The PBF Handbook

Designing and Implementing Effective Performance-Based Financing Programs

AIDSTAR-Two
capacity for impact

USAID
FROM THE AMERICAN PEOPLE

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MSH manages performance-based grants and contracts for health services on behalf of the US Government in different countries and provides technical assistance to private organizations and funding agencies to help them develop and implement their own performance-based financing initiatives. This assistance includes strengthening their ability to manage grants and contracts, estimating the cost of health services, setting fees and performance indicators, and improving systems for health information, financial management, and accounting.

The AIDSTAR-Two Project, supported by USAID and led by MSH, was launched in October 2008 to strengthen the organizational capacity of local HIV/AIDS programs and organizations and identify and share proven practices of HIV/AIDS programming in order to magnify collective impact. AIDSTAR-Two supports local non-governmental organizations (NGOs), civil society organizations (CSOs), public-sector institutions, and local, national and regional networks providing HIV/AIDS services. The project's overall objective is to contribute to stronger and more sustainable, country-led HIV/AIDS implementing organizations. The AIDSTAR-Two Consortium is composed of Management Sciences for Health; the International HIV/AIDS Alliance; Cardno Emerging Markets, USA, Ltd. (Cardno); Health and Development Africa; Initiatives, Inc.; Save the Children; and Religions for Peace. For more information about the project, please visit **www.aidstar-two.org.**

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Acronyms

AIDS	Acquired Immune Deficiency Syndrome
AIDSTAR	AIDS Support and Technical Resources
ART	Antiretroviral therapy
CHW	Community Health Worker
C&G	Contracts & Grants
CO	Contracts Officer
COP	Chief of Party
COTR	Contracting Officer's Technical Representative
CSO	Civil society organization
CHW	Community Health Worker
F&A	Finance & Administration
FP	Family Planning
HIS	Health Information Systems
HMIS	Health Management Information Systems
HIV	Human immunodeficiency virus
GF	Global Fund
GOR	Government of Rwanda
MDGs	Millennium Development Goals
M&E	Monitoring and evaluation
MOU	Memorandum of understanding
MSH	Management Sciences for Health
NGO	Non-governmental organization
PBF	Performance-based financing
PBC	Performance-based contracting
PEPFAR	President's Emergency Plan for AIDS Relief
RFA	Request for Applications
RH	Reproductive Health
RFP	Request for Proposals
SOW	Scope of work
STI	Sexually transmitted infection
STTA	Short-term technical assistance
SWAp	Sector-wide approach
TA	Technical assistance
TBA	Traditional Birth Attendant
TD	Technical Director
USAID	United States Agency for International Development
USG	United States Government
VCT	Voluntary counseling and testing
WB MAP	World Bank Multi-Country HIV/AIDS Program for Africa
WHO	World Health Organization

Preface

PERFORMANCE-BASED FINANCING (PBF) is a powerful means of increasing the quality and quantity of health services by providing incentives to suppliers to improve performance and achieve results. In support of the Millennium Development Goals, PEPFAR, the Global Health Initiative (GHI), and other important health initiatives, PBF can increase the use and quality of health services, stabilize or decrease the costs of these services, help use limited resources effectively, and improve staff motivation and morale, a proven incentive for staff retention.

In today's dynamic development environment—with government institutions and local civil society organizations providing health services, the growth of complex multi-sectoral partnerships, the decentralization of public health functions, and country ownership of health and other services—organizations and countries throughout the world are increasingly using PBF to help make improvements in health and development. PBF links an organization's funding to its achievement of agreed-upon targets and may include bonuses if the organization exceeds those targets.

This PBF handbook has been designed for use by both program design officers at US Government (USG) agencies at the central and country levels as well as for PBF implementers at national and local levels. It is our hope that presenting this comprehensive overview of PBF from both the funders' and the implementers' perspectives will help to facilitate the design, implementation, and evaluation of PBF programs that enhance service delivery and create positive health outcomes.

I. Introduction

A. What is Performance-Based Financing?

PBF is the transfer of money or material goods from a funder or other supporter to a recipient, conditional on the recipient taking a measurable action or achieving a predetermined performance target.[1] This handbook uses health programs and services as the basis for presentation, but the principles can be applied to any sector.

The term PBF will be used throughout this handbook, and is considered synonymous with "pay for performance (P4P)," "output-based financing," and "results-based financing (RBF)." There is some ongoing debate over the applicability of these and other related terms describing performance-based approaches. One useful resource for clarification is "Financial and Other Rewards for Good Performance or Results, a Guided Tour of Concepts and Terms and a Short Glossary" by Philip Musgrove (World Bank 2010) which can be found at **www.rbfhealth.org.**

PBF shifts most financial risk from the funder to the recipient: payment (or sometimes the "performance incentive" portion of the payment) is received when—or withheld until—results or actions are verified by the funder. Payment can be monetary or non-monetary and is issued upon achievement of predetermined performance targets. Performance payments may target supply-side and/or demand-side recipients.[2]

> In **demand-side PBF,** the funder provides incentives to recipients who are directly linked to an action or result. For example: conditional cash transfer programs in Nicaragua that pay families for fully vaccinating all of their children, providing food to tuberculosis patients who adhere to their treatment regimen, and giving new mothers in India money or vouchers for giving birth with a trained health professional.
>
> In **supply-side PBF,** the funder links incentives to the recipient's achievement of predetermined results. Recipients include institutions and/or individuals; in a health program, supply-side recipients might be service-providing institutions (clinic, hospital) and/or health care providers at any level. Results can be health service targets such as immunization rates, assisted deliveries, and quality indices, or they can be systems' targets related to management such as supervision systems, drug supply, or efficiency.

1. Performance-Based Contracting

Performance-based contracting (PBC) is a supply-side PBF approach involving the development of a contract or other formal agreement; such agreements may not be a part of other PBF program designs.[3] PBC refers to the process of developing a legal or formal agreement to govern the terms of payment. The contract or agreement must include a clear set of objectives and indicators, systematic efforts to collect and validate data on those indicators, and consequences based on performance. The consequences might be rewards or penalties for the contractor based on whether they achieve or fall short of the pre-determined objectives.[4]

1. Center for Global Development Working Group on Payment for Performance.
2. "Paying for Performance in Health: Guide to Developing the Blueprint." Rena Eichler and Susna De, Health Systems 20/20, December 2008 Draft.
3. Performance-Based Contracting for Health Services in Developing Countries: A Toolkit. Benjamin Loevinsohn. The World Bank, 2008. http://siteresources.worldbank.org/INTHSD/Resources/topics/415176-1216235459918/ContractingEbook.pdf
4. Ibid.

2. USAID Experiences with PBF: A Brief Background

USAID has supported PBF in a variety of projects,[5] including projects in Haiti (SDSH, HS2007, and HS2004) and Rwanda (HIV/PBF). The projects in Haiti and Rwanda are examples of PBF implementation using USAID mission support (both financial support and policy adaptations) along with cooperating agency technical assistance (TA). The projects in both countries have succeeded while using quite different PBF models. Haiti has proved successful due to health sector innovation rising through NGOs, while Rwanda exemplifies implementation of PBF within a Sector-Wide Approach (SWAp) and national policy framework. In Tanzania, Zambia, Uganda, Ghana, Nigeria, Kenya, and Liberia, roadmaps for implementing PBF were developed, some pilot studies have begun, and in some of countries project implementation is moving forward with support from the USAID mission, national ministries of health, and cooperating agencies' support (refer to Annex A for an overview of PBF programs and donors supporting PBF).

B. Purpose of this Handbook

The purpose of this handbook is to describe the implementation of PBF and to help the US Government effectively design programs that include PBF. Program design officers and national implementers will become familiar with basic concepts of PBF and lessons learned, in order to:

- make PBF approaches part of a project's overall framework
- clearly delineate what might best be determined by the USG and what might most usefully be left to the implementing agency to propose
- call for proposals drawing on an appropriate range of PBF approaches with greater insight and understanding of PBF
- avoid over-specifying implementation approaches that might hinder a project's ability to succeed

Although the handbook provides an overview of PBF in general, the implementation section focuses on supply-side PBF, specifically through performance-based contracting (PBC), performance grants, and memoranda of understanding (MOUs).

The handbook's annexes are intended to complement the information in the handbook, but are not essential reading for planning and implementing a PBF program.

5. Improving Health Outcomes Through Performance Based Financing. USAID Mini-University. Johannesburg, South Africa, April 3, 2008. John Pollock, with inputs from Uder Antoine, Paul Auxila, David Collins, Bernateau Desmangles, Rena Eichler, Gyuri Fritsche, Jean Kagubare, Kathy Kantengwa, and Louis Rusa.

II. Background

A. PBF: Underlying Theory

1. Paying for Outputs

Traditional payment mechanisms fund inputs, whereas PBF pays for outputs. Input financing requires payment in advance for things like salaries, drugs, supplies, and operating costs, resulting in a link between funding and results that is tenuous at best and expenses that are only justified after payment has been made (e.g., through financial audits). Paying for outputs indicates that money will only be paid for services that have been delivered or goals that have been met, establishing a direct link between funding and results or other performance measures.[6]

In implementing performance-based contracts, achieving results and agreed-upon performance targets are paramount. Managers at service delivery sites devise their own strategies to achieve their targets, thus incentive payments reward creativity and innovation. This is an empowering, hands-off approach sometimes known as the "black box."[7] Service providers can also be penalized if they do not meet targets; as the name PBF suggests, *only* measurable performance is rewarded.

2. Who's Who in PBF: Purchasers, Providers, and Controllers

PBF is based on the principal-agent theory of economics, that is, the idea that the interests of the principal (an organization, institution, or individual who engages another to accomplish a task) and the agent (the organization, institution, or individual engaged by the principal) can be aligned in a way that both parties benefit or gain utility from the contractual relationship. For successful PBF implementation, the interests of both parties must be aligned—they must have the same objectives (i.e., performance targets).

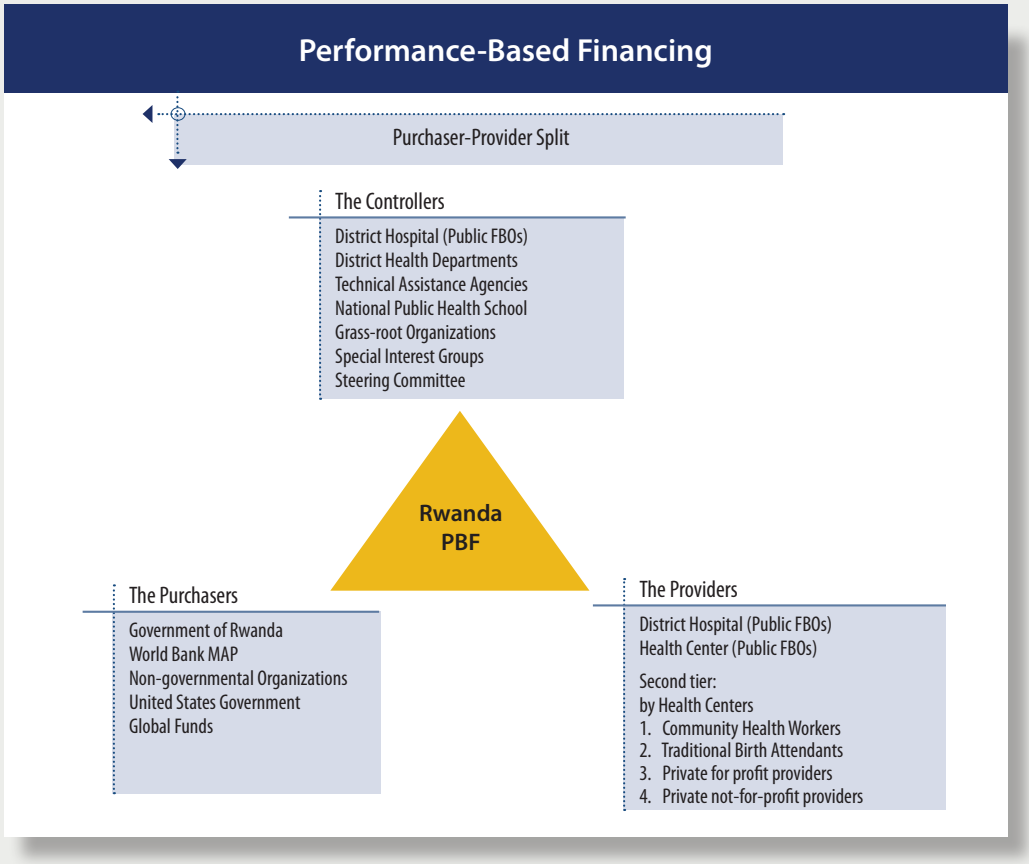
In PBF, the principal is the purchaser—the party setting targets and buying results from the providers in specific geographic catchment areas. The agent is the provider—responsible for developing innovative strategies and implementing activities that will improve the volume and quality of services and achieve the agreed-upon health targets or goals efficiently. There may also be an intermediary controller between these two parties who establishes and oversees adherence to rules and regulations. Specific details on the roles and responsibilities of these parties can be found in section III of this handbook, starting on page 15.

