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RWANDA



A VISION FOR HEALTH

Performance-Based Financing in Rwanda



The overarching goal is sustainable, improved health outcomes for the Rwandan people.

RWANDA

A Model for Health Sector Reform

Rwanda has caught the world’s attention. It is healing from civil war and the horrors of the 1994 genocide and forging a new identity as a peaceful, democratic, and unified nation. Ambitious social and economic initiatives in one of the poorest countries in the world are yielding results, including double-digit growth of the gross domestic product (GDP) for the past nine years, the global economic crisis notwithstanding.

But the vitality of a nation is measured by more than the GDP. The overall health and well-being of the population is a critical indicator, and a robust health care system is a prerequisite. In 2000, the *World Health Report* described Rwanda’s health care system as one of the weakest in the world. The Government of Rwanda responded with an ambitious health sector reform initiative, and in the last several years has been moving purposefully toward its goal of quality health care for all. Reforms begun in 2005 have brought health insurance to 85 percent of the population, and the availability, delivery, and quality of health services have steadily improved, in some areas dramatically.

From 2005 through 2009, the US Agency for International Development (USAID) provided funding and technical assistance to help Rwanda implement a performance-based financing (PBF) program that has proven to be a key factor in strengthening the health system. The Government of Rwanda has demonstrated the commitment and political will to build on the successes of the reforms and move toward a robust and internally sustainable health care system utilized by all Rwandan citizens.

Governments of other developing countries are taking note.



Final Report of the Rwanda HIV/Performance-Based Financing Project

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Management Sciences for Health (MSH), a global nonprofit organization based in the US, was the prime contractor, with Cordaid, HealthNet TPO, and IntraHealth International Inc. as subcontractors and partners. The project also worked closely with Belgian Technical Cooperation and other partners.

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RWANDA'S VISION

Quality Health Care for All

The *World Health Report 2000* made clear that Rwanda's health system was in need of intensive care: a fertility rate of 6.1 percent threatened the country's ability to avoid a food shortage crisis, the maternal and infant mortality rates were among the highest in the world, HIV prevalence was 3 percent in rural areas and more than 8 percent in the city of Kigali, and malaria was widespread. Quality of care was poor, financial barriers and lack of trust kept utilization of health services low, and the health sector was understaffed and demoralized.

The Government of Rwanda recognizes that a healthy population is the foundation for its social and economic goals and has made health system reform a priority. In its strategic plan for the health sector, the Ministry of Health proposed an ambitious three-pronged program to extend geographic and financial access to care, strengthen institutional capacity, and improve the quality of care and availability of human resources, medicines, and supplies. USAID, with funding through the US President's Emergency Plan for AIDS Relief (PEPFAR),

Performance-based financing demonstrates that it is possible to strengthen public health services in poor countries by introducing market forces.

contracted Management Sciences for Health (MSH) to assist the Ministry of Health with health sector reform. Performance-based financing was a key element of the reform strategy.

The Ministry plan features three interactive core strategies:

Performance-based financing increases funds at the operational level, provides information for decision-making, and induces strong staff motivation, thus improving quality on the facility side while also improving access on the population side.

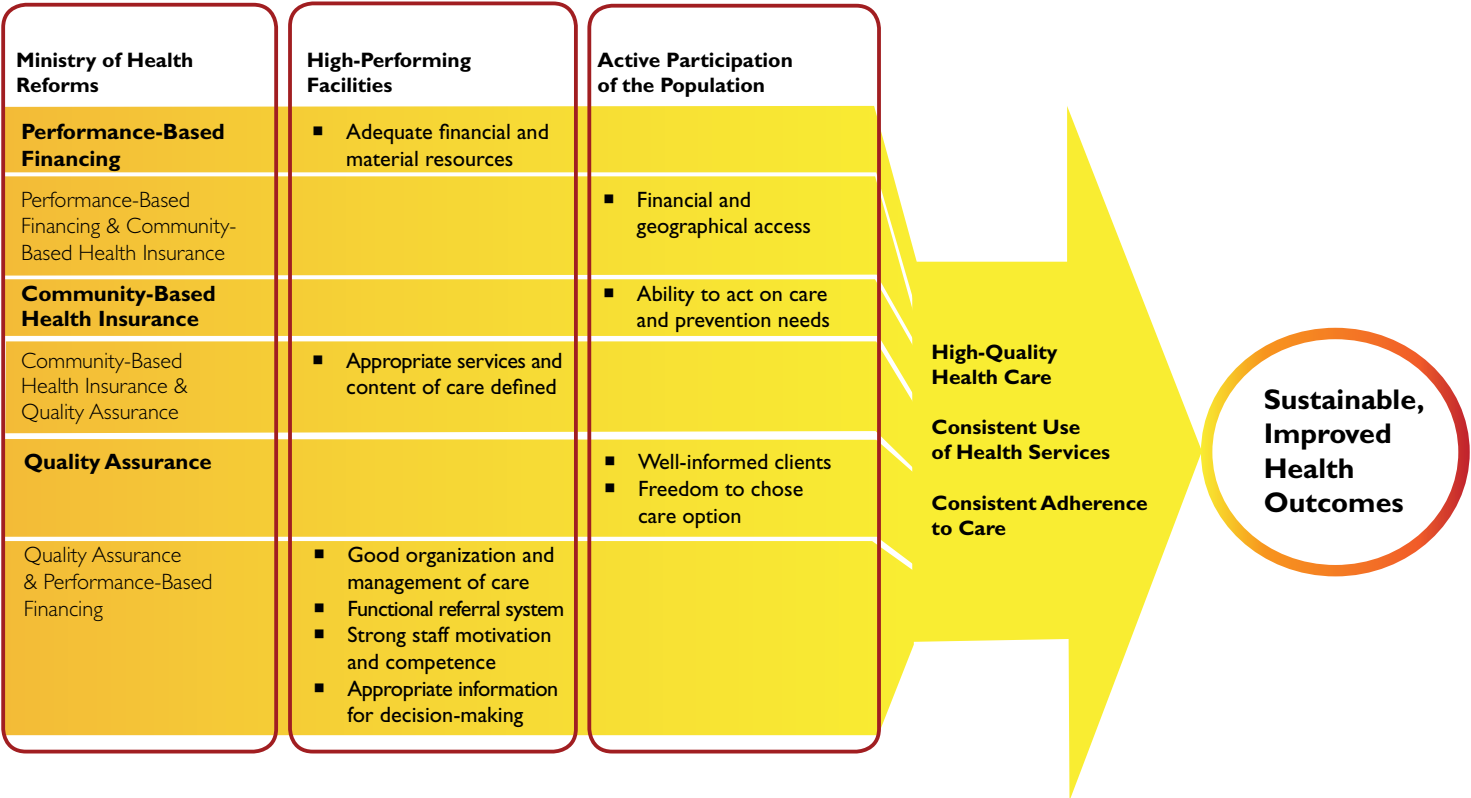
Community-based health insurance ensures broad access to health care so that patients have the ability to act on their care and prevention needs. It also provides a mechanism in determining appropriate care services on the provider side.

