REPUBLIC OF RWANDA

MINISTRY OF HEALTH
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PERFORMANCE BASED FINANCING PROCEDURES MANUAL FOR HEALTH FACILITIES
(Hospitals and Health Centers)

February 2021

Foreword

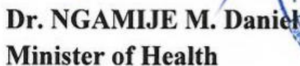
Since the year 2000, Rwanda has made remarkable progress in all sectors of development and specifically in the health sector, which was demonstrated by achieving most of the Millennium Development Goals (MDGs). The Performance Based Financing (PBF) approach institutionalized in Rwanda since 2008 has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

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

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

The PBF strategy is dynamic and guidelines merit to be reviewed regularly. That is why MOH avails this new version 2021 of PBF procedures manual to help users to comply with PBF principles and take into account all modifications introduced in the PBF Scheme.

We urge all health facilities (hospitals and Health Centers) to comply with this guiding document in order to ensure our health system is performing well with regards to the global and national targets.



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ACRONYMS

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

CHAPTER I: INTRODUCTION

1.1 Background

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

PBF implementation entails 3 main functions, namely performance contracting, assessment and payment. The Ministry of Health undertakes the overall strategic stewardship and sets policies and procedures to guide the implementation of the PBF strategy. Within the PBF system, there are two types of performance contracts. The health facility performance contracts is established and defines performance targets health facilities must meet in order to receive the motivational incentive payment.

The Ministry of Health establishes facility performance contracts for the referral, provincial, district hospitals and District steering committee. The individual performance contracts on the other hand is established between the management committee of the health facility and the employee, and defines the agreed bonus to be paid to the employee for satisfactory achievement.

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

Although initiated as a parallel program in 2012, hospital accreditation system offers goals and strategies that are complementary to and synergistic with the PBF program in a number of ways. Both aim to improve health facilities’ performance, and both assume that performance is, to some extent, controlled by intrinsic and extrinsic motivational factors relevant to the health service providers and managers. Also, both programs involve a third party to collect data and verify achievement of performance objectives against set targets or defined standards. To strengthen the complementarity of both programs, major reform in 2014 involved the linking of PBF and accreditation at the provincial and district hospital levels. The linkage aimed at avoiding duplication of efforts in implementing the two programs and as such, promote and achieve greater efficiency. The linkage involved developing and orienting health providers on the new instruments and tools for self-assessment and external assessment of quality of care, based on clear and measurable indicators.

This procedures manual documents the current PBF framework at health facility level. Section one provides a brief introduction, background and PBF historical developments. The second section describes the contribution of PBF to the Rwanda health sector achievements. The third section provides an overview of the performance-based financing principles and system elements. The fourth section

describes the PBF-Accreditation integration. The subsequent sections are grouped around the three PBF functions and implementation model (PBF Budget and payments, PBF audits, and performance contracting).

1.2 Historical development of PBF in Rwanda

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

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

From 2006 to 2013 the District hospitals were assessed quarterly by teams from the MoH central level and peer evaluators selected from other district hospitals staff. PBF payments were contingent on the evaluation scores assessed (60% central level team assessment and 40% for the peer evaluation). Despite high PBF score, there were persistent concerns about the quality of services delivered. This mostly emanated from the fact the PBF performance indicators at the time were not providing an accurate measurement of performance. A more comprehensive and deeper assessment of the quality of services was needed. Following the establishment of accreditation program for the DH’s in 2014, the PBF and accreditation system were linked. They started with five provincial hospitals, and the roll out to all hospitals occurred in 2016.

CHAPTER II: RWANDA HEALTH SYSTEM ORGANISATION

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

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

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

Figure 1: Rwanda Health System

Rwanda's Health System

Administrative structure	Health care delivery system	No. of public facilities/ CHWs	Av. Catchment area pop	Type of service offered
	Tertiary hospitals	8	National (~12 m)	Specialized hospitals serving the entire country Medical training
Provinces (5)	Provincial Hospital	4		
District (30)	District hospitals	40	~ 255, 000	-Provide government defined "Complementary package of activities (CPA) (C-section, treatment of complicated cases,.. -Provide care to patients referred by the primary health centers Carry out planning activities for the health district and supervise district health personnel
Sector (416)	Health centers	511	~ 23 000	Provide government defined "minimum package of activities at the peripheral level (MPA) This includes complete and integrated services such as curative, preventive, promotional, and rehabilitation services Supervise health posts and CHWs operating in their catchment area
Cell (2148)	Health posts	614		Services provided are similar, albeit reduced from, that by Health Centers. Established in areas which are far from health centers, Services include curative out-patient care, certain diagnostic tests, child immunization, growth monitoring for children under five years, antenatal consultation, family planning, and health education
Village (14,837)	Community Health Workers	58,567	~ 250	**Community-based** : Prevention, screening and treatment of malnutrition Integrated Management of Child Illness (CB-IMCI) Provision of family planning Maternal Newborn Health (C-MNH) DOT HIV, TB and other chronic illnesses Behavior change and communication

2.1 PBF contributions to health sector achievements

2.1.1 Quality, demand and accessibility of health care

The focus is to improve the quality of health-care services, including the management of health facilities, while continuing to expand geographical and financial accessibility (EDPRS II 2013-2018). PBF as a tool introduced positive competition among health facilities and fostered an environment where health care providers could take initiatives aimed at improving quality of services and advocate for their health facility to increase the utilization of services and thus the income generated, and indirectly their own incentives.

2.1.2 Human resources

A shortage of qualified human resources in the health sector is one of the biggest challenges facing the government. In order to fill the gaps, the Government has invested significant resources in pre-service training. In the meantime, concentrate on the high and middle-level cadre, the Government established the University of Rwanda/College of Medicine and Health Sciences (CMHS), which is in charge of training of health professionals.