An example of the purchaser-provider split in Rwanda demonstrating the different actors that make up the purchasers, providers, and controllers, is shown on the following page.

6. Presentation by Dr. Louis Rusa, Director, PBF Support Cell, Ministry of Health, Rwanda. "Scaling up Family Planning through Performance-Based Financing in Rwanda."
7. Performance-based financing and changing the district health system: experience from Rwanda. Robert Soeters, Christian Habineza, & Peter Bob Peerenboom. Bulletin of the World Health Organization 2006; 84:884-889. http://www.who.int/bulletin/volumes/84/11/06-029991.pdf

An Example of the Purchaser-Provider Split: Rwanda

'Purchasers' are those who pay for the service. This can be an NGO (which acts as the 'fund holder' or 'pass through mechanism' for other donors in addition to purchasing with its own funds), the national government, the USG (through USG Cooperating Agencies), and donors (e.g., World Bank, Global Fund). 'Providers' are the public, civil society and faith-based organization-managed health facilities (health centers and hospitals). Controllers are those who control the level of performance. In Rwanda the controllers include District Health Teams that certify a mix of quantity and quality deliverables in health centers and hospitals; technical assistants that control the performance of the district health teams and do random spot checks in health centers; a purchasing agency, an NGO, which also contracts grass-root organizations to carry out patient surveys; and systematic large scale surveys commissioned to the National Public Health School. There are various levels and types of control which vary from the basic control in register books (counting entries and thus verifying the quantities on the 'invoice') to more sophisticated random sampling of entries in register books and tracing clients in the community.

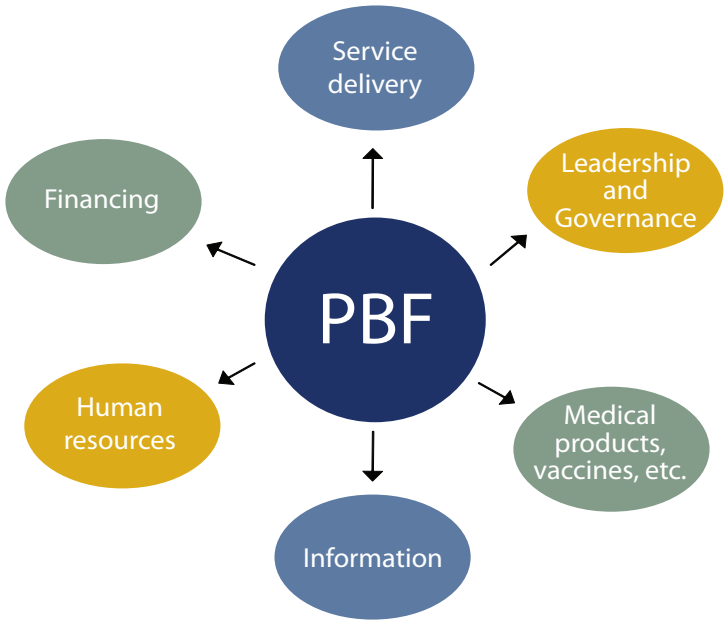


Source: Musango, Laurent, Gyuri Fritsche, Cedric Ndizeye, Ousmane Faye, Apolline Uwayitu, Alex Hakuzimana, Kathy Kantengwa, and John Pollock. 2007. "Provider Payment Mechanisms Using Performance-Based Financing/Performance-Based Contracting, Report on Progress in the Rwanda PRSP from the Government of Rwanda." Ministry of Health.

3. The Systems Approach to PBF

All actors in the PBF system need a clearly defined role at their level within the system, and for their interactions with other levels. The national level may create the policies and guidelines or authorize the PBF process (the controller role), but the actual service delivery occurs at the facility and community level. Data reporting, validation, and verification should be transparent at all levels, and information should flow in both directions among all levels. Successful implementation of PBF in health programs is therefore strengthened by considering what is to be accomplished within the context of the system.

PERFORMANCE-BASED FINANCING: A HEALTH SECTOR REFORM WITH SYSTEM-WIDE EFFECTS



4. System Strengthening Activities

A "health system" includes all organizations, institutions, and resources devoted to producing actions whose primary intent is to protect and improve health. A well-designed PBF program has excellent potential for positively impacting the overall health system. The potential is particularly strong if the MOH is a partner in the program, but even a program working solely with a network of NGOs can help strengthen an entire health system. The PBF program, along with targeting improved quality of and access to the health services themselves, can address the other system building blocks.

Performance improvements in the health system building blocks – leadership and governance, health services delivery, health workforce, information, health financing, medical products, vaccines and technologies, and financing – can be pursued by analyzing and then targeting changes/initiatives required to deliver services and interventions at high enough coverage to achieve specific health goals. This must be done in an evidence-based manner and link initiatives with program impacts. Using William Hsiao's "control knob" concept[8]—areas where actions can have system-wide impact—the PBF program can impact:

- **Financing.** Changing how resources are mobilized and allocated and how risks are pooled to insure risk protection

8. Hsaio, W.C. and S. Heller. "What macroeconomists should know about health care policy." International Monetary Fund. 2007. http://www.imf.org/external/pubs/cat/longres.cfm?sk=20103.0

- **Organization.** Changing the way financing and delivery are organized within a health system
- **Payment and incentives.** Changing the incentive structures for providers to shape performance and how providers interact with each other and with the consumer
- **Regulation.** Using the state's power to change behavior of both individuals and organizations
- **Influencing behavior of people and organizations**. Promoting innovations among providers to influence behavior of people and organizations

Taking a systems view to improving performance can enable stakeholders to clarify what problems have to be overcome in order to achieve the goal and even illuminate the direct and underlying causes of problems. The PBF program can use common indicators designated for M&E as a mechanism to effectively cross-fertilize among providers, who can then be encouraged to share successful strategies and approaches.

B. Why PBF?

1. Results—Health Impact

CONDITIONAL CASH TRANSFER (CCT):
A funder provides cash (instead of goods) to targeted poor and vulnerable households conditional upon their meeting defined goals (e.g., giving birth in a health facility, getting their children immunized, seeking training, etc.)

Introducing demand- and supply-side incentives (financial and material) to the provision of quality health services has the proven potential to improve health outcomes. Preliminary impact studies of demand-side financial incentives such as conditional cash transfer (CCT) programs in Mexico, Nicaragua, and Colombia indicate that use of CCTs is linked with a variety of improved health outcomes such as increased household use of healthcare services, improved immunization rates, and a decrease in babies born with low birth weight.[9,10,11,12]

Impact studies that evaluate performance-based contracting present a similar story. A review of 14 projects that contracted with non-state providers from a variety of settings and for a variety of primary health or nutrition services demonstrates that contracting for the delivery of primary care appears to be effective and that improvements can be rapid.[13] In this review, larger gains were observed when performance targets were health services that require limited or no behavioral changes, are time-limited, and can be measured (e.g., immunization, vitamin A supplementation, and prenatal care). Supply-side incentives are also effective at improving child nutrition.[14]

PBF can also help strengthen health systems by increasing the quality of services provided, improving service provider/facility efficiency, and facilitating access to and use of health services. Evaluations of performance-based financing to improve quality of care are limited, but themes and trends are emerging

9. Rawlings, L. and G. Rubio. "Evaluating the Impact of Conditional Cash Transfer Programs." The World Bank Research Observer 2005. 20(1):29-55. http://www-wds.worldbank.org/external/default/WDSContentServer/IW3P/IB/2007/03/07/000020439_20070307154105/Rendered/PDF/388790PAPER0WBRO0201101PUBLIC1.pdf
10. Barber, S.L. "Mexico's conditional cash transfer programme increases cesarean section rates among the rural poor." European Journal of Public Health, 23 Nov 2009. http://eurpub.oxfordjournals.org/content/20/4/383.abstract
11. Barham T., Brenzel L., and J. Maluccio. 2007. "Beyond 80%: Are There New Ways of Increasing Vaccination Coverage?" HNP Discussion Paper. Washington: World Bank. http://siteresources.worldbank.org/HEALTHNUTRITIONANDPOPULATION/Resources/281627-1095698140167/BarhamVaccinationCoverageFinal.pdf
12. Barber, S.L. and P. Gertler. "The Impact of Mexico's conditional cash transfer programme, Oportunidades, on birth weight." Tropical Medicine International Health 2008, 13(11):1405-1414.
13. Loevinsohn B. "Performance-Based Contracting for Health Services in Developing Countries: A Toolkit." The World Bank Institute 2008, p. 69-81. http://siteresources.worldbank.org/INTHSD/Resources/topics/415176-1216235459918/ContractingEbook.pdf
14. Chowdhury, S. 2001. "Educating for Health: Using Incentive-Based Salaries to Teach Oral Rehydration Therapy." Private Sector and Infrastructure Network Note 235. Washington: World Bank. http://rru.worldbank.org/documents/publicpolicyjournal/235Chowd-072501.pdf

in some countries, including Rwanda and Haiti. In Rwanda, as part of the national strategy and focus on health service quality, district health teams evaluate the quality of services delivered by health facilities, and performance payment levels are weighted by these evaluations. Preliminary studies demonstrate that this focus on improving quality is effective, with contracting provinces showing almost 30% higher composite quality scores than health facilities in non-contracting provinces.[15]

2. Results—Governance, Transparency, and Accountability

In addition to the benefits of PBF on health outcomes and strengthened health systems, PBF may help improve the institutional architecture of the health sector by linking expenditure of public funds to performance and validated results. As compared to traditional financing mechanisms, performance incentives encourage and enable good governance, transparency, and accountability. In PBF, performance indicators and corresponding payments are publicly developed and readily available; funding flows are publicly identified and recognized; and health results are openly monitored, evaluated, and verified.

The capacity of those working at all levels of the system is also strengthened as many of the skills required by PBF programs—financial management, monitoring and evaluation (M&E), and data verification—can help improve performance.

3. Limitations

While initial research is promising, the results of using financial incentives linked to health outcomes and impacts are not completely conclusive. Studies of non-conditional cash transfer programs also show positive impacts on nutritional status.[16] Such a result is not surprising in cases such as child nutrition, in which a powerful positive incentive already exists: Given the resources, virtually all mothers will feed their children properly.

Further studies are necessary to determine the medium- and long-range effects of financial incentives, and to distinguish the impact of incentives from the impact of the cash transfer. There are a range of chronic conditions —such as HIV/AIDS, diabetes, and asthma—that require prolonged and repeated contact with health service providers and significant behavior change. The impact of using financial incentives to address these health conditions is less well studied and additional research is necessary—particularly on the long-term impact of incentives and the efficacy of incentives on behavior change and the management of chronic diseases. Nonetheless, properly implemented PBF remains quite promising in its ability to help increase the quantity and quality of contracted health services, resulting in positive health outcomes.

4. Opportunity

Using performance and results as bases for evaluating health programs provides an opportunity to assure that the health programs being offered meet the perceived needs of the people and communities they are serving. While it is clearly understood why family planning services need to be selected voluntarily, it is just as important that families understand what the full range of health services are, why they matter, and how to access them. Health projects are significant opportunities to create the means to access services, but they are also powerful mechanisms for reinforcing the flow of information into communities that, in turn, can help build understanding of and motivation to access the full range of primary health care services.

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15. Eichler R., Levine R., and the Performance-Based Incentives Working Group. "Performance Incentives for Global Health: Potential and Pitfalls." 2009. Center for Global Development.

