
2	New Curative Case from outside the health centre catchment area	50
3	Newly registered antenatal care client from within the health centre catchment area	200
4	Tetanus vaccinations 2-5 for women in childbearing age	250
5	Growth monitoring new registered client 0-59 months from within the health centre catchment area	50
6	Malnutrition, new case hospitalized	2000
7	New User family planning (all methods except condoms)	1000
8	Existing User family planning	500
9	Child less than 11 months fully immunized	1000
10	Delivery at the health centre	2500
11	Pregnant women referred to hospital	2500
12	Elective referral curative case (with feedback from hospital)	200
13	Emergency referral (with feedback from hospital)	2500

PBF Indicators for HIV/AIDS

[Need to define]

PBF Indicators at the Community level

[Need to define]

[7] The index represents a relative value: it has been put at '100' for a new curative consultation originating from within the health centre catchment area. Unit costs will be calculated based on this index.

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Next Steps

(The 'next steps' incorporate the debriefing from the WB consultant B. Meesen from 23 Feb 06; see annex 13)

1. Agree on a National Model for PBF
   - Agreed:
     i. Debriefing from WB consultant B. Meessen 23 Feb 06 held (see annex 13): agreement reached on the principle of 'Separation of Functions'
   - Outstanding issues:
     i. Where to locate the 'Control'/Verification Function: Unité Santé et Famille/Mairie is proposed
     ii. Whether or not to start performance based contracting with the Unité Santé et Famille
     iii. Creation of a PBF model for the District Hospital
     iv. Creation of a PBF model for the Tertiary Hospitals
     v. Creation of a PBF model for the community based activities
     vi. Find the 'right fit' for the HIV/AIDS PBF monies
     vii. Determine the national HIV/AIDS PBF indicators
     viii. Calculations of the unitary costs for the 'minimal package of activity' indicators
     ix. Determine to which extent and to what level to incorporate 'Quality' in performance payments

2. Proper roll-out of the WB roll-out plan
   - Known:
     i. Gov monies will be targeted at Health Centers and at the Community level: donors will be requested to focus on District Hospitals
     ii. Any additional money through PBF, for instance through HIV/AIDS monies, not controlled for, might bias the results of the PBF impact study
   - Unknown:
     i. The result of negotiations on the issue of nationally fixed unitary costs for HIV/AIDS services versus appropriately costed HIV/AIDS PBF indicators
3. Implement the new national PBF model
   - Design a Toolkit
   - Use partners interested in PBF (e.g. the USAID Cooperating Agencies, Cordaid, HNI, GTZ, GF) to its fullest possible extent in rolling-out the PBF model (creation of and participation in the 'comite de pilotage', technical support to the verification agent etc)

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Annexes

1. List of Participants

No	Name	Position	Organization	Email	Mobile
1	Louis Rusa	Coordinateur Cellule d'Appui a l'Approche Contractuelle (CAAC)	MiniSante	rusarw@yahoo.fr	08500376
2	Georges Ntabashwa	Medecin Charge a l'encadrement technique CAAC	MiniSante		08500400
3	Rigobert Mpendwanzi	Charge de la Supervision des Activites de l'Approache Contractuelle CAAC	MiniSante	rigobertn21@yahoo.fr	08454668
4	Bruno Meesen	WB Consultant	WB	bmeessen@itg.be	
5	Werner Vandenbulcke	Coordinateur Approche Contractuelle	BTC	werner.vandenbulcke@btcctb.org	08559747
6	Willy Janssen	Appui aux DS de Kigali Ngali	BTC	willy.janssen@btcctb.org	08679884
7	Kathy Kantengwa	HCD Rwanda HIV PBF project	MSH	kathy_kantengwa@yahoo.com	08307855
8	Ousmane Faye	Chief of Party Rwanda HIV PBF project	MSH	ofaye@msh.org	08308835
9	Gyuri Fritsche	Health Care Financing Specialist Rwanda HIV PBF project	MSH	gfritsche@msh.org	08308834
10	Christian Habineza	Coordinateur National	Cordaid	memisa1@rwanda1.com	08502117
11	Cedric Ndizeye	Technical Advisor	HNI	cndizeye@yahoo.fr	
12	Nicolas Theopold	Economist Unit of Planning and Research MiniSante	MiniSante	nt.minisante@theopold.net	08499246
13	Andreas Kalk	Coordinateur du Secteur "Sante"	GTZ Santé	gtzsante@rwanda1.com	08306599
14	Appoline Uwayitu	QA	QA	nyampeta@yahoo.fr	
15	Emile Fundira	M&E Rwanda HIV PBF project	MSH	emilefundira@yahoo.com	

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2. Workshop Agenda and Schedule

Location: Centre Mamas Sportifs Kigali

Dates: 16 and 17 February 2006

Participants: 14 (MMiniSante/4; BTC/2; WB/1; MSH/3; GTZ/1; Cordaid/1; HNI/1; QA/1)

Secretarial Support: Mamy/MSH

Budget: Rent and food and beverages paid by BTCCTB; LCD projector, laptop, printer, flipcharts etc through MSH; organization and facilitation: MiniSante, BTCCTB and MSH.

Workshop Objectives:

1. To Determine the main Objectives for a National Performance Based Financing model for Rwanda
   - Methodology: advance reading, create main objectives of a national PBF model through the 'Prioritization Process Using Delphi Technique'

2. To Create a list of desirable attributes for a national PBF model for Rwanda
   - Methodology: advance reading, create a list of desirable attributes of a national PBF model through the 'Prioritization Process Using Delphi Technique'

3. To Agree on a National Model, or Models, to be used in Rwanda
   - Methodology: use of the Six Thinking Hats™ decision making technique

4. To Determine Site Goals, Deliverables and Indicators to be used in PBF Contracts
   - Methodology: Group work and report back to plenary; use of the Six Thinking Hats™ decision making technique

5. To Design a Monitoring and Evaluation System for use in PBF Contracts
   - Methodology: as above under 3

Preparatory Reading:[8]

- Conceptual Framework three PBF models in Rwanda
- The four power point presentations on PBF models from the Jan 19-20 WS
- Selected Reading on the 'Principal Agent Problem'
- Paper from Rena Eichler on 'Pay for Performance'
- Six Thinking Hats™ Summary

[8] Reading before arrival at the Workshop.

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Methodology:

- Preparatory Reading
- Plenary presentations and discussions
- Group work and reporting back to plenary
- Prioritization Process Using Delphi Technique
- Use of the Six Thinking Hats™ decision making technique
- Parking Lot

Schedule:

Day 1 : 16 February 2006				
Time	***Topic***	***Facilitator/method***	***Moderator***	***Outcome***
8.00 - 8.30	Opening and Workshop Objectives	LR/plenary		Understanding and agreement on the WS objectives
8.30 - 8.40	Ground rules	KK/plenary/flipchart	GF	Ground rules determined : mobile phones/parking lot etc
8.40 – 8.50	Prioritization Process Using Delphi Technique	GF/ppt/plenary		Understanding of the 'Prioritization Process Using Delphi Technique'
8.50 – 9.45	Objectives for a national PBF system	GF/Delphi	KK	Objectives for a national PBF system agreed upon
9.45 – 10.00	***Tea/Coffee***			
10.00– 12.00	Attributes for a national PBF system	GF/Delphi	KK	*
12.00-12.15	***Tea/Coffee***			
12.15– 13.00	Attributes for a national PBF system	GF/KK/NT		*
13.00-14.00	***Lunch***			
14.00-16.30	Attributes for a national PBF system	GF/KK/NT		Attributes for a national PBF system agreed upon
16.30– 17.00	Six Thinking Hats	GF/ppt/plenary		Understanding of the 'six thinking hats decision making technique'

Revised Schedule for 17 and 18 February 2006:

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Day 2 : 17 February 2006				
Time	***Topic***	***Facilitator/method***	***Moderator***	***Outcome***
8.00 - 8.30	Opening, revised schedule, explanation and discussion on Working Group Objectives	GF/plenary		Agreement on the revised schedule, agreement on the Work Group Guidance Sheets
8.30– 11.30	Group work 3 groups	GF/KK/NT		Tasks in guidance sheets accomplished; presentations ready
11.30-11.45	Recap Six Thinking Hats	GF		Understanding of Six Thinking Hats
11.45-13.00	Presentation 'Indicator Group' 15' and 60' discussion	GF/plenary/thinking hats	NT	Consensus on the Indicators to be used in the National PBF model

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Day 3 is a half day session: venue will be CAAC.

Day 3: 18 February 2006				
Time	***Topic***	***Facilitator/method***	***Moderator***	***Outcome***
9.00-9.15	Recap main points from day 1	GF		
9.15-10.30	Presentation 'M&E Group' 15' and 60' discussion	NT/plenary/thinking hats		Consensus on the M&E system to be used in the National PBF model
10.30-10.45	***Tea/Coffee***			
10.45-11.30	Presentation 'Regulation Group' 15' and 30' discussion	GF/plenary/thinking hats		Consensus on the level of regulation re the National PBF system
11.30-11.45	***Tea/Coffee***			
11.45-12.30	Parking Lot Issues and closure	LR/thinking hats	GF	Parking lots issues addressed (either in session or decision on how to address these outside the WS)

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3. Delphi Prioritization Procedure[9]

Objectives:

(A) To create a list of Objectives for a Rwandan Performance Based Financing Model

The process is the same as for under (B) but will aim at getting about three to five Objectives for such a model (we could ask for an initial listing of five objectives to work with). Basically, the discussion is always on a 'definition' for PBF, whilst this illustrates the issue; the issue is one of determining, getting consensus on, the Objectives of such a PBF model, the attributes and tools would, in principle, follow logically from there. I realized at a late stage that lots of confusion surrounding the discussion with colleagues at the national level is predominantly due to PBF being different things for different people.

(B) To create a list of desirable attributes of a Rwandan Performance Based Financing Model. This performance based financing model should have (i) an agency that pays, (ii) agencies that provide health services, (iii) a Monitoring and Evaluation system.

1. ***Pick a facilitation leader***. Note: propose GF, although a 'stakeholder', not part of any existing PBF model yet

2. ***Select a panel of experts***. Note: request the group to nominate an expert panel, a possible pick could be MOH/1; Cordaid/1; HNI/1; WB/1; BTC/1; MSH/1; GTz/1; QA/1 (8 total)

3. ***Identify a Straw Man Criteria List from the panel***. Note: all participants are asked to list on a piece of paper maximum 10 attributes of a national Performance Based Financing System. The attributes can be anything that specifies the system. Also non-panel members can participate at this stage. At this point there are no correct criteria. Discuss if need for primary criteria (for instance (a) work through the new admin systems at the district level, (b) need for an M&E system that is affordable).

4. ***The Panel Ranks the Criteria***. Note: each panelist ranks the list individually and anonymously. The ranking is compiled in a plenary. For each criterion the panel ranks it as 1 (very important), 2 (somewhat important) or 3 (not important).

