May 12, 2005

The Project Manager
Academy for Educational Development
(Contract No. GHS-I-00-03-00024-00)
1825 Connecticut Ave NW
Washington DC 20009
Phone: 202 884 8000
Fax: 202 884 8400
E-mail: mmcgunni@aed.org
E-mail: snorwood@aed.org
E-mail: preyes@aed.org

The Project Manager
Chemonics International
(Contract No. GHS-I-00-03-00025-00)
1133 20th Street NW
Washington DC 20036
Phone: 202 955 3300
Fax : 202 955 3400
E-mail: bbassan@chemonics.com
E-mail: eeiseman@chemonics.com

The Project Manager
John Snow, Inc.
(Contract No. GHS-I-00-03-00026-00)
44 Farnsworth Street
Boston MA 02210
Phone: 617 482 9485
Fax: 617 482 0617
E-mail: hashem@jsi.com
E-mail: kolivola@jsi.com
E-mail: lcampbell@jsi.com

The Project Manager
Health Star - Health Science Technical Assistance Research Consortium, Medical Service Corporation International
(Contract No. GHS-I-00-03-00027-00)
1716 Wilson Boulevard
Arlington, VA 22209
Phone : 703 276 3000
E-mail : msci@mscionline.com

The Project Manager
Research Triangle Institute (RTI)
(Contract No. GHS-I-00-03-00028-00)
P.O. Box 12194
Research Triangle Park NC
27709-2194
Phone: 919 541 6017
Fax: 919 316 3911
E-mail: barbara.kennedy@rti.org

The Project Manager
University Research Co.
(Contract No. GHS-I-00-03-00029-00)
7200 Wisconsin Avenue
Suite 600
Bethesda MD 20814
Phone: 301 654 8338
Fax: 301 941 8650
E-mail: tveldhuyzen@urc-chs.com
E-mail: mgebremedhin@urc-chs.com
E-mail: health-tasc2@urc-chs.com

U.S. Agency for International Development
Regional Economic Development Services Office,
East and Southern Africa
USAID/REDSO/ESA
P.O. Box 629
Village Market 00621
Nairobi, Kenya

Courier Address:
USAID/REDSO/ESA
ICIPE Complex
Kasarani Road
Nairobi, Kenya

U.S. Postal Address:
REDSO/ESA
Unit 64102
APO AE 09831-4102

Tel: 254-20-862400/02
Fax: 254-20-860870/949
www.usaidredso.org

The Project Manager
Management Sciences for Health (MSH)
(Contract No. GHS-I-00-03-00030-00)
784 Memorial Drive
Cambridge, MA 02139
Phone: 617 250 9500
Fax: 617 250 9090
E-mail: phume@msh.org

The Project Manager
Deloitte Touche Tohmatsu Emerging Markets, Ltd.
(Contract No. GHS-I-00-03-00031-00)
1001 G Street NW Suite 900W
Washington DC 20001-4546
Phon: 202-572-7096
Fa:202-572-7001
E-mail: jmathis@emergingmarketsgroup.com
E-mail: jmellis@emergingmarketsgroup.com

The Project Manager
ABT Associates
(Contract No. GHS-I-00-03-00039-00)
4800 Montgomery Lane
Suite 600
Bethesda, MD 20814
Phone: 301 347 5363
Fax: 617 492 5219
E-mail: carlos_carrazana@abtassoc.com
E-mail: patricia_poulton@abtassoc.com

The Project Manager
Initiatives Inc.
(Contract No. GHS-I-00-03-00040-00)
376 Boylston St., Suite 4C
Boston , MA 02116
Phone: 617 262 0293
Fax: 617 262 2514
E-mail: initiatives@att.net

SUBJECT: Request for Task Order Proposal (RFTOP) No. 623-P-05-022 for Rwanda Performance Based Financing Project

REFERENCE: Global Health - Technical Assistance and Support Contracts II (TASC 2)

Dear Sirs/Madams:

Enclosed is a statement of work for a proposed task order not to exceed $14,200,000.00 under the subject contract. Please provide this office no later than Tuesday, June 13, 2005 at 03:00 pm Nairobi, Kenya Time your technical and cost proposals for accomplishing the work requested in the Statement of Work attached via email to Gary C. Juste on gjuste@usaid.gov with a copy to Rose Gathungu on rgathungu@usaid.gov, and/or via facsimile to +254-20-860949 or +254-20-860870.

The Government intends to issue a Firm Fixed Price Task Order for this request. The period of performance to accomplish all work requirements under this task shall not exceed a total of four (4) years. The proposal shall include the following:

1. Your technical proposal with your proposed approach to accomplish the work requirements, deliverables, key personnel, and/ or a pool of short term expatriate and/or cooperating country national specialists who may be called upon to perform work under the resultant task order, the availability of personnel to complete the work and a proposed time schedule for the work. The technical proposal exclusive of personnel resumes and biographical data sheets shall not exceed 40 pages.

2. Your cost proposal for labor and "Other Direct Costs", such as travel, transportation, per diem, overseas allowances, in country training, non-expendable property, etc, including a detailed level of effort cost estimate. Please provide detailed level of effort information with a separate line item for each proposed individual and identify each by name and provide his/ her resume and duly completed AID Form 1420-17 Contractor Employee's Biographical Sheet as required by section B.8 of the contract. In the event that a specialist is not identifiable at the time of submission of the proposal, the offeror may show this as "TBD" (To Be Determined) but prior approvals shall be required before an

individual commences working. You must include a detailed narrative explanation of the basis of estimate for each proposed item. This explanation must identify the factors upon which the proposed costs were derived and show the arithmetic in reaching the cost figure. The information provided shall be sufficient enough so that a determination of its allocability, allowability, and reasonableness can be made by the Contracting Officer. All proposed personnel and/ or consultant(s) rates shall be negotiated between the Contractor and the Contracting Officer.

3. Biographical Data for any proposed personnel and/ or consultant which provides sufficient details to determine his/her suitability for the work to be performed and salaries (copy of AID Form 1420-17 attached).

4. Lobbying Certification (See copy enclosed).

5. A certification that no USAID employee has recommended an individual for use under the proposed task order who was not initially located and identified by your organization.

6. A statement as to the relationship of the proposed individual(s) to the Contractor (e.g., employee, consultant, subcontractor employee).

7. Complete the certification regarding Debarment, Suspension, Proposed Debarment, and Other Responsibility Matters as required by FAR 52.209-5 (copy attached).

8. A certification regarding compliance with the anti-kickback procedures as required by FAR 3.502-3 (Clause FAR 52.203-7 attached).

NOTE: Offerors are requested to guarantee that the key personnel included in their proposals will maintain their availability for the specific positions for a period of not less than, and preferably more than, 120 days from the time of submission of the Offer. Should the key personnel not be available for the position before the time limit has expired the offerors may no longer be considered for award.

Offerors should also note the existence of a "health procurement website" with extensive background documentation at www.usaid-rwanda.rw/procure.html

Ensure that all enclosures are properly completed and signed. Should you have any questions, you may contact Gary C. Juste on E-mail at gjuste@usaid.gov with a copy to Rose Gathungu on E-mail rgathungu@usaid.gov, and or at tel. no. +254-20-862400, Ext: 2836 and/ or fax no. +254-20-860949.

Please note that this does not constitute any guarantee that a task order will be awarded nor does it constitute any authorization by USAID to reimburse costs incurred in the preparation of a proposal.

Sincerely,

Gary C. Juste
Regional Contracting Officer
USAID/REDSO/ESA/RAAO

STATEMENT OF WORK

RWANDA HIV/AIDS PERFORMANCE BASED FINANCING (PBF)

Summary of Procurement

The purpose of this procurement is to obtain the services of a Contractor for a firm-fixed price contract under a Task Order pursuant to the "Technical Assistance Services Contract – 2" (TASC2) indefinite quantity contract (IQC) managed by USAID's Global Health Bureau for a two year base period with option to extend an additional two years to help the USG achieve targets of the President's Emergency Program For AIDS Relief ("the Emergency Plan").

The objective of the Task Order is to obtain technical services that, through graduated, national scale implementation of performance contracts for incentives and cost-sharing, will improve quality and access of HIV and AIDS services, as well as overall strengthening of primary care service delivery. Simultaneously, this Task Order will provide for significant support of GOR implementation of performance-based contracting of primary health care services. The contractor will provide a balanced array of activities to support national implementation of Performance-Based Financing of HIV/AIDS Services in order to achieve Emergency Plan PBF implementation targets.

Activities will be implemented at three levels:

i) National level, support of the Government of Rwanda (GOR) and its development partners to formulate, test, and refine procedures and policies for graduated national implementation of performance-based contracting of primary health care services, including HIV/AIDS services.

ii) Province and District level, support health districts to develop and strengthen governance, financial systems (contracting mechanisms) and independent oversight of performance-based contracting, including quality improvement mechanisms, improved supervision of district health teams, and strengthened HIV/AIDS service delivery, as needed.

iii) Community- and facility-based level, support community collaboration, provide TA to pilot sites to implement quality improvement programs and financial management for strengthening quality and volume of overall services and specifically HIV/AIDS clinical services necessary to implement performance-based financing/contracting to achieve Emergency Plan targets.

The Task Order is planned for a two year period with option to extend an additional two years for national scale-up, with approximately Year 1 budget of $1,200,000 and $3 million estimated for Year 2, subject to: i) *continued satisfactory achievement of contract milestones and targets; ii) approval of proposed plans by the State/Global AIDS Coordinator (S/GAC); iii) availability of funds; and iv) mutual agreement to proceed. Estimated funding for optional 3rd and 4th years is $4 million and $6 million.*

Note: Currently, GOR uses "Performance-Based Contracting" while this proposal uses "Performance-based Financing". This different language does not represent a different approach between GOR and USAID. USAID intends that the primary agreement between providers (including facilities and/or district networks) and payors, including GOR regarding incentive payments, be contractual.

1. Background

1.1 U.S. President's Emergency Plan For AIDS Relief

The U.S. Government (USG) is implementing the Emergency Plan strategy in numerous countries. The goals of the Emergency Plan strategy worldwide are to:

- Prevent 7 million new HIV infections;
- Treat at least 2 million HIV-infected people; and
- Care for 10 million HIV-affected individuals and orphans and vulnerable children affected by HIV and AIDS

The Emergency Plan is a $15 billion, 5-year unified government initiative, directed by the Office of the Global AIDS Coordinator in the Department of State (OGAC), and implemented in collaboration with the U.S. Department of State (DOS), the U.S. Agency for International Development (USAID), the Department of Health and Human Services (HHS), the Department of Defense (DOD), and other U.S. Government Agencies. Fourteen countries, including Rwanda, were initially selected to be "focus countries" based on high HIV burden, available country resources, and host government and civil society commitment to fighting the HIV epidemic. Rwanda's USG team includes DOS (Embassy), USAID, the Department of Defense, and HHS, as represented in Rwanda by the U.S. Centers for Disease Control and Prevention (CDC).

As described in more detail in the *U.S. Emergency Plan Five Year Strategy for Rwanda* found at www.usaid-rwanda.rw/procure.html, the USG is partnering with Rwanda to:

- Prevent 157,000 HIV infections.
- Provide care and support to 250,000 people, including 62,000 orphans and vulnerable children, and
- Provide antiretroviral treatment (ART) to 50,000 individuals.

The USG and its Rwandan and international partners will utilize a strategic balance of 1) rapid scale-up of prevention, care, and treatment interventions and 2) ongoing capacity building of critical institutions and systems to assure steady progress toward these ambitious targets and facilitate the continuation of essential HIV services beyond 2008.

The FY 2004 achievements and FY 2005 and future year targets (including direct and indirect support, as defined in relevant Emergency Plan guidance) are presented in Table 1 below. The annual targets noted as "To Be Determined" (TBD) are under review by the Emergency Plan Steering Committee and will be established during the FY 2006 planning process.

Table 1 Rwanda AIDS Emergency Plan Targets for 2004-2008

	2004	2005	2006	2007	2008
Infections Averted					
Total #	Computer Model. No Targets available.				157,000
Persons Receiving Care & Support					
Total #	17,939	42,241	TBD	TBD	250,000
Palliative/Non-ART/Basic	15,783	12,500	TBD	TBD	TBD
Palliative/Non-ART/TB	1,896	7,316	TBD	TBD	TBD
OVC	260	22,425	20,010	30,520	62,000
Counseling and Testing (CT)					
# persons receiving CT	104,059	183,903	TBD	TBD	TBD
Persons Receiving Treatment					
ART	4,386	14,135	21,613	33,080	50,000

Emergency Plan funding is subject to annual allocations by the U.S. Congress and the Department of State, and outside of USAID's normal planning and budgeting process. Overall country planning is undertaken jointly by USG participating agencies (DOS, DOD, USAID, HHS/CDC) in close consultation with the GOR. FY 2005 Emergency Plan funding for Rwanda is approximately $41 million, including all management costs. FY 2006-2008 levels are not yet known but assumed to be no less.