16. Aguero J., Carter M., and I. Woolard. 2006. "The Impact of Unconditional Cash Transfers on Nutrition: The South African Child Support Grants." Working Paper. Madison: University of Wisconsin. Website accessed 29 March 2010 http://www.aae.wisc.edu/carter/papers.html

III. Planning

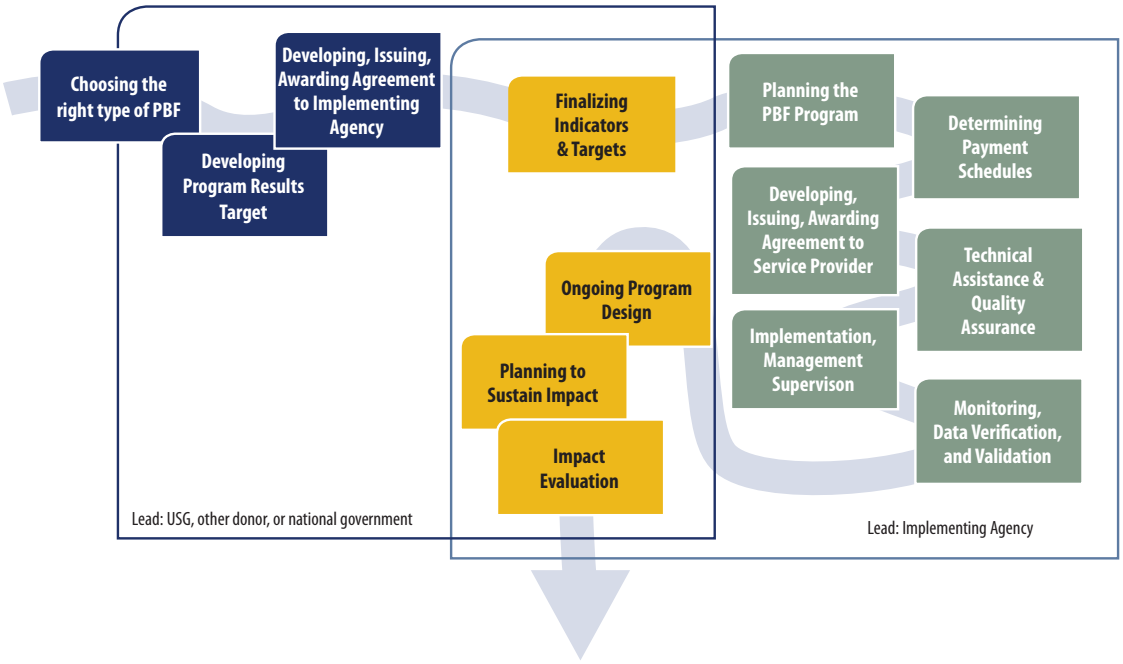
At the outset of planning and implementing a PBF program, it is advisable to conduct a situational assessment of the current structure, systems, and skills available to be part of a PBF system. In considering how to bring new resources (or reallocate existing resource flows) into efforts to improve health service delivery and progress toward impact goals, it is important to assess the current situation: strong points and systemic weaknesses and barriers to progress. Those who have a stake in the potential program must be fully engaged and have a common understanding of the goals of the program. In considering the use of PBF to drive results, it is particularly important to work with stakeholders to agree on the system's assets that should be the basis of the progress or improvement strategy. For instance:

- If a network of NGOs collectively provides services to half of a target population, it is likely beneficial to try to engage the network. Involving existing resources of that scale can help channel financial resources to more effectively sustain the impact beyond the life of the project, and improve efficiency and quality. This also facilitates the establishment of norms and standards for quality and communication, and creates opportunities for the positive use of peer pressure.
- If the public sector has established norms or has a PBF system with NGOs, it is essential to design the resource flows to reinforce cooperation and adherence to those norms.

At the outset of the program design, there are almost always goals and known problems, issues, resource deficiencies, or gaps that need to be clarified. During the project design phase, it is useful to have some stakeholder conversations to identify and articulate primary issues. However, articulation of the root causes of problems and strategies for resolving those problems should be left to the program implementer(s).

The PBF planning process starts with the USG or other funder choosing the right type of PBF, establishing program results targets, and developing, issuing, and awarding an agreement to an implementing agency or directly to a government Ministry of Health. It continues with the implementing agency planning the PBF program—including finalizing indicators and targets—determining payment/incentive structures, establishing an agreement with a service provider and collaborating with that partner on implementation, and then working in partnership with the USG or other funder on ongoing program design, including planning to sustain impact. Ideally an impact evaluation is part of the program. This process is outlined on the PBF flowchart on the following page.

PERFORMANCE-BASED FINANCING FLOWCHART



A. Choosing the Right Type of PBF

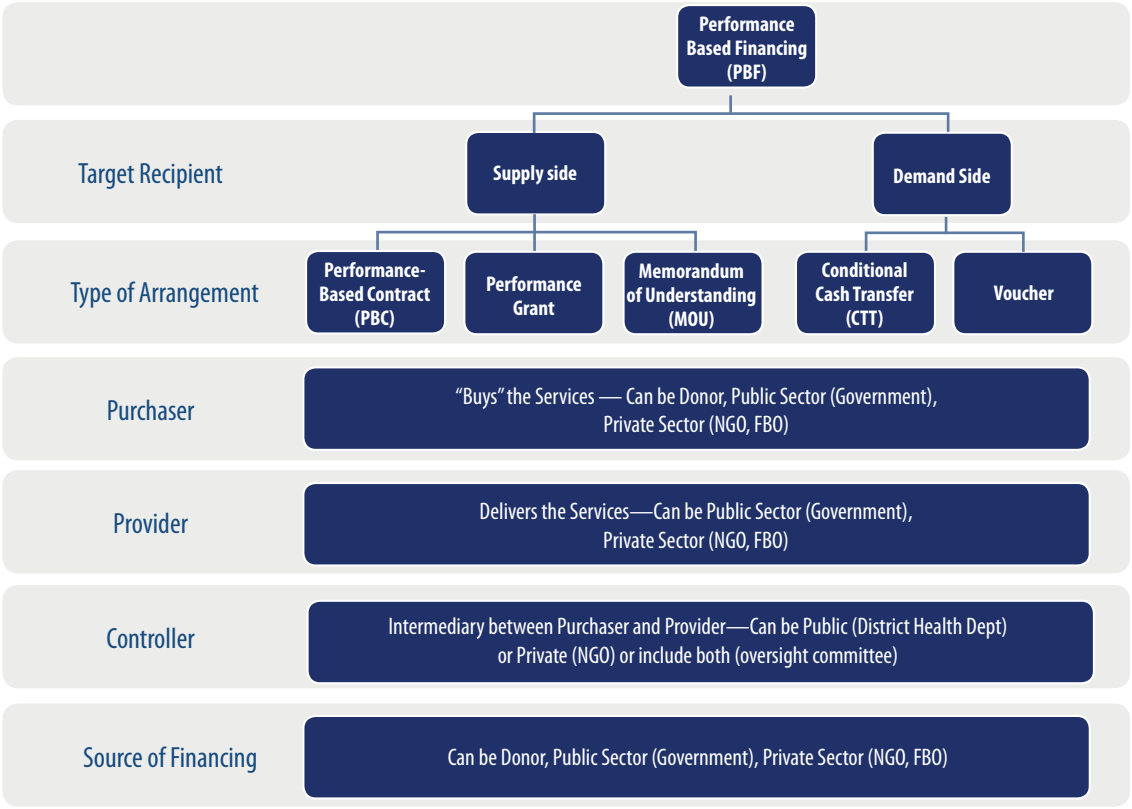
1. Types of PBF

As stated in the introduction, Performance-Based Financing is the transfer of money or material goods conditional on taking a measurable action or achieving a predetermined performance target.[17] The purchaser creates the targets and transfers the reward to the provider if the conditions are met. The varieties of mechanisms through which this can occur are illustrated in the diagram on the next page. The two broad categories of PBF are demand-side and supply-side, and within each there are several approaches. PBF programs may be a hybrid of several different mechanisms. In each case, however, there is some form of agreement between the two parties, and reward transfer is contingent upon the achievement of an agreed-upon goal or target.

The success of a PBF strategy depends on the actors and health system levels involved; selecting the right strategy begins with a review of the various types of PBF arrangements. The requirements of three main elements should be kept in mind: designing the PBF program, selecting the service provider(s), and managing the services.

17. Center for Global Development Working Group on Payment for Performance

PBF TYPES



The different types of arrangements are as follows:

a. Supply Side:

Performance-Based Contracting (PBC): *According to the US Government,*

> *A contract is a mutually binding legal instrument in which the principal purpose is the acquisition, by purchase, lease, or barter, of property or services for the direct benefit or use of the Federal government, or in the case of a host country contract, the host government agency that is a principal, signatory party to the instrument.*[18] *PBCs are legal, formally documented agreements that define roles, set goals and govern the terms of payment. They include a clear set of objectives and indicators; systematic protocols to collect and validate data on the progress toward selected indicators; and consequences—either rewards or penalties for the contractor—that are based on performance.*[19]

18. USAID Glossary of ADS Terms, 11/19/2009 revision. Accessed at http://www.usaid.gov/policy/ads/glossary.pdf

19. Loevinsohn B. "Performance-Based Contracting for Health Services in Developing Countries: A Toolkit." The World Bank Institute 2008. http://siteresources.worldbank.org/INTHSD/Resources/topics/415176-1216235459918/ContractingEbook.pdf

Performance Grants: A grant is a legal instrument whose principal purpose is the transfer of money, property, services, or anything of value to the recipient in order to accomplish a public purpose of support or stimulation authorized by Federal statute and where substantial involvement by the USG is not anticipated.Performance grants can be given where the recipient has articulated goals that are consistent with the purchaser's goals and are often appropriate if a local organization does not have a financial system that satisfies USG contracting requirements. Grants are generally for fixed amounts, but these amounts can be segmented to target specific goals. While it is not usually possible in the USG system to pay incentives for targets met, it is possible and reasonable to use progress toward targets as the fundamental basis for decisions to make additional rounds of grant commitments and the amounts to be committed.

Grants are fairly simple to set up and administer. They may not inspire ownership as effectively as contracts, but the mechanism is very useful when circumstances require its use. One concern is that there are limited remedies when performance problems or shortfalls occur. When grants must be used, it is critical to have a clear plan for technical assistance and quality assurance that gives the paying agency early and frequent insight into the situation of the grantee and progress toward goals.

Memorandum of Understanding (MOU): A MOU is a document that sets forth an agreement between parties. It may be used to cover a range of topics including results to be achieved, activities to be implemented, and the respective roles and responsibilities of each party. A MOU is not used for obligating funds for transfer. A MOU may, however, be used to confirm an agreement with a host government on a program that the USG will fund directly through a partnership with other parties. It may also be used as the basis for managing support inputs that are designed to enhance local government capacity by basing funding actions on results, or it may be used in connection with aligning USG project activities with commercial or private-sector matching fund arrangements. In the latter situation, the project might respond to contributions from matching-fund partners by increasing the project's commitment to joint activities, or by providing public recognition to the matching-fund partner.

b. Demand Side:

Conditional Cash Transfers (CCTs): CCTs are a method of stimulating demand for services by transferring cash payments to patients or consumers on the condition that they use a specified service. A CCT program can mitigate poverty for individuals or families that receive the cash at regular intervals and also build human capital (e.g., skills, etc). CCTs are also useful for local markets for goods, and so boost the local economy. In the context of a USAID project, great care must be taken to assure that the potential demand for cash transfers does not exceed the available funding.

Vouchers: Vouchers are a demand-side incentive method in which patients or consumers receive vouchers to access health care or other services and may also include indirect benefits, such as money for transportation. To receive payment, the service delivery provider then remits the vouchers to the purchaser. These vouchers can greatly reduce barriers to service access—validation systems must be automatic and, as with CCTs, the program design must be planned according to available financial resources.

2. Essential elements for successful PBF programs

Essential elements for successful PBF programs include:

- clearly defined goals
- documented roles and responsibilities of the actors
- transparency and accountability

- a functional Health Information System (HIS) and Health Management Information System (HMIS)
- strong Monitoring & Evaluation, as well as a data audit and data validation system

In addition, for PBF programs to be successful, all stakeholders including the government must be consultative and transparent in the design and management of health services.

PBF programs rely on having an established M&E or HMIS that is reliable and efficient. It is therefore important to establish a sound and effective M&E system for data collection, output verification, and periodic internal and external audits. In many cases, the national HIS and HMIS are weak and yield unreliable information; the challenge remains how best to integrate the PBF program while improving the existing system. In determining whether these essential elements are in place, it is critical to solicit inputs from stakeholders. To create a transparent system, contributions from stakeholders must be considered in the design of the PBF program, and their buy-in and ownership must be obtained. Roles and responsibilities of each stakeholder should be clearly described in the contract document.