Quality assurance activities define and measure performance and establish performance improvement feedback to continuously improve the quality of care.

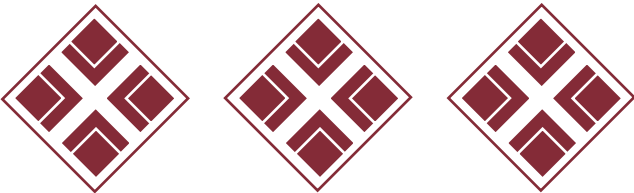
“For successful outcomes, a system must be managed by motivated people. Our system of incentive payments based on performance has significantly improved conditions for health providers at all levels.”

The Honorable Dr. Richard Sezibera, Minister of Health

Strategies for Health Sector Reform and the Determinants of Quality Health Care



The three strategies of health sector reform in Rwanda—performance-based financing, community-based health insurance, and quality assurance—reinforce one another and strengthen the determinants of quality health care. When health facilities operate in compliance with norms and meet expectations and the population consistently uses available health care services and follows the plan of care, the result is sustainable, improved health outcomes.



IMPACT

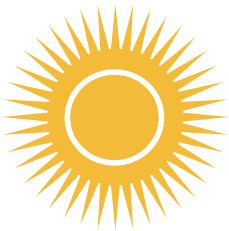
Performance-Based Financing

Performance-based financing is a contracting mechanism that is rooted in a simple premise: rewarding health service providers for positive results leads to even more positive results, which contributes to improved health outcomes.

The Rwanda HIV/PBF Project started in 2005 with the objective of improving the access, quality, and efficiency of HIV clinical services while ensuring that incentives for HIV services did not negatively affect primary care services. The project not only achieved that objective, but also contributed to overall improvement in the quality and delivery of basic health care services and the strengthening of the Rwandan health system.

In fewer than two years, the HIV/PBF Project surpassed its objectives.

Although simultaneous introduction of several reforms makes it difficult to single out any one cause for improvement, results from a 2008 World Bank-sponsored PBF impact evaluation revealed that overall clinical care improved significantly in districts where PBF had been introduced.