5. ***Calculate the mean and deviation.*** Note: for each item in the list find the mean value and remove all items with a mean greater than or equal to 2.0. Place the criteria in rank order and show the (anonymous) results to the panel. Discuss reasons for

[9] From 'Prioritization Process Using Delphi Technique' White paper by Alan Cline, Carolla Development http://www.carolla.com/wp-delph.htm

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items with high standard deviations. The panel may insert removed items back into the list after discussion.

6. ***Rerank the criteria.*** Note: repeat the ranking process among the panelists until the results stabilize. The ranking results do not have to have complete agreement, but a consensus such that all can live with the outcome. Two passes are often enough, but four are frequently performed for maximum benefit. In one variation general input is allowed after the second ranking in hopes that more information from outsiders will introduce new ideas or criteria, or improve the list (discuss).

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4. Objectives[10] for a National PBF system using Delphi

R	Objective	Mean	St. Dev.
1	Improve accessibility to services (financial and geographic)	1.17	0.41
2	Improve the motivation of staff and give them responsibility	1.17	0.41
3	Improve the quality of services rendered	1.33	0.52
4	Increase the quantity of services provided	1.50	0.55
5	To improve the health status of the population	1.50	0.84
6	Improve the efficiency and efficacy of the health system	1.67	0.52
7	Reinforce management autonomy of health services	1.67	0.52
8	Decentralise health financing / bring financial resources into periphery	2.00	0.89
9	To insure the equity of resource allocations	2.17	0.75
10	Increase the competencies of health staff	2.17	0.75
11	"Consolidation" of the health system	2.50	0.55
12	To contribute to poverty reduction	2.67	0.82
13	Include new actors in the health sector (HHs, authorities,...)	2.67	0.82
14	Reinforce the appropriation of health programmes by the population	2.67	0.82

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[10] The shaded areas have an average higher than the mean therefore representing consensus.

5. Attributes[11] for a National PBF system using Delphi

Ty	I	Attributes	Mean	St. Dev.
C	10	Systeme decentralise ou sont definis les roles et responsabilites des differents acteurs	1.00	0.00
C	1	Indicateurs de quantite claires facile a mesurer	1.17	0.41
C	37	Autonomie aux fosa de developper leur propres strategies en respectant la politique nationale	1.50	0.55
C	44	Definir un pacquet integre de services a acheter de facon equilibre et compatible avec le PMA, PCA	1.50	0.55
C	20	Contracting-in (contrats entre des structures de la syteme de Sante Publique; internal market)	1.67	0.82
C	2	Indicateurs de qualite claires facile a mesurer	1.67	1.03
C	49	Comite de pilotage au niveau du district, qui gere localement	1.83	0.75
C	13	Impacts sur les MDGs de sante	2.17	0.75
C	29	Nombre d'indicateurs limite	2.17	0.98
C	34	Modele contractuelle approprie pour chaque niveau du systeme de sante (integre)	2.33	0.82
C	43	Payment directe a la partie prenante	2.50	0.55
C	45	Choix d'indicateurs suivant des goulots d'etranglement au niveau decentralise	2.50	0.55
C	21	Payement a travers Minecofin sur autorisation de Minisante	2.67	0.52
C	4	Budgetisation par FOSA	2.83	0.41
M	30	Supervision de qualite	1.00	0.00
M	8	Systeme de controle defini et peu couteux et facile a controler	1.17	0.41
M	36	Obligation de documentation du modele	1.33	0.52
M	7	Systeme de monitoring claire (facile) et peu couteux	1.50	0.55
M	19	Possibilite d'analyse des donnes operationelles (SIS)	1.83	0.75
M	24	Monitoring = suivi regulier des indicateurs outputs (qualite et quantite)	1.83	0.98
M	22	Capacite d'auto evaluation (evaluation interne Minisante, externe pour l'impact)	2.00	0.63
M	28	Visite a domicile par un tiers independent	2.50	0.55
M	27	La mairie controle les registres mensuellement	2.83	0.41
M	41	Enquetes de satisfaction	3.00	0.00
R	12	Simple, affordable, efficient and sustainable	1.00	0.00
R	5	Moyens suffisants et disponibles pour couvrir tout le pays (inputs and outputs) unite de financement etant le District	1.00	0.00
R	32	Les partenaires renforcement la CAAC	1.17	0.41
R	33	Harmonisation du systeme au niveau nationale	1.17	0.41
R	50	Systeme transparent	1.50	0.55
R	48	Manuel de procedure disponsible (guide)	1.67	0.82
R	15	Coherent et souple avec l'environnement institutionnel (y compris longterme)	1.83	0.75
R	38	Prevoir une mise a niveau pour les FOSA avant le demarrage PBF	1.83	0.98
R	16	Systeme modulaire avec la possibilite des ajouts complementaires	2.17	0.75
R	14	Systeme convaincant pour assurer le soutien des differents acteurs	2.33	0.52
R	46	Limitation des effets pervers	2.33	0.52
R	42	Separation des fonctions	2.33	1.03
R	31	Les prixs s'ajustent quand la performance augmente	2.50	0.55
R	39	Determiner et evaluer les criteres d'entrée en PBF	2.50	0.55
R	35	Modele dynamique (dans les baremes des indicateurs) (possibilite d'ajuster localement)	2.83	0.41
R	25	L'appproche n'est pas restraint au public et aux agrees	2.83	0.41

[11] Attributes are grouped into three categories: 'C' for contracts, 'M' for monitoring and 'E' for Evaluation. The shaded areas represent attributes that have scored higher than average and, therefore, representing consensus.

6. Working Group Guidance Sheets

Workgroup Guidance Sheet: "Contracting, Indicators, Financial Flows" Group

Task	**Group Members**	**Preparatory Materials**	**Required Input**	**Expected Output**	**Time Frame**
Determine contracting partners for HC and DH PBF	Bruno Cedric Georges Ousmane Werner	- Project materials from BTC, Cordaid, HNI to explain current system	First round: use attributes and objectives determined in preparation Second round: use feedback from other groups to make adjustments as agreed	- Contracting partners defined	12.15-13.00 (45min) 14.00-15.15 (75min) 15.30-16.30 (60min) Total: 3 hrs
Financial flows		- Project materials and information from MoH		- One system that allows for the inclusion of Development Partners in their constraints	
Determine indicators to be used		- List of indicators used by different PBF schemes - MPA and CPA details		- List of indicators to be used - Separation of CPA and MPA	
Suggest price levels for indicators or total budget for PBF per capita		- Current price levels / per capita budgets used in existing systems		- Suggested set of prices(?) or system of variable pricing based on budget	
Target levels of indicators		- Current target levels used in existing systems		- Target levels, proposals for ceilings	

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Workgroup Guidance Sheet: "Monitoring and Evaluation" Group

Task	**Group Members**	**Preparatory Materials**	**Required Input**	**Expected Output**	**Time Frame**
Determine the team responsible for **quantity** monitoring	Christian Gyuri Rigobert Willy Appoline (QA) Emile	- Project materials from Butare, Cyangugu, BTC - Comparative study - Additional studies	First round: use attributes and objectives determined in preparation [Second round: use feedback from other groups to make adjustments as agreed]	- Model for quantity monitoring team, harmonized with contracting group	12.15-13.00 (45min)
Determine method to use for **quantity** monitoring (community?, sampling?, etc)		- Project materials - Comparative study - Additional studies		- Workable and efficient process chosen	14.00-15.15 (75min)
Determine frequency for **quantity** monitoring and links with indicators and regulation		- Project materials - Comparative study - Additional studies		- Cost effective and sufficiently thorough method chosen	15.30-16.30 (60min) Total: 3 hrs
Suggest contents of **quality** assurance process		- QA background docs - Project materials - Comparative study - Additional studies		- Agreement on how to treat quality, how to integrate with quantity measurement and indicator contracting	
Determine team responsible **quality** assurance		- Project materials - Comparative study - Additional studies		- Model for quality monitoring team, harmonized with contracting and quantity aspects	
Determine frequency for **quality** assurance process		- Project materials - Comparative study - Additional studies		- Workable and efficient process chosen	

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Task	Group Members	Preparatory Materials	Required Input	Expected Output	Time Frame
Work out the linkages between quality and quantity monitoring		- Project materials - Comparative study - Additional studies		- Highlighting of linkages and potential conflicts of both M&E objectives	
Draw up ideas for operational research to be implemented		- Existing studies		- List of topics with time frames for further development after workshop	

Workgroup Guidance Sheet: "Regulation" Group

Task	Group Members	Preparatory Materials	Required Input	Expected Output	Time Frame
Determine cornerstones of harmonization	Andreas Kathy Louis Nicolas	- Guide Approche Contractuelle - Project materials - Supporting Government legislation (e.g. MPA)	- Objectives, attributes determined at start of workshop - Input from other groups after first round	- Set of attributes that have to be identical across models -	12.15-13.00 (45min)
Define how much flexibility do implementers of PBF have to change national model elements ("degrees of freedom" for implementers of PBF)				- Variables / aspects that are necessary to be left to be determined at project level	14.00-15.15 (75min)
Determine procedure/conditions to modify aspects of PBF in Rwanda				- Draft decision rules to be drafted into Ministry instruction	15.30-16.30 (60min)
Propose a set of guiding documents / policies necessary to achieve regulation framework				- Set of necessary documents to incorporate policy decisions on PBF	Total: 3 hrs

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7. The Six Thinking Hats™ Decision Making Technique

Six Thinking Hats

A summary by Sylvie Labelle

Early in the 1980s Dr. de Bono invented the Six Thinking Hats method. The method is a framework for thinking and can incorporate lateral thinking. Valuable judgmental thinking has its place in the system but is not allowed to dominate as in normal thinking. Dr. de Bono organized a network of authorized trainers to introduce the Six Thinking Hats. Advanced Practical Thinking (APTT), of Des Moines, Iowa USA, licenses the training in all parts of the world except Canada (and now, Europe). APTT organizes the trainers and supplies the only training materials written and authorized by Dr. de Bono.

Organizations such as Prudential Insurance, IBM, Federal Express, British Airways, Polaroid, Pepsico, DuPont, and Nippon Telephone and Telegraph, possibly the world's largest company, use Six Thinking Hats.

The six hats represent six modes of thinking and are directions to think rather than labels for thinking. That is, the hats are used proactively rather than reactively.

The method promotes fuller input from more people. In de Bono's words it "separates ego from performance". Everyone is able to contribute to the exploration without denting egos as they are just using the yellow hat or whatever hat. The six hats system encourages performance rather than ego defense. People can contribute under any hat even though they initially support the opposite view.

The key point is that a hat is a direction to think rather than a label for thinking. The key theoretical reasons to use the Six Thinking Hats are to:

- encourage Parallel Thinking
- encourage full-spectrum thinking
- separate ego from performance

The published book Six Thinking Hats (de Bono, 1985) is readily available and explains the system, although there have been some additions and changes to the execution of the method.

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The following is an excerpt from John Culvenor and Dennis Else Engineering Creative Design, 1995)

White Hat on the Hats

There are six metaphorical hats and the thinker can put on or take off one of these hats to indicate the type of thinking being used. This putting on and taking off is essential. The hats must never be used to categorize individuals, even though their behavior may seem to invite this. When done in group, everybody wear the same hat at the same time.