3. Designing accurate and transparent M&E systems

Validation and accountability are critical components for an accurate and transparent M&E system. When introducing financial incentives for services, there is a danger that staff members may be tempted to falsify data in order to boost their income; a strong M&E plan will help counter this.

The following steps must be included in designing an M&E system:

- Collect baseline data in the areas where goals and targets are being established
- Devise a clear schedule for data collection (either at households or health facilities) with regular review of HIS or HMIS data (Validation)
- Benchmark with comparison/control groups (where possible)
- Assign responsibility for collection, analysis, reporting, and dissemination of data
- Budget sufficient funds and level of effort for M&E

4. Implementing PBF at different levels of the system

PBF needs to be a core element of a national program, with clearly defined roles and information and resource flow standards set for each level of the system. All actors in the PBF system need a clearly defined role within their level of the system, and for their interactions with other levels. The national or federal level may create the policies and guide the PBF process, but the actual service delivery occurs at the facility and community level. Data validation and verification should occur at all levels, and information should flow both ways between all levels.

5. Mapping streams of money

Mapping different streams of money means determining the sources and uses of different fund flows into the health system, and clarifying what is working and not working in terms of resource support to system functions. Common funding sources to map include subsidies from central and local governments, other USG-supported projects, other donors, as well as insurance reimbursements, and user fees. Resources to consider may include both cash and in-kind goods (e.g., drugs). In the case of user fees, it is important to understand the financial provisions for subsidized or 'free' services (vouchers, waivers, and exemptions). It is

also important to analyze any conditions applied to transfer funds to providers (e.g., performance targets). The mapping must include an analysis of the uses of the funds in terms of types of input (e.g., drugs, salaries) and services (e.g., immunizations).

This process helps program designers to assess the likely impact of PBF on other programs or funding sources, efficient uses of funds, and to anticipate likely provider and patient behaviors. Understanding these resource flows allows the program designer to accurately fill gaps, build on and partner with existing efforts that are having a positive effect, and avoid inadvertent duplication of effort, double payment for services, and/or undermining of system development.

The table below summarizes the key steps for both USG and implementing organizations to consider at the launch of their planning stage, when determining which type of PBF program to choose.

Key Steps for US Government and Implementing Organization in Choosing the Right Type of PBF

USG	Implementing Organization
• Review PBF types and identify strengths and weaknesses of different scenarios. • Articulate goals of implementing a program with PBF. • Perform a preliminary situational analysis. • Map the relevant players and stakeholders at each level of the system, including NGOs and Ministry of Health. • Identify key gaps and weaknesses. • Assess M&E capabilities, specifically HIS /HMIS, as part of the situational assessment. • Identify areas of weakness that should be targeted for capacity building or technical assistance. • Map the streams of money for the project design in order to estimate the probable budget. This may require an initial analysis at the design stage of the project. A detailed assessment should be built into the scope of work for the project and sufficient funds included in the budget.	• Review PBF types and identify strengths and weaknesses of different scenarios. • Consult with stakeholders to identify primary issues, root causes of the problems, and strategies for resolution. • Assess the different money streams currently flowing into the country from various donors, etc. • Finalize the preliminary situational analysis. • Identify barriers to successful PBF implementation as part of the situational and gap analysis; devise strategies to counteract these barriers. • Engage all stakeholders early and encourage transparency; this will be crucial to counteracting barriers. • Determine which mechanism would be most conducive to the country and context. Analysis of essential elements and contraindications for PBF should inform selection of PBF type. • Engage stakeholders and key players at each system level fully in the planning of PBF to ensure transparency.

B. Developing Targets

A new PBF program must align with national health targets and strategies, Millennium Development Goals (MDGs), and other national health goals. Goals have to be clear, with measurable indicators and negotiated targets that are linked to routine and transparent reporting and an effective system for validating data.

Performance is measured by comparing targets to actual achievements. Targets should be challenging, but not prohibitively so. Targets that are too high may be demotivating and counterproductive; targets that are too low may decrease innovation and suppress scale-up. Thus, establishing a baseline is a critical step in the process. This baseline can come from initial status assessments of service delivery partners if there is no other way to get the essential data. In addition, assumptions about strategies to reach the desired goals should be tested logically before targets are set. For instance, a goal of reducing infant mortality is often presumed to require improved service delivery at health centers. However, setting targets and measuring only services provided at health centers might be unsuccessful in reducing infant mortality significantly if most infant deaths are in the first few days of life after birth in the home.

Health system stakeholders may include: government health officials; government health workers; local politicians and local government officials; NGOs, CBOs, the for-profit private sector; the community; and other development partners or donors. The PBF planning process should include some key representatives from all stakeholder groups.

Engaging stakeholders early is essential for success in the design and implementation of a PBF program; it will allow planning to be specific and address the health system elements that need attention in order to meet program impact goals.

Key Steps for US Government and Implementing Organization in Developing Targets

USG	Implementing Organization
• Consult relevant source documents (DHS, national health plans, HMIS reports, etc.) to align targets with national strategies and establish baselines. • Identify stakeholders by asking key questions: Who makes the health system work (policy, service delivery, and ancillary services)? Who pays? Who uses the services? • Determine short-, mid-, and long-term goals. • Identify the basic package of health services or preferred package that each service delivery point would be responsible for delivering, if possible. Consult relevant source documents (DHS, national health plans, HMIS reports, etc.) to align targets with national strategies and establish baselines.	• Identify stakeholders and key national priorities and approaches already in place targeting them. • Draft a framework of illustrative indicators and targets that will track toward desired program results. • Devise strategies to consult with stakeholders and maintain regular lines of communication (following issuance of RFA or RFP, a 'bidders' conference' is generally desirable).

C. Developing, Issuing, and Awarding an RFP or RFA (US Government)

1. Developing the RFA or RFP (process for selecting implementing organization)

A request for applications (RFA) or request for proposals (RFP) is the mechanism by which US government agencies solicit and engage an implementing partner. These mechanisms are important to discuss here because RFAs and RFPs include the preliminary program design; they define the required outputs of the work and include a scope of work with expected outcomes and the selection criteria for award.

In general, RFAs and RFPs should be clear that the intended PBF instruments will generate payments that reinforce progress toward USG goals and are going to be fully allowable within the regulatory framework of the program. There may well be elements that will require special approvals within the USG system (for instance direct contractual arrangements with local government units).

This process allows the US government to choose a PBF program implementer on the basis of their proposed approach to and experience in implementing PBF programs. If this phase—effectively the preliminary program design—includes an appropriate, strategic approach to PBF, the program is more likely to be successful.

The team that develops an RFA or RFP should consist of technical and contractual USG staff in consultation with the MOH. Discussions should take place around the type of contracting mechanisms that would best serve the program's purposes. Important USAID mission decisions include whether to award a contract (RFP) or cooperative agreement (RFA), and whether to allow specific considerations under that mechanism, such as approval to issue grants under a contract. The contracting mechanism and the considerations under the mechanism impact the tactics that the implementing organization can use to operationalize the PBF program envisioned by the USG. USAID's Automated Directive System (ADS) and the Federal Acquisition Regulations provide good internal guidelines for USAID employees who are writing RFAs and RFPs.

2. Defining targets to be met by the implementing organization

The award document should specify overall goals and targets for the implementing organization to meet as part of their award. Specific service targets can be negotiated after award in the collaborative development of a performance management plan. These project targets should be stated clearly in the agreement's scope of work.

Setting clear targets allows the implementing organization to effectively allocate resources to results in overall program management, and allows the USG to efficiently monitor implementer progress, successes, and failures. As in any situation, clearly stated targets allow implementers to better meet expectations through all project phases, and to engage and utilize other organizations committed to the process, thus magnifying overall impact.

3. Awarding of contract or grant/cooperative agreement

After a USG selection committee reviews all of the proposals received, the USG may send questions to the applicants to clarify aspects of the application/proposal. USAID's Contracts Office will then select an implementer and award the project. The award signifies the start of the project and the relationship between the parties. If the award is a contract and the implementer intends to use a grants mechanism, a provision allowing grants under contracts is needed. If contractual arrangements with government units or parastatal organizations are contemplated, the means and permissible mechanisms also should be specified in order to comply with US law and government regulations.

4. Harmonizing with other donors implementing PBF programs

The implementing organization should make sure that their PBF program is implemented within the current context of the country. Other donors or government organizations may be doing work in PBF or a related area; these efforts need to be considered in the program design. If there is a national program or policy, it is essential that the implementer align with and support that policy. The implementation of a PBF program must harmonize with other government- or donor-supported programs in order to avoid duplication of payment or support, particularly while gaps persist elsewhere.

5. Setting a reasonable timeline to implement PBF

The amount of time it takes (from award) for an implementing organization to set up a PBF program and award their first round of PBF agreements is dependent on both the environment and the program's technical design. Instruments must comply with both USG regulations and the requirements of local legal structures. If recipients include public sector or parastatal units, there are approvals required from both the USG and the local government before action can be taken.

In comparatively simple situations, the PBF roll-out is likely to take six months from award (required steps include RFP design, issuance, bidders conference, selection, negotiation, documentation) but, even in complex situations, it should not usually require more than nine months from the point that the USG and the implementing organization reach agreement on the program structure.

It is critical to complete a timeline for each PBF program and re-evaluate it as things change in the environment. Some elements are within the control of the contracting agency (such as indicators, targets, timelines) whereas others are not. Changes in the timeline should be made according to context and justified if necessary.

Key Steps for USG and Implementing Organization in Developing, Issuing, and Awarding an RFA or RFP

USG	Implementing Organization
• Work with technical and contractual staff to complete a solicitation that can be competed for by contracting agencies. The procurement instrument could suggest that proposing agencies outline their strategy for an effective PBF program, including what mechanisms would be used with what kinds of recipient partners. • Work with technical and contractual staff to create targets in line with national strategies and goals. • Complete the selection, award the agreement, negotiate the terms and conditions, and sign on behalf of the USG. Specific requirements, expectations, or limitations regarding PBF instruments should be recorded. • Mandate that the contracting agency is aware of, coordinates with, and collaborates with all other agencies or donor-funded activities related to the award. • Give the contracting agency timely, appropriate guidance and feedback on program design (including indicators and targets) along with any required approvals for the selection criteria and the actual awards.	• Review the expected deliverables and targets and create a strategy to meet them, including draft indicators. • Review the award, negotiate and agree to the terms and conditions, and sign the document so that work can begin. • Ensure that the new PBF initiative effectively aligns with existing strategies. • Set a realistic timeline with all parties involved in each step of the process (including the contract/grants staff who will be issuing the solicitations and writing the awards and the technical staff who may be doing cost analysis to determine the appropriate performance indicators, targets, and payment schedule). • Hold stakeholders conference to inform and align all parties and agencies, update assumptions, and assure that new program is not redundant or in conflict with existing initiatives. • Draft PBF program RFP or RFA for review and approval by USG. • Issue RFP or RFA and hold bidder's conference to orient potential service contracting agencies.

D. Planning the PBF Program (Implementing Organization)

1. Institutional mechanisms: purchaser-provider split

As noted earlier, PBF program institutional mechanisms are based on a purchaser-provider split where the purchaser is responsible for setting targets and buying results from service providers who are contracted for service delivery in specific geographic catchment areas. There should be clear lines of responsibility and division of tasks between the purchaser and the service providers. Contracts that are drawn up and agreed upon between the two parties should specify selected deliverables and outcome target indicators to be achieved by the service providers and the corresponding fees to be paid by the purchaser.

Service providers are responsible for developing innovative strategies and implementing activities that will improve the volume and quality of services and achieve the health targets/goals. They need to plan and operate within the PBF framework with enough autonomy to permit innovation and independent resource allocation, but they also must be fully accountable for accuracy and quality, and understand that they are unable to exceed budgetary guidelines with any expectation of additional reimbursement.

The purchaser is responsible for setting the health targets and monitoring and verifying that results were achieved before making payment to service providers. The purchaser should have real autonomy over the actions it takes, such as the freedom to specify the benefits/service package, the freedom to place contracts with a range of providers, and the freedom to amend payment schedules. This function in the system is the framework for operations: The purchaser creates the motivation for performance through incentives, but also governs program action, quality, and scale by enforcing performance standards, assuring transparency in validation, and withstanding pressures for individualized adaptations to the system.