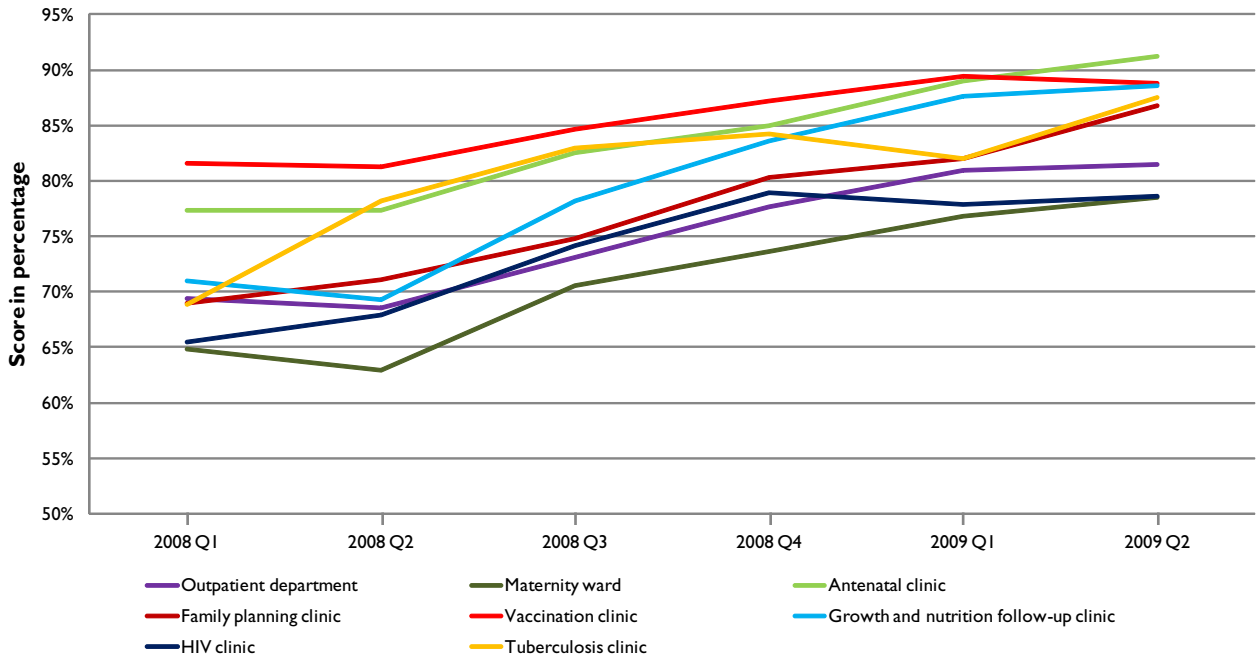


According to data from the Interim Demographic and Health Survey (2007–08) and other sources, indicators measured by the HIV/PBF Project showed the following improvements in primary health care:

- an increase in the contraceptive prevalence rate among married women from 10 percent in 2005 to 36 percent in 2007–08
- an increase in the percentage of births attended by skilled health personnel from 31 percent in 2005 to 52 percent in 2007
- a reduction in childhood mortality from 152 per 1,000 live births in 2005 to 103 per 1,000 live births in 2007
- almost 100 percent increase in the average number of women per health center (re)vaccinated against tetanus, an avoidable and often fatal disease

Quality Trends in Health Centers

Concerns that PBF requirements might shift the attention of health workers from quality toward productivity are refuted by data. All the services evaluated at the health center level show a significant increase in quality over six quarters. The graph shows annual average scores.



INCENTIVES FOR RESULTS

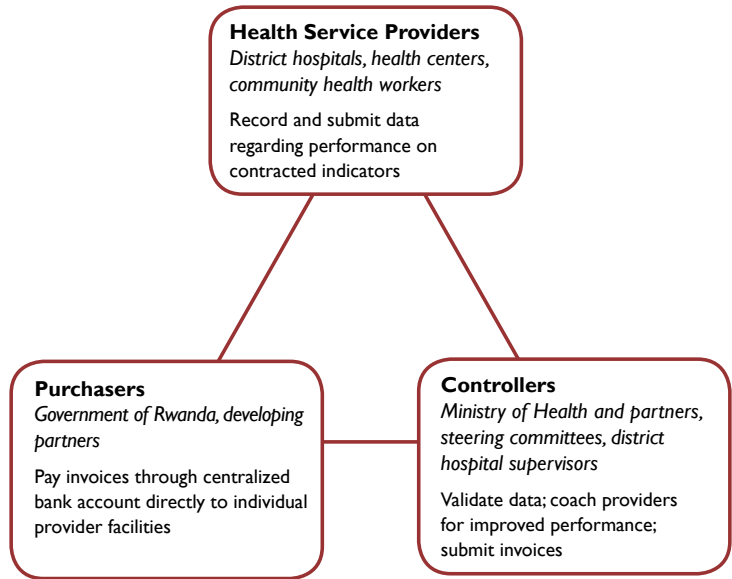
How PBF Works

Performance-based financing links monetary and non-monetary incentives with performance against quality and output goals at every level of the health care system, with an emphasis on local management and clinical care providers. PBF starts with contracts that clarify obligations of the government, developing partners (the purchasers) and health care facilities (the providers). For health centers, payment is based on the number of health services delivered multiplied by the fee set for those services, adjusted by a quality score based on a comprehensive checklist. The impact of PBF is strengthened by its integrated framework of evaluation, supervision, training, and management of health infrastructures. Access to data monitoring and verification systems promote accuracy, accountability, trust, and collaboration among all parties.

A key construct of PBF is the separation of functions among three parties: health service providers, purchasers, and controllers. This separation lessens the likelihood of conflict of interest, such as might occur if the health providers were also the controllers and could manipulate their own incentive payments. The parties interact in a way that

simultaneously involves oversight and technical support. For example, district hospital staff evaluate health centers, but also coach them on how they can close gaps between their targets and actual performance.

Separation of PBF Functions



“Financial rewards are surely motivating, but so too are supportive supervision, access to information, and other project initiatives that empower health care workers.”
Dr. Stephen Karengera, Director of Planning and Capacity-Building, Ministry of Health

WIN-WIN

National Standards, Local Ownership



Decentralization and engagement by local health care managers and providers are important factors in the success of performance-based financing. Health facility directors are empowered to improve performance through the decentralized administrative structure and budgets, and the payment of PBF funds directly into health facility bank accounts. These measures institutionalize local control and autonomy. PBF rewards positive results for the quantity and quality of contracted health services, so local directors tend to reallocate their resources if they are not furthering their goals. Directors use accurate, timely data available on the PBF website as well as their understanding of the local communities’ needs to make adjustments.

Although most health care workers recognize the intrinsic rewards of providing quality services and take pride in doing so, historically low wages and lack of resources have made recruiting, retaining, and motivating health workers challenging. Since the introduction of PBF, the health workforce has grown by 250 percent and retention has improved.

In addition to monetary incentives, PBF fosters health worker participation in problem-solving and improving quality of care. These improvements lead to greater support from the community and increased utilization of health services. The result is a self-sustaining process that leads to improved health outcomes for the Rwandan people.