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

2.1.3 Health financing

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

The PBF reward to the HFs has been decreasing over the past five years due to the decrease of partners funds, while, the Government fund is increasing every fiscal year from 2015-2016 to 2017-2018.

2.1.4 Health sector successes

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

CHAPTER III: PERFORMANCE-BASED FINANCING DEFINITION OF CONCEPTS AND PRINCIPLES

This section first provides the definition of the most common PBF-related concepts and terms, followed by sub-sections on key PBF principles as they are applied at the hospital level (district, provincial and referral).

3.1 Definitions of concepts

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

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

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

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

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

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

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

PBF implementation can be summarized into three basic steps:

1. The "purchaser" (usually a ministry of finance and partners) and the "provider" (a health facilities). Ministry of Health establishes a contract that defines provider performance targets and the amount of payment it will receive from the purchaser for achieving those targets.
2. Results in attaining performance targets are verified on a regular basis by an independent agency.
3. Based on verification, the provider receives payment according to the level at which they achieved agreed-upon targets.

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

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

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

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

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

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

3.2 PBF Principles

The PBF approach is based on 3 principles:

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

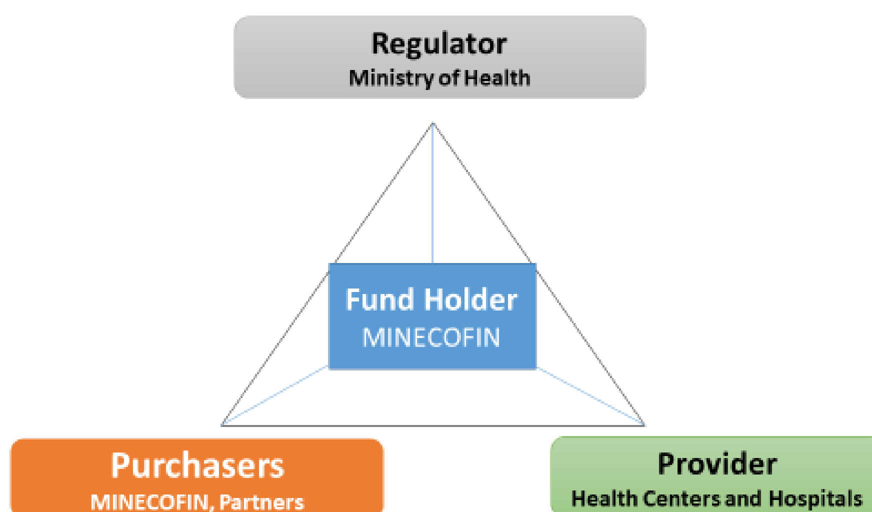
3.2.1 The Separation of Functions

This section describes the institutional setup in PBF implementation ensuring separation of functions, roles and responsibilities. Separation of functions is paramount to effectively and efficiently implement

the PBF strategy and to avoid conflict of interest. These imperatives require that the regulator, the fund holder or the purchaser and the provider all be different from one another.

Figure 2 below shows the functions and respective institutions involved in PBF implementation at hospital level. MOH is the regulator and sets policies and procedures. The providers are the hospitals delivering health services to the population whereas The purchasers are the Ministry of Finances and Partners.

Figure 2: Separation of Functions in Hospital PBF



3.2.1.1 The regulator - Ministry of Health

The overall management of the PBF is the responsibility of MoH as the regulator with main functions including; regulation (setting the policies, norms and procedures), supervision and facilitation of the PBF implementation, resource mobilization and resource allocation. The Department in charge of planning, Monitoring & Evaluation and health financing (DPM&EHF) in the MoH is involved in implementing the PBF strategy at central and decentralized levels.

The roles of MoH in the implementation of PBF Strategy include:

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

- Develop the PBF policy, procedures and select services to be purchased through PBF and identify resources needed.
- Revision of PBF indicators and targets.

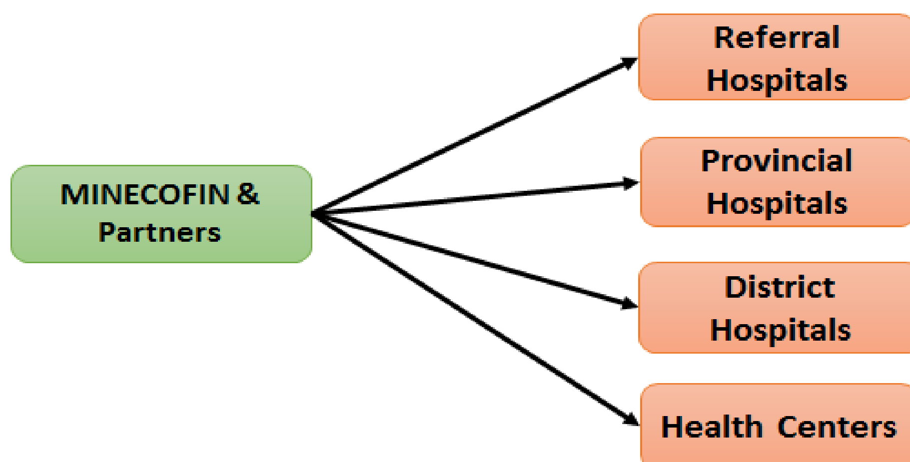
Notice: The Ministry of Health can set ad hoc indicators according to the emergency and priorities to be considered for PBF payment.