2. Elements of motivation

The PBF approach should strive to improve the intrinsic and extrinsic motivation of health workers. 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 (see table below). PBF schemes can be used as leverage for initiating innovative and proactive management actions that will motivate employees. PBF monetary incentives can directly target the health workers and/or target the organization as a whole.

PBF Elements of Motivation

Practical	Dynamic
Money	Information
Living Conditions	Communication
Safety	Recognition
Food	Community Leadership Role
Facilities	Positive Result from Achievement
Equipment	Technical Exchange*
Supplies	Skill Updates*
Community Support	Supervisory Support*

* Primarily for supply-side consideration

Source: John Pollock SOTA conference slides, South Africa, 2008

Carefully designed performance-based approaches can align health worker incentives with societal goals of improving the population's health. 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. Individual incentives are the most direct way to promote performance but are also the most burdensome to monitor centrally and therefore less sustainable. Generally it is best for the agency to contract with organizations, which can, in turn, design internal incentive programs to motivate and reward individual achievement.

In any case, PBF incentives should be sufficiently attractive to change the behavior of potential recipients and improve the motivation to achieve the results. It is important to assess the existing incentive environment before choosing the most appropriate incentive approach. The USG project can be designed to include technical assistance to PBF recipient organizations in areas such as financial systems, planning, and capacity building so that the local managers of the PBF contracts are well-equipped to translate their knowledge of the current environment into effective program investments that will improve performance and achieve results.

3. The choice of indicators and modeling risk

Performance indicators for PBF can include health service results as well as management results. It is critical to take into account existing country visions and goals, the country's epidemiological profile, and consultations with key stakeholders when choosing indicators. Defining a baseline consists of examining both quantity and quality aspects of existing performance in addition to problems and challenges and allows for identification of performance gaps and specific service targets for PBF. Sample indicator schedules from various PBF projects can be found in Annex B.

The number of indicators purchased must be limited to avoid high transaction costs. This is an area where the investment in consultation and review to get a useful, appropriate, and manageable set of indicators is valuable. A weighting formula for quality can be applied to selected service indicators; this can be a vital element to prevent loss of quality in individual service transactions as the level of service provision increases.

For assigning relative importance to the array of indicators, a logical, participatory process can be used to determine which indicators will be purchased and how they will be weighted in the payment schedule. In addition, financial modeling should be performed based on the unit fees set for each indicator. In this way, the risk of paying above the budget ceiling (in a linear payment scheme) becomes clear and can serve as a reality check for the unit fees in light of the anticipated volume of services. Contracts should indicate payment ceilings if the schedule is based on service units rather than on thresholds reached; any payment beyond a ceiling (or target) would require an amendment, even where excess achievement is desirable. Alternatively, targets or thresholds can be used to trigger payments while specifically determining the total amount to be paid. Using targets is simpler in some contexts and maintains a level of risk—and thus additional motivation to the provider—that is lost when payments are made for each service provided.

4. PBF and Tiahrt

It is essential in any primary health care program using PBF to include reproductive health and family planning in the array of services being tracked, both to respond to clients' unmet needs for services and also to meet broader national health goals. The Tiahrt amendment, enacted in the 1999 Foreign Operations Appropriations Act, reflects values and principles concerning voluntary family planning projects and informed choice that guide USAID family planning assistance. The amendment stipulates that "there be no incentives to individuals in exchange for becoming acceptors or to program personnel for achieving

targets or quotas for numbers of births, acceptors, or acceptors of a particular family planning method."[20] In designing PBF programs, sensitivity to Tiahrt standards must be built in. The focus that the Tiahrt provisions place on voluntarism in service provision, which relate specifically to reproductive health and family planning, is a positive reminder that the overall environment for service delivery should be the provision of high quality services that are readily available to people who understand the value and importance of the services themselves and have the confidence to demand those services.

USAID-funded PBF programs should comply with all USAID regulations, including the Tiahrt amendment. As such, it is not permitted to ask service delivery providers to achieve predetermined numerical targets or quotas for family planning. Subsidies for family planning services should be carefully balanced with subsidies for other health interventions. If high tariffs are combined with excessive promotion of family planning, conditions could arise that would negatively affect voluntarism—a situation with legal and policy, as well as public health and ethical implications.

Summary of Tiahrt Requirements for Voluntary Family Planning Projects

1. Service providers or referral agents shall not implement or be subject to numerical targets or quotas of total number of births, number of family planning acceptors, or acceptors of a particular family planning method. Quantitative estimates or indicators used for budgeting or planning purposes are permissible.
2. No incentives, bribes, gratuities, or financial reward for family planning program personnel for achieving targets or quotas, or for individuals in exchange for becoming a family planning acceptor.
3. No denial of rights or benefits such as food or medical care to individuals who decide not to use family planning services.
4. Clients must be provided comprehensible information on benefits and risks of the family planning method chosen.
5. Experimental methods must be provided only within the context of a scientific study, and participants must be advised of all potential risks and benefits. This issue will rarely be a concern in field programs.

More information can be found at: **http://www.usaid.gov/ourwork/global health/pop/voluntarism.html.**

Focusing family planning indicators for payment, for example, on meeting unmet demand (as estimated in conjunction with the MOH leadership), assuring continuous supply of commodities, and routine access to accurate information and counseling to those considering or using a family planning method are all effective for PBF. Tracking users, new adopters, and discontinuation of methods and overall contraceptive prevalence rate is useful, but these data should not be connected to PBF payments.

Partners participating in the PBF program may want to consider the inclusion of "tracking indicators" to assess progress or identify potential backsliding. Including tracking indicators not associated with incentive payments nor with numerical performance targets are also helpful in improving family planning access. The PBF initiative could include new family planning users, discontinuation, and contraceptive prevalence rate as benchmarks/targets. The initiative should not hold individual providers or referral agents to the three prohibited indicators (numerical targets or quotas of total number of births, number of family planning

20. Guidance for Implementing the "Tiahrt" Requirements for Voluntary Family Planning Projects. USAID: April 1999. Technical Guidance on the "Comprehensible Information" Paragraph of the Tiahrt Clause. USAID: April 1999. http://www.usaid.gov/our_work/global_health/pop/tiajim3b.pdf

acceptors, or acceptors of a particular family planning method, as described in the summary qualifications box, above). PBF initiatives should be able to ensure compliance with the statute. If the PBF program managers feel that they do not have enough management control over how a clinic manager manages the implementation of the PBF program, then they shouldn't choose indicators that may be problematic related to the Tiahrt Amendment. If there is any question on the design of an indicator for FP/RH, Mission and Implementers are encouraged to contact the Senior Policy Advisor in the USAID Office of Population and Reproductive Health.

5. Finalization of PBF program

The finalized PBF plan, outlining the elements of motivation to be used, indicators selected, and payment plan should be documented by the implementing organization and reviewed and approved by the US Government.

Before the implementing organization issues an RFA or RFP to service delivery providers, all elements of the PBF program should be mapped out and approved by the USG. In general, it is important to be clear that the intended PBF instruments will generate payments that reinforce progress toward USG goals and are going to be fully allowable within the program's regulatory framework. There may be elements that will require special approvals within the USG system (e.g., direct contractual arrangements with local government units); these elements and other policy considerations should be anticipated at the program-design stage but may require reconfirmation at the time of implementation.

Create a detailed PBF strategy that maps out the incentives, indicators, and payment plan to the service provider.

Key Steps for USG and Implementing Organization in Planning the PBF Program

USG	Implementing Organization
• Detail the purchaser-provider split in the agreement between USG and the implementing organization. • Stipulate the types of motivation that can be paid based on the regulations for the type of agreement (RFA or RFP). • Provide approval of the indicators selected. It is expected that the service indicators will match those that the implementing organization has been committed to in its own contract with USG; management indicators applicable to PBF partners/recipients are less likely to be defined in that contract. • Review indicators and payments determined by implementing organization to ensure compliance with the Tiahrt amendment. • Approve implementing organization's PBF program.	• Detail the purchaser-provider split in the agreement between USG and the implementing organization. • Assess the different elements of motivation that can be offered, and determine which will provide the best incentive to achieve maximum results. • Lead the indicator selection process; this may involve key stakeholders from the MOH and NGOs. Consulting the key targets laid out in the RFA or RFP can provide a basis for selection. • Ensure compliance with the Tiahrt Amendment. The indicators should be balanced so that family planning indicators are not favored heavily. • Create a detailed PBF strategy that maps out the incentives, indicators, and payment plan to the service provider.

E. Determining Payment Structures (Implementing Organization)

1. Costing: approaches and function

Costing is determining the monetary value of the resources needed to provide services. The costs need to be estimated for the targeted numbers of services, which will generally be greater than the numbers of services currently or previously provided. Services may also need to be provided at higher levels of quality than previously, which may also involve increased costs. This means that costs have to be modeled to take into account the impact of the different service and quality levels on both fixed and variable costs. This is best done using standard costs which are based on the quantity of provider time, drugs, supplies and utilities required to provide good quality care and the estimated prices for those resources. The unit cost of each service is estimated and then multiplied by the target number for each service to arrive at the total cost of the facility. Note that historical costing of services is not generally useful since it is unlikely to provide good projections of the cost of scaled-up services, especially if quality also needs to be improved.

It is important to accurately project the cost of providing the target numbers of services to be included in the PBF so that the amount of funding included in the contract or grant is sufficient to provide these services. If the funding is too low, it is likely that the targets will not be met or the quality of care will not be at the desired level. If the funding is too high, resources will be wasted. Understanding the projected cost of services also means that the amount of the incentive can be related more accurately to those costs. In addition, the ability to project the cost for different numbers of services allows for the inclusion of financial incentives that vary with volume of services, so that the total costs of the PBF program can be calculated (facility budget + performance incentives). As a practical matter, the costing exercise in any environment may take up to six months to finalize, since no matter whatever mechanism is used, it is essential to gather data and analyze it in relation to service standards, with review and input from local clinical service providers to assure that realistic estimations are being made. Under some circumstances, therefore, it may be necessary to engage a first round of agents for service delivery based on historical program costs and targeting improved efficiency.

2. Budget

Once the targets have been set and the costs have been projected, a budget can be agreed upon between both parties. If the provider agrees with the norms, standards, and prices used to develop the cost model, then once the target numbers of services are entered into the agreement, the budget can be produced straight from the cost model; the only area of negotiation that is required relates to the incentive payments and the organization's administrative costs. These costs are the indirect costs incurred by the organization as a whole and relate to all the service delivery points, as opposed to the direct administrative costs of each service delivery point, which should be included in the modeled service delivery costs.

The budget details the expected costs of providing services at a certain targeted level of utilization. Budgets must be aligned with the M&E and performance plans so that targets can be achieved with the level of funding provided. The budgets must cover the length of the agreement but should be broken down by relevant time periods. If the agreement is for three years the budget should be set for the period of performance but broken out by year. If the targets are different for each year, the budget must be adapted for each year. The budget must cover both purchased resources and resources acquired in-kind. The sources of funds should also be shown in the budget and should cover all sources, including user fees and goods and services received in-kind. This provides an accurate estimation of all of the expected inputs into the system.

3. Payment mechanisms

The payment mechanism describes the structure, timing, and type of payments to be made from the purchaser to the provider. Selection of payment mechanism may be subject to rules and regulations of both the USAID mission and the host country government. Many consider the setting of fees, incentives, and payment schedules to be more of an art than a science (hence the numerous PBF pilots and trials that have been put in place). The key is to do it carefully and to design by stages.

There are several options for determining payment to service providers including fixed total budget, cost reimbursement total budget, payment by service and payment per capita. Fixed price total budgets cover the total cost of providing the target numbers of services. Cost reimbursement total budgets cover the total cost of providing actual numbers of services, and require documentation of all costs. Payment by service and per capita involves setting a unit fee per service delivered or per person, respectively. The payment mechanism should include a timeline for payments (i.e., whether they will be transferred quarterly or annually, and how the targets will be split up accordingly).

The penalties or risks, as well as the incentives, should also be detailed here. If an agency is required to submit service data and perhaps an invoice on a certain date, the consequence of missing that date must be explicit.

4. Setting payment levels: costs and incentives

The payment levels are the agreed upon fees or rewards transferred to the provider by the purchaser upon meeting targets. Payments may be made on an individual service basis, in which the quantity of services is multiplied by a unit fee. If this is the case, ceilings may be established so that service providers cannot claim an indefinitely large payment and the purchaser can operate within a budgeted ceiling. The unit fee for each service should be informed by but not necessarily equal to the actual cost of that service, as determined by the costing exercise described previously. In public sector programs, the establishment of these rates must be in conjunction with MOH authorities and may, in fact, require a conference with all stakeholders to assure understanding and avoid setting up conflicting or perverse incentive situations. Payment levels can also be an agreed upon percentage of the total negotiated budget of the service provider. In this case, there should be a threshold that must be met for full payment of the agreed upon percentage. See Annex B for examples of payment levels in different PBF projects.