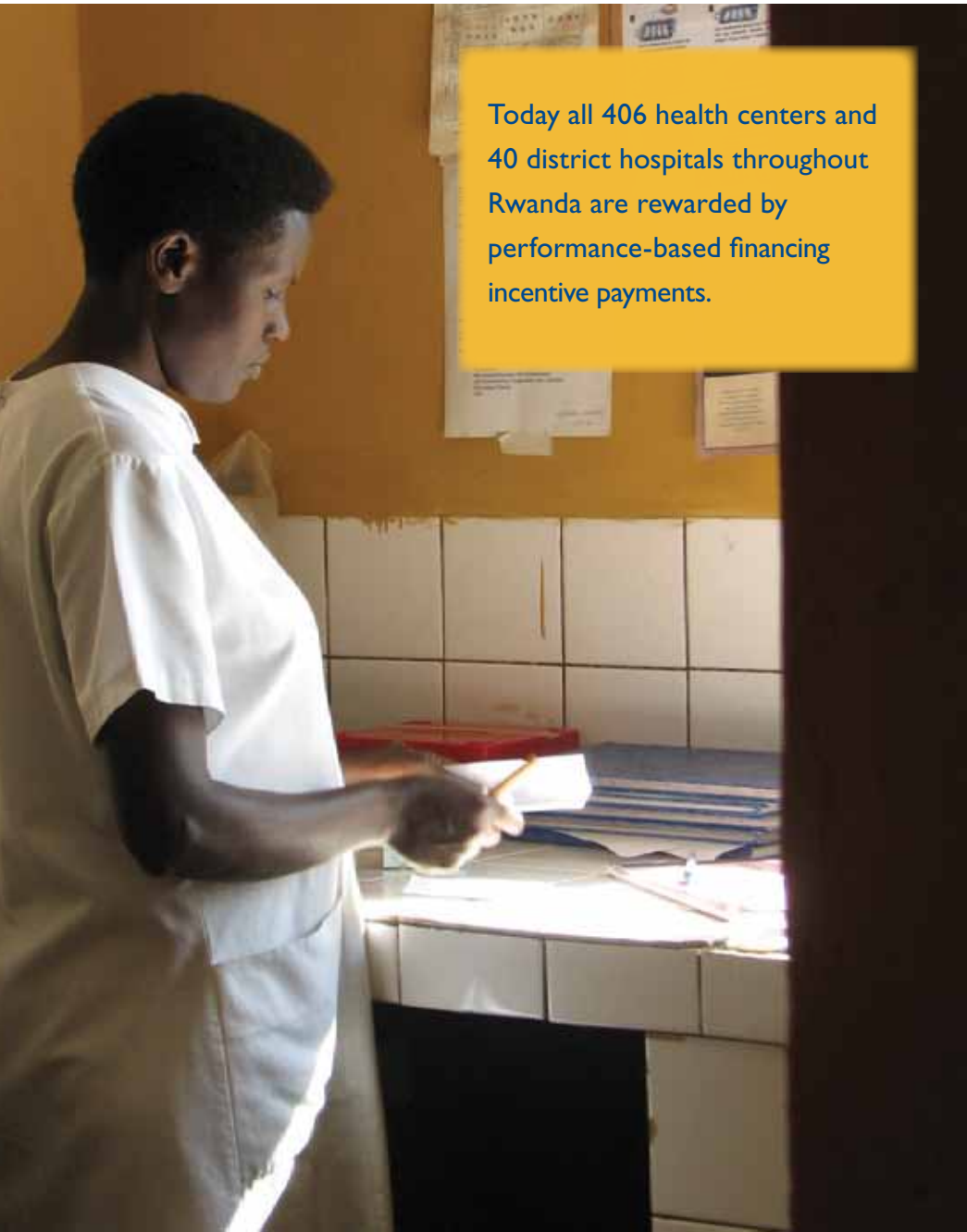
Building a Foundation for Performance-Based Financing

With support from USAID, MSH worked with the Ministry of Health to build a sustainable PBF program through the following accomplishments:

- **Developed PBF models** and rolled them out nationally to district hospitals, health centers, and community health worker cooperatives
- **Defined essential quantity indicators** and developed evaluation tools for primary health services and HIV care
- **Developed a web-enabled health information system** ensuring the widespread availability of accurate, timely data
- **Formulated the data verification processes** necessary to measure results
- **Established a dynamic new Ministry of Health website** to publicize services and encourage utilization



COLLABORATING TO CURE AN AILING HEALTH SYSTEM



Today all 406 health centers and 40 district hospitals throughout Rwanda are rewarded by performance-based financing incentive payments.

Three PBF pilot program agencies had determined what was effective in their regions and had identified the population's need for services. Under the leadership of the Ministry and the support of the HIV/PBF Project, these organizations formed a strong coalition for leveraging PBF and implementing reform on a national scale. However, their approaches differed, especially with regard to defining and measuring quality. Information sharing, cooperative development, and buy-in were needed to build consensus around a national approach.

The Ministry of Health and MSH brought all stakeholders together in a technical working group. Using a participatory process, the group developed the health center model, followed by the district hospital model and the community health model, which is still being rolled out. After an extensive evaluation, the district hospital and health center models were rolled out as uniform national models in 2008. This process reinforced the importance of collaboration and communication to achieve a vision of health system reform that all parties could support enthusiastically.