It is emphasized that the Emergency Plan is a rapidly evolving initiative, and annual and ultimate targets and levels accorded to Rwanda are subject to U.S. Presidential, Congressional, and Department of State decisions and appropriations on an annual basis. It is possible that targets and levels may vary by total and/or on a year-on-year basis, requiring some adjustment of the Contractor's Annual Workplans and targets. The USG will collaborate closely with the Contractor as Emergency Plan funding and guidelines evolve to assure necessary degrees of flexibility are built into all Workplans and strategies over the course of the cpntract. PEPFAR has established the PEPFAR Steering Committee to jointly oversee the implementation of all PEPFAR activities. GOR co-management of PEPFAR activities is assured through active participation of the PEPFAR Steering Committee.

The legislated objectives and parameters of the Emergency Plan are found in H.R.1298, United States Leadership against HIV/AIDS, Tuberculosis, and Malaria Act of 2003 which can be accessed through www.thomas.loc.gov. More current information on the Emergency Plan is found www.state.gov/s/gac.

Background literature on Rwanda and the Government of Rwanda, USG, and Emergency Plan programs may be found at www.usaid-rwanda.rw/procure.html. Additional background on USAID activities in Rwanda over the past 40 years that may be of interest is available under "Rwanda" in USAID's Development Experience System (DEXS) at www.dec.org. Useful resources on prevention, care, and treatment programs for HIV and AIDS can be found at www.usaid.gov, "Our Work", "Health", "HIV/AIDS", "Publications".

1.2 Summary of Rwanda Context

Rwanda is among the least developed countries in the world, ranking 159 of 177 in the United Nations Development Programme's (UNDP) 2004 Human Development Index (HDI). Some 60% of the population of almost 8.5 million lives in poverty and over 90% is involved in agriculture, mostly subsistence farming. The infant mortality rate is 111 deaths per 1000 live births, the maternal mortality rate is 1400 per 100,000 births, the adult literacy rate is only 69%, and GNI per capita is only $230.

Although the country has made important progress since the 1994 genocide, much remains to be accomplished if sustainable social and economic development is to take place.

The medium-term framework for Rwanda's recovery is its Poverty Reduction Strategy Paper (PRSP, June 2002) and corresponding Policy Matrix. The PRSP is set within the context of a long-term development strategy elaborated in the Government of Rwanda's (GOR) document "Vision 2020." As shown in Figure 1, the PRSP emphasizes the need to rebuild the rural economy, while at the same time addressing the social problems generated by the war and genocide and rebuilding a functional, responsive and transparent system of governance.

PRSP Progress Reports from June 2003 and October 2004 (ref. www.usaid-rwanda.rw/procure.html) document that the GOR has made good progress on a number of key reforms underlying implementation of the PRSP, implementing an ambitious program of sociopolitical reforms aimed at improving justice and governance and empowering the population through decentralization, in parallel with economic reforms. Real GDP growth rate was estimated at 5.1% in 2004 and is projected to remain about 6% in the near term, exceeding that of most African countries of comparable levels of development.

Figure 1: PRSP Core Program

- Intensifying small-scale agriculture & livestock, including extension, credit, support to marketing
- Labor intensive public works, including environmental infrastructure (agro-forestry, marshes, terracing, water management) & rural roads
- Malaria & HIV/AIDS prevention & support to health pre-payment schemes (*mutuelles)* & outreach
- Primary school textbooks
- Economic infrastructure, including rural road maintenance and rehabilitation & rural electrification
- Skills development for youth, women, & small business start-up funds
- Adult literacy
- *Gacaca*
- Demobilization & reintegration into socio-economic activities
- Shelter provision for the homeless
- Development of sector strategies

Rwanda's decentralization efforts are moving ahead. Enabling legislation was passed by the Parliament, and local elections were held successfully in March 2001 to establish multi-tiered levels of representative local government. With reference to Figure 2 on the next page, popular participation in local government has been stressed, with a system of representative office and sectoral and multi-sectoral citizen committees at each level of 106 Districts and several thousand sectors (*Umurenge)* and cells (*Utugari*). The Community Development Committees in each Administrative District have been particularly active in channeling citizens' participation in various social and development activities. Although the GOR has begun to transfer budget resources to the local councils to supplement meager local tax revenues, the process is not well established. Local technical services – notably health and education – frequently lack both recurrent and development budgets, and contract staff may be unpaid for months at a time.[1]

One of the more difficult PRSP actions that the GOR took on in 2004 was public sector "retrenchment," eliminating 41% of civil service positions, down to a total of 1,365 positions. The GOR laid off approximately 400 more people than positions, because it intends to use the restructuring to professionalize the staff. As an example of the effects of "retrenchment" on sector programs, the Ministry of Health (MINISANTE) decreased the number of positions from 184 down to 80, losing a total of 104 civil

---

[1] Distinction must be made between Civil Service employees, who receive salaries from the central GOR on a monthly basis through the equivalent of electronic transfers at local banks, and contract employees, who are paid from recurrent cost budgets, which are much less reliable.

service positions. As described in Section 2.1 below, this has resulted in a significant "streamlining" of Provincial Health Offices, down to one person, and an integration of former District Health Teams into District Hospitals. In terms of the impact on health services, Section 2.2 later in this document provides a recent table that shows that there are 4,889 active health care providers working at health centers and hospitals (public and NGO/FBO) in Rwanda. If one assumes that some of the 80 MINISANTE civil service positions retained in the "retrenchment" are administrative, this means that over 98% of all active health care providers in Rwanda are non-civil service contract employees paid for by fee-for-service or other health financing schemes, including donors.

Figure 2: Snapshot of Local Government (Administrative) and Health Districts in Rwanda

Area	Decentralized Government	Health Sector
Province (*Intara*) 11 , plus the City of Kigali	• Coordinates planning, execution & supervision of Central Gov't programs; coordinates services delivery of decentralized structures. • Head: Prefet (appointed) • Includes representatives from all deconcentrated tech. and admin. services. • Manages payroll for all civil servants in the Province.	• Contiguous boundaries with political-administrative Province. • Comprises all health structures within the Province. • Headed by Provincial Director of Health, Gender, and Social Affairs
Health District (HD) 40		• Primary operational unit of health system, as of February 2005 forms part of District Hospital Team. • Primary structure is **District Hospital** (or largest Health Center, where no hospital yet exists). As of February 2005 there were 40 HDs but only 34 District Hospitals. • Comprises 1-5 ADs, within a given Province, with catchment population of 150-200,000. • Headed by Health District Medical Officer (who is also Hospital Director) • Provides training & supervision of all health facilities/programs in the HD and maintains and manages District Essential Medicine stocks. •
Local Gov't District (AD) (*Akagere)* 106	Primary unit of decentralized Local Governance in Rwanda. • Council • District Executive Council (DEC, indirectly elected) 5 statutory members: Mayor + sectoral Vice-Mayors • Community Development Committee (CDC): members to include Vice-Mayor for Finance & Economic Development; Woman, Youth Representatives; representatives from each Cell; and others it may deem necessary • Executive Secretary (non-civil service local contract position) serves as admin. head of District Administration • Technical & Admin. Staff (Mix of deconcentrated civil service & local-hire contract positions)	• **Health Centers**: Each AD has several Health Centers for which it is responsible. Provides minimum health care package. Services a catchment population of 15-20,000. • There are also Health Outreach personnel (*Animateur/Animatrice*) throughout Rwanda who are generally attached to Health Centers but are based in communities. Some are paid and many are volunteer, within GOR and various NGO/FBO programs.
Sector (*Umurenge)*	Administrative entity with structures similar to those of AD: Several in an AD.	
Cell (*Utugari)*	Administrative entity with structures similar to those of Sector.	
"Community"	Hilltops, hamlets, self-identified groups, CBOs, FBOs, etc.	Term used to cover the population in the catchment area of a health facility.

The new system has given rise to some structural anomalies that do not easily fit in the administrative decentralization scheme. For example, health districts and administrative districts are not fully aligned. Several important district referral hospitals that serve more than one administrative district do not routinely receive central funding for other than civil servant salaries. Some hospital services are approaching crisis status due to diminished and irregular funding. Donor and NGO partner funds – so plentiful in the early post-conflict years – are declining and/or tied to specific development projects rather than operating costs. Local communities, local governments, and technical service providers must be empowered with financial resources, and must work together if progress is to be maintained.

The GOR is collaborating with international and domestic partners to increase domestic resource mobilization at all levels of the system. However, there is still a substantial external financing gap for the near term. The World Bank has recently awarded a long-term Public Sector Capacity Building credit of $65 million to the GOR to implement the PRSP, with health and education as the first two sectors to benefit. Other partners – notably the European Union (EU), Netherlands, United Kingdom (UK), and Sweden – are also providing some quick-disbursing aid. The USG, through the Decentralized Health Project, has served a key role in establishing a fiscal decentralization framework, and continues to provide assistance in administrative and health decentralization.

Performance- Based Financing (Contracting): (See 2.5). The Ministry of Health is actively developing a plan (with other international financing, including UNICEF and World Bank) to support performance-based financing of primary health care in Rwanda. This plan includes:

- Coordination with the Performance-Based Financing Unit in the Department of Health Services (DSS),
- Development of local governance structures at province and health district.
- Development of independent audit capacity to supervise the quality of care and assure reported performance.

This HIV-PBF procurement is intended to support the capacity and the efforts of the Ministry of Health (Department of Health Services) and local health care facilities to implement performance-based contracting of primary health care services, including HIV/AIDS services. The HIV/AIDS component is to be implemented in a manner that assures that primary care health services are not depleted or weakened by diversion of basic health resources into HIV/AIDS service delivery. Strengthening of overall service delivery through performance-incentives for general indicators of service delivery that include HIV/AIDS (e.g. total patient visits, patient satisfaction, etc) above and beyond attainment of HIV/AIDS performance targets, is expected in this procurement. Incentives for HIV/AIDS services should be proportionate with other health service incentives.

1.3 HIV and AIDS in Rwanda

1.3.1 Summary Status of the Epidemic

During the three months of killing in 1994, mass rape, sexual torture, and psychological trauma were common. The massive population flows that followed the genocide resulted in new urban and rural settlement patterns and uncertainty regarding HIV prevalence rates. The most recently available data are from the 2003 HIV sentinel surveillance system at 24 antenatal clinics (ANC) nationwide. These 2003 data indicated a 6.4% median prevalence in urban sites and 2.8% median prevalence in rural sites, ranging from 1.2% to 16.2% nationally. Rwanda is one of the least urbanized countries in Africa, with 83% of the population residing in rural areas.

HIV prevalence data by age and sex are limited. The 2003 national sentinel surveillance conducted among pregnant women recorded the following crude prevalence rates by age group: 5.2% among 15-19 year olds; 4.3% among 20-24 year olds; 6.5% among 25-29 year olds; 5.8% among 30-34 year olds;

5.1% among 35-49 year olds; 3.4% among 40-44 year olds; and 1.3% among 44-49 year olds. Population groups presumed to be most vulnerable include commercial sex workers, the military, orphans and vulnerable children (OVC, including child-headed households and street children), and discordant couples. Events related to the 1994 genocide and its aftermath have created other potential populations at high risk including widows, child heads of household and a large prison population of nearly 100,000 inmates incarcerated since the mid 1990s2. The process of community-led traditional justice (or *gacaca*) currently underway will result in a massive reintegration of the majority of these prisoners into Rwandan society over the next few years. Given the high fertility rate (TFR of 5.8), low contraceptive use (4%) and low condom use in the general population (1.4% female, 4% male), spouses and partners are increasingly at high risk.

More information on the epidemic is available in numerous documents available on the website associated with this procurement www.usaid-rwanda.rw/procure.html

1.3.2 Summary of Rwandan, International and USG Response to the Epidemic

The GOR has demonstrated a strong response to the HIV and AIDS epidemic through collaborative national program planning and monitoring. With reference to key documents available at www.usaid-rwanda.rw/procure.html, a national HIV/AIDS action framework is in place and a national M&E plan has been developed collaboratively by GOR, USG and other major donors, including the World Bank, United Nations' agencies, EU, German Aid (GTZ), Belgian Cooperation, and the Netherlands. The HIV Cluster, a committee of GOR and donor representatives, is charged with coordinating all HIV/AIDS-related donor activities. The USG chairs the HIV Cluster and is also a voting member in Rwanda's Country Coordinating Mechanism (CCM) for the Global Fund. On the CCM and under Emergency Plan, the USG collaborates with numerous key GOR partners, including the National AIDS Council (CNLS) and its provincial (CPLS) and district (CDLS) counterparts, and the Ministry of Health (MINISANTE) at the national level – notably through the Minister of State for HIV/AIDS, the Department of Health Services (DSS) and the Treatment and Research AIDS Center (TRAC) – and Rwanda's 40 decentralized Health Districts and about 400 public sector facilities.