- <u>Supervision</u>
    - Enforce the implementation of PBF principles and guidelines;
    - Manage, monitor and analyze PBF Data;
    - Monitoring the PBF model at all levels;
    - Provide technical support to the PBF implementers;
    - Plan and conduct PBF system assessment and PBF Data counter verification.
    - Oversight and coordination of PBF District level steering committees
- <u>Resource mobilization</u>
    - Advocacy for increasing PBF budget.
    - Involving more partners in PBF system
    - Advocate for PBF sustainability.
- <u>Resource allocation</u>
    - According to the fiscal year budget available, the Ministry of Health allocate PBF Budget for each hospital. This PBF budget allocation is based on criteria set by MoH according to its priorities. This budget allocation is applied to the quality score of the hospital.
    - Determine unit cost for quantitative indicators based on PBF budget available.
    - Request the funds holders to disburse PBF payments.
    - Ensure distribution of PBF funds according to health facility production

3.2.1.2 The Purchasers

The Ministry of Finance and Economic Planning (MINECOFIN) and Partners are the purchasers of performance results from Referral, Provincial, District Hospitals and Health Centers as shown in the figure below.

Figure 3: Purchasers for Health Facilities PBF



3.2.1.3 Organization of PBF at Decentralized level

Role and Responsibilities:

At district level there is a steering committee in charge of PBF matters which is composed by the following members:

1. Director or in charge of health at District; (Chairperson)
2. Hospital Director General; (Co-Chair)
3. PBF focal person at the hospital (Secretary);
4. Planning and M&E officer at the hospital;
5. RSSB Branch Manager at district level;
6. Community health focal person at hospital level;
7. Director of Pharmacy at district level;
8. Representative of health centers in each hospital catchment area;
9. Representative of Community PBF sector steering committees
10. Representative of development partners supporting health activities in the district;
11. Representative of CHWs cooperatives in the district.

The District Steering Committee (DSC) coordinates PBF activities at the decentralized level (Health Facility & Community) with the following specific responsibilities:

- To operationalize the PBF strategy at local level;
- To Conduct verification of quantitative and qualitative PBF indicators;
- To ensure that PBF data entry in PBF Database is completed on time;
- To ensure that the preparatory meeting of DSC was held and PBF Data verified;

- To hold a quarterly or ad hoc meeting to discuss and address health issues within the district and validate PBF data from database with comparison to PBF evaluation results;
- Daily management of the PBF database;
- To submit on time, the report including minutes and PBF invoices to the central level;
- To ensure that all PBF transfers to health facilities from central level have been received; Formulate and review the strategies for improving the quality of care in health facilities;

Figure 4: Hospital PBF administrative model- Summary of the institutions and their roles

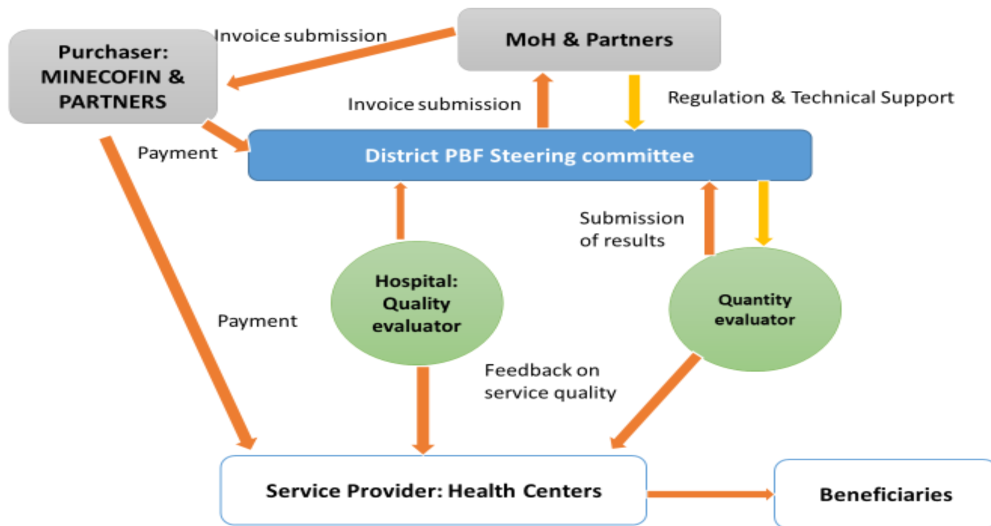
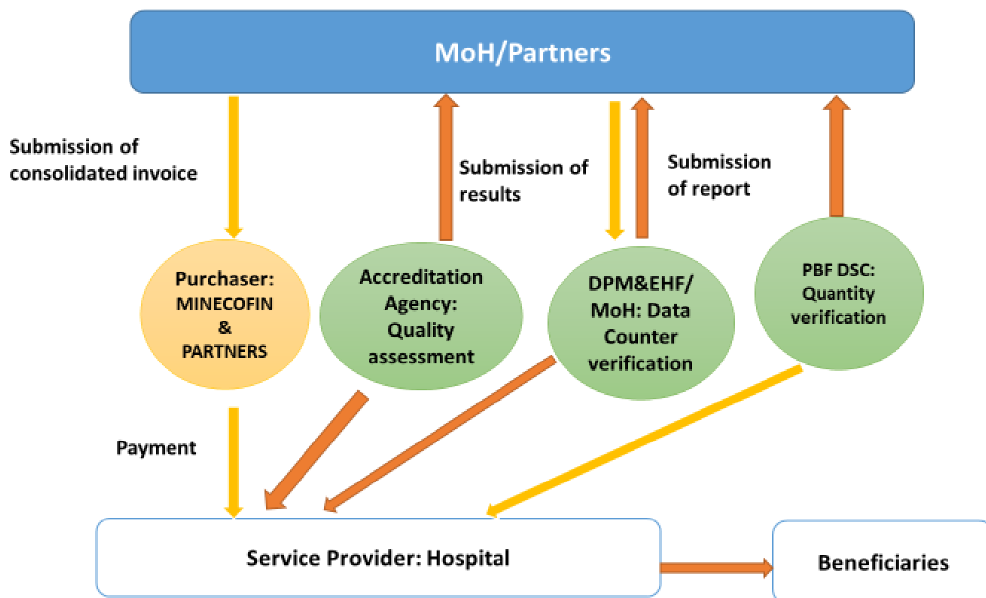