IMPLEMENTING PBF ACROSS RWANDA

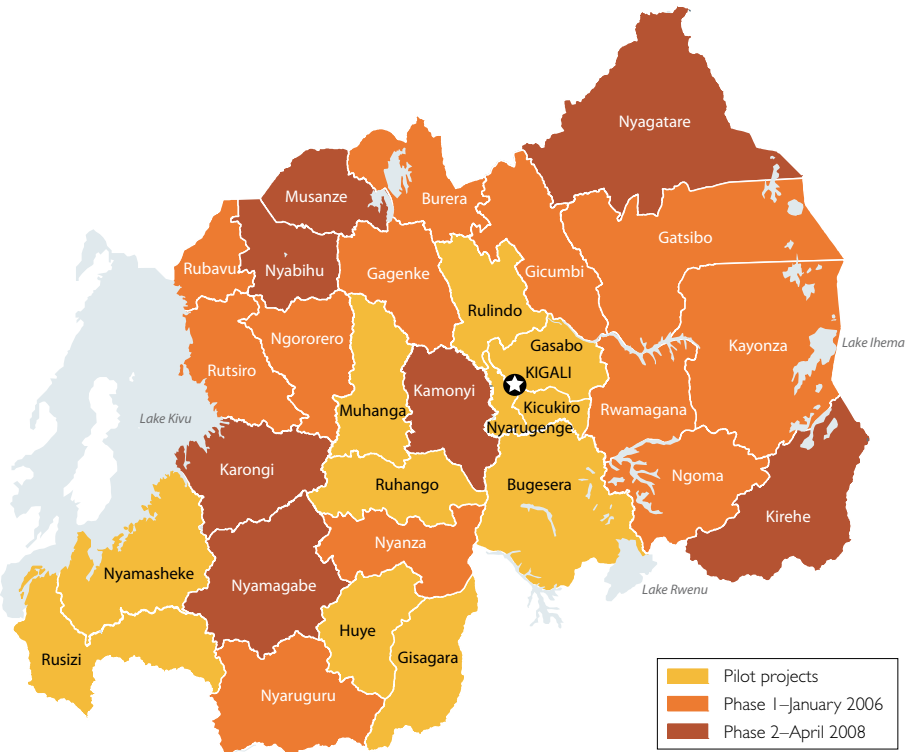
Implementing and maintaining distinct PBF models for health centers, district hospitals, and community health cooperatives is a complex undertaking that requires buy-in and coordination among many players.

At about the same time PBF was introduced, the Ministry of Health decentralized the district health center administration to build autonomy at the local level. This strategy ultimately succeeded but added a layer of complexity. The reconfigured administrative structure put new people in new positions and required clarification of roles and responsibilities among staffers who needed to learn to work together effectively as a team.

Some implementation tasks were straightforward, although labor intensive. Costing of services was a prerequisite for contract development, as was identifying performance indicators for both quantity and quality. PBF tools, measurement and evaluation procedures, and the mechanisms for control and evaluation had to be designed and documented. An ambitious undertaking to train thousands of Rwandans to carry out their respective roles required extensive materials, infrastructure, and staff. Effectively gather-

ing, storing, analyzing, and reporting data depended on a centralized information system that did not yet exist. The Ministry of Health did not allow these impediments to thwart the progress of the reform initiative. With support from USAID and MSH, the PBF infrastructure was gradually put in place, and today all 406 health centers and 40 district hospitals throughout Rwanda are rewarded by PBF incentive payments. PBF roll-out to community health worker cooperatives at every health center (comprising about 60,000 community health workers) is underway. All are monitored and rewarded according to quality assurance and service delivery metrics.

Performance-Based Financing Roll-Out



The phased roll-out of PBF in Rwanda: the eleven pilot districts (in yellow). Twelve districts (in orange) followed in 2006, and seven districts (in red), which served as controls for a PBF evaluation study, were added in 2008.

PLANNING FOR SUSTAINABILITY

The Next Generation of Health Managers

Scaling up PBF and ensuring a sustainable health system depend in large part on a workforce capable of (1) transferring PBF knowledge and skills to others through technical assistance, training, supervision, and coaching, and (2) supporting the HIV/PBF Project's partners in the roll-out. The project has developed national-level trainers and technical assistants who are highly knowledgeable about PBF tools and their use, quality assurance in the PBF process, and data management. They help the Ministry of Health build capacity at the central, district, health facility, and community levels.

At the end of the project, there were 40 clinical PBF master trainers, 16 trainers with quality assurance expertise, and 152 trainers to prepare 60,000 community health workers, two-thirds of whom have already been trained. In addition, the trainers have worked with about 2,000 district hospital, health center, and Ministry of Health staff members.

The training expertise developed by the PBF capacity-building strategy is a sustainable resource vested in the Rwandan people.



The project also offered MSH's Virtual Leadership and Development Program at the district level. MSH helped the Ministry develop manuals that outline the objectives, strategies, and structures of the national program to ensure that PBF is used consistently across districts.

The Young Professionals Program responds to the Ministry's need for qualified junior and mid-career professionals to fill positions as staffing needs arise. The project placed young professionals in full-time positions with the Ministry's teams for a year. This strengthened the Ministry's human resource capacity both by allowing delegation of tasks and by providing the supportive supervision and mentoring essential for the young professionals' development. The first Young Professionals Program prepared 12 men and women, all college or university graduates with no prior health sector experience, to work for the Ministry of Health.