USG and Government of Rwanda have formed an Emergency Plan Steering Committee that includes representatives of CNLS, the office of Minister of State for HIV/AIDS, DSS, TRAC, the Ministry of Economic Development and Finance (MINECOFIN), the Ministry of Gender and Promotion of Women (MIGEPROF), the Ministry of Education (MINEDUC), and the *Centrale d'Achat des Medicaments Essentiels de Rwanda* (CAMERWA). The Emergency Plan Steering Committee has formed working groups to focus on results: prevention, treatment and clinical care, non-clinical care and support, USG/GOR co-management, and M&E, including epidemiological surveillance.

Through the combined work of these various GOR agencies, the USG, and numerous development partners, prevention of mother-to-child transmission (PMTCT) and counseling and testing (CT) services are now available at more than 25% of the 400 existing MOH facilities. All of Rwanda's 34 district hospitals will be providing ART by 2005, and plans are in place to expand ART services to the health center level. A total of 145 health centers and district hospitals offer Tuberculosis (TB) services, and at least 66 health centers supported by the Global Fund offer "integrated VCT", which is defined in Rwanda's Global Fund Round 1 proposal as including:

- VCT, including confidential, individual counseling and rapid, anonymous testing
- PMTCT, integrated in antenatal services, linked to VCTand other health centre services, including nutritional support and follow-up the mother and child post partum.
- Treatment of opportunistic infections (OIs) for People Living with HIV/AIDS (PLWHA)
- Diagnosis and treatment of STIs using the syndromic approach

2 GOR, 2003

- Coordination of TB and VCT services to assure cross-testing and referrals.
- Developing effective referrals between health centres and community services for home-based care and psychosocial support
- Supporting IEC Activities to promote integrated VCT services.

The USG currently supports approximately 12 integrated sites and over 80 PMTCT and 28 CT sites. These numbers increase monthly.

There is great variation, by facility, in the package of "integrated" services. Delivery of the overall continuum of care for PLWHA varies considerably by facility and a full package of care is not typical. As a pre-Global Fund, pre-Emergency Plan baseline, the Rwanda Services Provision Assessment 2001 (RSPA, January 2003) found in 2001 that 79% of Rwanda's GOR and NGO-managed health facilities provided some HIV/AIDS services, with a high of 95% providing some form of counseling but only 35% providing education related to home care and 53% providing psychosocial support. Referral systems between community and health facilities are often weak . As summarized above, HIV/AIDS service delivery (CT, PMTCT, ARV) has risen dramatically due to Global Fund and the Emergency Plan funding. However, implementation is inconsistent, with geographic gaps in coverage and inconsistency of availabiliry of full package of care.

USG-GOR collaboration has led to formulation and application of national norms and standards for PMTCT, CT, anti-retroviral treatment (ART), STI management, and other key public health programs related to the epidemic. Palliative care and STI services are weak, without national standards or specific financing.

2. Summary Rwandan Health System

2.1 Health Services Organization

Rwanda has made steady progress in deconcentrating personnel and functions to sub-national levels to both adminsitrative and health districts. Attention to both structures is important to those working with HIV and AIDS. The multi-sectoral CNLS is organized according to the administrative structures, with CDLSs located in most of the 106 administrative districts, whereas the MINISANTE services are allocated based on 40 health districts.[3]

According to the RSPA, and as updated, the system includes the following:

- Three national referral facilities, the Butare Teaching Hospital, the Teaching Hospital in Kigali, and King Faycal Hospital in Kigali.
- 11 Provincial Health Offices, plus the Public Health Department of the City of Kigali. These do not provide direct health services, but rather administrative and technical support. As of February 2005 they were reportedly down to only one civil service position, as the GOR envisages phasing out Provinces at some point in the future. Importantly, civil service health personnel throughout the Province are still paid by the Provincial Treasury, whereas contract health personnel are paid directly by individual Hospital or Health Center accounts.
- 40 functional Health Districts. In February 2005 the former Health District Team (administrative and supervisory staff, district essential medicine stores) were integrated into the District Hospital staffing patterns/team. There are 34 District Hospitals, with a mean hospital capacity of one bed per 1,000 people, although great variation among districts and provinces. In Health Districts without hospitals, the largest Health Center serves as the Health District focal point.

3 A new World Bank loan for Public Sector Reform, signed November 2004, will address the health and education sectors in its first two years. It is not yet known what impact, if any, it will have on health decentralization systems.

- 365 peripheral health facilities at the end of 2001, including 252 Health Centers and 113 Health Posts and Dispensaries. Since the RSPA Survey in 2001, the MINISANTE has been phasing out Health Posts in favor of more comprehensive Health Centers.

In 2001, 40% of primary and secondary health facilities were operated by NGOs, including faith-based organizations (FBOs) and religious missions, and are integrated into Rwanda's public health system as "agréée" facilities. Agreée facilities typically receive some limited additional external financing and managerial support.

As of 1999 there were also 329 private commercial health facilities in Rwanda – excluding pharmacies, which the RSPA did not record – of which more than 50% were in or near Kigali. Among these facilities, 63 were headed by physicians, 242 were headed by nurses, and 14 were headed by persons without medical training. The commercial private sector is believed to be growing considerably and is increasingly recognized by the MINISANTE as a valued contributor to health services in Rwanda. There is not yet any formal certification or regulation of private facilities. Few provide care and treatment for HIV/AIDS. Private facilities cannot procure ARVs outside of the national drug procurement agency, CAMERWA. The USG, through a separate Decentralization and Health Project, is working with MINISANTE and health professional associations to formulate private sector norms and standards and systems to apply such norms and standards, with certification an ultimate goal.

A package of activities was developed in 1998 for each level of the health system, with a minimum package of activities (MPA) at the Health Center and complementary packages of activities (CPA) each for the District Hospitals and national referral hospitals. *Importantly, the MPA and CPA do not yet include defined activities for HIV/AIDS diagnosis, testing, counseling, treatment, and care, and these are thus carried out only in those sites supported by the Global Fund, the Emergency Plan, and other donors*. The GOR has a current working group on "Integrating HIV/AIDS into the Health System" which is reviewing the MPA to include HIV/AIDS and possibly other vertical donor funded programs. Terms of Reference for consultation on strengthening primary care is currently proposed by this working group. The PBF contractor, under this award, is expected to collaborate with the GOR and health cluster and to support activities to integrate HIV/AIDS into health policy and financing.

The 2001 RSPA found great variation in the application of the MPA and CPA: 57% of health facilities offered all the defined range of basic outpatient maternal, child, and reproductive health services, with essentially all of these (56%) offering services at the minimum frequency. Almost half (49%) of the health facilities offered some health services through community outreach, with health centers more likely to do so than hospitals. The most common outreach services were child immunization (82% of facilities) and growth monitoring (49%). Even in 2001 (pre-Global Fund, pre-Emergency Plan) an impressive 37% of facilities offered some form of HIV/AIDS counseling or testing through community outreach.

It is sobering to mention that in 2001 only 74% of Rwandan health facilities had an onsite water source (i.e., water supplied in the facility by tap or available within 500 meters of the facility, which may not be available year round) and only 53% had a regular supply of electricity or a backup generator with fuel. A modest 33% had both a regular supply of water (year round) and electricity. Numerous donor-funded efforts have improved these percentages since 2001, but there is still a long way to go before Rwanda's health facilities are able to provide high quality basic services.

2.2 Health Personnel

There is a dearth of trained doctors, highly skilled nurses, and paramedical personnel at all facilities due to "brain drain" related to comparatively low salaries. The number of physicians working in the public sector has steadily decreased over the past decade and is well below the norm. Approximately 200 medical

doctors are practicing at health facilities in Rwanda at present (many others are employed in managerial or administrative positions). Nurses (public and private sector, all levels of qualification) practicing in Rwanda also work as nutritionists and social workers. As of 2003, there were 89 trained pharmacists in Rwanda (36 in the public sector and 53 in the private sector).[4] There are an estimated 125 professional midwives in the country. Medical and nursing professional education lack quality clinical practicums. The Kigali Health Institute provides a three-year course for paramedical physiotherapists, midwives, laboratory technicians, etc., but there are virtually no advanced-level personnel in these fields in the country.

The most recent figures available on specific categories of health personnel come from the preliminary findings of the USAID-financed "Human Resources Assessment for HIV/AIDS Service Scale-Up". These preliminary, unpublished findings are summarized in Table 2.

4 *National HIV/AIDS Treatment and Care Plan*. The Government of Rwanda, 2003.

TABLE 2: Active Health Providers in Rwanda, 2004

	Doctors	Medical assistants	Nurses A1 or A2	Nurses A3	Other doctors or nursing staff	Nutritionists A!	Nutritionists A2	Nutritionists A3	Social workers A1	Social workers A2	Social workers A3	Sanitation technicians	Other	Lab techs A1	La techs A2	Lab techs A3	Other technicians	Auxiliary staff and aids	**Totals**
Health centers and hospitals (All facilities) N=402	204	63	2314	240	41	19	50	21	10	295	43	7	107	16	162	57	182	1148	**4889**
Health centers N=366	6	53	1168	135	11	9	34	16	7	130	40	3	67	1	85	47	77	833	2720
District hospitals N=33	98	6	672	66	3	8	14	4	1	53	3	3	27	7	48	9	37	281	1340
Referral hospitals N=3	100	4	474	39	27	2	2	1	2	22	0	1	13	8	29	1	68	34	827
% of total health workforce	4.3 %	1.3 %	47.4%	4.9 %	0.9 %	0.4 %	1 %	0.4 %	0.2 %	4.2 %	0.9 %	0.1 %	2.2 %	0.3 %	3.3 %	1.1 %	3.8 %	23.3 %	100%

Table 3 shows the 2003 GOR national HIV/AIDS Treatment and Care Plan estimates for medical and community health personnel needs **exclusively for HIV/AIDS** during the period 2004-2008:

TABLE 3: Projected Full Time Equivalent Medical Personnel Requirements for HIV/AIDS

			Cumulative			
Medical Personnel	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**
Doctors	31	85	151	227	307	307
Reference doctors	20	25	25	25	25	25
Nurses	39	115	217	338	473	473
Lab techs	73	146	219	292	365	365
Specialized lab techs	15	30	45	60	68	68
Pharmacy personnel	32	64	95	95	95	95
Counselors	38	111	210	329	461	461
Subtotal	**247**	**576**	**962**	**1,367**	**1,794**	**1,794**
Animateurs	3,667	7,333	11,000	11,000	11,000	11,000

(Animateurs = Community Health Workers)

Thus, the estimated needs for HIV/AIDS care and treatment personnel over the next five years exceed the total supply of health personnel in the following categories: doctors, lab technicians, specialized lab technicians, counselors (social workers) and pharmacists[5].

The USG Five Year Strategy calls for increases in volume and quality of health care workforce training, job retooling, improved supervision and increased remuneration to address human resource shortages. The GOR is working on sustainable improvements in civil sector policy while increasing targeted pre-service and in-service training for critical staff and building effective systems for supervision and communication at and across HIV care and treatment facilities.

Through multiple activities, the USG plans to continue to provide technical and financial assistance to:

1) Reform national human resource policies, including expanding revising salary scales for public sector health providers, and nurses' legal scope of practice to include limited prescribing of ARVs under defined, supported, graduated supervision of physicians.

2) Expand HIV/AIDS personnel and roles through:
    a. Support of TRAC's required training for ARV management.
    b. Fellowships for HIV/AIDS program managers to enhance technical, administrative and managerial skills;
    c. New large scale HIV/AIDS in-service training program for nurses to strengthen basic nursing skills for independent practice beyond their traditional role, including limited ARV prescribing;
    d. MPH and public health certificate program with a technical focus on HIV/AIDS.

3) Maximize quality and efficiency of health care delivery through strengthening supervision and communication systems; providing incentives; and engaging staff in improving quality.

2.3 Health System Financing

5 Although data on pharmacists was not collected in the preliminary phase of the study, the National HIV/AIDS Treatment and Care Plan states that as of 2003, there were 89 licensed pharmacists in Rwanda.