White Hat thinking

This covers facts, figures, information needs and gaps. "I think we need some white hat thinking at this point..." means Let's drop the arguments and proposals, and look at the data base."

Red Hat thinking

This covers intuition, feelings and emotions. The red hat allows the thinker to put forward an intuition without any need to justify it. "Putting on my red hat, I think this is a terrible proposal." Usually feelings and intuition can only be introduced into a discussion if they are supported by logic. Usually the feeling is genuine but the logic is spurious. The red hat gives full permission to a thinker to put forward his or her feelings on the subject at the moment.

Black Hat thinking

This is the hat of judgment and caution. It is a most valuable hat. It is not in any sense an inferior or negative hat. The rigor or negative hat. The black hat is used to point out why a suggestion does not fit the facts, the available experience, the system in use, or the policy that is being followed. The black hat must always be logical.

Yellow Hat thinking

This is the logical positive. Why something will work and why it will offer benefits. It can be used in looking forward to the results of some proposed action, but can also be used to find something of value in what has already happened.

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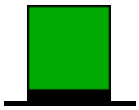
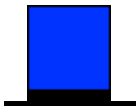


Green Hat thinking

This is the hat of creativity, alternatives, proposals, what is interesting, provocations and changes.



Blue Hat thinking

This is the overview or process control hat. It looks not at the subject itself but at the 'thinking' about the subject. "Putting on my blue hat, I feel we should do some more green hat thinking at this point." In technical terms, the blue hat is concerned with meta-cognition.

This was an excerpt from Edward de Bono's "Why Do Quality Efforts Lose Their Fizz?" Quality is No Longer Enough, The Journal for Quality and Participation, September 1991

This page supplied by Sylvie Labelle who can be contacted at syllab@videotron.ca

Last updated: 7th May 2005

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8. Conceptual Framework of the three Rwandan PBF Models

Variables / Model	Purchaser	Provider	Who does Monitoring?	Third Party Monitoring	No of Clinics under contract	No of Hospitals under contract	ECD's under contract (v)	No of Indicators	Quality Measured	Range of Remuneration	Project Budget per capita per year $	PBF Budget reaching clinics per capita per yr $	Average Health Worker Income Fr/month	Donors
Cyangugu model	Agence d'Achat (Cordaid at Province Level)	Health Facilities, public, NGO/FBO *and* private sector run	(i) ECD's; (ii) Supervisors Agence d'Achat and (iii) M&E program officer	Associations des Enqueteurs' (reporting to M&E program officer) (iii)	**26** (+14 HP and 19 private dispensaries subcontracted)	**4**	**4**	**11** (CS) and **9** (H) plus **10** HIV/AIDS Indicators at H level and **13** ECD	Through ECD's and incorporated in remuneration: up to 15% of payment	Rfr 150-2500 (CS) and 250-15000 (H)	**$2** (2005)	**$0.41(i)** (2004)	**Fr 64,176** (2004)	Gov Rw; Cordaid; MAP/WB; others
Butare model	Comite de Pilotage (at Province Level)	Health Facilities, public and NGO/FBO run	(i) ECDs; (ii) Focal Point Steering Cttee (a bit)	Six-monthly by School of Public Health	**36**	**3**	**4**	**11** (CS) and **9** (H) plus **10** HIV/AIDS Indicators at H level and **13** ECD	None (planned for introduction in 2006)	Rfr 40-5000 (CS) and 600-3500 (HIV/AIDS); 200-8000 (H)	**$0.3** (2005)	**$0.13 (i)** (2004)	**Fr 60,641** (2004)	Gov Rw; MAP/WB; others
BTC model	BTC PBF office (MiniSante PBF dep Kigali level)	Health Facilities, public and NGO/FBO run	(i) ECD's; (ii) Supervisors of Supervisors from central BTC office/MiniSante PBF department	None	**75**	**4**	**6**	**13+31** (CS), **7+15** (Palu), **7+15** (TB), **34+48** (H), **27+29** (ECD), **2+6** ECD (TB), **5+12** ECD (Palu) (vi)	Through the use of composite indicators: each quantitative indicator has a twinned composite quality indicator: payment for quantitative outputs based on % quality achieved	Rfr 100-3000 (CS); 25-1500 (H) with point system (H); pointsystem (ECD) and Rfr 150-2500 (Palu)	**$1.57** (2005)	**$0.08 (ii)** (2005)	**Base salary + Fr 10,000- 20,000** (2005)	Gov Belge (NLP and PNILT in future)

(i) Data from GPOBAV report
(ii) Data from BTC/CTB: based on available budget for PBF payments for clinics in 2005
(iii) 35 patients choosen at random each quarter from each CS traced in the community
(iv) 15 patients choosen at random each two months from each CS traced in the community
(v) Equipe Cadre de District
(vi) x+y: y is quality Indicator

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9. Conceptual Framework of the Indicators used in the three Rwandan PBF Models

"BUTARE-Model"

Conceptual Framework taken from 'Conceptual frameworks for health systems performance: a quest for effectiveness, quality and improvement'. Arah, O.A et al, In J for Quality in Health Care 2003; Vol 15,N5, pp 377-398

No	*Performance Indicator*	*Remuneration (Fr)*	*Model*	*Target Level in Health System*	*Type of Measure*	*Relation to System Function or Objective*
1	Mosquito net sold by CHW	100	Butare	Community Outreach	Process	Prevention of Malaria Morbidity and Mortality; Public Health
2	DPT 3 lost to follow up retraced by CHW	100	Butare	Community Outreach	Process	U-5 Health; Prevention; Public Health
3	*[Participation a la strategie avancee?]*	*600*	*Butare*	*?*	*?*	*?*
4	CHW report completed	5,000	Butare	Community Outreach	Process	Public Health
5	New Consultations	40	Butare	Clinic	Process	Access and Utilization
6	First Prenatal Consultation	100	Butare	Clinic	Process	Antenatal Care; Prevention
7	Fourth Prenatal Consultation	1,000	Butare	Clinic	Process	Antenatal Care; Prevention; Quality of ANC
8	New FP users	1,000	Butare	Clinic	Process	Family Planning Uptake
9	Institutional Delivery	2,500	Butare	Clinic	Process; Outcome	Increase Institutional Deliveries
10	Referred Delivery	2,500	Butare	Clinic	Process	Quality of Delivery Care; Decrease Maternal Mortality
11	Measles vaccination	500	Butare	Clinic	Process	U-5 Health; Prevention
12	Tetanus 2-5	500	Butare	Clinic	Process	Maternal and Infant Health; Prevention
13	Newly diagnosed AFB+PTB	1,500	Butare	Clinic	Process; Outcome	Decrease Mortality due to TB; Public Health
14	TB treatment completed	1,500	Butare	Clinic	Process; Outcome	Decrease Mortality due to TB; Quality of TB program; Public Health
15	AFB+ TB referred	1,500	Butare	Clinic	Process; Outcome	Decrease Mortality due to TB; Quality of TB program; Public Health
16	Feedback to Clinic after a Referral	200	Butare	District Hospital	Process; Outcome	Quality of Ref Process; Quality of Ref Patient Care; Cont Educ Clinic Staff
17	Medical Consult of Referred Patient	350	Butare	District Hospital	Process; Outcome	Quality of Ref Process; Quality of Ref Patient Care
18	Institutional Delivery referred by Clinic	2,500	Butare	District Hospital	Process; Outcome	Quality of Ref Process; Decrease Maternal Mortality
19	Obstetrical Emergency	2,500	Butare	District Hospital	Process; Outcome	Decrease Maternal Mortality
20	CS	7,500	Butare	District Hospital	Process; Outcome	Decrease Maternal Mortality
21	Major Surgical Intervention	8,000	Butare	District Hospital	Process	Clinical Care; Surgical
22	Minur Surgical Intervention	750	Butare	District Hospital	Process	Clinical Care; Surgical
23	Bilateral Tuba Ligation/Vasectomy	8,000	Butare	District Hospital	Process	Family Planning Uptake
24	IUD insertion/Norplant	3,000	Butare	District Hospital	Process	Family Planning Uptake
25	Documented death	2,500	Butare	District Hospital	Outcome	Ability to do Clinical Audits; Continuous Quality Improvement; Quality of Care
26	Newly diagnosed AFB+PTB	1,500	Butare	District Hospital	Process; Outcome	Decrease Mortality due to TB; Public Health
27	TB treatment completed	1,500	Butare	District Hospital	Process; Outcome	Decrease Mortality due to TB; Quality of TB program; Public Health
28	VCT test	600	Butare	Clinic	Process	HIV prevention and care
29	Couples tested	1,500	Butare	Clinic	Process; Outcome	HIV prevention and care; Quality of VCT services
30	HIV+ persons referred to the DH	600	Butare	Clinic	Process; Outcome	HIV prevention and care
31	Pregnant women tested for HIV	600	Butare	Clinic	Process	HIV prevention and care
32	Pregnant women tested for HIV return for results	600	Butare	Clinic	Process; Outcome	HIV prevention and care; Quality of VCT process
33	Partners tested	1,500	Butare	Clinic	Process; Outcome	HIV prevention and care; Quality of VCT process
34	HIV+ pregnant women treated with NVP	600	Butare	Clinic/DH	Process; Outcome	HIV prevention and care; Quality of PMTCT process
35	HIV+ pregnant women delivering at HF	3,500	Butare	Clinic/DH	Process; Outcome	HIV prevention and care; Quality of PMTCT process
36	Newborn from HIV+ women receiving NVP	600	Butare	Clinic	Process; Outcome	HIV prevention and care; Quality of PMTCT process
37	Child from HIV+ mother tested after 9 months	1,200	Butare	Clinic	Process; Outcome	HIV prevention and care; Quality of PMTCT process
38	ARV: first visit	600	Butare	District Hospital	Process	HIV prevention and care; ARVs uptake
39	ARV: 2nd visit after six months	600	Butare	District Hospital	Process; Outcome	HIV prevention and care; Quality of ARV delivery system
40	ARV: 3rd visit after 12 months	600	Butare	District Hospital	Process; Outcome	HIV prevention and care; Quality of ARV delivery system
41	ARV: 4th visit after 18 months	600	Butare	District Hospital	Process; Outcome	HIV prevention and care; Quality of ARV delivery system
42	ARV: 5th visit after 24 months	600	Butare	District Hospital	Process; Outcome	HIV prevention and care; Quality of ARV delivery system
43	HIV+ persons receiving Cotrimoxazol	600	Butare	Clinic	Process	HIV prevention and care; Quality of supportive treatment
44	TB patient voluntarily tested for HIV	1,000	Butare	Clinic	Process	HIV prevention and care
45	Minutes of weekly DHT meetings	10%	Butare	DHT	Process	Monitoring and Supportive role of DHT
46	Minutes of monthly DHT -Titulaires meetings	5%	Butare	DHT	Process	Monitoring and Supportive role of DHT
47	Monthly financial statement of district admin	5%	Butare	DHT	Process	Monitoring and Supportive role of DHT
48	Report on the fortnightly medical supervision	15%	Butare	DHT	Process	Monitoring and Supportive role of DHT
49	Paramedical supervision reports	15%	Butare	DHT	Process	Monitoring and Supportive role of DHT
50	Report on the availability of first line drugs	15%	Butare	DHT	Process	Monitoring and Supportive role of DHT
51	Report on the vaccines availability	10%	Butare	DHT	Process	Monitoring and Supportive role of DHT
52	SIS reports from clinics entered in database	10%	Butare	DHT	Process	Monitoring and Supportive role of DHT
53	Demand for ambulance met	0	Butare	DHT	Process	Monitoring and Supportive role of DHT