Figure 5: Health Center PBF administrative model- Summary of the institutions and their roles



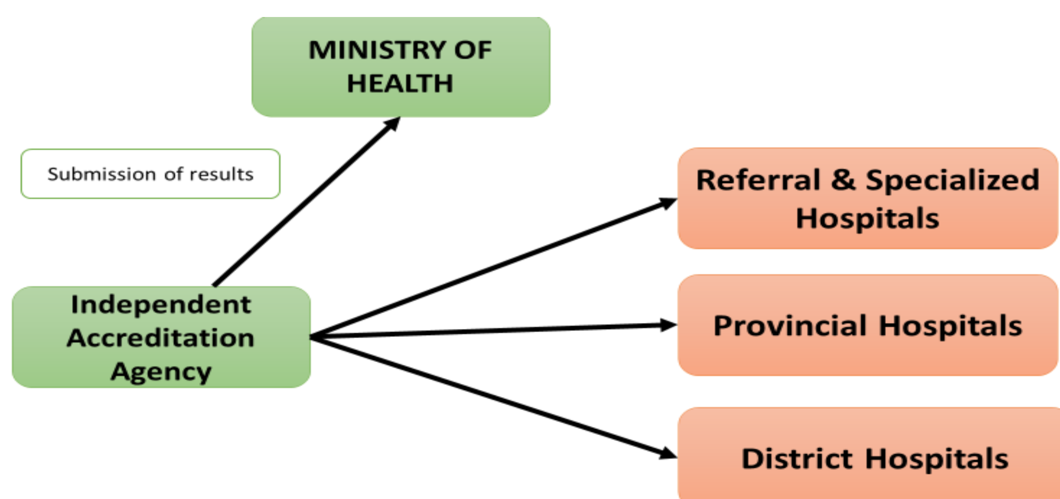
3.2.1.4 The provider

As earlier defined the provider is the entity that implements strategies and activities that will improve the volume and quality of services in view of producing results meeting or surpassing the targets or goals agreed-upon according to the terms and conditions of the contract established with the purchaser(buyer). The role of provider is played by all health facilities taking part in the PBF strategy. Under the current PBF framework, the specialized and Teaching hospitals receive direct budget funds as top-up from MINECOFIN, while for Referral, provincial and district hospitals, PBF funds are allocated based on the criteria established by MoH.

3.2.1.5 The Surveyor

Another principle considered in separation of functions is the assessment. The accreditation progress assessment at hospital is summarized in the schema below (Figure VI).

Figure 6: External Assessment Schema



The performance assessment of Hospitals is conducted by the Independent Accreditation Agency that undertake the following roles and responsibilities:

- To plan and coordinate the accreditation assessment activity
- To conduct the accreditation progress assessment once a year per hospital
- To present findings from the assessment to hospital
- To present the assessment results to the Ministry of Health
- To conduct training of surveyors

The Assessment of national and teaching hospitals (KFH, CHUK, CHUB) is conducted by an internationally accredited quality improvement and accreditation body for healthcare facilities.

3.2.2 The Contractual approach

In Rwanda, the PBF contract is signed between the provider and the purchaser. Here the providers are hospitals and the purchaser is the Government of Rwanda represented by the District and the Ministry of Health.

3.2.2.1 Importance of contracts

The PBF contract allows the concerned parties to have clarity on their respective commitments, obligations, roles and responsibilities. The parties who sign the PBF contract are committed to respect its clauses. The provider has committed to provide quality health services meeting or surpassing the targets or goals agreed-upon according to the terms and conditions of the contract established with the purchaser while the Government or other partners have the obligation to provide the motivation funds for the level of achievement attained for both qualitative and quantitative indicators.

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

3.2.2.2 Types of contracts

There are four types of PBF contracts in Clinical PBF model:

- *District Steering Committee (DSC) Contract:* Contract between the District and the DSC(*Annex1)*
- *Hospital contract:* This is the contract between MoH, District and the Hospital (*Annex2)*
- *Health Center contract*: This is the contract between the District, Sector and the Health Center (*Annex3)*
- *Individual Performance contract:* This is the contract between the health facility and the employee (*Annex4*)

3.2.3 Indicators to be purchased

Quantitative indicators are purchased in the framework of motivating providers to increase the utilization of services.

The evaluation of quantitative indicators is led by the District Steering committee that defines the list of evaluators, these evaluators are selected among the members of the District steering committee or any other staff from health facility.

CHAPTER IV: HOSPITAL PBF AND ACCREDITATION INTEGRATION

4.1 Context and approach

Accreditation national program initiated in 2012 commenced with 5 provincial hospitals and later scaled up to 37 District Hospitals. The accreditation and PBF programs are complementary strategies, providing greater synergy and efficiency with the accreditation and PBF Link. Prior to the link, the MoH managed the two programs separately.

The PBF had been successful for the past ten years and contributed to the motivation and retention of health professionals by improving health services quantitatively and qualitatively.
The accreditation assessment progress has three levels:

- level 1: the policies, procedures, protocols and plans must be developed and communicated to all staff
- At level 2: the processes described in the policies, procedures or plans must be implemented in a consistent way
- At level 3, there are data to confirm successful risk reduction strategies and continued improvement.

4.2 Accreditation assessment organization

The Accreditation performance assessment is organized by an external agency that contracts with the Ministry of Health and the assessment is conducted by the certified assessors.
The Assessment is best conducted as a systematic process on a regular basis. This activity is performed at least once per year although frequency can change based on need.