Setting the level of the incentives requires careful analysis and planning. The amount of the payment must be sufficient to provide the necessary motivation to maximize the quantity and quality of services but not so much so that it is a waste of scarce resources. The planning must take into account the likely impact of the incentives on provider behavior, which will depend both on the amounts paid and the types of service for which they are paid.

Partners participating in the PBF program may need some form of advance funding to finance the base costs of services. This funding can be provided through innovative payment schedules connected to early deliverables fully within the control of the recipient organizations if formal advances are considered undesirable. It is also possible to separate support for base costs from performance awards.

Key Steps for USG and Implementing Organization in Determining Payment Structures	
USG	**Implementing Organization**
• Include the development of cost models and training of counterparts in the use of those models in the scope of work.	• Provide the technical assistance and training needed to develop and use the cost models. The development of the models will be needed at the beginning of the project; the training is a subsequent step that may need to be repeated. • Determine budgets for provision of services at agreed-upon target levels • Establish payment mechanisms to be used with service providers. • Determine incentive payment levels (in consultation with MOH and other stakeholders if the situation requires).

F. Developing/Issuing an RFA/RFP; Awarding an Agreement (Implementing Organization)

1. Selection criteria

The selection criteria are part of the RFA/RFP document issued by the implementing organization and explain how the selection panel will evaluate the proposals submitted by the potential awardees. A point system is usually applied to each criterion. The selection panel should include the contracting agency professionals and could also include staff from USG or the MOH.

In most cases when the implementing organization has completed the RFA/RFP and releases it, they will hold a 'bidders' conference' to publicly present the program and its goals, explain the rules and procedures required to submit a proposal, and provide an explanation of how the selection criteria are documented and scored. Holding this public bidders conference improves the ability of provider agencies to submit responsive proposals and reinforces transparency.

The procurement process needs to comply with the rules and regulations of the contracting agency agreement with the USG. These regulations require selection criteria to allow for a transparent award process.

2. Awarding of PBF grants or contracts

The completion of the procurement process occurs when the parties sign the agreement to legally bind them for the work to be implemented. The agreement is created by the awarding agency and the receiving organization can review and make comments prior to signature.

Joint signature marks the official start of the implementation of the contracted work, which will hopefully result in positive incentives through the accomplishments of the targets set by the design team at the outset of the process. Where some forward funding is needed, the signing of the agreement can be used to trigger the first payment in a fixed-price contract payment schedule.

Key Steps for USG and Implementing Organization when Developing, Issuing, and Awarding an Agreement	
USG	**Implementing Organization**
• Approve agreement mechanism to be used and performance goals to be targeted. • Participate in the selection panel and may review the selection criteria for approval depending on the requirements. • Approval of the awardees.	• Determine the best agreement mechanism for the PBF program and strategy, including consultation with an experienced contract professional from the implementing organization, who functions as part of the team designing the strategy. • Define the criteria and the point system so that it is very clear to the organizations proposing and the team evaluating.

IV. Implementation

A. Technical Assistance & Quality Assurance

1. Coordinating partners: the Extended Team approach (implementing organization)

To ensure the success of PBF implementation, a 'Coordination Mechanism' among the partner organizations should be established. This can be in the form of the development of an Extended Team, a group which allows for partners in the PBF system to team with other stakeholders to perform a number of functions. These might include bridging the gap between policy and implementation, assisting the provider in the implementation of its PBF system, and providing technical assistance and capacity building as needed. This kind of partner network can be effective in assuring common understanding of standards and goals. It also creates a forum that facilitates cross-fertilization among service partners to accelerate the adoption of positive innovations or efficiencies.

With this approach, objectives can be achieved through tasks and responsibilities such as providing the necessary support, including training, development of action plans, and evaluation; harmonizing the actions and interventions of the various partners; and giving technical assistance as well as providing quality assurance.

Coordination between ministries of health, donors, and development partners is a crucial factor in the success of a PBF program. Frequent coordination, careful setting of agendas, excellent documentation, and timely dissemination are essential success factors in developing national policy. As noted previously, stakeholders are important when mounting Performance-Based Financing systems. PBF involves financial incentives and indicators, which attract interest from health professionals and politicians alike. Furthermore, the nature of PBF can generate resistance from powerful actors. PBF can be a threat to 'business as usual,' and involves a change in the way productivity and health results are incentivized. Increasing transparency and cooperation through coordination mechanisms is therefore essential.

2. Management

The management of the PBF program involves both oversight and administration of the mechanism (contract, grants, and/or MOUs) and technical integration with the project technical and performance monitoring plans.

The USG's implementing contractor should have clear procedures for technical support to service delivery organizations, assuring that quality standards are recognized and adhered to, and also assuring that results are tracked against overall program goals.

The contractor should also have a communications plan that includes routine performance feedback to each provider organization, support for the development of performance improvement plans, and data and technical-operational innovation-sharing instruments. The plan ensures that all participants in a PBF effort are informed of overall progress, and know how innovations have been used and how they are performing.

There will be some participating providers that do not perform well. With support, almost all can become successful, but there may be cases where the implementing organization must put a provider organization on probation (warning with standards for improvement) or cancel contracts or grants outright. These actions are likely to be politically sensitive and it is essential that the USG is aware of the issues and remedial actions to be taken before they are taken, and that the USG supports the project's implementer if external pressures are applied.

3. Business plans

Business plans are created at the health center level, in which a set of predefined targets are determined and strategies to achieve these targets are outlined by facility managers. The business plans are a key element of the PBF system because they map out the PBF strategy on a facility basis and allow for the identification of innovative facility management. Managers are able to focus on the relationship between operational efficiency and maintaining quality.

Service delivery occurs at this level, so a micro-level of business planning is essential. Targets for the indicators are given, but it is entirely within the control of the manager to achieve these targets. In addition to the monetary incentives that result from reaching targets, managers receive non-monetary incentives such as recognition, ownership, and positive results. The business plans provide accountability for the managers, and good business plans for well-performing centers can be used as a model for poorer performers.

Key Steps for USG and Implementing Organization during Implementation: Technical Assistance & Quality Assurance

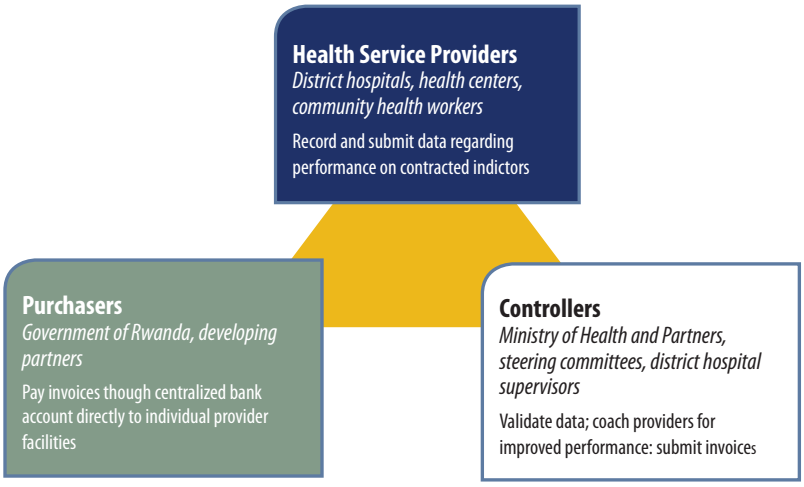
USG	Implementing Organization
• Communicate routinely with the implementing organization to avoid unforeseen surprises. • Support the implementing organization and insulate the PBF program from external pressures that are likely to arise.	• Initiate the creation of a coordination mechanism to provide technical assistance to PBF; this can be in the form of an Extended Team. • Manage contracts, grants, and MOUs at all levels of the system. • Ensure that individual service delivery points have created their business plans, mapping out their targets and potential strategies to achieving their goals. • Develop communication plans to assure: routine performance feedback to each provider organization; support for development of performance improvement plans; data and technical-operational innovation sharing.

B. Monitoring, Data Validation and Verification

1. Checks and balances: levels of control and separation of functions

A key construct of PBF is the separation of functions among three parties: the providers, purchasers, and controllers, as shown in the figure below, an example from Rwanda. 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 how to close gaps between targets and actual performance.

SEPARATION OF PBF FUNCTIONS



In the Rwanda PBF model (featured here because it is a USAID-sponsored effort that has become national policy), the design of the health center component has introduced six levels of control to avoid conflicts of interest:

1. **Written contracts:** These contracts lay down the rules and regulations that govern PBF, and include clauses that deal with fraud. These contracts are written between the health center management committee and the district PBF steering committee (on behalf of the MOH). This first level of control ensures that data submitted in the monthly invoice are true. Regular control for the quantity and quality of performance is essential.
2. **Monthly control by the district controllers**: This team controls and verifies the health facility productivity. Controllers count every single entry in the designated primary register, and sign off on the monthly invoice.
3. **Quarterly District Steering Committee Meetings:** In these meetings, the monthly invoices are compared with the quarterly consolidated invoice, printed from the database. The reason for comparing these two sets of invoices is to intercept data entry errors.
4. **Monthly Extended Team Meetings** at the national level.
5. **Quarterly Community Client Satisfaction Surveys and Quality Counter Verification:** These surveys are meant to answer three questions: Is the client known in the community? Has the client actually received the service? What was the opinion of the client on the service received?
6. **'Due diligence' on procedures:** This includes the received minutes of the steering committee proceedings, and the signed and approved consolidated district invoices. Data are triangulated with data from the database.

PBF introduces powerful incentives to increase the volume and quality of services. Professional ethics and immediate feedback on their level of performance are strong motivators for health workers, besides the financial incentives. The purpose of this separation is to avoid or reduce conflict of interest or collusion. When products/outputs/performance need to be assessed, and are linked contractually to money, having an independent controller, and credible checks and balances becomes important.

2. Avoiding distortion

Distortion takes place when health care providers neglect services that are not subject to incentives, resulting in poor functioning and subsequently to worse outcomes of diseases managed by these services. In addition, distortion may be caused by service delivery providers attempting to earn more payment than they are owed.

To avoid these situations, a comprehensive PBF model should be put in place that covers all services, HIV and non-HIV clinical services as well as management indicators, and also addresses the quality of all services the health facilities provide. This can be accomplished through adjustment of quantity payments by a quality measure which is assessed for the complete health facility (see also under quantity and quality in the following section). Other solutions could include incentivizing quality separately, providing extra yearly bonuses for these overall quality performances, or taking into account outcome indicators at the community level.

The possibility of fraud is also addressed through the system of checks and balances, and separation of functions, described above. In the Rwanda case, contract provisions addressed the concern about potential

fraud directly. This was possible because the program is national policy and Rwanda has specific legal and policy stances characterized officially as 'no tolerance.' More generally, PBF programs will not operate with such strong policy support. It is important to be clear up-front about process and validation standards and the consequences for not meeting them. It is not necessary to characterize the reasons for failures that lead to adverse decisions within the program as long as the decisions are made and communicated and acted on. If the data system is transparent to all participants it will be clear that there is no reward for distortion or falsification and that such acts will become widely known and have negative consequences.

3. Quantity and Quality

Performance is measured not only in terms of the quantity of services, but also the quality of service delivery. The quantity is the volume of services delivered, such as the number of voluntary counseling and HIV testing visits at a clinic. The quantity of services should be compiled regularly and systematically, using a universal database such as an HMIS. The quality of service delivery is determined by indicators that are objectively verifiable and tangible, using supervisory visits and checklists.

In Rwanda, for example, PBF has redefined measurement of quality so that the focus is no longer solely on clinical care, but includes elements of management, administration, and client satisfaction. The performance measure is a fee-for-service hybrid, conditional on the quality of general services provided, including HIV services. Fourteen Basic Health Packages and ten HIV indicators are purchased. The quality supervisory checklist contains 118 composite indicators, across 13 services, including HIV services. For the District Hospital model, the performance measure is the composite score from a balanced score card with 52 composite indicators, over 350 variables.