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"CYANGUGU - Model"

Conceptual Framework taken from 'Conceptual frameworks for health systems performance: a quest for effectiveness, quality and improvement'. Arah, O.A et al, In J for Quality in Health Care 2003; Vol 15,N5, pp 377-398

No	Performance Indicator	Remuneration (Fr)	Model	Target Level in Health System	Type of Measure	Relation to System Function or Objective
1	New consultations	150	Cyangugu	Clinic	Process	Access and Utilization
2	Number of admission days	150	Cyangugu	Clinic	Process	Clinical Care
3	Children Completely Vaccinated	1,000	Cyangugu	Clinic	Process	Quality of EPI program; U-5 Health; Prevention
4	Tetanus Vaccinations 2-5	200	Cyangugu	Clinic	Process	Quality of EPI program; Quality of MCH program; Maternal and Infant Health; Prevention
5	Mosquito Net Distribution	1,000	Cyangugu	Clinic	Process	Decrease Malaria Morbidity and Mortality; Public Health
6	Delivery at the Health Facility	2,000	Cyangugu	Clinic	Process; Outcome	Maternal Health
7	Family Planning New Acceptors	1,000	Cyangugu	Clinic	Process; Outcome	Family Planning Uptake
8	Family Planning Existing Users	750	Cyangugu	Clinic	Process; Outcome	Family Planning Uptake; Quality of FP services
9	Family Planning IUD or Implants	2,500	Cyangugu	Clinic	Process; Outcome	Family Planning Uptake
10	Family Planning Referral for Surgical Method	3,000	Cyangugu	Clinic	Process	Family Planning Uptake
11	Antenatal Care New Client	150	Cyangugu	Clinic	Process	Antenatal Cared; Prevention
12	VCT	600	Cyangugu	Clinic	Process	HIV prevention and care
13	VCT couples tested voluntarily	1,200	Cyangugu	Clinic	Process; Outcome	HIV prevention and care; Quality of VCT services
14	VCT: HIV+ client referred to the Hospital	600	Cyangugu	Clinic	Process; Outcome	HIV prevention and care
15	PMTCT	600	Cyangugu	Clinic	Process; Outcome	HIV prevention and care; Quality of PMTCT services
16	PMTCT couples tested voluntarily	1,200	Cyangugu	Clinic	Process; Outcome	HIV prevention and care
17	PMTCT clients informed about the results	600	Cyangugu	Clinic	Process	HIV prevention and care; Quality of PMTCT services
18	PMTCT clients treated with Nevirapene	600	Cyangugu	Clinic	Process; Outcome	HIV prevention and care; Quality of PMTCT services
19	HIV+ clients treated with Cotrimoxazol	50	Cyangugu	Clinic	Process; Outcome	HIV prevention and care; IO; Quality of HIV Prevention and Care
20	TB patients tested for HIV voluntarily	600	Cyangugu	Clinic	Process	HIV prevention and care
21	New consultations at DH by MD	500	Cyangugu	District Hospital	Process	Clinical Care
22	Number of admission days	250	Cyangugu	District Hospital	Process	Clinical Care; Hospital Efficiency
23	Major Surgical Intervention	15,000	Cyangugu	District Hospital	Process	Clinical Care; Surgical
24	Minor Surgical Intervention	1,000	Cyangugu	District Hospital	Process	Clinical Care; Surgical
25	Normal Delivery	3,000	Cyangugu	District Hospital	Process; Outcome	Maternal Health
26	CS	7,500	Cyangugu	District Hospital	Process; Outcome	Maternal Health
27	Abnormal Delivery	5,000	Cyangugu	District Hospital	Process; Outcome	Maternal Health
28	Bilateral Tuba Ligation or Vasectomy	15,000	Cyangugu	District Hospital	Process	Family Planning
29	Implants or IUD	2,500	Cyangugu	District Hospital	Process	Family Planning
30	VCT	600	Cyangugu	District Hospital	Process	HIV prevention and care
31	PMTCT clients treated with Nevirapene	600	Cyangugu	District Hospital	Process	HIV prevention and care; Quality of PMTCT services
32	PMTCT children of HIV+ clients treated with NVP	600	Cyangugu	District Hospital	Process	HIV prevention and care; Quality of PMTCT services
33	HIV+ client first visit after 6 months	600	Cyangugu	District Hospital	Process	HIV prevention and care; Quality of IO services
34	HIV+ client second visit after 12 months	600	Cyangugu	District Hospital	Process	HIV prevention and care; Quality of IO services
35	HIV+ client third visit after 18 months	600	Cyangugu	District Hospital	Process	HIV prevention and care; Quality of IO services
36	HIV+ client fourth visit after 24 months	600	Cyangugu	District Hospital	Process	HIV prevention and care; Quality of IO services
37	HIV+ clients treated with Cotrimoxazol	600	Cyangugu	District Hospital	Process	HIV prevention and care; Quality of IO services
38	TB patients tested for HIV voluntarily	600	Cyangugu	District Hospital	Process	HIV prevention and care

"BTCCTB - Model"

Conceptual Framework taken from 'Conceptual frameworks for health systems performance: a quest for effectiveness, quality and improvement'. Arah, O.A et al, In J for Quality in Health Care 2003; Vol 15,N5, pp 377-398

No	*Performance Indicator*		*Remuneration (Fr)*	*Model*	*Target Level in Health System*	*Type of Measure*	*Relation to System Function or Objective*
1	Total des nouveaux cas au cours du mois	Indicateur de qualité: l'entrée et sortie de l'ordinogramme sont notées dans le registre des consultations	100	BTC	Clinic	Process	Access and Utilization; Quality of Care; Administration
2	Total des jours d'hospitalisation des sortants	Indicateur de qualité:1. La fiche d'hospitalisation correctement et complètement remplie.2.Toute hospitalisation de plus de 10 jours doit être justifiée	300	BTC	Clinic	Process	Access and Utilization; Quality of Care; Administration
3	Total des consultations CPN au cours du mois rapporté (NC + AC)	Indicateurs de qualité:1. Fiche de CPN correctement et complètement remplie en 2 ex. 1 pour la mère et 1 au C.S. bien classée dans l'échéancier 2. Invitations écrites aux abandons endéans la semaine après l'absence	100	BTC	Clinic	Process	Antenatal Care; Prevention; Quality of Care; Administration
4	Total des enfants de > 11 et < 59 mois consultés au cours du mois	Indicateur de qualité:1. Double de la fiche de suivi correctement et complètement remplie et présente dans l'échéancier du centre.2. Pèse-bébé et balance en bon état de marche 3. Courbe de la croissance bien traçée 4. Endéans 1 semaine :invitation écrite des abandons	100	BTC	Clinic	Process	Nutrition; Prevention; Quality of Care; Administration
5	Total des mois de couverture PF dispensés au cours du mois	Indicateur de qualité: fiche PF correctement et complètement remplie et bien classée dans l'échéancier	100	BTC	Clinic	Process; Outcome	Family Planning Uptake; Administration
6	Nombre de sortants avec poids / taille > 80 %	Indicateurs de qualité: 1. Fiche de suivi et carte nutritionnelle (voir: Standards de prestations) bien remplie 2. Démonstrations de cuisine correctes 3. Conseils nutritionnels bien compris e.a. Lait artificiel (Lait d'arachide - lait de soya - lait de vache)	3,000	BTC	Clinic	Process; Outcome	Nutrition; Prevention; Quality of Care; Administration
7	Nombre de réhabilités avec poids / taille > 80 % et critères de qualité respectées)	Indicateurs de qualité: 1. Fiche de suivi et carte nutritionnelle (voir: Standards de prestations) bien remplie et classées dans l'échéancier 2. Démonstrations de cuisine correctes 3. Conseils nutritionnels bien compris e.a. Lait artificiel (Lait d'arachide - lait de soya - lait de vache)	3,000	BTC	Clinic	Process; Outcome	Nutrition; Prevention; Quality of Care; Administration
8	Nombre de moustiquaires vendus au cours du mois rapporté	Indicateur de qualité: 1. La moustiquaire est attachée à domicile 2. Le CS est en possession d'un registre des ventes bien rempli + un reçu avec date, nom et adresse de l'acheteur.	500	BTC	Clinic	Process; Outcome	Public Health; Decrease of Malaria Morbidity and Mortality
9	Total des urgences effectivement et correctement référés (Fiche de référence bien remplie)	Indicateur de qualité: fiche de référence correctement remplie	1,000	BTC	Clinic	Process; Outcome	Quality of Referral Process; Administration
10	Accouchements assistés ou correctement référés au CS avec partogramme correctement et complètement remplie	Indicateur de qualité: Partogramme de l'accouchement ou de la référence correctement et complètement rempli + Mère + enfant(s) vivants	2,000	BTC	Clinic	Process; Outcome	Maternal Health; Quality of Referral Process