Regular financial transfers from the central level (MINISANTE and others) are still inconsistent, in part because the GOR operates on a cash basis and can only transfer funds when they are available. For sectoral ministries such as MINISANTE, when funds are available, they are provided to the decentralized sectoral offices through the Prefet's office in each respective Province. Although the Prefet's office receives budget allowances for specific sectors, s/he has the authority to re-allocate funds for more urgent needs. A USAID-financed study for the 2000 Rwandan Fiscal Year (RFY)[6] reported that out of total funds for the health sector transferred from the Ministry of the Economy and Finance (MINECOFIN) to Byumba, Butare, Kibuye, and Kigali-City provinces for the year, the Provincial health services only received 38.02%, 45.22%, 52.89%, and 54.88% respectively; the balances were used by the respective Prefets for more urgent needs.[7]

A GTZ paper documented health financial flows in two Provinces – Butare and Byumba – in 2002. The provinces together have 5 health districts, 5 district health hospitals, and 69 health centers for about 1.4 million people. Essentially, the study documents that "…when moving progressively to the periphery … the government's contribution to health services became continuously smaller, and that of the population and of donors more and more important. .. At the district level, the population provided nearly 40% of the overall budget. … Of the total budget of all health centers in the project area [N=69], 60% was provided by donors, 35% by the population, and as little as 4% by the government." [8]

At the health center level, the budget is maintained in two accounts, Pharmaceuticals and Operating Costs, under the oversight of a Health Management Committee. The Pharmaceuticals account is a revolving fund through which the health center purchases essential medicines from the District Pharmacy (or other sources, where such exist) and adds a small mark-up to cover its management costs. The Operating Costs account covers all other expenses, of which contract staff salaries make up the largest share. Given the large dependency on donor and out-of-pocket funding, and the widespread poverty in Rwanda, it is not surprising that there is significant variation in the financial status of health centers throughout the country.

As part of its national (socio-political and administrative, as differentiated from health) Decentralization Strategy (www.usaid-rwanda.rw/procure.html) the GOR is also providing increasing support to Administrative Districts (ADs), who are tasked with providing financial and management support to Health Centers within their purview. To date, the ADs have focused more on establishing their new offices, repairing critical district infrastructure, and initiating economic activities to increase their tax bases (and revenues). Through a parallel USAID project, the Decentralization and Health Project, over the period FY 2005 – 2008, USAID will foster integration of health financing into "unified" AD plans in four provinces: Gikongoro, Gitarama, Kibungo, and Kigali-Ville. The World Bank and other donors are initiating similar strategies in other Provinces, so that some relief for health centers may arrive in the next few years.

Until ADs can assure steady funding to supplement fees generated by health centers, the paucity of funding for health service delivery will continue to limit the availability and motivation of health personnel (and thus quality of services). As stated earlier, only about 2% of active health care providers are civil servants paid by the GOR, and the balance are contract employees, generally paid by the respective health facility (or donor or NGO program). The base salary for a doctor working in the public sector is $100-$260 per month, and nurses earn less. In contrast, doctors working for international organizations often make $1,000 per month or more. Public sector recruitment and retention of other categories of health workers are similarly constrained. The GOR has recently instituted a variation of a "hardship allowance" to induce civil service staff to accept and stay in postings outside of urban areas.

---

6 The Rwandan Fiscal Year is the calendar year, January 1 – December 31.
7 Cheikh S.A. Mbengue, "Le Secteur de la Sante du Rwanda Face Aux Reformes de Decentralisation," prepared under USAID financing for the PRIME II project and the MINISANTE, March 2001, p.. 12.
8 Kalk, et.al., pp. 6-7.

The number of mutual health associations (voluntary, community-based prepayment plans) is increasing. They are contributing somewhat to lessen the cost to their members, but membership is still out of reach for most of the two-thirds of the population living below the poverty line. Most mutuelles do not fully recover their costs of care, which are therefore shifted elsewhere. Additionally, many insurance schemes and most *mutuelles* do not cover complex hospital treatment and care for chronic diseases, including HIV and AIDS.

2.4 Quality of Care:

Quality of patient care is limited by many factors, particularly lack of resources, such as water, electricity, commodities, staff, training and supervision. However, within this overall underfunded setting, there are easily appreciated and measurable differences in quality and efficiency of care from site to site. For example, "agree" sites (faith-based facilities) receive limited external financial and managerial inputs and are generally regarded as higher quality than public sector facilities. PBF programs currently in place have demonstrated significant increases in quality and volume of care, with relatively modest incentive payments.

For HIV/AIDS, there are two central-level MINISANTE entities that are critical to ensuring the delivery of quality HIV/AIDS services, the Department of Health Services (DSS) and the Treatment and Research AIDS Center (TRAC). TRAC is the agency responsible for clinical care standards and their implementation, while DSS is responsible for overall management of facilities, including financing, human resources, supervision, and quality of care delivery. Operationally, TRAC leads the introduction of new HIV/AIDS services, and the DSS is responsible for mainstreaming and scaling up these services into the MPA and CPA, through its oversight of the district health teams and sites.

Supervision of health care delivery in public facilities has declined as a result of decentralization as funds have been diverted for higher priorities at provincial and administrative district levels. Supervision of health centers and hospitals is to be provided by the Health District Team, normally through a number of district supervisors who are supposed to supervise each sub-sector at each health center at least once/quarter. Norms and standards for supervision are established in sub-sector or service protocols within (and outside of) the established MPA (for minimum package, see Health Decentralization Strategy at www.usaid-rwanda.rw/procure.html). Full provision of MPA, however, is often not achieved due to lack of funding for fuel and other transport needs. Transport and support of supervisors is often dependent on the availability of donor/NGO funding for such purposes.

Rwanda has benefited from six years of TA through the Quality Assurance Project which implemented the Collaborative Approach. Using the collaborative approach, treatment of specific health conditions were improved by bringing together staff from many sites to learn from each other how to define, measure and improve performance through process redesign. Signficant improvements in PMTCT, VCT, ART, as well as non-HIV services were demonstrated at nearly all sites. The interventions were most frequently improvements in processes identified by staff, rather than additional resources, such as training, new equipment or other large investments.

The quality of care in Rwanda has been clearly responsive to small, targeted inputs, including technical assistance, as demonstrated in the last ten years by a wide range of donors and interventions. The MOH has recognized that these improvements do not continue after the resources stop and the overall system of health care delivery has not become quality-focused. The Ministry of Health is seeking to systematically improve the quality of health care delivery through the use of performance incentives tied to improved quality. PBF is viewed by the Ministry as a quality improvement tool as much as a productivity tool.

The HIV-PBF Contractor is expected to support quality improvement activities at national and health district levels integrated with performance incentive implementation.

Currently, the MOH and the Health Cluster have established technical working groups on human resources, performance-based financing, integrating HIV/AIDS into the Health System, and others. With multiple successful pilots of performance-based financing, Minisante has made national implementation of Performance-Based Financing of basic community health services a priority. The GOR has identified approximately 850,000,000 RFr ($1.5 million dollars) for support of Community Health Performance-Based Contracting for 2005, additionally supported by a UNICEF funded technical advisor. In concert with PBF, Minisante has prioritized investment in human resources at high levels in the Minisante as a prerequisite to improved quality of care, through restructuring professional training, increased salaries, and strengthened supervision. An additional position in the Ministry for Health Human Resources is under consideration.

2.5 Summary of Performance Incentive Experience in Rwanda

To improve staff motivation and increase performance at decentralized health facilities, several donors have been providing performance incentives to health care providers throughout Rwanda. These activities – generally referred to as "*l'approche contractuelle*" in French, and performance-based financing (PBF) in English – are expected to cover about 36% of health centers in the country – about 133 out of 365 -- by mid-2005.

Although each implementing partner has slightly different financing modalities, the activities essentially involve:

- Written contracts between a financing agency and a health service provider (e.g., a health center, a health district, a district hospital) and its related Health Management Committee.
- Establishment of key indicators for which the service provider will be paid, and a per-unit price for each indicator or a bonus for achieving a certain target.
- Payment by the implementing partner to the health facility account for achievements-per-indicator (direct health services are generally paid on a per capita basis).
- Respect for budget autonomy for health center/Health Management Committee use of the funds. (It is noted, however, that every site visited reported that they allocate 40% to staff bonuses and 60% to operating cost accounts, so there is some harmonization of use.)
- Conduct of periodic independent validation of patient registers, actual patient interviews by community groups and other records to verify results achieved.
- On-going performance plan dialogue and improvement, including appeals based on external circumstances, between providers, payors, supervisors and patients about indicators. Performance quality is appreciated to be continually improving, rather than static and fixed.

The following PBF projects are currently underway and/or planned:

- Swedish Aid, through HealthNet: since 2002, 19 health centers in Kabutara and Gakoma health districts in Butare Province. (Note: Sweden is no longer providing funding in the health sector, so the project is operating on residual funds.)

- Belgian Cooperation: by 2/2005: all 43 health centers in Kigali-Rurale; by 3/2005, all 26 health centers in Kabgayi Health District (Gitarama Province); and 6 semi-rural health centers in Kigali-Ville. The Belgians hope to add by the end of March 2005 the 3 hospitals of Kigali-Rurale, the Hospital of Kabgayi, and the health district teams of Rutongo, Ruli, Kbuga and Bugesera for Kigali-Rurale, Muhima for Kigali-Ville, and Kabgayi for Kabgayi Health District.

- Netherlands, through CORDAID NGO: 25 (out of 27) health centers and 1 hospital in Cyangugu Province, plus the four health district teams.

- GTZ: since July 2004, all 7 health centers in Kibirizi health district in Butare Province, all 7 health centers covering a population of about 250,000 in Ngarama, Kisaro, and Rushaki ADs in Byumba Province, and (in a different format) the *Ecole de Science Infirmiere* in Byumba.

The World Bank is planning to launch some version of PBF in Butare (building on the HealthNet experience), Gikongoro, Cyangugu (building on the CORDAID experience), and Umutara Provinces in 2005. As part of its activity, the WB is currently developing a rigorous evaluation of PBF for HIV/AIDS. The GOR reportedly may also use some of its Global Fund monies for PBF for HIV/AIDS.

Although there are slight variations, most of these schemes pay modest per-capita (or per unit) incentives for indicators that relate directly to Millennium Challenge Goals in primary and reproductive health care, as follows:

- Number of consultations (new cases only).
- Number of deliveries conducted.
- Number of deliveries correctly transferred (to referral facility).
- Number of pregnant women correctly vaccinated.
- Number of persons registered for family planning [9].
- Number of children vaccinated against measles.
- Number of new sputum smear positive TB cases.
- Number of patients completing TB treatment.

Payments-per-capita generally range from 200-300 RF (US 40 – 60 cents) for a new consultation to 1000 RF (almost US$2) for a delivery. Some of the schemes, notably the Cyangugu/CORDAID project, also provide an initial grant for facilities upgrading and purchase of equipment and materials. Total outlay varies from about US$0.25 per capita in the HealthNet/Butare experience to US$1.50 per capita in Cyangugu.[10] In spite of financial variation, studies and reports of the PBF experience in Rwanda uniformly document increased patient use and coverage rates. An independent assessment of the longest running scheme (HealthNet in Butare) documented less than 2% fraud.[11]

Existing program reports demonstrate increased utilization rates and patient satisfaction among participating providers and the communities they serve[12]. Reports from other developing countries also document steady and significant improvements in quality and efficiency when targets/activities are clearly defined and easily measured. [13] [14] [15] Because of these impressive results, there is increased interest in initiating a national Performance-based financing/contracting program for primary health care and community health services, including PBF for HIV/AIDS services. At a February 2005 workshop, the

9 No incentives are paid for family planning. This Project conforms to Tiahrt Amendment
10 Personal communication, Adreas Kalk of GTZ.
11 Ntaganira, Dr. Joseph. Initiative pour la Performance “Enquete de Controle dans les Districts Sanitaires de Kabutare et Gakoma,” Universite Nationale de Rwanda Ecole de Sante Publique, December 2003,.
12 Meessen, Bruno; Musango, Laurent et Hashala, Jean-Pierre ; “L’Initiative pour la Performance”, Ministere de la Sante, et Health Net International, Pays-Bas. Juin 2004.
13 Eichler, Rena, “Performance-Based Payment to Improve the Impact of Health Services: Evidence from Haiti” World Bank Institute Online Journal, April 2001.
14 Soeters, Robert, “Improving government health services through contract management: a case from Cambodia” Health Policy and Planning; 18(1): 74-83, Oxford University Press, 2003.
15 Unpublished data from Soeters, Robert, “Performance-based financing through the contractual approach in Rwanda”

Cyangugu providers proposed a list of indicators for World Bank Multi-Sectoral HIV/AIDS Project (MAP) financing:

<u>VCT</u>

- Number of persons counseled – 300F
- Number of tests conducted – 600F
- Number of HIV positive persons referred to District Hospital – 600F

<u>PMTCT</u>

- Number of pregnant women tested – 600 F
- Number of women tested who return to learn their results – 600F
- Number of HIV positive women informed – 600F
- Number of HIV positive women treated with NVP – 600F
- Number of newborns treated with NVP – 600F

<u>ARV – Population of HIV positive patients</u>

- Number of persons coming for 1st clinical visit and enrollment for treatment – 600F
- Number of persons coming for 2nd visit at 6 months, with lab test – 600F
- Number of persons coming for 3rd visit at 12 months – 600F
  Etc.