In Haiti, a system called the Service Delivery and Management Assessment Protocol is used. With this system, the service data are validated and the quality of services delivered is verified by multi-disciplinary teams visiting each service provider site. Teams may include staff of other service provider organizations in the program. All of the reported service data are validated against clinical records and then the team observes and analyzes service protocols in use, tests a sampling of clinical records in the community to assure accurate representation, and reviews the operations and management procedures that support service delivery. Each service provider organization is provided with a summary report and a recommended performance improvement plan.

It is necessary to objectively verify conditions to provide quality care as well as verify the actual quality of care provided, with strong impact on performance payments. Including quality in the performance equation avoids and or mitigates the effects of purchasing only certain services, by protecting the general quality of services as a whole. The validation process may have to be as frequent as quarterly at the start of a program, but once it is understood to be inextricable from the program as a whole, the process becomes a motivator for internal use of monitoring systems by managers and a force for creating a culture of quality within the system or network.

4. Health Management Information System (HMIS)

The HMIS is a tool to collect data on service provision and is an integral part of the PBF approach. A good HMIS is a critical tool for health managers to make decisions regarding efficiency and quality of services. When set in place, this system facilitates the availability of information used to document the results of PBF. It requires the contribution of all PBF partners in collecting and analyzing the information. A well-designed data system can become a major asset in streamlining otherwise complex operational requirements.

In the PBF system, if a service is not counted and documented, the provider will not get paid for it. This provides a powerful incentive for the service providers to complete their HMIS forms or databases in a timely and accurate manner (data validation is addressed in a subsequent section). In addition, the HMIS must match up with the indicators that have been selected in the PBF system. If the indicators are not being measured somewhere in the HMIS, a new method of data collection and validation will have to be devised. Finally, HMIS data may provide the necessary information to establish a baseline for targets that are set in the PBF agreements.

5. Data collection, sharing, auditing, and validation

To ensure that while volume increases, quality does not decrease, data audit and verification should be executed for both quantity and quality indicators. The volume of services may be verified by comparing HMIS data to registers and patient records at individual facilities, while the quality of services may be verified with checklists and client satisfaction surveys.

Data should be collected consistently, on a regular basis, and by well-trained staff. A system of data sharing should be in place, in which data are regularly made available to all stakeholders and interested parties.

Data collection is critical to ensure the consistency and accuracy of reporting of services delivered. Utilization data is important because it provides evidence of service delivery and thus is a basis for payment and is also critical for management decisions. If progress is not being made toward meeting targets, the manager may need to consider other strategies for service delivery, such as increased community outreach, behavior change communication and social marketing. Data sharing ensures transparency, so that all stakeholders can have access to data from service delivery providers. This, in turn, discourages fraud, since data anomalies will quickly be made evident.

A good system of data validation is integral to implementing PBF successfully. Data audits may be internal and conducted by the PBF partners during supervisory visits or rapid evaluations; or, audits may be performed externally by a third party company or an independent consultant.

The objective of this data audit and verification is to ascertain that the data collected at service delivery points are reliable and accurate. At the same time, this process serves as an independent, unbiased approach to assess the satisfaction of clients who contracted the health services. Multiple levels of data validation enhance the reliability, completeness, timeliness and use of performance data. These levels ensure that service providers do not attempt to solicit more payments than agreed-upon, in addition to penalizing providers for deteriorating quality.

6. Results

Performance-based financing is focused on results. The purchaser only pays for results, and these results must be clearly demonstrated and validated through rigorous documentation. The results can show progress being made toward achieving targets. Results can imply an 'impact' on health status or register as intermediate contributions along a broader pathway to impact.

Results tell the story of quantity and quality in PBF systems. Donors and governments alike insist on evidence-based results when determining how to spend their money. Results of both quantity and quality are necessary to document the positive changes attributable to the application of PBF. As such, results should be disseminated regularly to keep relevant stakeholders informed of progress.

Key Steps for USG and Implementing Organization in Monitoring, Data Validation and Verification

USG

- Monitor regular reports detailing results from service delivery providers.
- Assist/guide implementing organization to align PBF program data collection and indicators with USG global indicator and data requirements.

Implementing Organization

- Ensure that PBF design includes a separation of functions and various levels of control.
- Ensure that incentives do not favor particular services too heavily to prevent distortion.
- Include quality indicators, whether they are specific individual indicators or an overall quality score based on a checklist.
- Assess HMIS to ensure that system is adequate for data collection on PBF indicators.
- Provide capacity building and/or technical assistance for HMIS as needed.
- Detail the methods by which quantity of services will be validated in a clear, transparent manner. Also, a method for the determination of the quality of services should be established.
- Specify the effect the quantity of services will have on the payment plan; i.e., whether there is a fee for each service, or a threshold.
- Clearly plan quality indicators such as supervisory quality checklists.
- Devise a plan for regular data collection, sharing, and analysis to promote transparency; and disseminate results with progress toward achieving indicator targets.
- Follow up with providers that are behind in achieving targets.
- Create an open, transparent data validation process, with both internal and external data audits.

C. Evaluation

An impact evaluation assesses changes over time in a specific population or region that can be attributed to a project or program. The evaluation may focus on impact indicators such as infant mortality or service indicators such as quality of care. The baseline, timeframe, target population, target area, and indicators should all be explicitly defined. Impact evaluations should be performed by neutral third parties to prevent bias.

Impact evaluations provide evidence that a program has or has not been successful. If it has been successful, elements from the program may be implemented elsewhere. If not, the program design should be analyzed and any lessons learned disseminated. It is critical that a plan for impact evaluation be formulated during the initial PBF planning phase. Baseline data must be established, and criteria for success determined. While impact evaluations are necessary, it is also important to acknowledge the difficulty in attributing impact to one specific project or program. This is especially true in most developing country settings, where numerous donors and government entities may be implementing multiple projects at the same time. Controlling for external factors, if and where possible, is critical.

Key Steps for USG and Implementing Organization in Evaluation

USG	Implementing Organization
• Include the need for an impact evaluation in the original scope of work. • Determine the definition of success for the program. • Consider the potential benefit of contracting a neutral third party evaluation team to conduct the impact evaluation. • Disseminate results, including lessons learned. • Incorporate positive approaches into future programs and identify less successful approaches to improve upon or discard.	• Include an impact evaluation in the work plan and timeline. • Identify and provide key data required to assess impact. • Incorporate positive approaches into future programs and identify less successful approaches to improve upon or discard.

D. Planning for Sustainable Impact

In early discussions of PBF program design, the question on sustainability is often raised as if the process was an expensive new element that has to cover all of its variable and fixed costs to pay its way. It is often expressed as "Who will pay for PBF after the project is over?" In fact, a PBF initiative takes existing resource flow and channels it into activities that are steered toward higher quality, improved operational efficiency, and strong impact on results.

For sustainability, all partners and stakeholders need to be mobilized and feel ownership in the program. The Rwandan national PBF models were designed using a participatory process involving all stakeholders. Seeking common ground and consensus among partners with different models was the ultimate aim. The prime coordination forum on PBF implementation issues was created. The Extended Team Approach, a collaborative approach involving all PBF actors, was initiated as a strategy to bridge the gap between policy and implementation, and to assist the MOH in implementing its vision for PBF nationwide.

Sustainability ensures resources are available, including the required combination of resources to pay for performance, but also for technical assistance, if necessary. The program to be implemented should be based on a valid and direct cause-and-effect relation, with a clear understanding of the objectives, specified tasks in the correct sequence, and good communication and coordination with compliance.

The best way to think about ensuring the sustainability of a PBF program is to make sure that all the stakeholders are engaged, understand how and why the program is structured as it is, and strive for quality, efficiency, and impact, whatever the size of the resource flow.

Sustainability inevitably involves a "handover" from the original donor or implementing partner. Well in advance of the end of the PBF program, plans must be set in motion for a transition to the next phase. Transition requirements will vary, but should always involve a handover to avoid the classic project cycle calamity of having established, useful programs suddenly evaporate leaving local partners and authorities in the lurch. Decisions need to be made regarding the roles still played by the project as it ends (who should be the next purchaser, controller, how will the providers maintain services through the transition period). Services have to be continued and the incentive programs need to be maintained as part of the system if disruptions are to be avoided. One way to address this is to hold a stakeholder conference six months to a year before the project end to explore transition issues so that there are no unpleasant surprises.

To be truly sustainable, PBF programs, where possible, should be initiated with a goal towards local/national ownership. The transition process—the passing on of roles such as 'purchaser'—should begin as early and gradually as possible so that service provision is not interrupted and momentum is not lost. Both the USG and the implementing organization should have a plan for transitioning from one project to the next.

Key Steps for USG and Implementing Organization in Planning for Sustainability

USG	Implementing Organization
• Maintain communication with stakeholders to encourage ownership. • Engage stakeholders on strategies for sustainability. • Plan for next steps and handover at the end of current PBF project. • Avoid losses in the system: If a procurement process needs to begin again, ensure that the timeline coincides with the end of the current project (an overlap of 4 to 6 months will allow for the transition to be made with certainty; a shorter interval creates concerns for stakeholders; and a gap in timing creates real and unavoidable losses in the system). • Oversee communication and handover between implementing agencies.	• Maintain communication with stakeholders to encourage ownership. • Engage stakeholders on strategies for sustainability. • Plan for next steps and handover at the end of current PBF project (perhaps in the context of a stakeholder conference). • Provide information needed to new implementing organization, if applicable, for handover.

V. Annexes

A. Overview of Select USAID Programs with PBF Elements

Country	Project Name	Start & End Date	Funder	Contracting Agency	Project Description	Type of PBF	Technical Area(s)
Afghanistan	REACH	2003-2006	USAID	MSH	To increase the use of health services, REACH made grants to local and international NGOs to improve health services.	Performance-Based Grants	PHC
Afghanistan	Tech-Serve	2006-2008	USAID	MSH	Assisted the MoPH in awarding and managing $51 million in grants to 16 local and international NGOs. 600,000 clients served each month through 349 health facilities and posts.	Performance-Based Grants	PHC
Ethiopia	HCSP	2007-2011	USAID	MSH	National PBF Program for Federal Ministry of Health (MoH)	Grants	HIV/AIDS, TB
Guinea	PRISM Family Planning and Health	1997-2002	USAID	MSH	Expanded access to services at the community level by developing HMOs and MURIGAs to remove economic barriers to care.	Community Based Health Insurance Programs	FP, RH
Guinea	PRISM II	2003-2007	USAID	MSH	Expanded access to services at the community level by developing HMOs and MURIGAs to remove economic barriers to care.	Community Based Health Insurance Programs	FP, RH
Haiti	Haiti Health Systems 2004	1995-2005	USAID	MSH	Targeted vulnerable populations in Haiti to provide equal access to primary and reproductive health services; developed health services to be more self-sufficient and sustainable.	Performance-Based Grants	HIV/AIDS, TB
Haiti	Haiti Health Systems 2007	2005-2007	USAID	MSH	Targeted vulnerable populations in Haiti to provide equal access to primary and reproductive health services; developed health services to be more self-sufficient and sustainable.	Performance-Based Grants	PHC
Haiti	SDHS	2007-2010	USAID	MSH	Performance-based grants with public sector and 27 NGOs	Performance-Based Grants	PHC
Honduras	AIDSTAR-Two	2009-2011	USAID	MSH	Organizational capacity building to local NGOs that provide HIV prevention and counseling and testing services to Most At Risk Populations	Performance-Based Contracts	HIV/AIDS
Kenya	Kenya Health Care Financing Project	2008-2013	USAID	MSH	Shifting money from hospitals to primary health care using a conditional grant program to politicians	Conditional Grants	PHC
Kenya	APHIA Financing and Sustainability (AFS)		USAID	MSH MSH	Mission hospital PCEA Chogoria has 30 clinics and some clinics were operating with huge deficits. An incentive program for clinic staff was put in place to improve performance	Performance-Based Contract	PHC