4.2.1 Scoring

The level of effort achieved after measuring standards compliance is dependent on the score obtained for each level, and ranges from a score of 0 to 3 marks. For each standard there are 3 levels of effort. In the total, the maximum score for each standard met is 18 marks and the least 0.

4.2.2 Reporting

4.2.2.1 Hospital Feedback on Assessment findings

The Accreditation Agency prepares a narrative report, which contains findings, score and recommendations for each risk area.
After verification, the Clinical and Public Health services department reconciles the reports and the final report is later submitted to the respective hospitals.

4.3 Facilitation of accreditation standards

The main mission of the internal and external facilitators is to support hospitals in standards implementation so as to develop strategies for meeting standard and improving quality of services.

CHAPTER V: PBF BUDGET AND PAYMENT FOR HOSPITALS

5.1 Sources of Funds

PBF funds are pooled from various sources including Government of Rwanda, development partners and hospital through internal generated revenues.

5.2 Annual PBF Budgeting and Payment at Hospitals

The repartition of PBF and financial Budget for Hospitals is done according to the level/category of each hospital (CHUs, Referral Hospitals, Provincial Hospitals and District Hospitals). The percentage used is determined by the Ministry of Health.

5.2.1 Financial Annual Budget for Hospitals

The CHUs and some specialized hospitals receive a financial envelope, and their budgets are determined by the central level according to:

- Budget available
- Size of the hospital
- Number and qualification of staff.

The calculation of PBF Budget for hospitals (Referral, Provincial and district Hospitals) is calculated based on the criteria set by the Ministry of Health Central level according to health sector priorities.

5.2.2 Quantitative indicators unit cost allocation at Hospital level.

The quantitative indicators unit cost allocation for each indicator varies from one indicator to another. The MoH in collaboration with RBC decide on the unit cost considering key criteria, such as coverage (if the indicator is lowly or highly achieved, the money is allocated accordingly so that it goes up; priorities of Government if it has reached higher level, it is given less money accordingly). Some indicators involve many role players so as to be reached because of its complexity. Also some indicators are collected rarely, money is allocated accordingly.

The steps to calculate the cost of PBF quantities indicators are:

- Baseline: Find the previous year's quantity (FY) for each indicator
- Calculate the variance (by comparison) of the last 2 years
- Projected variance (financial) = (Baseline * variance for 2 years + Baseline year).
- The team for weighting the indicators is composed by some staff from MoH, RBC, Partners, Beneficially and even from the Local government
- The weight of the indicator: Some indicators are considered critical and given a higher weight indicator.

5.2.3 PBF Payment cycle

After the hospital performance progress assessment, the report is submitted by Clinical and Public Health services department to the department of planning, M&E and Health Financing to initiate payment process referring to PBF budget allocated.

After payment order preparation, the Ministry of Health request the Ministry of Finance to proceed with the payment to hospital accounts through national bank. The PBF payment to Hospitals is done on quarterly basis while the Top UP for CHUK, CHUB and RMH is monthly paid.

5.2.4 Monetary incentives

Following the accreditation progressive assessment, the scores attained for each hospital are applied to its available PBF quarterly envelop. In case the hospital meets a target and exceeds the expected target the hospital will benefit a higher performance index during the calculation of its new budget.

5.2.5 Non-monetary incentives

Non-monetary incentives are also key in the performance reward process. More innovative rewards need to be considered to motivate hospitals that have accomplished to a certain defined upper level of achievement. There are currently very few non-monetary incentives. These include:

- A certificate of accreditation recognition for the level achieved
    - ❖ Level 1 recognition: Is awarded when a hospital meets the following criteria:
        - An average score of at least 75% for each risk area at Level 1;
        - An overall average score of at least 85% at Level 1
        - All critical standards are met at 80% at Level 1
    - ❖ Level 2 recognition: Is awarded when a hospital meets the following criteria:
        - Level 1 standards are met as described above with 100% of critical standards;
        - An average score of at least 70% for each risk area at Level 2
        - An overall average score of at least 75% at Level 2
        - All critical standards are met at 80% at Level 2
        - In some cases, at Level 1 and Level 2 comprehensive risk mitigation plans may be in place that demonstrates how the standard will be met within a specific timeframe and specific responsibilities defined.
    - ❖ Level 3 Recognition: This decision results when an organization meets all the following conditions.
        - Level 1 & 2 scores as noted above
        - An average score of at least 60% for each risk area at Level 3
        - An overall average score of at least 70% at Level 3
        - All critical standards are met at 100% at Level 3
- Priority in training as well as publication in the local Medias

PBF funds are held by MINECOFIN and managed like other public funds. Every health facility prepares an annual action plan integrating all the expected income sources including PBF revenues and expenses

including the incentives for hospital staffs. The amount from PBF payment is included in the hospital revenues during the planning process and is allocated to strengthening health facilities capacity to deliver qualitative services.

5.2.4 Redistribution of remaining PBF balance

In general, the all hospitals cannot get a score corresponding to 100%, so after PBF payment, there is a remaining balance. The MOH can redistribute the amount to the hospitals, according to their performance, as a quarterly or annually motivation.

5.3 Staff performance evaluation and PBF Payment

5.3.1. Staff performance evaluation

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

The individual performance evaluation is done on monthly basis and conducted by the immediate supervisor of the employee according to the organizational structure and approved by a second supervisor where necessary.

The PBF evaluation process is as follows:

- Self-evaluation of each employee on the achieved activities;
- Evaluation of the employee by the immediate supervisor
- Evaluation of the employee by the second supervisor where necessary;
- Every department or Unit submits the evaluation results to Human Resources Officer by 5th of the month following the evaluated period.
- A consolidated report is generated by Human Resources Officer and final payroll is transmitted to Director of Administration and Finance by 15th of the month following the evaluated month.for payment process.