These are preliminary indicators identified by one group of health care providers in Cyangugu and do not represent any national norms or standards on use of PBF for HIV/AIDS.

As shown by the preliminary payment schedule presented above, to date there is no attempt to relate PBF payments to actual costs of services. The PBF schemes have been instead viewed as <u>additive incentive programs</u> by providers and financing agencies alike.

Currently, the DSS is developing proposed national and district structures to implement performance-based contracting of primary health care services on a national scale. The development of national and district governance structures and procedures is dynamic and not yet functioning beyond donor-funded programs. However, a Rwandan expert has been hired to support coordination of donor PBC activities and initiation of performance-based contracting for community health services, such as mosquito nets and other low-cost interventions. A division within the Department of Health Services is planned to coordinate all performance-based contracting. Current plans call for development of provincial “Comites de Pilotage” which will sign contracts with health facilities, while health districts will provide independent oversight of performance reports. The PBF contractor of this award is expected to coordinate all HIV/PBF activities with these national structures, as well as contribute support to national implementation of these activities.

The matrix we have used below to estimate costs is only illustrative. Recent meetings on incentive payments have indicated a wide range of guidelines for payments. Therefore, for planning purposes the Offeror should view this matrix data as purely illustrative and must ensure that any incentive payments and cost sharing proposals that are later developed by the Contractor fit well with ongoing pilot schemes and do not distort the MOH’s general plan for PBF. What we must guard against is a system of PBF payments for HIV/AIDS that might indeed expand HIV/AIDS services in the short run, but could diminish overall health care services in the long run.

PERFORMANCE INCENTIVE FUNDS EXAMPLE FOR BUDGET PROPOSAL:

VCT, PMTCT AND ART (Contractor is expected to determine HIV incentives amounts consistent with other incentives already established for non-HIV health services as well as do costing for HIV services).

Incentive Assumptions: Average $10,800/site/year

Year 1: A minimum of 9 pilot sites by end 1st year (avg 4.5 full year)
Year 2: A minimum of 35 Sites by end 2nd year (avg 20 full year)
Year 3: A minimum of 70 Sites by end 3rd year (avg 55 full year)
Year 4: A minimum of 100 Sites by end 4th year (avg 86 full year)
VCT/PMTCT initial visit = US$4.50/capita excluding test kit
One HC does average 200 clients/month or 2400/year
PMTCT follow-up visits = US$1/m-I pair, assume 50/month
TB/OI Care visit = US$2.00/capita inc. lab costs
One HC does average 50 clients/month

Cost Sharing for VCT, PMTCT Added to all the Above Sites for budget purposes. Cost sharing estimated at $20,000 per site per year (includes only additional cost of service provision to add as part of package to sites listed

ART plus Performance Incentives, plus Cost Sharing for VCT, PMTCT. ART addition estimated at $100,000 per site per year (includes only additional cost of ART, including drugs, to selected sites listed above as pa
1st year 0 sites; 2nd year a minimum of 1 site; 3rd year a minimum of 4 sites; 4th year a minimum of 9 sites

<u>This procurement is intended to support the DSS to implement PBF of HIV/AIDS services as part of their national implementation of PBF of primary health care services.</u> The implementer is expected to support the DSS to develop, pilot and institutionalize these national and district level governance structures and procedures.

3.0. DETAILED STATEMENT OF WORK

3.1. General Description of Performance Based Financing Activities

3.1.1 Financial support of HIV/AIDS clinical services: Currently, all Rwandan HIV/AIDS services (ARV, PMTCT, CT, OI/palliative care) are donor-funded. Through the provision of performance-based incentives, PBF is viewed as a means to directly finance local providers to deliver HIV/AIDS services as well as to motivate staff and to improve quality of care. Rwandan experience to date in HIV/AIDS services scale-up demonstrates the need for:

1) An initial investment to improve the facility, purchase equipment and provide training.

2) After initial investment, on-going financial support to pay for on-going costs of HIV/AIDS service provision.

3) Financial inputs, tied to improved performance, to motivate underpaid personnel.

<u>3.1.2.</u> <u>Initial Pilots</u>: To facilitate initial implementation, it is anticipated that HIV-PBF would be initially implemented in sites that have already received some previous investment for:

- HIV-AIDS clinical services delivery

- Primary health care service delivery **and/or**
- Performance-Based Incentives for basic health care services

It is considered quite possible that models of HIV-PBF will differ in the above settings. For example, sites that have previously received intensive support of HIV services may need more attention to primary health care services than sites that have previously established PBF contracting of basic health services. Once models are established or in later stages, i.e. optional years 3 and 4, the contractor may propose supporting initial investment for new sites, i.e. sites that have not received any external health investment to expand capacity. A listing of USG-assisted facilities is found at:
www.usaid-rwanda.rw/procure.html

USAID requirements restrict direct budget support of public health facilities operating costs, which has made it difficult for USAID implementers to directly finance public health facilities for HIV service delivery costs. It is hoped that HIV-PBF will provide a vehicle to finance HIV/AIDS services as part of "performance incentives" to assure that basic health services resources are not diverted to HIV/AIDS, which would weaken the overall health system. Mature HIV/AIDS sites (sites whose HIV/AIDS service capacity has already been developed by investment) would "graduate" from USG clinical implementor support to PBF financing, without need for continuing financial support from the initial implementer.

For sites not yet providing HIV/AIDS clinical services, other USG HIV/AIDS clinical service providers are expected to provide the initial investment and clinical training.

A desired outcome of this HIV-PBF is a mechanism to provide Emergency Plan funds directly to health facilities/providers for high quality/efficient HIV/AIDS services.

3.1.3. Transition of clinical sites to PBF from intensive HIV/AIDS donor support: USG will assist in coordination of implementation of HIV-PBF at sites where other USG implementing partners are located. USG implementing partners are expected to "graduate" mature sites once these sites' HIV/AIDS capacity is fully developed. The other USG implementers will withdraw from PBF sites and transfer their technical and financial support to new sites for initial investment and capacity enhancement. Funding for on-going HIV/AIDS services to mature sites will then be provided by the contractor through HIV-PBF. Additionally, for sites where there is no other donor support of HIV/AIDS services; HIV-PBF incentives also should include a component of cost-sharing to continue funding of on-going services. PBF of HIV services should provide a comparatively more sustainable means to support national scale-up of HIV services throughout Rwanda. Once PBF mechanisms and controls are established and HIV clinical capacity is established, external HIV/AIDS funding could reach providers through these established mechanisms.

The HIV-PBF contractor is expected to focus on performance-based payment for HIV-AIDS clinical services results, development of continuous quality/performance improvement systems and strengthening supervision/performance-monitoring systems including clients, communities, service providers, and authorities, as appropriate.

3.1.4. Protection of Basic Health Services: While Emergency Plan funds must be directed towards HIV/AIDS service delivery or system support necessary for HIV/AIDS target attainment, baseline assessment and on-going monitoring of routine health service performance indicators, as well as HIV/AIDS, are expected as part of the PBF procurement. Financial incentives will be tied to indicators of both HIV/AIDS services delivery and to broader health delivery activities (that include HIV/AIDS services), such as total patient volume, patient satisfaction, facility standards, etc. Additionally, incentives for improved HIV/AIDS services can be withheld or reduced if basic care indicators correspondingly decline. Performance incentives and indicators should be targeted to assure that HIV/AIDS services are strengthened without weakening other basic health care services. (For example, providers might not receive their performance incentives for HIV/AIDS services if patient volume for non-HIV services

declines.) Baseline assessment and monitoring of basic health care service delivery capacity is expected. Performance incentives can be tied to overall health system strengthening if HIV/AIDS performance targets are attained. (For example, an indicator for "improved quality of medical records" could receive performance incentive payments, if HIV/AIDS targets are also met.) **The contractor is expected to assure that routine basic health services do not decline but improve overall. The contractor is also expected to compare models of care, including sites that have previously had performance-based contracting of basic health services and sites that have previously had intensive support of HIV services.**

3.1.5. Mutuelles: In Cyangugu and other areas there are some health centers benefiting from PBF that also work with *mutuelles. A mutuelle is a community-based, voluntary, pre-payment insurance scheme. Currently, the GOR is considering making mutuelles required, rather than voluntary.The contractor is expected to coordinate PBF activities with government interventions to support mutuelles.*

Note: USAID's new Decentralization and Health Finance Project will address *mutuelles* with the DSS and will specifically explore the impact of HIV/AIDS-related services and care on the functioning and viability of *mutuelles*. The PBF Contractor would be expected to work closely with the DHP Contractor to assure that DHP concerns and conditions are fully met in any collaboration.

3.1.6. Issues of patient protection, quality assurance and informed consent, particularly with testing, require that roll-out of PBF for HIV/AIDS be undertaken in a measured manner with the patient's interest foremost. Contractors are expected to take measures to assure that performance incentives do not result in medically inappropriate or unwanted HIV/AIDS services.

3.1.7 Balanced national strengthening and pilot implementation: The HIV-PBF Contractor will work with MINISANTE and provincial and district health teams to develop financing/contracting mechanisms for national implementation of HIV-PBF as part of a larger project to implement performance-based contracting of primary health care. Simultaneously, the contractor is expected to meet pilot targets defined below. **If the contractor does not meet Emergency Plan targets, it is doubtful that future funding from the Emergency Plan will continue.** The contractor will work with DSS and USAID to develop a work plan that pilots and develops national performance-based contracting implementation needs while simultaneously meeting Emergency Plan targets. The GOR is expected to provide additional resources necessary to implement national performance-based financing/contracting activities that are outside of and beyond the program components related to HIV-PBF. It is expected that the contractor will implement some PBF activities on a different time schedule than national plan implementation in order to achieve EP targets. If there are delays in national performance-based contracting implementation that threaten the contractor's achievement of Emergency Plan targets, the contractor, GOR and USAID will jointly negotiate a revised work plan for the contractor.

Performance finance payments in the PBF contract will flow **either**:

1) Directly from the PBF contractor to the health facility **or**
2) Directly from the PBF contractor through established government mechanisms to the health facility, if government mechanisms are adequately developed to meet USG contracting requirements.

The PBF contractor may suggest other routes in the interest of supporting GOR/provincial capacity to manage performance-based contracting.

It is emphasized that USAID intends that the Contractor provide payments for HIV/AIDS indicators either: i) through nationally developed financing/contracting mechanisms of the Performance-

Based Financing of HIV/AIDS Health care; or ii) through direct contracts with the health facility or health district Management Committee. Such funding flows constitute one variable to be piloted and developed under the contract, in negotiation with USAID and GOR.

3.1.8 Collaboration with USG and other partners: Section 2.1 above identifies the USAID-financed Decentralization and Health Project (DHP) in which USAID will foster integration of child survival/infectious disease and family planning/reproductive health financing into "unified" AD plans in four provinces: Gikongoro, Gitarama, Kibungo, and Kigali-Ville. DHP is being implemented by the U.S. non-profit organizations IntraHealth International, Inc. (IntraHealth) and Research Triangle Institute (RTI) and would form a natural partner for the HIV-PBF Contractor. Section 2.5 above identifies several international organizations that are undertaking PBF for non-HIV/AIDS services in selected districts of Rwanda who would also form natural partners. These include international organizations HealthNet, CORDAID, Belgian Cooperation, and the German GTZ. These groups would all be potential collaborators to provide complementary non-HIV/AIDS financing for a balanced PBF approach. The HIV-PBF Contractor is encouraged to enter into Memoranda of Understanding, sub-contracts, or other appropriate agreements to assure such collaboration in the pilot and roll-out phases of the project. The PBF Contractor would be expected to work closely with the DHP Contractor to assure that DHP concerns and conditions are fully met in any collaboration. The PBF Contractor would be expected to work closely with World Bank and Global Fund to assure that donor and GOR PBF activities are harmonized, including monitoring and evaluation, to allow cooridinated national implementation and rigorous comparison of PBF interventions.