Developing Local Leadership: The Virtual Leadership Development Program



“ Now when we have a problem we don't look outside ourselves for solutions or blame. We see it as a challenge and respond with 'What can we do?'" *Dariya Mukamusoni*

Since participating in the eight-month Virtual Leadership Development Program (a program that combines web-based courses with face-to-face meetings), Dariya and a team from the Nyamata District Hospital, where she is director, have embraced the idea that everyone can be a leader at his or her job. Using their new understanding of leading and managing practices, the team developed an action plan to reduce infant mortality at their hospital. The benefits to the team are already evident. “We see things differently, and we can accept others' opinions. It's not who's right or wrong, it's 'How can we work together to make things better?'"

BUILDING A QUALITY MANAGEMENT SYSTEM

Few countries of Rwanda’s economic status have a national-level focus on quality systems, although in high-income countries such efforts are known to improve the population’s overall health.

From the start, the Ministry of Health intended the triad of performance-based financing, community-based health insurance, and quality assurance to improve the quality of services in the health sector. In 2008, the Ministry decided to create a national quality management framework, and asked for the HIV/PBF Project’s help in this effort. For the third and fourth years of the project, MSH’s role shifted to capacity-building that included strengthening of the Ministry’s organizational performance; development of quality assurance and information systems; a greater advocacy role; and training and technical assistance, especially with regard to community-based health insurance.

The quality management framework rests on the principles of client focus, teamwork, data-based decision-making, and reliance on a systems approach. Defining, measuring, and improving quality by closing the gap between current and expected levels of performance are essential.

“The functional analysis shows the way to achieve our goals for health sector reform. The methods used to improve communication, clarify roles, and build critical systems were so powerful that I use them in my new role at the Ministry of Natural Resources.”

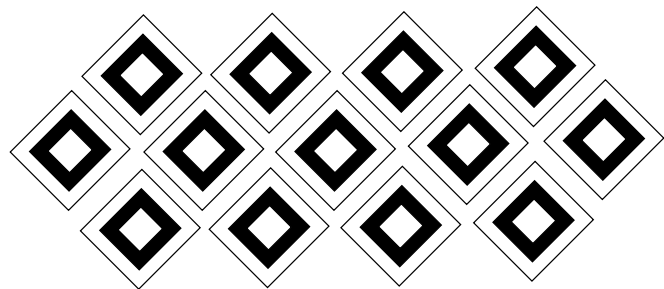
Caroline Kayonga
Former Permanent Secretary, Ministry of Health

- The following planned activities are geared to improving the overall health of Rwandans:
- In early 2009 the Rwandan cabinet approved the Charter of Patient Rights and Responsibilities, which stresses partnership and shared commitment.
 - Plans are underway for a quality management governance structure to build effective leadership and transparent processes. The plan will adapt existing committees at the district and health center levels and create a new body at the national level.
 - The primary purpose of supervision will move beyond verification to a supportive approach that includes management training, coaching, and problem-solving.
 - A new national quality improvement framework will standardize measurement of quality and reduce indicators to a manageable number. The framework will monitor quality and measure quality improvements.
 - Customer care norms will define the treatment patients can expect and the type of reception and behaviors they should expect from health care workers.
 - Integration of the national quality measurement database into health information systems will create synergies among Ministry of Health programs.



- ### Functional Analysis of the Ministry of Health
- A technical assistance team from the project collaborated with senior Ministry officials to improve the performance of 30 Ministry units and allied institutions. The two-year effort resulted in the following improvements that enhanced the Ministry’s ability to deliver quality health care services:
- Clarification of roles and identification of the root causes of breakdowns in systems made clear the obligation for communication and shared accountability.
 - Signed memoranda of understanding resulted from dependency mapping in which the leaders of 30 Ministry and allied health institutions documented their needs and obligations.
 - The Young Professionals Program addressed the need for a qualified pool of public health professionals.
 - Standard operating procedures spelled out a structural realignment of the roles of those responsible for ensuring compliance.
 - A framework for quality improvement validated a single set of quality indicators with commonly understood definitions as well as an integrated supervisory approach.
 - Functional analysis of community-based health insurance led to numerous structural changes and operations adjustments.