Country	Project Name	Start & End Date	Funder	Contracting Agency	Project Description	Type of PBF	Technical Area(s)
Madagascar	Madagascar Population Support Project (APPROPOP)	1993	USAID	MSH	SDSA sub agreements providing financial, material, & technical support to public and private sector partners which successfully completed a project design and application process	Performance-Based Grants	FP
Malawi	Community Based Family Planning and HIV/AIDS services	2007-2010	USAID	MSH	Promote fully functional, high quality, integrated family planning and HIV/AIDS services to clients in rural areas through a revitalized network of 1,000 community based distribution agents	Performance-Based Contracts	MH, FP, HIV/AIDS
Nicaragua	UMS: PRONICASS	2005-2010	USAID	MSH	Develop managers and leaders who achieve results in the areas of reproductive health, HIV/AIDS, infectious disease and MNCH through working with both public and private organizations	Developed results based budget for Ministry of Family Welfare	HIV/AIDS, RD, CDC
Philippines	IFPMPH	1993-1995	USAID	MSH	Financed municipalities to provide reproductive health services	Performance-Based Grants	FP, MH, CS
Philippines	IFPMPH	1995-2002	USAID	MSH	Earlier activity under FPMT used performance thresholds with LGUs that was an early demonstration of the impact of performance-based approaches to improving performance	Performance-Based Grants	FP, MH, CS
Rwanda	HIV/PBF	2005-2009	USAID	MSH	Worked with Rwanda MoH to implement PBF initiatives that fund services delivered through health centers and hospitals in most districts	Performance-Based Grants	HIV/AIDS
Rwanda	IHSSP	2008-2013	USAID	MSH	Provide Technical Assistance to the Rwandan MOH as it implements national PBF system	Performance-Based Grants, Conditional Cash Transfers	PHC
South Africa	IPHC	2004-2010	USAID	MSH	Capacity building and performance- based grants to 23 community based organizations. Helped 19,000 OVC receive vital services in 2008.	Performance-Based Grants	HIV/AIDS, RH, FP, CS
Sudan	SHTP-II	2009-2010	USAID	MSH	Introducing PBF in 12 counties to scale up access to high quality health services	Performance-Based Contracts	CS, FP, HIV/AIDS
Uganda	STAR-E	2009-2014	USAID	MSH	The overall goal of the program is to increase access to, coverage of and utilization of quality comprehensive HIV/TB prevention, care and treatment services within district health facilities and their respective communities	Performance-Based Grants	HIV/AIDS, TB
Uganda	STRIDES	2009-2014	USAID	MSH	Providing health services in 15 districts using fully functioning service delivery points and PBF as strategies	Performance-Based Contracts	FP, RH, CS

B. Sample Indicators and Payment Schedules: Haiti and Rwanda

1. Haiti

The Haiti performance benchmarks, targets, and payments are shown in the table below. The Haiti model uses fixed-price contracts plus an award fee. The indicators chosen are a combination of service delivery indicators, such as full immunization coverage, prenatal care visits, and assisted deliveries; and management indicators, such as submitting an annual action plan and monthly reports. A random selection of five service delivery indicators is made in addition to selecting indicators for vaccination and prenatal care. NGOs that meet all targets are awarded a 6% bonus, resulting in a maximum possible of 106% of annual negotiated budget.

Benchmark	Proportion of Annual Negotiated Budget
Sign contrract	10 percent
Submit annual action plan	15 percent
Submit monthly reports	1/12 of 10 percent of approved budget each month
Recommendations on financial system strengthening applied	No money
Quarterly requests for payment submitted	March 1: 20 percent
	July 1: 20 percent
	October 1: 13 percent
	November: 6 percent
80 percent of children under one completed vaccinated	1.5 percent
50 percent of pregnant woman receiving three prenatal care visits	1.5 percent
Random choice of one indicator from the following list:	3 percent
50 percent of children under five weighted according to guidelines	
63 percent of deliveries are assisted by a trained attendant	
44 percent of women with new births receive a home postnatal care visit	
50 percent of pregnant women tested for HIV during a prenatal care visit	
75 percent of new positive TB patients are also tested for HIV	
Timely submission of quarterly reports to the project	No money
Supervision systems with specified criteria in place	No money
Additional bonus if all previous targets are met	6 percent
Maximum possible	106 percent of negotiated budget

Source: CGD Performance Incentives for Global Health

2. Rwanda

The figure below shows the payment schedule for the Rwanda National PBF Model in 2008. The Rwanda model uses fee-for-service payment with a quality score. A total of 24 indicators have been selected: 14 indicators for primary health care including antenatal visits, immunization, delivery, family planning, and referrals; and 10 indicators specifically relating to HIV/AIDS services. Composite criteria for validation of each indicator are determined, as well as a unit fee per service. The Rwanda model also uses a quality score as a deflator, according to a formula as follows:

Total award payment to a facility = (Volume * Unit Fee) * % Quarterly Quality Score

The Quality Score is based on the facility's performance against a checklist of quality indicators, performed quarterly.

	Indicator	Composite Criteria	Payments (FRW)
1	Curative Primary care: New Cases	Information in the register on: number, name, sex, new case, address, clinical symptoms, examination, diagnosis, outcome, treatment, zone/outside zone	100
2	Antenatal Care: New Cases	Information in the ANC register on: new cases, physical exam, obstetric exam, additional exams, and follow-up appointment	50
3	Antenatal Care: Women with 4 ANC Visits	Information in the ANC register on 4 standard visits (1st, 2nd, 3rd trimester and 9 months)	200
4	Antenatal Care: TT Vaccine 2-5	Information in the ANC register on the 2nd, 3rd, 4th or 5th TT Vaccination	250
5	Antenatal Care: Second dose of Sulfadoxine	1) ANC register containing information on SP; 2) SP administered after the 4th month of pregnancy and before the 8th month of pregnancy, with the interval between the two doses of at least one month	250
6	Antenatal Care: Referral of High-Risk Pregnancy before the 9th month	Counter-referrals received within the month of evaluation signed by the District Hospital doctor	1,000
7	Growth Monitoring: 11 – 59 month child consult at Health Center	Information in the register on: number, name, sex, address, age, height/weight	100
8	Family Planning: New User	Information in the Family Planning register on name, age, address, examination, history, physical examination and modern method prescribed	1,000
9	Family Planning: Existing User	Information in the Family Planning register on monitoring of existing users	100
10	Immunization: Fully Immunized Child	Information in the register on: number, name, date of birth, sex, address, dates of BCG, OPV 1, 2, 3, Pentavalent 1, 2, 3 and measles, with respect to vaccination calendar, by the end of the first year	500
11	Delivery attended at Health Center	Partograms in the maternity register with: name, stages of labor, and delivery	2,500
12	Delivery: Referral of emergency obstetric cases	Counter-referrals received within the month of evaluation signed by the District Hospital doctor	2,500
13	Referral for severe malnutrition	Counter-referrals received within the month of evaluation signed by the District Hospital doctor	2,000
14	Emergency Referral	Counter-referrals received within the month of evaluation signed by the District Hospital doctor	1,000
15	VCT: Number of patients tested	Nil	500
16	PMTCT: Number of couples tested for HIV	Nil	2,500

	Indicator	Composite Criteria	Payments (FRW)
17	PMTCT: Number HIV+ woman on ARV treatment during pregnancy	Nil	2,500
18	PMTCT: Number of children born to HIV+ mothers tested for HIV	Nil	5,000
19	Treatment: Number of HIV+ patients tested for CD4 count every 6 months	Nil	2,500
20	Treatment: Number of HIV+ patients treated with CTX every month	Nil	250
21	ARV: Number of new adult patients receiving ARV treatment	Nil	2,500
22	ARV: Number of new pediatric patients receiving ARV treatment	Nil	3,750
23	HIV Prevention: Number of HIV+ who use family planning methods	Nil	1,500
24	TB/MST: Number of HIV+ patients tested for TB	Nil	1,500

Source: Rwanda PBF website, **www.pbfrwanda.org.rw**

C. Sample Model Implementation Timeline (Sudan Health Transformation Project-II)

Activity	Person Responsible
Project Start-Up	
0.0 Start-Up Activities	
0.1 Establish presence in country CSO	HR, COP, F&A
0.2 Develop and submit essential project documents to USAID	COP, M&E, TD
0.3 Conduct SHTP II project start-up meeting with MOH/USAID	COP & Team
Result #1: Expanded access/availability of high impact services and practices	
1.1 Provide transition funding to lead agencies to continue services until PBC subcontracts are issued.	
1.1a Review lead agency agreements to determine level of tranisition funding	TD
1.1b Release sole source RFP	CO
1.1c Review proposals	COP, TD
1.1d Provide pre-subcontract agreements to all LAs	CO
1.1e Negotiate and sign contracts with lead agencies	COP, CO
1.1f Develop planning M&E, reporting tools	M&E, TD
1.1g Disburse funding	F&A
1.1h Review and approve work plans and M&E plans	TD, M&E, COP
Monitor reports and financial statements	TD, F&A, M&E
Provide written feedback to each county	TD, F&A, M&E
1.2 Develop a performance-based contracting program	
1.2a Define Finance & Payment Flows (written procedures of Finance & Payment Flows)	
1.2b Define contract structure (sample contract) with MOH	F&A, C&G, CO, STTA
1.3 Develop and implement a plan for building MOHSW PBF capacity	
1.3a Draft Contracting Guidelines and Procedures	F&A, C&G
Get approval of contracting model and procedures from USAID and MSH Home Office	F&A, TD, USAID, CO, MSH-Camb
1.3b Develop mechanisms for monitoring performance-based contract to the MOH reporting requirements	M&E
1.3c Develop common tools, approaches and systems for managing subcontracts	TD, M&E, STTA
1.3d Organize MOH staff orientation on the PBC process	COP
Assess HMIS system currently in place; develop/update as necessary	TD, M&E, STTA
1.4 Implement PBC pre-bidding process	
1.4a Define overall performance-based contracts goals and objectives	COP, TD
1.4b Hold workshops with potential subcontractors to inform them about PBC and foster buy-in to the process	COP and Team
1.4c Decide services to subcontract	TD, STTA
1.4d Define subcontract scope (e.g. catchment areas, target population, products, etc.)	
1.4e Conduct baseline assessment of services in 12 countries to establish targets and dollar amounts for each conrract	M&E Director, STTA
1.4f Conduct costing of PHC package	STTA
1.4g Develop subcontracts terms (targets, deliverables, $ amount, duration)	TD, M&E
1.4h Design monitoring and evaluation criteria and identify indicators to measure subcontract performance based on SHTP II and MOH indicators	TD, M&E, STTA
1.4i Determine payment mechanisms	F&A, C&G

Activity	Person Responsible
1.5 Conduct an open and competitive procurement process	
1.5a Form an Evaluation Committee and determine evaluation criteria	F&A, C&G
1.5b Develop the bidding document (RFP)	C&G, CO
1.5c Disseminate Request for Proposal	F&A, CO
1.5d Organize open proposal preparation workshops	COP and Team
1.5e Review rank proposals wtih Evaluation Committee	TD, STTA
1.5f Select performance based subcontract partners	COP
1.5g Receive USAID approval for subcontract awards	CO
1.6 Conduct subcontract development & negotiation	
1.6a Negotiate subcontract agreement indicators and performances, targets with recipient service providers	COP
1.6b Conduct a pre-award assessment of the selected NGOs	C&G
1.6c Award subcontracts	CO, F&A
1.6d Sign subcontracts	CO, F&A
1.6e Work with new subcontract partners to submit facility transition plans to ensure smooth transition between NGOs where required	
1.7 Manage performances based subcontract implementation	TD and tech team
1.8 Monitor subcontract performance against milestones defined in subcontract	
1.8a Establish assessment teams for baseline survey (and for later use in PBC validation visits)	M&E Director
1.8b Collect/Receive subcontractor performance reports (service data and progress on other indicators	
1.8c Monitor NGO/FBO performance using Performance reports and assessment protocols (possibly use an independent group) before payment	M&E Director, Joint Team
1.8d Make payments on schedule in accordance with performance reports	
1.8e Conduct sporadic validation visits by Joint Assessment Team (interim QA method)	M&E Director, Joint Team
1.8f Conduct routing visits (support supervision) to countries in need of specific assistance	TD, M&E Director, F&A, COP
1.8g Adapt Haiti's SDMA validation tool for use in Sudan	M&E Director, STTA
1.8h Activate assessment teams for PBC validation visits	M&E Director
1.8i a. Annually conduct Service Delivery & Management Assessement (SDMA) protocol to all Subcontractors	COP
1.8j Provide written feedback to each county	TD, M&E Director, F&G
Evaluate performance against Monitoring and Evaluation indicators (quarterly)	TD
Award fee payment	F&A
Award con't contract or adapt/change contract agreement based on M&E results (after 1 year)	
1.9 Develop FFSDP model for South Sudan	
1.9a Circulate materials on FFSDP to LAs and MOH	TD
1.9b Conduct workshop to agree on core elements of a FFSDP	TD, COP
1.9c Develop document on FFSDP for South Sudan	TD, COP

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