3.1.9 Clinical Care Expertise: With reference to 6.2 below, the HIV-PBF Contractor will be selected for its expertise in health financing, health administration and quality improvement. The HIV-PBF Contractor is expected to rely on in-country resources for HIV/AIDS clinical care assistance. For HIV/AIDS clinical expertise and inputs, the MINISANTE DSS, TRAC, vertical entities such as the National TB Control Program (PNLT) and CAMERWA, and decentralized health district teams are all well positioned to participate. Several USG Emergency Plan partners – including Family Health International, IntraHealth, the Elizabeth Glazer Pediatric AIDS Foundation (EGPAF), and Columbia University Mailman School of Public Health – have well-established relationships with numerous health centers, hospitals, and district networks throughout Rwanda. The HIV- PBF Contractor is encouraged to enter into Memoranda of Understanding, sub-contracts, or other appropriate agreements to assure collaboration in the pilot and roll-out phases of the project.

3.1.10 Continuous Quality Improvement (CQI): A desired outcome of HIV-PBF is enhanced capacity of health facilities, district supervisors and DSS to implement and manage Quality Assurance, Continual Quality Improvement (CQI) and/or Performance Improvement (PI) activities, including linking these activities to contracting and to receiving financial incentives. Quality improvement will be supported through this PBF by various activities, such as requirements for (pre)conditions for PBF contracting as well as for directly linking financial incentives to quality of care. Preconditions for contracting can include demonstration of expanded HIV/AIDS capacity, assessment of "readiness" to graduate from donor support of clinical services to PBF, training, facility investment, etc. On-going conditions can include participation in Continuous Quality Improvement activities, such as collaboratives, as implemented by the DSS and supported by the PBF contractor.

CQI/Performance Improvement activities are based upon a continuing cycle of: 1. Assess, 2. Plan, 3. Implement, and 4. Evaluate for both clinical care and administration/management activities at pilot facilities. In formal CQI or PI programs, providers and other facility team members engage in on-going study of consequential medical problems:

- Assessment of a possible problem
- Planning of an intervention to address the problem
- Implementation of proposed intervention

- Evaluation of the intervention to see if the problem persists

The Collaborative Model that has been implemented in Rwanda, which brings together provider teams from different sites to share experience, is one type of CQI activity.

Under the CQI component, the contractor would support DSS and health district-implementation of formal training and procedures in CQI in pilot sites, as well as at district health levels of pilot sites and at the national DSS level. The contractor would develop national requirements for establishment and work plans for quality improvement committees and use of national clinical protocols, as preconditions for sub-contracting.

The contractor would recommend quality based indicators for performance-based reimbursements. One example of a quality based indicator should be compliance with national clinical protocols. Having received considerable investment in Quality Assurance, the DSS and health districts have some capacity to oversee and collaborate to implement quality improvement activities. The contractor is expected support further enhancement of this capacity as well as motivate providers to improve quality through performance incentives.

The contractor would work with DSS and QAP (QAWP) to transition/expand QA activities, including appropriate staff, office support and other investments to support from HIV-PBF, under management of DSS and provincial and/or district activities. The desired result is to support DSS and provincial/district management of quality improvement activities in HIV-PBF as a model for quality improvement in other PBF activities in primary health care. Mechanisms and processes for improving quality in primary care, including HIV services, which would assist in performance improvement, resulting in providers receiving increased financial incentives for improved quality.

Specific activities to be funded in Quality Improvement would be support of experienced Rwandan staff to define a program of quality improvement for sites participating in PBF for primary care, including HIV/AIDS (PMTCT, VCT, palliative care, IOs, STIs, ART), as well as broader health care activities that impact HIV/AIDS services (infection prevention, basic skill strengthening, medical records, etc). The quality improvement program should include QA process training for all facility staff, collaborative approach, patient satisfaction assessment, follow-up of patient feedback to providers, study of sentinel events, development of complaint procedures, etc, both as requirements of sub-contracting and as activities that improve indicator achievement, thus resulting in higher performance and greater reimbursement.

3.2 Objective and Strategy

The project is called HIV/AIDS Performance Based Financing (HIV-PBF).

The Contractor shall provide technical services to support national implementation of performance-based contracts as well as to implement performance-based financial incentives of HIV/AIDS services at selected pilot sites in Rwanda. The desired end result is measurable improvement in quality, volume and efficiency of HIV/AIDS services as well as development of a national system of performance-based contracting. On a phased basis, during the first two years, the PBF contractor will assist 35 pilot sites to implement performance-based fnancing/contracting. During the optional two years (years 3 and 4), national coverage is anticipated. The financial incentives will improve access, quality, and efficiency of HIV/AIDS clinical services while protecting and actively strengthening overall primary health care service delivery.

The contractor will work at three levels:

i) National level: technical and logistical support of the Ministry of Health (DSS) to formulate, test, refine and implement procedures and mechanisms for progressive national implementation of performance-based financing of HIV/AIDS services. The HIV-PBF is one component within a national program of performance-based contracting of primary health care. The Contractor is expected to provide support to GOR to develop national implementation of Performance Based Contracting as necessary to implement HIV-PBF.

ii) Province and District level: collaboration with and investments in decentralized health, HIV/AIDS, local government, and other public and private sector partners to improve performance-based financing and to strengthen supervision and coordination of HIV/AIDS clinical care

iii) Community- and facility-based level: provide TA and support to improve:
   a. Management and administration of facility and staff
   b. Quality/efficiency of overall and HIV/AIDS clinical service delivery.
   c. Improve implementation of performance based financing/contracting, including provider performance plan approval, coaching and follow-up including appeal, of actual performance.

The Task Order contract will be incrementally funded for a two year period with option to extend an additional two years for national scale roll-out, with $1,200,000 - $1,500,000 approved for the first year, and an estimated $3.0 million requested for Year 2, subject to: i) *continued satisfactory achievement of contract milestones and targets; ii) approval of proposed plans by the State/Global AIDS Coordinator (S/GAC); iii) availability of funds; and iv) mutual agreement to proceed.* The funding for optional years 3 and 4 is estimated at $4 million for year 3 and $6 million for year 4; however, these amounts will be adjusted based upon success of project and availability of funds. It is possible that the bulk of clinical HIV Emergency Plan services may be funded through HIV-PBF if early experience demonstrates success.

National development of performance-based contracting mechanisms: Throughout the duration of the contract, the contractor will work in partnership with the GOR to support the GOR's development of a national performance-based financing/contracting system while simultaneously attaining Emergency Plan targets. ***Achieving Emergency Plan annual targets is necessary for continued funding.*** The process of achieving EP targets will assist national health system development as well as address the HIV/AIDS epidemic.

Emergency Plan targets for this Performance-based financing procurement are:

1. At least 9 sites are providing performance based financing by month 12 for palliative care, counseling and testing and PMTCT.

2. At least 35 sites are providing performance based financing by month 24.
   The COP05 requires that "there is a demonstrated 10% improvemement in quality and 10% increase in productivity by month 12".

3. Clinical services being reimbursed through PBF should include Counseling and Testing, PMTCT and palliative care for patient volume and quality of care.
   At least one site should pilot performance-based financing of ARV services by month 18.

4. Target: 30 people trained related to policy, management and/or capacity building, including stigma and discrimination reduction programs.

Required Technical and Support Services:

The required technical and support services are expected to include but not necessarily be limited to:

- Long and short term technical assistance as needed to implement national HIV/AIDS PBF with:
    - Department of Health Services (DSS)
    - Local authorities for oversight and governance of PBF, including development of direct contracts with facilities and implementation of continuous quality improvement.
- Necessary administrative and logistical support to DSS and local health districts to implement HIV/AIDS PBF,
    - Including establishing and fully supporting an office in DSS to support PBF;
    - Logistical support of DSS, provincial and/or health districts necessary to implement HIV-PBF. This may include support of provincial and district staff to oversee provider contracts, assure quality and performance through an independent audit.
- Support to/provision of a regional conference,
- Development and dissemination of information on best practices related to performance based incentive structures and health services financing;
- Training
- Administration and management of performance-based incentive payments, including development and management of contracts and on-going contract administration with providers.

Long term technical assistance will be primarily in health financing, health care administration and management and continuous quality improvement at district and facility levels. Clinical expertise in HIV/AIDS service delivery should be sought from sources already in country.

It is emphasized that the Emergency Plan is a rapidly evolving initiative, and ultimate levels accorded to Rwanda are subject to U.S. Presidential, Congressional, and Department of State decisions and appropriations on an annual basis. It is possible that funding levels may vary by total and/or on a year-on-year basis, requiring some adjustment of the Contractor's Annual Workplans and targets. The USG will collaborate closely with the Contractor and GOR as Emergency Plan funding and guidelines evolve to assure necessary degrees of flexibility are built into all workplans and strategies over the course of the Task Order.

3.4 Tasks and Phasing

Over a 24 month period the HIV-PBF Contractor shall undertake the following tasks:

Months 1 – 6: Preparation (The following activities should be started and well underway. Most will continue throughout the project life)

- Mobilization and establishment of technical expertise in DSS and appropriate provincial and/or health districts for implementation of HIV-PBF.

- Development of a modest office in DSS that is fully supported to implement HIV performance based financing/contracting.
- Build on current work of DSS and other health developmental partners to conduct a detailed targeted evaluation of PBF experience in Rwanda to date that shall include but not be limited to:
  - Status of GOR implementation of PBF of primary health care and adequacy of developed structures for HIV-PBF implementation.
  - Prior and on-going PBF systems, including participating facility or entity, indicators, rates paid, governance, critical factors for success or negative impacts, financing structure, performance oversight, quality of care, community involvement, etc.
- Support the DSS to host a <u>Dissemination Workshop</u> on the above evaluation, including comparison of Rwanda's experience with other relevant regional models,
- <u>Recommendation of initial pilot sites</u>, contract terms, for HIV-PBF, based upon jointly developed selection criteria made in collaboration with DSS, TRAC, and other relevant stakeholders. The Contractor may propose consideration for careful monitoring of some non-PBF comparison sites or traditional input funding as controls to demonstrate the effects of PBF on service delivery.
- The HIV-PBF Contractor shall undertake "PBF Contractual Readiness" work in pilot sites/health districts, governance, financial and oversight structures, to include, but not be limited to both site-based and systemic assistance.
- Support the DSS to pilot and implement national mechanisms for HIV-PBF pilots. Provide recommendations for initial piloting of HIV-PBF, including indicators, structure of contracts and payment flows, oversight and governance, , indicators for incentive financing, financing flows, local governance of PBF and independent assessment of performance.
- Work with DSS and other authorities to develop agreed mechanisms for HIV-PBF pilot sites where national mechanisms are not yet developed.
- Collaborative development of site-specific business plans for participating facilities/offices, where needed, while respecting budget autonomy of clinical sites.
- Development of supervision, quality assurance and monitoring plans, in close collaboration with DSS, provincial, and health district teams. Such plans may result in performance contracts with district health teams for supervision and quality assurance of PBF programs.
- Development of patient protection systems, such as informed consent, to protect against overuse of "incentivized" activities, such as voluntary CT. Develop-and implement contracts directly with health sites or use nationally established mechanisms when developed.

<u>Indicators:</u>

- **<u>"Core" indicators</u> <u>for reimbursement will correspond to Emergency Plan targets</u>**, specifically: numbers of patients who receive HIV counseling and testing, PMTCT and palliative care for HIV infection and the quality of these services. ARV service indicators may be piloted after initial PBF-HIV implementation has started. Other indicators reflecting different aspects of service delivery will be developed by the contractor, including indicators to assure that routine basic health services are not declining.

- An on-going process for developing, evaluating, refining and verifying indicators will be developed with DSS. It is expected that lessons will be learned as pilots roll-out and that these lessons will be shared collaboratively and incorporated into pilot performance contracts on a continuous basis.

- Performance-based incentive schemes in Rwanda have typically focused on quantity. The following illustrative example of performance incentives for HIV/AIDS services is more complex but likely to meet the need to provide high-quality HIV/AIDS care within a strengthened overall system:

  - Composite Indicators: A PMTCT indicator with several components, all of which must be met to achieve 100% of the PMTCT indicator (e.g., PMTCT indicator will include: x% of all pregnant women receiving iron folate, y% attending ANC within 1st trimester, z% making four ANC visits before delivery, % taking Nevirapine correctly, etc.)