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

1. If the grade of the employee is ≥ 80%, the employee receives 100% of their due PBF allowance; therefore, being granted the total amount according to his/her index (this is considered after applying the score of Health Facility).

2. If the grade of the employee is < 80 up to 60%, the employee's PBF allowance will be calculated in proportion to the score obtained (e.g: 200,000Rwf * 60%= 120,000Rwf)
3. If the overall grade of the employee is < 60%, the employee's PBF allowance will not be granted (this concerns the individual evaluation before applying the score of Hospital).

Evaluation Tools: Evaluation of an employee’s individual performance at Hospital level is assessed using the evaluation form that examines each employee’s performance in the workplace.

5.3.2 Individual PBF Payment

The individual PBF payment is carried out every month based on individual performance score obtained by the staff combined with the hospital score to make the average as final PBF result.
For example, if a hospital X is scored at 90% and an employee Y of that hospital obtained 80% of PBF score, that employee will get motivation payment equivalent to the average between 80 and 90, (80+90)/2 = 85% .

The performance of the Director General of the hospital for the calculation of individual monthly PBF is determined by the overall score of the hospital for last assessment.

The PBF strategy being an output based model, the monthly individual Performance score obtained is applied to the evaluated month but paid for next month. (Ex: The individual performance score of November 2020 will be used for PBF Payment of the same month in the December 2020)
During the official leave or mission (annual leave, mission abroad, maternity leave, sick leave...except the study leave with scholarship) and the employee has no activities performed to be evaluated within the month, the employee is paid the individual motivation (PBF) based on the average of his three (3) previous monthly performance score. This is applied for a leave that does not exceed three months calendar.

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

In case of non-satisfaction of the results of the individual performance, the staff can appeal to the Management Committee of the Hospital, if not satisfied by the resolution from Management Committee, the Board of Directors will solve the dispute.

5.4 PBF Financial Audit

PBF funds management follows the same rules as those governing public finance management in Rwanda; the hospital manager is responsible for the management and reporting of all public funds including PBF.

For financial audit purpose, the internal or external auditor will carry out regularly the audit exercise to ensure that all public funds received and used by the hospital including PBF were properly managed according to the finance regulations.

CHAPTER VI: HEALTH CENTER PBF EVALUATION

6.1 PBF indicators

The Health Centers in the Rwandan health system provide curative, preventives, and promotional health activities. The performance-based financing covers all the minimum package of activities in order to increase the quality and quantity of the overall package. Through the defined qualitative indicators, the aim is to strengthen compliance with national standards in health service delivery. These standards cover all elements of the basic operations of a health facility (personnel, infrastructure, equipment, medicines, hygiene, procedures etc.).

PBF has a fixed cost for each quantitative selected indicator. The choice of indicators depends on the national health priorities of the government or development partners. These indicators are revised periodically according to the need and priority of the program. The weight and unit cost of each indicator are reviewed according to national priorities related to health programs.

6.2 Performance evaluation process

The PBF evaluation tools are available at district and hospital level both in soft and hard copies. This procedures manual describes the evaluators profile and sampling methodology,

6.2.1 Evaluators Profile

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

a) Selection of the evaluator of the quantitative evaluation

The PBF District Steering Committee is responsible for selecting the evaluators who will be performing the evaluation of quantitative indicators at health facility level.

b) Selection of the evaluators for qualitative evaluation

The Director General of the Hospital is responsible for the selection of qualitative evaluators from staff of the hospital. The qualitative evaluation team should be multidisciplinary and well trained. The evaluator has to be experienced in his field of evaluation.

6.2.2 Sampling methodology

The PBF evaluation cannot cover all beneficiaries of health services in a health center, a sampling approach is required for selecting the representative sample to be applied to the entire cases.
The selection of cases to be evaluated follows a systematic random sampling method.

a) Document review

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

b) Selection of the cases

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

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

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

c) Direct observation

The number of cases to observe for each activity is indicated in the evaluation form (specifically the qualitative form).

6.2.3 Process of monthly evaluation for quantitative indicators

a) Self-evaluation

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

b) Evaluation Schedule

The Quantitative verification is done monthly or quarterly according to package evaluated (Ex: MPA is evaluated monthly while TB is quarterly).

c) Conducting the evaluation

A schedule of quantitative evaluation in health center is established monthly by the team of evaluators selected. The evaluation team is composed of at least 2 people to ensure the transparency of results from the evaluation. Evaluators work with the head of the health center or the head of services being evaluated. At the end of the evaluation, the collected data are compared with data from the self-evaluation, discussed and agreed with names and signatures of the evaluators and the head of the health center (or her/his representative). A copy of the evaluation results is given and kept by the health center. The original copy of the evaluation is sent to the focal person of the district PBF steering committee.

6.2.4 Qualitative indicators evaluation Process

a) Evaluation Schedule

The evaluation of qualitative indicators is conducted quarterly on monthly basis by the team from hospital. The evaluation exercise cannot be extended in the following quarter.

b) Evaluation process

The steps below are defined in the evaluation process of qualitative indicators:

- The evaluation is done without informing the team of the health center;
- The visit for the evaluation is scheduled according to the day the activity is planned;
- The evaluator works with the responsible of the activity for the observation of cases or his representative;
- At the end of the evaluation, the evaluating team takes time to present findings to the staff of health center.

6.2.5 Documentation

The health center has the responsibility to ensure the availability and accessibility of all tools and documentation from Central level (MoH, RBC, …) such as norms, standards, flowcharts, protocols, and guidelines. This documentation should be available permanently for the health center staff and to the evaluation team during their visits.