11	Total des enfants complètement vaccinés au cours du mois	Indicateur de qualité 1: Température du frigo dans les limites. 2. Si frigo marche au pétrole, toujours une réserve de min. 5 l. de pétrole au centre 3. Fiche de vaccination et de croissance correctement remplie, double au centre classée dans l'échéancier. 4.Invitations écrites envoyées endéans 1 semaine 5; Vitamine A correctement distribuée	1,000	BTC	Clinic	Process; Outcome	U-5 Health; Prevention; Quality Control; Administration
12	Nombre de nouveaux cas TB	Indicateur de qualité : Dépisté selon l'algorithme de dépistage du PNILT (Une série de 3 ex. de crachats)	2,000	BTC	Clinic	Process	Decreased Mortality due to TB; Public Health
13	Nombre de cas TB guéris	Indicateur de qualité: Nombre de nouveaux cas TPM+ enregistrés et guéris ou "traitement terminé" (Taux de succès de traitement)	5,000	BTC	Clinic	Process; Outcome	Decreased Mortality due to TB; Public Health; Quality of TB treatment program
14	Nombre de tuberculeux qui ont été testé pour le VIH	*	1,500	BTC	Clinic	Process; Outcome	Decreased Mortality due to TB; Public Health
15	Nombre de femmes accouchées qui sont resté 3 jours complets après le jour de l'hospitalisation	*	2,000	BTC	Clinic	Process; Outcome	Maternal Health; improvement of post-delivery care
16	Total de nouveaux cas de Paludisme consulte au cours du mois	Total des nouveaux cas avec: 1. entrée des ordinogrammes: fievres, convulsions, cephalees, douleurs lombaires, ictere et paleur et Sortie: Paludisme. 2. Documenter l'exclusion des autres causes de fievre. 3. Traitement Paludisme conforme aux protocol nationale posologie et duree.	100	BTC	Clinic	Process	Decreased Malaria Morbidity and Mortality; Administration; Clinical Care; Quality Improvement
17	Total des sortants gueries aux cour du mois	Total des sortants avec: fiches d'observation correctement remplie, et traitement conforme aux protocole nationale	300	BTC	Clinic	Process; Outcome	Decreased Malaria Morbidity and Mortality; Administration; Clinical Care; Quality Improvement
18	Total des urgences de Paludisme referees	Total des urgences referees avec fiche de reference correctement remplie, 1. Entrée et Sortie de l'ordinogramme utilise. 2. Traitement pretransfert conforme aux protocole nationale.	2,000	BTC	Clinic	Process; Outcome	Decreased Malaria Morbidity and Mortality; Administration; Clinical Care; Quality Improvement
19	Total des rapports hebdomadaires des cas de Paludisme par mois	Total des semaines avec: Fiche de seuil d'alert et Epidemique correctement remplie chaque semaine et correctement afichee aux CS	250/semaine	BTC	Clinic	Process	Decreased Malaria Morbidity and Mortality; Administration
20	Total des femmes enceintes consultees au cour du mois	Total des femmes ayant recu 2 doses correctement administrees avec intervalle d'un mois	500	BTC	Clinic	Process	Decreased Malaria Morbidity and Mortality; Antenatal Care; Prevention

21	Gestion des produits de laboratoire	Total des jours du mois avec: 1. Fiches de stock disponible et a jour, 2. Seuil d'alert calculee, 3. Sans rupture de stock	50/jour	BTC	Clinic	Process	Decreased Malaria Morbidity and Mortality; Pharmacy Stock Control System
22	Gestion des médicaments antipaludiques et consommables	Total des jours avec: 1. Fiches de stock disponibles et a jour, 2. Seuil d'alert calculee, 3. Sans rupture de stock antipaludiques	50/jr	BTC	Clinic	Process	Decreased Malaria Morbidity and Mortality; Pharmacy Stock Control System
23	Réunion d'audit clinique (entre médecins)	Rapport de réunion disponible endéans les 3 jours. Décisions (instructions) clairement notées et numérotées. (Qui va faire quoi, quand et comment) Vérification des décisions lors de la réunion suivante.Preuve documentaire de l'exécution de la décision	5,000	BTC	District Hospital	Process	Hospital Management; Clinical Care; Continuous Quality Improvement; Administration
24	Réunion des médecins avec les chefs de service	Rapport de réunion disponible endéans les 3 jours. Décisions (instructions) clairement notées et numérotées. (Qui va faire quoi, quand et comment) Vérification des décisions lors de la réunion suivante.Preuve documentaire de l'exécution de la décision	7,500	BTC	District Hospital	Process	Hospital Management; Clinical Care; Administration
25	Réunions du comité de gestion	Rapport de réunion disponible endéans les 3 jours. Décisions (instructions) clairement notées et numérotées. (Qui va faire quoi, quand et comment) Vérification des décisions lors de la réunion suivante. Preuve documentaire de l'exécution de la décision	5,000	BTC	District Hospital	Process	Hospital Management; Administration
26	Réunions d'analyse des rapports de supervision par rapport aux normes	Rapport de réunion disponible endéans les 3 jours. Décisions clairement notées et numérotées	15,000	BTC	District Hospital	Process	Hospital Management: Continuous Quality Assurance; Administration
27	Réunions d'évaluation du Plan d'Action précédent + rédaction d'un nouveau Plan d'Action (Semestriellement) N.B. Plan d'action devient grille de supervision.	Rapport d'évaluation disponible + nouveau plan d'action	5,000	BTC	District Hospital	Process	Hospital Management; Administration
28	Réunion d'analyse des données du SIS	Rapport de réunion disponible endéans les 3 jours. Décisions clairement notés et numérotés	5,000	BTC	District Hospital	Process	Hospital Management; Clinical Care; Administration
29	Disponibilité au niveau de la direction des rapports de supervision - rapports de réunions - rapports de formation et autres documents	Bien rangés et accessibles dans les 5 min.	2,500	BTC	District Hospital	Process	Hospital Management; Administration; Quality of Filing System
30	Outils de gestion bien remplis et à jour. - Seuil d'alerte défini - Commande en cas d'alerte - Pas de ruptures de stock	Outils de gestion bien remplis et à jour. - Seuil d'alerte défini - Commande en cas d'alerte - Pas de ruptures de stock	1,250	BTC	District Hospital	Process	Hospital Management; Qualtiy of Pharmcy Stock Control System

31	Nb de jours de rupture de stock en médicaments vitaux	Pas de médicaments manquants	-25,000	BTC	District Hospital	Process	Hospital Management; Quality of Phamacy Stock Control System
32	Disponibilité des médicaments à la garde	Médicaments essentiels disponibles	5,000	BTC	District Hospital	Process	Clinical Care; Quality of Pharmacy Stock Control System
33	Supervisions mensuelles des différents services à l'aide d'une grille de supervision y compris: le service de prise en charge du VIH + Labo +RX + Nutrition + Kine + Pharm. + Maternité	Liste des services à superviser + calendrier + rapports de supervision avec décisions clairement notées et numérotées	7,500	BTC	District Hospital	Process	Clinical Care; Continuous Quality Improvement; Internal Supervision; Administration
34	Supervision mensuelle des services logistiques et financiers par l'administrateur-gestionnaire à l'aide d'une grille de supervision: Buanderie + Véhicules + Toilettes et Hygiène + Réception (Caisse) + Comptable	Liste des services à superviser + calendrier + rapports de supervision avec décisions clairement notées et numérotées	3,750	BTC	District Hospital	Process	Hospital Management; Administration
35	Retro- informations des supervisions réalisées	Rétro-information = Cahier de supervision +Rapport de supervision + instructions (sur 5 supervisions)	2,500	BTC	District Hospital	Process	Hospital Management; Administration
36	Suivi de la supervision	Vérification de l'exécution des instructions de la supervision précédente inclus dans le rapport de la supervision suivante	1,250	BTC	District Hospital	Process	Hospital Management; Administration
37	Formation organisée par l'hôpital pour le personnel de l'hôpital sur un thème dont le besoin de formation est prouvé	Rapport de la formation + pré et post test	25,000	BTC	District Hospital	Process	Hospital Management; Continuous Education
38	Saisie mensuelle des rapports SIS	Fait endéans les 14 j après la fin du mois	2,500	BTC	District Hospital	Process	Clinical Care; Hospital Management
39	Existence d'un plan d'établissement	*	2,500	BTC	District Hospital	Process	Hospital Management; Governance
40	Existence d'un règlement d'ordre intérieur	*	2,500	BTC	District Hospital	Process	Hospital Management; Governance
41	Existence d'un plan d'action (= grille d'évaluation)	*	2,500	BTC	District Hospital	Process	Hospital Management
42	Existence d'un plan des activités	*	2,500	BTC	District Hospital	Process	Hospital Management
43	Activités du mois exécutés (En %)	% (100% = max remuneration)	25,000	BTC	District Hospital	Process	Hospital Management
44	Radiologie : registres des examens et fiches de stock correctement et complètement remplis.	Complets et bien remplis	2,500	BTC	District Hospital	Process	Clinical Care; Administration
45	Liste des consultations et des sesions correctement et complètement remplie	Complets et bien remplis	2,500	BTC	District Hospital	Process	Clinical Care

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46	Inventaires présents dans les services	*	2,500	BTC	District Hospital	Process	Administration
47	Inventaire mis à jour 1x par mois	Inventaire mis à jour 1x par mois	5,000	BTC	District Hospital	Process	Administration
48	Pièces manquantes dans l'inventaire	Zéro	(-12,500/piece)	BTC	District Hospital	Process	Administration
49	Equipement essentiel en panne	Zéro	-25,000	BTC	District Hospital	Process	Administration
50	Phonie en état de marche	En état de marche	25,000	BTC	District Hospital	Process	Administration
51	Hygiène et propreté	Toilettes propres - four d'incinération propre - terrain propre.	2,500	BTC	District Hospital	Process	Administration; Clinical Care
52	Gestion financière	Comptabilité mensuelle en ordre - Livre de caisse à jour	5,000	BTC	District Hospital	Process	Administration
53	Maintenance	Planification de maintenance préventive - Registre de maintenance préventive bien tenu	5,000	BTC	District Hospital	Process	Administration
54	Logistique (Véhicules)	Le carnet de bord et le carnet d'entretien correctement et complètement remplis.	5,000	BTC	District Hospital	Process	Administration
55	Promptitude	Lors de la supervision mensuelle, tout document ou statistique doit être présenté endéans 5 minutes après la demande	25,000	BTC	District Hospital	Process	Aministration
56	VCT	Fiches et registres bien remplies	100	BTC	District Hospital	Process	HIV Prevention and Care; Administration
57	PMTCT	Fiches et registres bien remplies	100	BTC	District Hospital	Process	HIV Prevention and Care; Administration
58	ARV	Fiches et registres bien remplies	100	BTC	District Hospital	Process	HIV Prevention and Care; Administration
59	Nombre de consultations médecin (lors d'une session de consultation)	Fiches de consultation + registre bien remplies	100	BTC	District Hospital	Process	Clincal Care; Administration
60	Consult Kine	Fiches de session + registre bien remplies	100	BTC	District Hospital	Process	Clinical Care; Administration
61	Nombre de sortants du mois	Fiche d'hospitalisation bien remplie	1,000	BTC	District Hospital	Process	Hospital Management; Administration; Quality of In-Patient Care
62	Accouchements eutociques	Partogramme bien remplis - fiche d'hosp bien remplie	1,000	BTC	District Hospital	Process	Clinical Care; Maternal Health; Administration
63	Accouchements dystociques	Partogramme bien remplis - fiche d'hosp bien remplie	1,500	BTC	District Hospital	Process	Clinical Care; Maternal Health; Administration
64	Césariennes	Pas d'infection de la plaie + protocole opératoire bien rempli	1,500	BTC	District Hospital	Process; Outcome	Clinical Care; Maternal Health; Administration
65	Nombre d'ex de labo : Urine	Registres bien remplis + contrôle qualité du progr lab de distr.	25	BTC	District Hospital	Proces	Clinical Care; Quality Control; Administration
66	Nombre d'ex de labo : Selles	Registres bien remplis + contrôle qualité du progr lab de distr.	25	BTC	District Hospital	Process	Clinical Care; Quality Control; Administration
67	Nombre d'ex de labo : gouttes épaisses	Registres bien remplis + contrôle qualité du progr lab de distr.	50	BTC	District Hospital	Process	Clinical Care; Quality Control; Administration
68	Nombre d'ex de labo : hématologie	Registres bien remplis + contrôle qualité du progr lab de distr.	25	BTC	District Hospital	Process	Clinical Care; Quality Control; Administration
69	Nombre d'ex de labo : biochimie (photomètre)	Registres bien remplis + contrôle qualité du progr lab de distr.	50	BTC	District Hospital	Process	Clinical Care; Quality Control; Administration
70	Réunions ECD	Rapport de réunion disponible endéans les 3 jours. Décisions clairement notées et numérotées. Qui va faire quoi et quand	1/137 points	BTC	Base Administration District	Process	District Health Management; Administration