- Development of indicators for reimbursement should be a collaborative process with clinical and administrative input. The PBF Contractor will work closely with DSS, other donors and community colleagues to determine indicators. The amount of money provided for incentives should include additional costs of HIV services.

Emergency Plan funding is to be used for HIV/AIDS indicators, recognizing that effective HIV/AIDS services cannot be delivered through an inadequate health care system and should not compromise delivery of other basic care.

Strengthening and protection of primary health care services: Routine monitoring and evaluation should include HIV/AIDS, basic primary care and other health indicators and services. This could include facility cleanliness, patient satisfaction, appropriate medical records, infection prevention techniques, etc. Strategies to protect basic health services could include:

i) Financial incentives for improving health service outputs/indicators or withhold HIV incentive payments if basic health service outputs/health status indicators decline. .

ii) Cost sharing plus incentive payments for facilities not receiving other financing of HIV/AIDS services to assure that non-HIV budget resources are not diverted towards HIV/AIDS.

NOTE: Given the provisions of the Tiahrt Amendment, the HIV-PBF Contractor shall assure no USG funds are used for incentives for family planning.

Months 7-12

- Performance-based contracting between clinical care sites and either governmental structures or the contractor starts. By the 12th month, at least 9 sites will be presenting performance data for incentive-based reimbursement.

- Collaboration with MINISANTE DSS, Planning, TRAC, and other relevant development partners to cost planned HIV/AIDS services and to begin to assess potential scenarios for and likelihood of sustainable financing of such services over time, through health insurance and *mutuelles,* drug access initiative agreements, etc.

- Review and sharing of performance data by contractor and DSS.

- Continued collaboration with DSS, MINECOFIN, partners to determine optimal financial pathways for PBF incentive payments for national system of performance based contracting.

- The PBF Contractor shall continue to assist the DSS and local health authorities to pre-test/initiate PBF model(s) in the pilot sites/networks, and shall revise, as needed, indicators, pricing, quality assurance, supervision, and contracts and financial flows.

- TA to sites in financial management, human resource management, continuous quality improvement.

Months 13 - 18

- Performance-based contracting between clinical care sites and either governmental structures or the contractor continues to expand. **By the 18th month, at least 22 sites will be presenting performance data for incentive-based reimbursement**
- Continued support of MINISANTE/DSS's implementation of PBF. Planning with DSS, TRAC, and other relevant development partners to cost planned HIV/AIDS services and to assess potential scenarios for and likelihood of sustainable financing of such services over time, through health insurance and *mutuelles,* drug access initiative agreements, etc.
- Continued provision of PBF payments for indicators. Continued review and sharing of performance data from pilot sites. Continued review of indicators, associated reimbursement and their impact on HIV/AIDS and non-HIV/AIDS services.
- Continued TA to sites in financial management, human resource management, quality improvement, etc as needed.
- Continuous support of independent assessment of quantity and quality of indicators and services through nationally-developed/agreed oversight mechanisms.
- Reporting of performance to stakeholders. Development of a regular system of provision of performance data to stakeholders (providers, consumers and health authorities) on quality and productivity of sites.
- Performance formulas, system logistics re-evaluated and refined as indicated.
- Support of targeted evaluation and dissemination of HIV-PBF pilot, national and regional processes for financial and clinical oversight of performance, impact on non-HIV Services with recommendations for procedure improvement/strengthening.

By end of Month 18, USAID and GOR will have completed an evaluation of results to date of HIV-PBF and a decision to exercise the option to continue the project for optional two years will be made. Adjustments to proposed budget and work plan will be made based on pilot experience if the option is exercised..

Month 18 - 24

- Performance-based contracting between clinical care sites and either governmental structures or the contractor continues to expand. By the 24th month, at least 35 sites will be presenting performance data for incentive-based reimbursement.
- By the end of month 24, at least one site should present data for performance-based financing of ARV services indicators.
- Conference and written report to disseminate results of HIV-PBF will be held. This will include in-depth discussion of lessons learned, including: indicators, impact on targets and performance including both productivity and quality, governance and oversight, recommendations for national scale-up, etc.

3.5 Tangible Results

By end Task Order Year 1 (FY2006):

- Targeted Evaluation of PBF in Rwanda completed and disseminated.
- Defined mechanisms for financing flow, contract development and management, governance and performance audit of HIV-PBF developed and implemented.
- Defined national structures and mechanisms for performance-based contracting of health services, including HIV/AIDS.
- Pilot sites (no less than 9) implementing PBF and providing PMTCT/CT/basic care to patients with reported (and independently verified) baseline and periodic performance indicators and performance incentives paid.
- Target: 10% increase in HIV-PBF patient volume/site/year and/or 10% improvement in quality as defined by composite indicator.
- No decline in non-HIV health service outputs or health status indicators (attributable to decreased health services due to PBF)
- Improvement in overall health service procedures that include HIV/AIDS as well as non-HIV/AIDS services, e.g. facility standards, medical records, patient satisfaction, patient volume, etc.

By end Task Order Year 2 (FY2007):

- Development of contracting mechanisms for national implementation of performance based contracting will be developed by DSS with contractor support, including governance, oversight, clinical audit, quality assessment, procedures to determine indicators, develop mutually agreed performance plans for sites. These mechanisms will be used, to the extent possible, for HIV/AIDS service delivery.
- Pilot additional PBF sites (at least 35 total, including at least one ARV delivery site) demonstrating:
    - Measurable improvements (10%) in efficiency and quality (additional targets to be established during Year 1) of:
        - HIV/AIDS services
        - Overall health services that include both HIV/AIDS and other clinical services.
- No adverse impact on non-HIV/AIDS clinical services.
- The contractor will demonstrate the impact on patient volume and on quality that initiation of PBF has caused.
    - Monitoring and evaluation of PBF will be harmonized with other M&E programs of other donors so that PBF interventions themselves can be compared.
- Dissemination Conference on results of HIV-PBF presented. Depending on decision to extend, conference will present plan for national scale-up or lessons learned.

4. GENERAL DESCRIPTION OF TECHNICAL ASSISTANCE SERVICES

4.2 Long-Term (and short term) Technical Assistance

The Contractor's proposal must define technical qualifications and experience and position descriptions for the members of the long-term technical assistance team proposed (See job descriptions for key personnel Section 6.4). The composition of the team, including proposed short term technical assistance, should reflect (A) an understanding of the issues/problems and focused, synergistic approach to performance-based financing for HIV/AIDS in Rwanda; and (B) tasks, results and targets to be accomplished on a specific time-line related to Emergency Plan targets

5. IMPLEMENTATION AND MANAGEMENT OF PROGRAM

5.1 Core Office and District Representation

The Contractor shall support the establishment of a fully supported modest office in Minisante/DSS as necessary to provide technical assistance and support to Minisante for PBF pilot development, national development of HIV-PBF and national development of performance-based contracting, including HIV/AIDS. An additional project office may be established if required for management activities under the contract if adequate services are not possible at DSS. The office(s) will provide all administrative and management support to the Contractor under the program, including implementation of financial and accounting systems for commodity procurement, arranging for and supporting in-country training, processing of short-term consultants, provision of all travel and support for long- and short-term personnel, etc. The PBF Office will operate under the general supervision of the Chief of Party.

The Contractor should plan to provide all administrative and management support necessary to the functioning of Contractor activities in the target pilot sites, including support to visiting Contractor staff and short-term consultants, local commodity procurement, arranging for and supporting local training, accounting for and oversight of performance-based payments, etc. Depending on progress of development of national PBF implementation, the contractor will directly support oversight of HIV-PBF or will work via established government oversight mechanisms. Over the life of the two year project, (with option to renew for an additional 2 years), support for development of governmental oversight mechanisms is anticipated and transition to use of these mechanisms is anticipated.

The Contractor may, at its option, establish some mode of permanent representation at provincial comite de pilotage or at health districts if necessary for management of pilot sites in one or more district(s). If permanent representation is desired, the Contractor is encouraged to consider "least-cost" possible means of achieving such representation, such as co-location in a district administrative or health office/facility.

In addition to the long-term TA positions necessary to achievement of Contractor Results, the Contractor is expected to propose adequate technical and support staff for the core office. Contractors are encouraged to maintain a low budget and minimal administrative costs, and shall define in detail the proposed arrangements and staffing.

5.2 Headquarters Supervision and Support

Offerors shall include in the proposal a discussion of proposed corporate headquarters supervision, support, and quality control efforts under the Contract. Given provisions for designation of a fully authorized Chief of Party (see 5.3.1 Relationshps with USAID Rwanda and 6.4 Contractor Personnel), and provision for activity-funded full-time staff at the local office, any direct level of effort attributable to

headquarters activities is expected to be focused primarily on that required for sourcing information and technical expertise to support the field team.

5.3 Roles and Relationships

5.3.1 **Relationships with USAID Rwanda.** The Contractor shall be responsible for ensuring achievement of all products and reports required under this Contract. The Chief of Party shall be authorized to represent the Contractor in all matters pertaining to the execution of the Statement of Work, with the possible exception of Contract amendments, for which authority shall be delegated at the discretion of the Contractor's home office. The Chief of Party will serve as the Contractor Representative in Rwanda for the purposes of this contract, and will be responsible for the activities of all long- and short-term personnel under the contract.

The Chief of Party shall receive technical direction from the USAID Cognizant Technical Officer (CTO) or his/her designee, only.

5.3.2 **Relationships with Implementing Agencies**. The Contractor shall support and work directly with the PBF Implementing Unit or other designated unit of Minisante and with other key Rwandan, American, and international partners of USAID to assure that all activities are collaboratively programmed. Additionally, the contractor will work with all organizations or structures developed by the Ministry of Health to implement PBF of HIV/AIDS services. The contractor will work to support the development and implementation of the DSS's performance-based contracting of health services, including HIV/AIDS.

USAID values its established partnership with the GOR and will maintain and strengthen this partnership in coming years. In accordance with USAID protocols and subsequent to USAID introductions in its zones of intervention, the Contractor shall coordinate closely with agencies of the GOR, NGOs, international organizations, CBOs, FBOs, and other partners (contractors/grantees) receiving USG funds from, or otherwise collaborating with, USAID and the Emergency Plan Steering Committee partners. The Contractor shall work closely with these organizations to assure improved coordination of Rwandan, American, and international partners in delivery of resources, and program-related monitoring and evaluation of impact.

The lead counterpart agencies for this contract at the national level are expected to be the Performance-Based Financing unit of MINISANTE, the Department of Planification in DSS, other departments of DSS, and TRAC. Depending on sites/networks selected for PBF pilot work, the Contractor shall also work closely with Provincial and District health teams, and with participating health center staff and their related Health Management Committees. Where such exist, the Contractor is also expected to work with community-based and faith-based organizations, including Health Committees, PLWHA associations, women's groups, quality partnerships, etc.

The Contractor will also work closely with USAID and the key Rwandan and international implementing agencies to assure that all activities are collaboratively programmed as part of an expanded team mode of operation. Over the past five years, USAID has held periodic meetings of implementing partners to foster the exchange of ideas and to discuss and coordinate activities. Participants have included all implementing partners getting direct USAID funding (Field Support and/or bilateral). USAID plans to regularize and formalize this forum under the new strategy. The current plan is to hold quarterly meetings. USAID intends that partner forum will serve as an effective means of integrating plans and activities to assure the integration necessary to achieve results becomes a reality. USAID will work with the Contractor and other USG partners, in particular those supporting the delivery of clinical HIV/AIDS and primary care services to facilitate the implementation of HIV-PBF.

The extended team mechanism should lead to a much more coordinated approach to health and decentralization sector resource transfers, and should help ensure that the best ideas are brought to the table and that activities are conducted in a cost-effective manner. Technical and operational coordination of activities is expected to create a cohesive environment and program while reducing the burden imposed on Rwandan counterparts.

5.3.3 Logistical Support. The Contractor shall be responsible for all logistical support except:

- Duty free entry for Contractor and dependents of HHE and POV, professional and ICT commodities purchased with USAID funds under the activity; customs clearance (with the exception of customs exemption letters provided by USAID) shall be the responsibility of the Contractor.
- Long-term residence visas for long-term technical advisors and their dependents.

Any other possible Mission support or Contractor access to Mission services will be determined by Mission policy in existence at any given time during the life of the contract.

5.4 Annual Workplan

As stated earlier, it is emphasized that the Emergency Plan is a rapidly evolving initiative, and annual and ultimate targets and levels accorded to Rwanda are subject to U.S. Presidential, Congressional, and Department of State decisions and appropriations on an annual basis. It is possible that targets and levels may vary by total and/or on a year-on-year basis, requiring some adjustment of the Contractor's Annual Workplans and targets. The USG will collaborate closely with the Contractor as Emergency Plan funding and guidelines evolve to assure necessary degrees of flexibility are built into all Workplans and strategies over the course of the CA.