6.2.6 PBF Database

The national PBF scheme uses the following web site: hmis.moh.gov.rw/pbfrwanda/dhis2 a database accessible via the internet. The main purpose of the PBF database is to improve data management, data analysis and smooth invoicing system.

6.2.6.1. PBF Data entry

The quantitative and qualitative evaluation activities are followed by data entry exercise in PBF database in order to enable the invoice generation. The user name and password are given to every district steering committee focal person to enable him access to the PBF database.

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

- District quarterly PBF invoices
- Health Facilities specific reports for a given period.
- Table of indicator values to be used in pivot tables for ad hoc analysis, etc.

6.2.6.2 PBF data base management

The PBF database www.hmis.moh.gov.rw/pbfrwanda/dhis is a component of health management information system (HMIS) managed by the Ministry of Health with the following main responsibilities:

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

CHAPTER VII: PBF BUDGET AND PAYMENT FOR HEALTH CENTERS

7.1 Sources of Funds

PBF funds are pooled from various sources including Government of Rwanda, development partners and health center through internal generated revenues.

7.2 Determination of unit cost for quantitative indicators:

The quantitative indicators unit cost allocated to each indicator varies from one to another. The MoH in collaboration with RBC programs determine the indicator weight considering key criteria, such as coverage, target achievement and the unit cost is fixed according to the available budget.

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

- ✓ Setting up the current production (baseline) related to each indicator considering the data of previous years using data from HMIS.
- ✓ Finding out the variance noted at least between two previous years during implementation of PBF program. (Current production – Previous production)/Previous production. The variance may be negative or positive.
- ✓ The projected production is calculated by applying the variance to the current indicator production as illustrated in the following formula Pn = [(P0 + P0*r)]
  - Pn=Projected production
  - P0= Current production
  - r= Variance or average variation of years
- ✓ Weighting: The weight of each PBF indicator is calculated based on national and program priority, level of effort required to perform and achieve the indicator, possible bottlenecks to be encountered and level of achievement for existing indicators. This exercise is conducted by a panel of people who propose individual weights for each indicator and the average is calculated and adopted. This exercise is conducted periodically based on program needs and evolution.
- ✓ Costing: After determining the weight for each indicator, a formula to link this weight is calculated in order to come up with the unit cost. Below is the formula: (unit cost for indicator 2= unit cost of indicator 1 (UC1) multiplied by weight of indicator 2 (W2) divided by weight of indicator 1 (W1), example; UC1*W2/W1).

Note that the first unit cost can be adjusted to affect all the others depending on the total available budget.

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

Table 3: Determination of unit cost for quantitative indicators

N°	INDICATORS (I)	2015-2016	2016-2017	Variation of quantity 2015-2016 and 2016-2017 in %	Quantity Expected FY 2017-2018	Weight rwf (W)	Relative weight %	Unit Cost (UC)	Total budget by indicator
1	Number of newborn who attend all 4 PNC visits	126,890	122,539	-3%	118,337	6000	13%	1139	134,786,064
2	Number of pregnant women who received full course (90+ days) of iron folic acid tablets	126,890	122,539	-3%	118,337	1000	2%	190	22,464,344
3	Number of pregnant women with 4 standard ANC visits (check in the register of ANC)	55,576	56,459	2%	57,356	6000	13%	1139	65,328,517

7.3 Billing and Payment Process

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

The total validated data of each indicator multiplied by the unit cost of the indicator will be taken into account for provisional billing. The consolidated quarterly results obtained through the monthly billing of the quarter multiplied by the result of the quarterly quality score (in percentage). Performance payment formula = Σ (#validated Production * Unit Cost) *% Quality Score.

7.4 Production, validation and transmission of Quarterly Final Invoices

7.4.1. Preparatory meeting

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

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

7.4.2 District Steering Committee

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

The signed invoices are sent to the Permanent Secretary of Ministry of Health for payment. The Ministry of Health will make a compilation of the invoices and prepare a list of beneficiaries (Hospitals and

Health Center), then a payment order is prepared and submitted to the Ministry of Finance which effects the payment to the HFs through the National Bank of Rwanda.

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

Table 5: Example of PBF invoice generated by data base

2016Q4

Quarterly HIV Invoice

#	Facility Name	Bank	Account	Oct	Nov	Dec	Total	Quality	PBF Payment
1	Gakurazo CS	BP	424141019611	1,894,500	2,970,447	1,394,148	6,259,095	89.83	5,622,545
2	Gashora CS	BP	424303337111	626,553	662,870	623,674	1,913,097	83.5	1,597,436
3	Gihinga CS	BP	424300840911	1,452,258	1,375,124	870,761	3,698,143	94.83	3,506,949
4	Juru CS	BP	424142870911	819,994	943,508	405,875	2,169,377	84.33	1,829,436

7.5 Timeline of transmission and payment of the PBF invoice

The table below shows the process and timeframe of PBF invoices payment from the assessment and approval by the district PBF steering committee to the transfer of funds to the health facilities banks accounts.

Table 6: Timeline of transmission and payment of PBF invoices

Step	Activity/Task Process	Duration and deadline	Responsibility
1.	Conduct PBF evaluation and enter data in PBF database of Health Facilities for all packages	**Quantity:** - Monthly (Ex: HIV&MPA) - Quarterly (Ex: TB&SPRP)	PBF DSC
		Quality: Quarterly (before the end of the evaluated quarter)	Hospital
2.	Organize a meeting to validate the results and PBF invoices	Quarterly	District Steering Committee

3.	Submit quarterly report of PBF District Steering Committee including minutes and PBF invoices to MoH	• July-Sept:10th Nov • Oct-Dec: 10th Feb • Jan-March: 5th May • April-June: 10th Aug	Districts
4.	Consolidate PBF invoices	Quarterly	PM&EHF Department
5.	Proceed with payment of PBF funds to District Steering Committee and health facilities	Quarterly	DG Corporate Services

Note 1: The total PBF funds from Central Government aim to incentivize the staff of Health Center based on their performance. The health Center is not allowed to use PBF funds from central level for any other purposes such as: running cost, purchase of medication, payment of salary for contractual staff, etc.