IMPROVING ACCESS TO HIV CARE



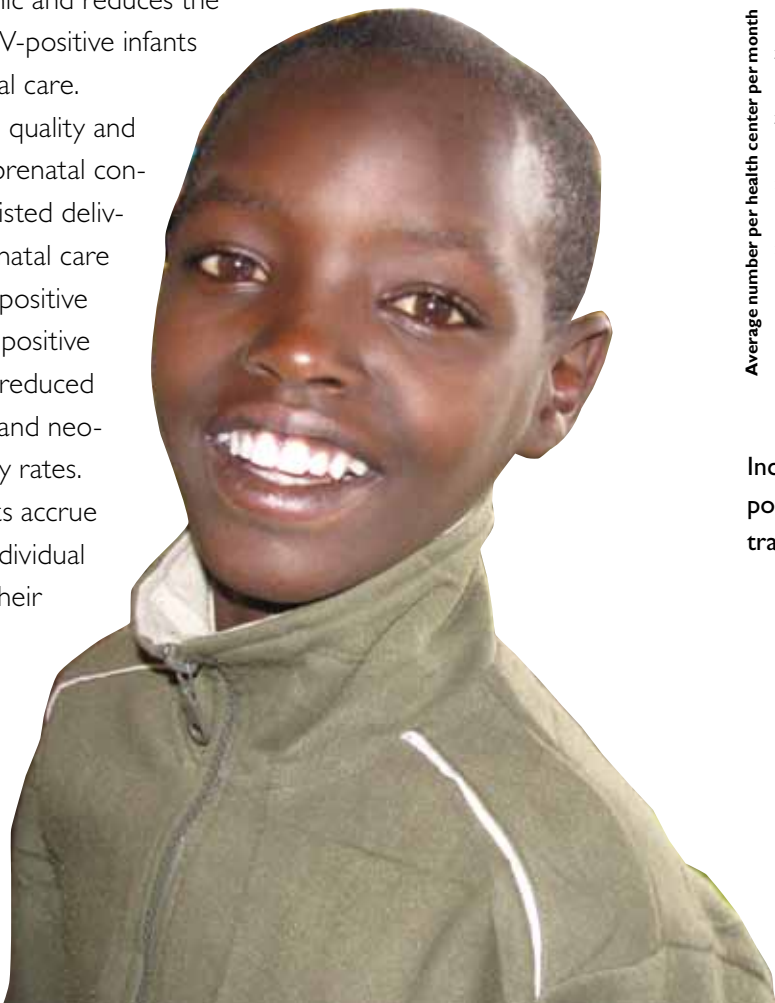
Improving access to, delivery, and quality of HIV prevention and care while at the same time strengthening overall health care are primary goals of the Rwanda HIV/PBF Project. Voluntary counseling and testing (VCT), provisions of anti-retrovirals, and family planning to prevent mother-to-child transmission are critical initiatives to help stem not only the spread of the disease itself, but also the social and economic unraveling that are the by-products of HIV and AIDS.

In 2005, inefficiency was generally such that, with improvements, additional services could be provided using existing resources. For example, VCT for HIV is a service tracked by PBF. In four health centers in the Gicumbi District, USAID typically paid \$13.30 for each VCT test in 2005–06. About a year after the introduction of PBF, demand for testing had increased by 275 percent, leading to greater economies of scale and reducing the cost of this service to \$4.47 per VCT session.

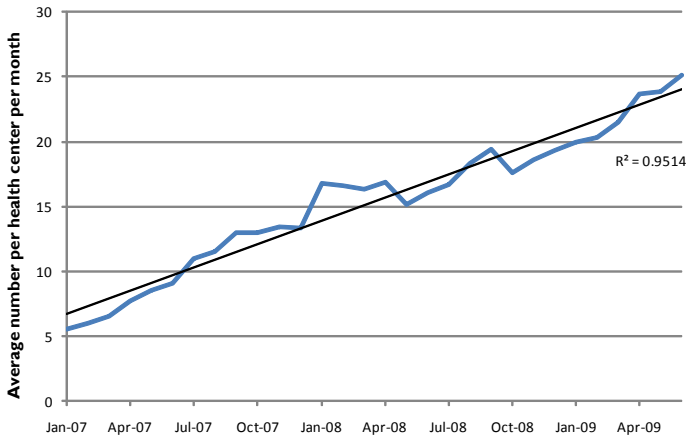
During the scale-up of PBF, the number of women using family planning methods increased fivefold. Offering family planning methods to HIV-positive women helps stem the

AIDS pandemic and reduces the number of HIV-positive infants needing special care.

Improved quality and utilization of prenatal consultations, assisted delivery, and neo-natal care for both HIV-positive and non-HIV-positive women have reduced the maternal and neo-natal mortality rates. These benefits accrue to not only individual women and their families, but to Rwandan society as a whole.



HIV-Positive Women Using Family Planning



Increased utilization of family planning methods by HIV-positive women stems the spread of mother-to-child transmission of the virus.

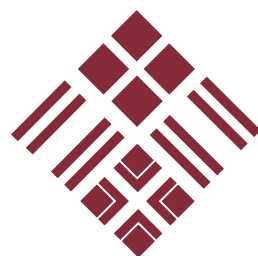


Living with HIV

Marie Tereza has been coming to Kabusunzu Health Center for 12 years, but it became an anchor for her in 2006 when testing revealed that she is HIV positive. In addition to providing Marie Tereza with ongoing counseling and medical care, the staff also persuaded her husband to get tested. Marie Tereza is not ashamed—she speaks candidly with her children about HIV and AIDS and advocates testing, education, and openness about HIV and how to prevent it. She has noticed improvements in the health center in recent years: medicine is always available, and she spends much less time waiting to be seen. “I no longer waste time; I can be at home taking care of my family,” she says, “and that’s important to me.”



SUCCESSSES AND LESSONS LEARNED



The successful design and implementation of performance-based financing rested heavily on the Ministry of Health's leadership and commitment. The Ministry embraced the urgency of the task at hand and deftly managed the transition from multiple threads held by the various stakeholders

to a single strand managed by the Ministry with the support of the stakeholders. The following are lessons learned by the HIV/PBF Project

in the process of this successful transition:

- The Ministry of Health's wholehearted commitment to PBF is essential. The Ministry, with the support of the Government of Rwanda, moved swiftly