71	Réunion de l'équipe de la base administrative	Rapport de réunion disponible endéans les 3 jours. Décisions clairement notées et numérotées. Qui va faire quoi et et quand	1/137 points	BTC	Base Administration District	Process	District Health Management; Administration
72	Réunions titulaires	Rapport de réunion disponible endéans les 3 jours. Décisions clairement notées et numérotées. Qui va faire quoi et quand	1/137 points	BTC	Base Administration District	Process	District Health Management; Administration; Monitoring and Supervision
73	Gestion des médicaments	Documents dont liste en annexe bien remplis - Seuil d'alerte défini - Commande en cas d'alerte - Pas de ruptures de stock	20/137 points	BTC	Base Administration District	Process	District Health Management; Administration; District Pharmacy Stock Control System
74	Nb de jours de rupture de stock en médicaments vitaux	Pas de rupture de stock de 10 médic. traceurs	(- 10/137) points	BTC	Base Administration District	Process	District Health Management; Administration; District Pharmacy Stock Control System
75	Entretien de la chaîne de froid	Fiche de température remplie et température dans les limites admises.	10/137 points	BTC	Base Administration District	Process	District Health Management; Administration; District EPI Cold Chain Management
76	Nb de jours de rupture de stock en vaccins	Pas de rupture de stock de vaccins	(-10/137) points	BTC	Base Administration District	Process	District Health Management; Administration; District EPI Cold Chain Management
77	Visites de supervision intégrée + relevé des données Approche Contractuelle	1 visite / CS / mois	20/137 points	BTC	Base Administration District	Process	District Health Management; Administration; Monitoring and Supervision
78	Réunions d'analyse des rapports de supervision par rapport aux normes	1 réunion par mois (evt. intégrée dans réunion ECD et/ou réunion Titul.	1/137 points	BTC	Base Administration District	Process	District Health Management; Administration; Monitoring and Supervision
79	Supervision approfondie sur une activité prioritaire	1 supervision approfondie sur une activité prioritaire	10/137 points	BTC	Base Administration District	Process	Quality of Care; Monitoring and Supervision; Administration
80	Retro- informations des supervisions réalisées	Document de rétro-information existe au CS + copie au district	1/137	BTC	Base Administration District	Process	Quality of Care; Monitoring and Supervision; Administration
81	Suivi de la supervision	Exécution du suivi confirmée dans le rapport de suivi de la supervision précédente inclus dans le rapport de la supervision suivante	5/137	BTC	Base Administration District	Process	Quality of Care; Monitoring and Supervision; Administration
82	Nombre de formations recommandées par le Comité de Gestion de l'Approche Contractuelle (=dont le besoin est prouvé par la recherche action)	Rapport de la formation + pré et post test	20/137	BTC	Base Administration District	Process	Continuous Education; Administration
83	Réunions des COSA - 1 membre de la BAD participe aux réunions des Cosa de chaque CS 1 fois par semestre.	Copie du rapport présente au district	5/137	BTC	Base Administration District	Process	Community Participation; Governance; Administration
84	Réunions avec les animateurs sanitaires - 1 membre de la BAD participe aux réunions des Cosa de chaque CS 1 fois par semestre.	Copie du rapport présente au district	5/137	BTC	Base Administration District	Process	Community Participation; Governance; Administration
85	Rapport mensuel	Disponible au district endéans les 2 semaines après la fin du mois	5/137	BTC	Base Administration District	Process	Clinic Administration; District Health Administration
86	Saisie mensuelle des rapports SIS	Faite avant la fin du mois suivant	1/137	BTC	Base Administration District	Process	Clinic Administration; District Health Administration
87	Réunions d'analyse des données DU sis	Rapport de réunion disponible endéans les 3 jours. Décisions clairement notées et numérotées -Rétro information au cours des réunions des titulaires	1/137	BTC	Base Administration District	Process	Clinic Administration; District Health Administration
88	Existence d'un règlement d'ordre intérieur	Existe	1/137	BTC	Base Administration District	Process	District Health Administration; Governance
89	Existence d'un plan d'action	Existe	1/137	BTC	Base Administration District	Process	District Health Administration; Governance
90	Existence d'un plan des activités	Existe, y compris les activités des programmes verticaux	1/137	BTC	Base Administration District	Process	District Health Administration; Governance

91	Activités exécutés (En %)	100%	(% * 10/137)	BTC	Base Administration District	Process	District health Administration
92	Promptitude	Tout document doit être présenté dans les 5 min après la demande + la comptabilité du projet doit arriver à la direction avant le 4 du mois	10/137	BTC	Base Administration District	Process	District Health Administration; Quality of Filing System
93	Complétude	Les rapports mensuels, la saisie du SIS, la transmission du SIS et les relevés mensuels	2/137	BTC	Base Administration District	Process	District Health Administration; Quality of SIS data management
94	Gestion financière	Comptabilité mensuelle en ordre - Livre de caisse à jour	1/137	BTC	Base Administration District	Process	District Health Administration; Financial Management
95	Maintenance	Planification de maintenance préventive - Registre de maintenance préventive bien tenu - Equipement en panne doit être réparé dans la semaine - les phonies marchent	2/137	BTC	Base Administration District	Process	District Health Administration; Logistics
96	Logistique (Véhicules)	Le carnet de bord et le carnet d'entretien doivent être correctement remplis.	2/137	BTC	Base Administration District	Process	District Health Administration; Logistics
97	Total des rapports hebdomadaires des cas de Paludisme saisis	Total des rapports hebdomadaires saisis et envoyes au plus tard le mercredi de la semaine suivante	250/semaine	BTC	Base Administration District	Process	District Health Administration; Decreased Morbidity and Mortality due to Malaria
98	Les releves mensuels de donnees AC/Paludisme des centres de sante par mois	Total des rapports des releves mensuels envoyes a la CGAC au plus tard le 28 du mois suivant (1 rapport par mois et par CS)	10,000	BTC	Base Administration District	Process	District Health Administration; Decreased Morbidity and Mortality due to Malaria
99	Total des rapports hebdomadaires des cas de Paludisme rapportes par mois	Total des semaines avec: 1. Fiche de seuil d'alerte et epidemique correctement remplie et affichee au niveau du DS, 2. Action prise selon les directives du programme	2,500/sem	BTC	Base Administration District	Process	District Health Administration; Decreased Morbidity and Mortality due to Malaria
100	Gestion des medicaments antipaludiques et consomables	Total des jours avec: 1. Fiches des stock disponibles et a jour, 2. Seuil d'alerte calcule, 3. Sans rupture de stock des antipaludiques	330/jour	BTC	Base Administration District	Process	District Health Administration; Decreased Morbidity and Mortality due to Malaria
101	Gestion des produits de laboratoire	Total des jours avec: 1. Fiches de stock disponibles et a jour, 2. Seuil d'alert calculee, 3. Sans rupture de stock	150/jr	BTC	Base Administration District	Process	District Health Administration; Decreased Morbidity and Mortality due to Malaria

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10. Presentation "Regulation' Group

Ministry of Health – CAAC

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Results of "Regulation" Group Work

REPUBLIQUE DU RWANDA

MINISTERE DE LA SANTE
B.P. 84 KIGALI

17 February 2006

Regulation: Input Financing

- Before starting PBF, a donor will have to finance inputs necessary for implementation of PBF
- No recurrent input financing is expected to be given; it should be paid through output financing

Slide 2

Regulation: Donors who cannot finance the entire package of activities

- By default, donors are expected to finance the package of activities determined by the CAAC, at the conditions defined in the national model

Scenarios for donors who cannot finance the whole package of activities:

1. Minisante finds another financing source(s) (donor or Government) to pay for the part of the package that isn't covered
   -> Feasible?
2. Donor creates "consortium" with other financing source(s) and shows that whole package is financed; work through piloting committee
   -> Difficult to coordinate?
3. Donor is allowed to pay with composite indicators
   -> Do we still have a harmonised system?

Slide 3

Regulation Environment:
Scenario 1: Minisante finds partner

- The CAAC is the lead agency to identify sources to finance the gap
- District level committee should be formed to pool resources and coordinate
- The donor is not allowed to increase indicator prices fixed by the CAAC

Slide 4

Regulation Environment:
Scenario 2: Donor finds partner

- The donor identifies sources to finance the gap and proposes to Minisante (CAAC)
- CAAC evaluates and decides
- District level committee should be formed to pool resources and coordinate
- The donor is not allowed to increase indicator prices fixed by the CAAC

Slide 5

Regulation Environment
Scenario 3: Composite Indicators

- Donor has a large budget specific to an area (e.g. HIV/AIDS)
- Creates different composite indicators which pay for their intervention area but assure their intervention doesn't destabilise the system
- Means that indicator prices are different to the rest of the system

Questions:

- Who will be allowed to implement this and under which conditions?
- Is this scenario preferable or scenario 1?

Slide 6

Changes in the model

National Review:

- Update at national level can be made by CAAC and passed on to districts

Local adjustments:

- Districts can request the change in price of an indicator (e.g. because of high / low performance), which CAAC has to evaluate and approve
- CAAC can add, remove or adjust indicators for the local level, following evaluation

Slide 7

Guiding Documents for Regulation

- Regulation framework will be defined in Ministerial Instructions
  - Definition of terms
  - Description of the model
  - Geographic distribution of partners
  - Indicator prices
  - Anchoring of Task Force as forum of technical assistance for the support of CAAC
- Manual of procedures / guide for actors in districts
  - Clarifies the role of each type of actor
  - Includes the contracts in annexes
  - Is written in simple, practical terms
  - Clarifies the support of donors in terms of technical assistance to government structures
- Register of partners
- Terms of reference of the CAAC
- Performance Based Financing Policy

Slide 8

DRAFT March

11. Presentation 'Indicator' Group

Groupe "Contrats & Indicateurs"

17/2/2006

Les FOSA

- CS représentée par un *comité de (co)gestion COGE* (membres: COSA + personnel).
- Contrat écrit entre *COGE* et individu + R.O.I. + Profil de Poste
- Prévoir un plafond pour prime individuelle (pour pousser au recrutement).
- Questions:
  - Quid des représentants élus secteurs/cellules?
  - HD: C.A. à établir? Dir Hôp.? COGE?

L'acheteur: Comité de Pilotage

- **Forces:**
  - a fait ses preuves à Butare.
  - implique tout le monde.
  - Permet de coordonner des fonds avec différentes contraintes.
  - peut s'adapter aux changements (ex: nouveau BF, réforme administrative…).
  - transparence (e.a. pour CAAC).
  - permet d'impliquer des acteurs tels que le niveau central, l'ESP pour l'appui au démarrage.