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

7.6 Staff performance evaluation and PBF Payment

7.6.1. Staff performance evaluation

PBF at Health Center level is governed by a performance contract signed between the employee and the institution. The contract specifies the obligation of the employee and employer, the modalities of payment and the period of evaluation. In addition to the contract, the employee signs Key Performance Indicators (KPIs) with his immediate supervisor. The KPIs hard copies signed at the beginning of the month will be used for evaluation in the agreed upon period. They include basic indicators and strategic interventions measurement indicators based on the action plan of the Health Center.
The individual performance evaluation is done on monthly basis and conducted by the immediate supervisor of the employee according to the organizational structure. It is preceded by the employee's self-evaluation. The PBF evaluation is executed in accordance with the schedule described below.

- Self-evaluation of each employee on the activities achieved;
- Evaluation of the employee is conducted by the immediate supervisor and the second supervisor (where possible);
- A consolidated report is generated by the Administration and Human Resources Unit and final results are transmitted to finance unit before the 5th calendar days of the month following the evaluated month.

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

4. If the grade of the employee is ≥ 80%, the employee receives 100% of their due PBF allowance; therefore, being granted the total amount according to his/her index (this is considered after applying the score of health center).
5. If the grade of the employee is < 80 up to 60%, the employee's PBF allowance will be calculated in proportion to the score obtained.
6. If the overall grade of the employee is < 60%, the employee's PBF allowance will not be granted (this concerns the individual evaluation before applying the score of Health Facility).

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

7.7.2 Individual PBF Payment

The individual PBF payment is carried out every month based on individual performance score obtained by the staff combined with the health center quality score to make the average as final PBF result. For example, if a health center X is scored at 90% and an employee Y of that HC obtained 80% of PBF score, that employee will get motivation payment equivalent to the average between 80 and 90, (80+90)/2 = 85%.

The performance of Head of health center for the calculation of individual monthly PBF is determined by the overall quality score of the health center for last quarter.

The PBF strategy being an output based model, the monthly individual Performance score obtained is applied to the evaluated month but paid for next month. (Ex: The individual performance score of November 2020 will be used for PBF Payment of the same month in December 2020).

During the official leave or mission (annual leave, mission abroad, maternity leave, sick leave...except the study leave with scholarship) when the employee has no activities performed to be evaluated within the month, the employee is paid the individual motivation (PBF) based on the average of his three (3)

previous monthly performance score. This is applied for a leave that does not exceed three months calendar.

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

In case of non-satisfaction of the results of the individual performance, the staff can appeal to the Management Committee of the health center, if not satisfied by the resolution from Management Committee, the health committee will solve the dispute.

CHAPTER VIII: PBF SYSTEM MONITORING & EVALUATION AND DATA COUNTER VERIFICATION

8.1 PBF System Monitoring and Evaluation

The monitoring and evaluation of PBF strategy is an activity conducted by the Ministry of Health in order to ensure the smooth implementation of PBF scheme at decentralized level and the compliance with the existing guidelines.

8.1.1 Objective

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

- To ensure the existence of updated PBF contracts and other PBF documents
- To assess effective implementation of clauses stipulated in the contracts;
- To monitor the Health Facilities evaluations process
- To ensure that PBF transfers have been received to the HFs' accounts;
- To ensure that PBF received were paid to staff on time according to PBF principles;

8.1.2 Methodology for monitoring and evaluation

The monitoring and evaluation of PBF scheme is conducted by visiting some selected health facilities that are under PBF contract to ensure all PBF documents, guidelines and tools are available and followed to implement smoothly the strategy. A check list is prepared by the team from the Ministry of Health to be used for collection of needed information. After the monitoring and evaluation exercise the team from MoH give feedback to the visited HF by sharing recommendations aiming to improve the implementation of PBF strategy. At the end of the activity a comprehensive report is provided and submitted to the MoH hierarchy.

8.2 PBF data counter verification

The Ministry of Health is responsible for counter-verification of quantitative PBF data at health facility level where PBF scheme is implemented.

8.2.1 Objective

The Ministry of Health conducts a bi-annual counter-verification exercise of health facilities data to ensure the level of accuracy and reliability and provide further recommendations for data quality improvement. The specific objectives of PBF data counter-verification are:

- To verify whether the data reported in PBF database are similar to data from PBF evaluation form and register (source of data).
- To identify the root cause of data discrepancy
- To formulate recommendations in the framework of improving data quality

8.2.2 Selection of health facility to be visited

The PBF data Counter-verification exercise is done by selecting Health Facilities based on indicators with outliers or abnormal trends identified during the data analysis. The selection of health facilities to be visited for data counter-verification is guided by the following criteria:

- Availability of outliers
- Abnormal trend when comparing data of two or three successive quarters
- Random sampling

After data analysis done by MoH/PBF team using different methods (download indicators in PBF database, use of pivot table by comparing data of different quarters), a report is given to the Head of Planning, M&E and Health Financing department through the Director of Planning and Health Financing Unit. Based on the report showing the outliers and abnormal trends, the leaders will decide to recommend the data counter verification exercise.

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

ANNEXES

List of Appendices

Annex 1 : Contract between the District and the DSC

Annex 2 : Performance Contract between Purchaser and Hospital

Annex 3 : Contract between the District and the Health Centre

Annex 4 : Individual PBF Contract for Hospital & Health Center

Annex 5 : Individual PBF evaluation form for Hospital and Health Center