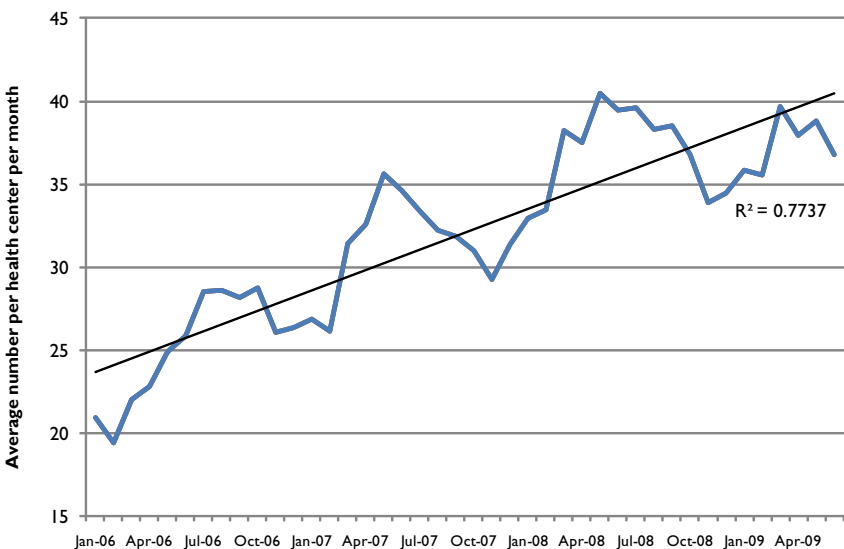
to bring together stakeholders in a collaborative process to achieve health care reforms. The long-term sustainability of PBF in Rwanda rests with the leadership of the Ministry.

- There is no halfway with PBF. All stakeholders—policymakers, administrators, health care providers, consumers—must understand and believe in the potential of PBF.
- The transition to PBF requires a fundamental shift in the way people think about health financing in developing countries. Advocacy is required, backed by a clear and consistent communication strategy.
- Effective coordination with partners is a prerequisite, as are strong health systems management components, such as information technology, leadership, and governance.
- Data integrity and accessibility are essential and foster confidence in the system. An information system with levels of control must be in place to withstand external scrutiny. Stringent monitoring is critical.

“The Government of Rwanda has made performance-based financing a national policy to be rolled out across all sectors, and the work that has been done has served as a model for replication.”

Dr. Luis Rusa, National PBF Director, Ministry of Health

Increase in Attended Births in Health Facilities



Maternal health is furthered when women deliver in health centers, attended by skilled health workers who can provide emergency services if complications arise. The number of women giving birth in health centers doubled during the PBF project.

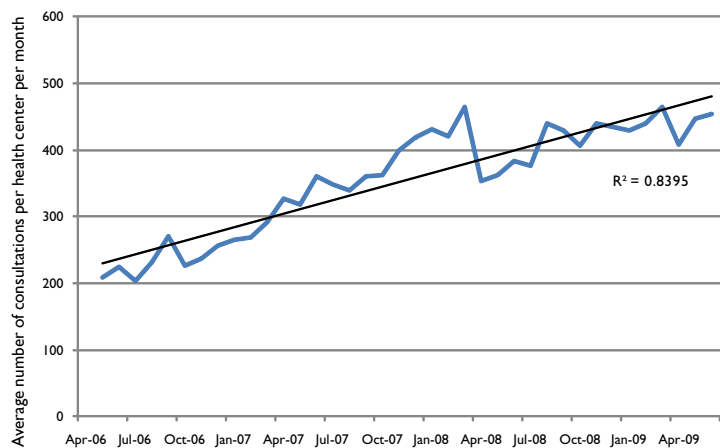
- PBF must be built on clearly defined, agreed-upon, measurable, and achievable goals.
- Incentives for performance against goals are effective motivators. The ability of health care workers to earn a livable wage is key to recruiting and retaining a robust health workforce, although most providers also say that receiving regular feedback and resources to do their jobs well are strong motivators for performing to the best of their abilities.
- A well-conceived and executed training program is a prerequisite to the expansion and sustainability of PBF. This requires skilled Rwandan trainers and a systematic strategy for transferring expertise and capacity to Rwandan citizens.



MEETING CHALLENGES FOR A PROMISING FUTURE

The upcoming publication by the World Bank of a detailed evaluation of PBF impact in Rwanda will provide new insights about the HIV/PBF Project, but early indicators are promising. Child health is a key indicator of the general health of the population, and initial results indicate that at facilities with PBF, the child mortality rate is lower and the children are healthier than at sites with no PBF or with conventional interventions.

Child Growth Monitoring



An essential way to reduce child mortality (death before the age of five) is to track children’s nutritional status and intervene as early as possible if the child does not follow the expected growth curve. The number of children monitored in this way doubled during the PBF scale-up period, and the child mortality rate decreased by 30 percent.

Results like these were made possible by the vision of the Government of Rwanda and the leadership of the Ministry of Health, which instituted reforms to empower and inspire stakeholders and reward performance in pursuit of quality health care and improved health outcomes for the Rwandan people. The Ministry set in motion the transi-

The biggest challenge for the near and long-term future will be to sustain and enhance these dramatic and systemic changes.

tion from multiple PBF approaches to one national approach. The implementation of PBF models followed by the quality management initiative, coordination with community-based health insurance and other reforms, as well as the great progress made toward a single platform for data collection and analysis, have better equipped the Ministry to achieve its goals.

Although the HIV/PBF Project and other reforms are now institutionalized, integrated information systems, more sophisticated use of data, and continued training, especially of community health workers, are among the challenges that lie ahead. The behavior changes among health care workers and introduction of a culture of quality need to be sustained and reinforced.

The Government of Rwanda and its people see the promise of the future. The health and well-being of the Rwandan people will continue to improve.



CREDITS

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