L'acheteur: Comité de Pilotage

- **Caveat:**
  - Ne peut être que transitoire (un peu lourd pour certains niveaux), à terme une séparation des rôles à des personnes morales distinctes sera sans doute préférable.
  - Régularité des réunions à garantir.
  - Prévoir un budget pour les réunions.

Propositions

- **Comité de Pilotage** = un contrat multilatéral où les engagements respectifs sont précisés.
- Présidence à confier au Maire ou à son représentant (Unité Santé & Famille).
- Le critère de 4 réunions par an + rapport est mis comme ind. de processus dans l 'évaluation de la performance de la mairie.
- NB: la CAAC pourra également refuser de payer les FOSA tant que rapport pas envoyé.

Composition

- Par district ou en regroupement (choix à laisser?)? Au moins:
  - Maire (élu)
  - Unité Santé & Famille du District (technicien?)
  - Hôpital (directeur + superviseur?)
  - CAAC
  - Partenaire / Bailleur décentralisé
  - Représentants des CS (publics / agréés)
  - ESP ?

Mission du Comité de Pilotage

- Apprécier les résultats des FOSA du dernier trimestre (output) et les évaluations de processus.
- Délibérer les résultats et goulots d'étranglement.
- Vérifier la bonne exécution des engagements respectifs.
- Prendre des sanctions le cas échéant / Faire des rappels à l'ordre.
- S'accorder sur les ordres de paiement.
- Assurer la transparence dans les décisions.

Autres fonctions pour un PBF réussi

- [1] Monitoring de la performance achetée.
- [2] Supervision formative.
- [3] Calcul des subventions et consolidation.
- [4] Production de l'information analytique et rapport.
- [5] Ordre de paiement officiel.
- [6] Paiement.

⇒ Nécessite une activité d'exécution courante.

Une 1° controverse

- Consensus:
  - La qualité des soins / services est un vrai problème au Rwanda.
  - Le PBF peut contribuer à améliorer les choses.
  - Mais la qualité dépend également d'autres facteurs (ex: formation initiale, présence des inputs adéquats, éthique du personnel, supervision formative…).
  - Il faut éviter de créer l'illusion que l'approche PBF va régler tous les problèmes.
  - Il faut prévenir les attaques des personnes hostiles à l 'approche PBF.

Sémantique?

- Opportun de parler d 'indicateurs de qualité?
- La qualité technique est multidimensionnelle et peut être extrêmement difficile / coûteuse à apprécier. Nous ne pourrons jamais mesurer que certains de ces composants. Nous sommes biaisés vers ce qui est facile à mesurer. Ce n'est pas nécessairement ce qui est le plus déterminant pour la santé de l'usager. Le personnel pourrait en venir à négliger ce qui compte vraiment.

Propositions

- (1) Certains des indicateurs que nous aimerions rémunérer ne sont pas des indicateurs de qualité des soins, mais plutôt des indicateur de bonne administration / gestion (ex: remplissage des fiches). ⇒ Préférable de parler d'indicateurs de processus ou de faire des sous-catégories.
- (2) Le CAAC doit entrer en discussion avec les intervenants travaillant sur la qualité (ex: assurance-qualité). Nous devons éviter que le PBF nuise aux stratégies reposant sur des mécanismes de motivation différents.
- (3) Nous devons penser la qualité de façon globale. Le PBF peut contribuer : gratifier le CS qui recrute un infirmier A1 ou qui établit un cercle de qualité, « Bourses de formation»...

Une 2° controverse

- Consensus:
  - PBF impose une vérification de ce que l'on achète.
  - Rapport $=_{(1)}$ Registres $=_{(2)}$ Fiches $=_{(3)}$ Réalité
  - Egalités (1) et (2): personnel tenu par le secret médical.
  - Egalité (3): un acteur de la communauté.
  - Les CS ont besoin d'appui pour régler leurs goulots d'étranglement sur le mode du coaching et de la formation.

Monitoring ≠ Supervision?

- **Monitoring:** dissuader/détecter la fraude par un contrôle.
- **Supervision:** aider l'équipe du CS à progresser.
- Préférable de ne pas confondre les deux fonctions sur une même personne (exp. Gakoma). Le superviseur ne doit pas être craint, mais sollicité. Le monitoring peut être accaparant.
- Les « skills » ne sont pas les mêmes: le contrôleur doit être quelqu'un de pointilleux et strict; le superviseur-formateur doit être compétent dans son domaine particulier (cf. ECD intégrée à HD), empathique et gagner la confiance (les problèmes sont révélés).
- Intérêt d'une séparation des rôles: un mauvais score sur les indicateurs de processus évalués par le contrôleur ⇒ une demande par le CS pour une supervision/formation répondant au mieux à ses besoins spécifiques (≠ approche top-down actuelle).

A prendre en compte

- Expérience du BTC est différente: les deux fonctions peuvent être complémentaires.
- Constat:
  - Manque d'évidence sur le meilleur modèle.

⇒ (1) Faire une recherche comparative et rigoureuse serait pertinent.

(2) L'avis des CS serait intéressant.

Question moins discutée: HD

- Expertise différente!
- Monitoring des hôpitaux:
  - CT: CAAC, CHU, Tiers, Partenaire, Projet?
  - LT: Fédération des mutuelles, Agence Nationale des Hôpitaux?
  - Distinguer selon les types d'indicateurs?
- Supervision des hôpitaux: CHU, consultant du CHU, accréditation?

Fonctions [3-6] pour CS

- [3] Calcul des subventions: Même que [1]
- [4] Production de l'information analytique et rapport: Même que [1] (computer skills!) A lier au GESIS?
- [5] Ordre de paiement officiel pour fonds publics: MCH? (MINISANTE! CAAC?)
- [5]' Ordre de paiement officiel pour fonds extérieurs (ex: VIH/SIDA): partenaire.
- [6] Paiement fonds publics: MINECOFIN.
- [6]' Paiement fonds extérieurs: partenaire.

Fonctions [3-6] pour HD

- [3] Calcul des subventions: Partenaire/CAAC?
- [4] Production de l'information analytique et rapport: Hôpital?
- [5] Ordre de paiement officiel pour fonds publics: CAAC
- [5]' Ordre de paiement officiel pour fonds extérieurs: partenaire/projet.
- [6] Paiement fonds publics: MINECOFIN.
- [6]' Paiement fonds extérieurs: partenaire/projet.

Indicateurs retenus pour le schéma CS «GR-WB»

Activités	Indicateurs
Consultation curative	Nouveaux Cas
Consultation prénatale	NC ; Couverture effective ; VAT2-5 ; sous prophylaxie malaria (pas dans GESIS)
Suivi de la croissance	Impact réel ? (CS peu capable de gérer les cas problématiques) ⇒ Groupe de Travail ?
Malnutrition	Multifactoriel ; CRN en fermeture ⇒ Groupe de Travail ?
Planning Familial	Exp. CORDAID ? USAID ! Utilisatrices en fin de mois ?
Accouchement	Nombre d'accouchements simples et d'accouchements référés ; nécessité d'une évaluation préalable (légère !) sur la capacité des CS et de l'HD.
Vaccination	Enfant complètement vacciné
Référence Urgente	Se concentrer sur les cas de palu graves. MDG !

Indicateurs non retenus pour le schéma «GR-BM»

Activités	Indicateurs
Hospitalisation	Refuser : à ne pas favoriser au niveau des CS (sauf si accréditation ? ⇒ demander aux agréés de développer un référentiel ?)
TB	Résultat un peu décevant du côté du BTC ; ailleurs ? A financer par autre chose que le Scheme GR-BM ?
Moustiquaires imprégnées	Scheme Communautaire
Traitement Paludisme	50% des Nouveaux Cas curatifs.
VIH	MAP/MSH/US Gov. projects

VIH/SIDA

- Concerne: MAP, MSH, US Gvt, TRAC…
- Constituer un groupe de travail avec comme mission:
  - Sélection d'indicateurs.
  - Argumentaire pour chaque indicateur retenu.
  - Proposition de prix relatifs.
  - Rapport à soumettre au CAAC pour décision.

PRIX INDICATEURS OUTPUTS

- Nécessité de faire des simulations. Variables à intégrer:
  - Budget disponible.
  - Activités existantes.
  - Taux de croissance escompté.
  - Nombre de FOSA.
  - Prix relatifs.
  - Personnel.
  - Compétition à quel niveau?
- Réfléchir à un passage progressif d'un paiement lié au coût réel (pour les outputs)? Expérience à venir du côté de MSH!

DRAF

12. Presentation 'Monitoring and Evaluation' Group

Monitoring and Evaluation

Group 2: Appoline, Emile, Christian, Willy & Gyuri
17 Feb 06

Group Consensus on M&E

- Monitoring of Composite Indicators
  - E.g. Number of HIV+ pregnant women that come to deliver in the Health Facility and who take their Nevirapine
- Each HF need a Quality Improvement Team
- Third party verification needs definition

Team for Monitoring 1

- District Hospitals: Administrative District Authorities
  - Management/Organization
    - Frequency once per month
  - Accreditation/certification etc from UTH level
- Health Clinics: DH team
  - Financial Audit through Administrative District
  - General Practitioners (plurivalent staff) as much as possible, if not possible take specialized staff
    - Frequency: once per month

Team for Monitoring 2

- Community Based PBF Activities
  - Team DH or Administrative Unit
  - Frequency once per month

PBF Governance at District Level

- Committee de Pilotage (steering committee) at district level
  - Triggers payment for PBF activities at Administrative Authorities, DH, Clinic and Community level
  - Membership well-defined, includes CAAC, PBF actors, Admin Authorities, DH director, representatives from Clinics etc

Third Party Monitoring 1

- Committee de Pilotage (steering committee) at district level is a kind of 'third party'), if however, the Cttee de pilotage would need a 'measuring stick' sufficiently 'independent' to be credible to exercise its duties and checks if contracting parties have done what they are supposed to do (this involves Admin Authorities, DH, Clinics, Community Health Workers)

Third Party Monitoring 2

- Link the mutuelles at the district level into the 'committee de pilotage'
- Due to the roll-out of the mutuelles these will have an important stake in the quality, effectiveness and cost of health services provided (guide them into the PBF system)
- Need for a third party agency
  1. Cyangugu Model
  2. Butare Model
  3. Collaborative Approach Model

DRAFT March 1

13. Debriefing presentation Bruno Meesen 23 Feb 06

Plan d'action pour la mise en place du FBP: Quelques questions qui demeurent…

Bruno Meessen

23 Février 2006

Grandes étapes

- Etablir les modèles (rôles, flux, indicateurs, prix).
- Ecrire les contrats-types.
- Mapping des financements pour les hôpitaux + Articuler les fonds VIH/SIDA de PEPFAR
- Informer les niveaux décentralisés.
- Evaluer le respect des pré-requis.
- Former les niveaux décentralisés et appui au démarrage.
- Monitoring.
- Premier décaissement.

1. Modèle national

- Principaux défis:
  - Produire 1 modèle national pour les CS.
  - Elaborer une stratégie pour les hôpitaux.
  - Intégrer le projet PEPFAR.
  - Produire 1 modèle basique pour le schéma communautaire.

Constats et pistes d'action

- CS PBF: nets progrès ces derniers jours. Reste à rédiger un document descriptif (fr/en/kw) + montants par activité.
- Hôpitaux: problématique complexe, expérience à accumuler, trop tôt pour un modèle unique. Laisser de la place à des expérimentations différentes.
- SIDA: faire tout le processus qui vient d'avoir lieu pour les CS (indicateurs, prix…). Impliquer les acteurs actifs dans le VIH/SIDA.
- Communauté: une note existe, mais c'est peu. Ne faut-il pas qu'une cellule spécifique soit mise en place?

Question méritant un examen attentif: le contrôle

- **Option proposée: le District (Secteur / Cellule)**
- Avantages: claire séparation des rôles (par rapport à la supervision/formation); l'entité décentralisée défend l'intérêt de ses administrateurs contre les « abus » des prestataires.
- Inconvénients: la capacité est à mettre en place, les ressources humaines sont trop limitées aujourd'hui, risque que l'Unité « Santé & Famille » soit aspirée dans d'autres activités.
- Financement sur le schéma communautaire?
- **Règles d'or:**
  - il faut institutionnaliser cette fonction.
  - Il faut qu'elle soit financée.

Validation

- Proposition: le MINISANTE présente le modèle final à différents panels pour avis:
  - District (éval: capacité à jouer leur rôle, défis identifiés).
  - ECD (éval: distribution des rôles, propres capacités, défis identifiés).
  - ESP + Assurance Qualité (éval: articulation PBF sur qualité, défis, opportunités & risques)?
- Objectifs: (1) préparer le plan de mise en œuvre; (2) améliorer le modèle.
- Règles:
  - Demander l'avis du SG sur cette idée?
  - 1 journée, 1 panel.
  - Un panel ne s'exprime que sur son volet.
  - Atelier (présentation du modèle et justification des choix, questions et réponses puis huis-clos, feedback par le panel à Louis avec argumentation et recommandations).
  - Pas de capacité à émettre un feu rouge, mais possibilité de donner des conseils et faire des recommandations.
- Risque: la CAAC recommence ses délibérations. Proposition: processus exclusivement national, mais la CAAC peut préparer la ppt et le descriptif en commun.

Etude « PBF » versus « Input »

- Ce qu'on veut démontrer: le type de contrat détermine la performance des CS.
- ⇒ Pour prouver cela, il faut que tous les autres facteurs soient maintenus égaux.
- Il faudrait que le budget pour les centres de santé « input » / population = budget pour tous les centres de santé PBF / population.
- Chaque budget doit inclure les subsides, mais également les coûts de transaction (PBF: contrôle, Comité de Pilotage, y compris hors budget). ⇒ Par capita, les CS PBF recevront moins sous forme de subsides. A intégrer dans les simulations.

2. Contrats

- Priorité aux contrats pour les deux schémas financés par le budget du gouvernement.
- Résultats:
  - CS (input/output): version draft.
  - Contrat établissant le Comité de Pilotage.
  - Communautaire: en route.
- Etapes suivantes:
  - si CS avec VIH/SIDA: un contrat MSH-CS + ajout au contrat de CP.
  - Hôpital: laisser une grande latitude aux partenaires.

Quelques idées nouvelles

- « Le GR se réserve le droit de communiquer à la population du pays, via les médias nationaux, les variations de performance observée entre districts mettant en oeuvre le FBP ».
- « Le Comité de Gestion du Centre de Santé réservera 5% des recettes totales du FBP au financement de la formation continue du personnel du centre de santé ».
- « Le Maire veillera à ce que le personnel de l'Unité « Santé & Famille » ne soit pas distrait de ses tâches par des activités sans relation avec la stratégie FBP... »
- « Il est autorisé à l'Unité « Santé & Famille » de sous-traiter les vérifications à domicile aux responsables « santé » des cellules, dans la mesure où ces derniers ne sont pas, simultanément, engagés comme agents de santé dans le cadre du FBP à base communautaire ».

Eléments non intégrés à ce stade-ci

- Indicateurs et barème pour les outputs.
- Indicateurs de bon remplissage des outils de gestion (si ce n'est pondération).
- Indicateur de qualité des services.
- Engagement financier des partenaires.
- Annexe (ex: protocole de contrôle).

3. Mapping des intervenants PBF

- Objectifs:
  - Identifier les ressources disponibles hors budget GR.
  - Orienter les partenaires pour la couverture la plus complète du pays.
- Défis:
  - Rigidité des contrats avec certains partenaires ⇒ à renégocier pour certains?
  - Quid des zones vierges d'assistance? Communication vers le personnel hospitalier à prévoir! Ex: Kabutare.

4. Information des niveaux décentralisés

- Objectif:
  - Etablir une bonne compréhension quant aux objectifs, règles du jeu et ressources disponibles.
- Défis pour le niveau central:
  - Développer le matériel communicationnel et didactique (2 jeux de ppt).
  - Former les facilitateurs.
  - Schéma CS + « ECD »: Couvrir l'ensemble des districts Phase 1 et 2 avec un atelier de 2 jours / district.
  - Schéma Communautaire: Même approche?

Contenu de l'atelier "Achat aux CS"

- Participants: CS, HD, District (mairie et unité « Santé & Famille »).
- Journée 1:
  - Présenter les motivations et objectifs du FBP.
  - Présenter le modèle national.
  - Présenter le contrat et la définition rigoureuse des indicateurs retenus.
  - Présenter les pré-requis à satisfaire.
  - Présenter les prochaines étapes.

Suite

- Journée 2:
  - Les équipes se réunissent pour fixer leur plan d'action pour se préparer au démarrage.
  - La CAAC facilite et accompagne le processus.
  - Accord sur les prochains rendez-vous (évaluation et formation).

Constats et pistes d'action

- C 'est un work package très cohérent ⇒ Sous-traiter son développement à 1 seul acteur?
- En kinirwanda?
- Propositions:
  - Impliquer l'Ecole de Santé Publique?
  - Mais le Minisanté doit vérifier tous les matériels et assister aux séances.
  - Financement: partenaires? Facturer cela aux centres de santé (sur budget PBF 1-3/2006)?

5. Evaluation de l'atteinte des pré-requis « Schéma CS »

- Objectif:
  - Vérifier que les districts et formations sanitaires sont prêts pour la mise en oeuvre des FBP.
- Défis pour le niveau central:
  - Rencontrer les équipes pour discuter du résultat de leurs propres évaluations.
  - Dans chaque district, visiter un nombre d'entités identifiés comme potentiellement plus faibles (à identifier via le GESIS).
  - Donner le feu vert aux entités prêtes.

Constats et pistes d'action

- Difficile aujourd'hui d'avoir une idée de la charge de travail.
- Les partenaires au niveau décentralisé peuvent être précieux pour régler les goulots d'étranglement.
- La CAAC devra évaluer les rapports remis par les ECD.
- Qui fera les visites d'évaluation? Idéalement une équipe mixte (CAAC + ECD + ?). Financement?
- Prévoir une formule pour ceux qui se mettront en règle plus tard dans l'année.

6. Appui pour le lancement

- Objectifs:
  - Former les équipes (District, HD, CS) aux outils de gestion et procédures.
  - Faciliter la mise en place du Comité de Pilotage.
  - Transmettre les contrats d'achat pour signature.
- Défis pour le niveau central:
  - Développer le manuel des procédures et les outils de gestion
  - Former les formateurs.
  - Couvrir l'ensemble des districts Phase 1 et 2 avec les formations.
  - Appui et suivi.

Constats et pistes d'action

- Une partie du travail est standard (formation), mais une partie risque d'être du cas par cas.
- Nécessité de travailler avec les mairies et unité « Santé & Famille »
- Rôle pour la CAAC sur le terrain. Soutien des partenaires pour la logistique?

7. Pilotage et monitoring

- Objectifs:
  - Piloter les FBP pour leur meilleure réussite.
- Stratégie retenue:
  - Comité de Pilotage dans les districts.
  - Suivi par la CAAC.
- Défis pour le niveau central:
  - Equipes pour accompagner les districts.
  - Analyser les premiers résultats.
  - Identifier les obstacles dans les zones en retard.

Constats et pistes d'action

- Ça va être lourd pour le Minisanté Kigali:
  - Participation au Comité de Pilotage.
  - Analyse des données.
- Répartition des zones à suivre?
- Qui financera la logistique pour le niveau central et les Comités de Pilotage? Schéma communautaire?

8. Décaissement

- Objectifs:
  - Dépenser l'argent qui a été budgétisé.
  - Rémunérer les entités conformément aux contrats.
- Défis pour le niveau central:
  - Procéder au premier décaissement.
  - Assister au Comité de Pilotage.
  - Organiser un système fluide d'ordre de décaissement consolidé.
  - Dépenses ≈ Budget

1° décaissement: constats et pistes d'action

- L'argent est là. Ne pas l'utiliser nuit à la crédibilité du MINISANTE.
- Propositions:
  - Faire un 1° décaissement identique pour tous les centres de santé pour le « capacity building et la mise en place ».
  - Le 2° décaissement devra être conforme aux contrats (Input/Output).

Décaissement aux centres de santé: constats et pistes d'action

- Difficile aujourd'hui d'avoir une idée de la charge de travail. Mais sans doute un mi-temps.
- Va nécessiter des routines administratives claires.
- La Cellule doit mettre en place cette capacité administrative.

Dépenses ≈ Budget: constats

- Contraintes des finances publiques: trésorerie, commitment du MINECOFIN.
- Si barèmes fixes, incertitude quant à la facture totale car dépendant des prestations qui vont être produites par les centres de santé.
- Paiement ex post et non ex ante comme pour les autres postes de dépenses. ⇒ Quid pour les mois de novembre et décembre?

Dépenses ≈ Budget: pistes d'action

- Adopter des barèmes fixes, mais s'assurer avec les simulations que les achats seront < budget. Prévoir le solde pour l'achat de qualité, une prime aux meilleurs, une répartition selon les « points accumulés »...
- Avantages: très transparent et prévisible pour les CS, met le MINISANTE en position de force.
- Conditions: les simulations doivent être précises.

Analyse générale

- Le Gouvernement du Rwanda et ses partenaires ont mis la barre haut.
- La vision, le leadership, les capacités, l'expertise et les financements sont là.
- C'est une réforme: le leadership est important, mais il sera d'autant moins utile que les modèles seront adéquats, les risques prévenus, la phase préparatoire soignée et le pilotage serré.

Calendrier

- Identifier ce qui peut se faire en parallèle et ce qui est séquentiel.
- Confier des paquets homogènes aux différents acteurs pouvant contribuer à la mise en place.
- Les partenaires doivent s'engager pour un appui précis (domaine et « territoire »).

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