The Contractor will be required to develop Annual Workplans keyed to each US Fiscal Year of the project. A draft of the first annual work plan will be due within 60 days after project initiation.

The successful Contractor will be expected to assist USG to assure that Rwanda Emergency Plan-specific plans and budgets are i) Supportive of national implementation of Performance-Based Financing; ii) Well coordinated and mutually reinforcing with those of other Emergency Plan implementing partners; iii) explicitly linked to achievement of Emergency Plan and GOR National M&E Framework and UNGASS targets; and iv) prepared in a timely manner.

Contractors should assure that all research or data collection activities under the program are undertaken in collaboration and/or consultation with the GOR. In this regard, Contractors will utilize existing resources of collaborating partners, including libraries, documentation centers, and field personnel, to the extent practicable in the collection and collation of selected datasets, as opposed to generating parallel data and/or hiring separate staff. Contractors should collaborate closely with USAID and its Emergency Plan partners to assure compatibility of efforts and to avoid possible redundancies.

USAID encourages broad PVO/NGO and private sector networking and collaboration in all activity undertakings. Contractors should participate in periodic seminars and conferences to share and disseminate experiences among key actors in Rwanda, in the public, private, and parastatal communities.

5.5 Monitoring, Evaluating, and Reporting

The PBF Contractor must provide comprehensive plans for monitoring, evaluating, and reporting on achievements and impact. The PBF Contractor must harmonize its M&E plan with the GOR and those of other donors, including the World Bank, to support rigorous comparison of PBF interventions and traditional types of HIV/AIDS services financing.

Specific data required are of several types: i) those that report on progress toward Contractor-proposed milestones and targets under the CA (this includes those data required from health facilities to demonstrate impact of PBF on health service delivery performance for both HIV services and primary care services) ii) those that measure the Emergency Plan HIV/AIDS target indicators, and iii) those that measure related achievements.

The first type of data should include reporting on the Contractor's contribution toward a selected number of milestones and targets toward which the Contractor is working. The Contractor will monitor indicators which trigger performance/incentive payments to health centers and other service providers. This includes baseline and periodic monitoring of HIV and primary care services. These indicators will become part of the Contractor-proposed reporting as they are identified. Other than the incentive/performance payment indicators, milestones/targets chosen by the Contractor to gauge its progress, and establishment of timing and/or coverage targets related to each, shall be elaborated in the Contractor proposal and reported quarterly, synchronized with other Emergency Plan reporting requirements. The PBF contractor is expected to provide reports to USAID-Rwanda to assist in routine reporting to OGAC.

Illustrative indicators that may be included in the Proposal are listed below. Note that these are considered illustrative only and the Contractor is encouraged to propose those that are most relevant to its work:

- Number of health centers engaged in PBF.
- Baseline and periodic measurements of health service delivery outputs (patient volume, numbers of procedures, etc) for primary health care and HIV services.
- Number of health centers utilizing one or more HIV/AIDS indicators for PBF.
- Numbers of health centers whose reported performance varied from independent audit.
- Utilization rates, per indicator, in pilot health centers.
- Number and types of supervision visits per center.
- Number and types of training provided.
- Number of people trained (disaggregated by sex).
- Number of business plans developed with Health Management Committees.
- Number of community/client-based evaluations undertaken.

The second set of data would include reporting against the Emergency Plan HIV/AIDS targets as currently listed and defined in *The President's Emergency Plan for AIDS Relief Indicators, Reporting Requirements, and Guidelines, Revised based on FY2005 Country Operation Plans, DRAFT September 30, 2004.* Contractors should read *the U.S. Emergency Plan Five Year Strategy for Rwanda* and Rwanda Country Operation Plan 2005, found at: www.usaid-rwanda.rw/procure.html for a listing of all Emergency Plan Indicators. Contractors should identify and quantify those indicators/targets they expect to impact.

The Contractor shall provide the USG the requisite data for Emergency Plan reporting as required by the Emergency Plan, currently anticipated as every six months, as part of its quarterly reporting requirements. (That is, every other quarterly report would also include reporting on Emergency Plan indicators for the preceding 6 months period).

The PBF Contractor may be collaborating with other USG implementing partners providing clinical assistance to sites, with the potential for double-counting of indicators. USAID will work closely with all its partners to assure that such double-counting is avoided, targets are appropriately allocated and/or shared and that site-specific achievements are recorded accurately.

The Contractor will be expected to undertake provider data collection and independent verification strategies that ensure reliability and accuracy of progress toward expected accomplishments. In all cases the Contractor is expected to support GOR developed -monitoring efforts with other Emergency Plan colleagues, local health authorities, and other donor/partner programs, to assure that monitoring and evaluation systems are as cost-effective as possible. The methodologies for collection and actual data collected under the HIV-PBF Contract may need to be harmonized for ease of aggregation for Emergency Plan's reporting needs. The Contractor is encouraged to work with USAID and its Emergency Plan Team colleagues, as necessary to USAID management and reporting, to assure all data it is collecting and providing use USAID's harmonized systems. Such harmonized systems are essential if data collected by different partners in different districts/provinces is to be aggregated for USAID reporting purposes.

Contractors should be prepared for revisions in required core indicators and reporting requirements during the lifetime of the award.

5.6 Quarterly and Annual Reports

The Contractor shall submit to USAID/Rwanda five (5) copies in English of the following reports.

5.6.1 Quarterly Progress Reports. Not later than two weeks following the close of each quarter, the Contractor will prepare and submit to USAID quarterly reports. This report will summarize progress in relation to agreed upon milestones contained in the Annual Workplan, and will specify any problems encountered and indicate resolutions or proposed corrective actions. For each action, the Contractor will designate responsible parties and establish a timeframe for completion. The report will list activities proposed for the next quarter, noting where they deviate from the approved Annual Plan.

The Contractor will include in each quarterly report a list of all HIV-PBF contracts and performance incentives paid during the reporting period, as well as all sub-agreements (PBF or other) in force during the reporting quarter.

Until all Contractor-procured commodities are received and installed, the quarterly report will include an update on the procurement plan. The update should inform on tenders in preparation, tenders out for bid, awards, shipment, carrier name, and expected arrival date of major commodities.

As described above, it is currently expected that Emergency Plan reporting will be on a semi-annual basis. This means that in every other quarterly report, the Contractor would also need to include reporting on required Emergency Plan indicators. The Contractor will report on Emergency Plan target attainment in a time frame coordinated with Emergency Plan reporting requirements.

5.6.2 Annual Reports. At the end of each year of the CA, the Contractor will submit an annual report covering activities of the previous year. These reports will provide a succinct presentation of Contractor achievement of Contractor results, milestones and targets in the previous year, with supporting discussion as warranted, including as necessary to explain any shortfalls. These reports will summarize progress, provide an analysis of impact based on activities completed or in progress, and suggest resolution of any outstanding issues.

5.7 Consultant Reports

The Contractor shall additionally provide USAID Rwanda with five (5) copies of the products -- studies, trip reports, materials developed -- of all short-term consultants under the contract within 30 days of completion of the consultancy. In general, reports shall be in English or French. Where a report or document is more appropriately developed in Kinyarwanda – e.g. a training manual for local leaders – USAID may, at its option, request an English-language abstract.

6.0 CONTRACTOR PERSONNEL

The Contractor will recruit, hire, orient, and support the technical, administrative and support personnel to plan and implement all Task Order activities. The Contractor will provide all administrative, logistical and technical support for its personnel, including both long-term employees and short-term consultants. These categories of personnel are described in the following subsections.

Long-term personnel

The Contractor will provide a team of two long-term, expatriate specialists to provide technical support needed to strengthen the GOR’s ability to deliver Performance Based Financing (also called Performance Based Contracting), particularly as it relates to HIV/AIDS. The specialists will lead the Contractor’s effort to implement the tasks described in the Scope of Work. The qualifications, skills and experience required for these two specialists are stated below. Relevant experience of the long-term, expatriate specialists shall include long-term experience in projects in developing countries that are similar to that represented in this scope of work. Previous experience in USAID-funded projects is highly desirable for both long-term specialists.

Offeror shall propose one of the two long-term expatriate specialists as the Team Leader (Chief of Party). Ideally this person would be the Health Care Financing expert. However, this choice may be affected by a number of factors, including previous experience as Chief of Party for a technical assistance team. Criteria for the team leader (over and above the technical qualifications required to fill one of the two specialist positions), are included below following the descriptions for the two expatriate long-term specialists.

Signed letters of commitment shall be provided for each long-term candidate. The two long-term specialists are designated key personnel.

- **Health Care Financing Specialist**

  This individual shall have a minimum of seven years of experience and progressively increasing responsibility in the area of health care financing related to health care service delivery, particularly at the primary health care level, with at least four years of this health care financing experience in developing country settings. This specialist must be able to provide a combination of skills and experience directed at the development of a Performance Based Finance system for HIV/AIDS. Experience in USAID-funded health projects, particularly with HIV/AIDS programs, is highly desirable. Strong interpersonal skills are required. The specialist shall possess, at a minimum, a Masters degree in health management or administration from an accredited university program, or a combination of health professional degree-level training and a Masters degree in management, business, or public administration. The specialist shall be fluent in reading, writing and speaking English and fluent in reading and speaking French, or at a minimum of an FSI 3/3 equivalency.

- **Health Systems and Management Specialist**

  This individual shall have at least seven years of experience and progressively increasing responsibility in the areas of health systems and management. The emphasis of prior work shall have been in health services management and health systems development in a developing country environment. Substantive experience in development of resource allocation-related information systems (such as health management information systems, financial management systems, pharmaceutical logistics systems, human resource management systems) is required. Significant involvement in health reform activities is desirable. Experience in USAID-funded health projects, including HIV/AIDS-related work, is highly desirable. Experience with implementing Quality improvement/ performance improvement programs in health care provider organizations desired. Strong interpersonal skills are required. The specialist shall possess, at a minimum, a Masters degree in health management or administration from an accredited university program, or a combination of health professional experience and a Masters degree in management, business, or public administration. Undergraduate training in anthropology and/or sociology would be a plus. The specialist shall be fluent in reading, writing and speaking English, and fluent in reading and speaking French, or at a minimum of an FSI 3/3 equivalency.

- **Additional criteria for the Team Leader**

  The Offeror shall propose one of the two specialists described above to serve in a dual capacity as the Team Leader. In addition to fulfilling the qualifications described above for one of the specialist positions, the individual proposed as Team leader shall have the following additional qualifications: (1) strong leadership and management skills; (2) experience as Team Leader (Chief of Party) in developing country health projects of similar scope and complexity; (3) prior experience in USAID-funded activities and knowledge of USAID regulations is highly desirable; 4) strong interpersonal skills, including a history of diplomatic interaction with government officials at all levels in a developing country setting; and (4) excellent analytical skills.

PROPOSAL

1. INSTRUCTIONS TO OFFERORS

The following elements comprise the basis for award of this Task Order.

a) Selection of an Offeror for award will be based on an integrated assessment and judgment based on the overall evaluation of four areas: (1) Technical and management factors, (2) personnel, (3) past performance, and (4) cost.

b) The Government will make an award to the responsible Offeror whose offer conforms to this Task Order Request for Proposal and is most advantageous to the Government, cost and other factors considered. For this solicitation, cost is initially least important. As proposals become more equal in their technical merit, the evaluated cost will become more important.

c) The Government's selection process will consider only those proposals found to be of acceptable value with acceptable risk to the Government. The award may be made to an acceptable Offeror whose proposal is not the lowest in cost but is sufficiently advantageous to the Government to justify payment of a higher cost.

d) Discussions may be conducted with those Offerors determined by the Contracting Officer to be in the Competitive Range. However, the Government reserves the right to award on initial offers without discussions.

e) The scope of work for TASC2 is designed to provide comprehensive support for Performance Based Financing for HIV/AIDS. USAID will consider joint proposals from multiple TASC2 IQC holders as long as working arrangements are clearly defined in the joint proposal.

f) Technical proposals will be evaluated by a Technical Evaluation Committee comprised of USAID and MOH officials.

g) Proposals are due within 30 calendar days of issuance of the request for Proposals.

2. MINIMUM REQUIREMENTS FOR PROPOSALS

Length of Technical Proposals

Technical proposals shall not exceed 40 pages in length, not including annexes. All proposals shall be prepared in a 12-point font with at least one-inch margins (top, left, bottom and right). (CVs and charts that appear in annexes may have a different font and margins.)

Inclusion of full Curricula Vitae and Contractor Employee Biographical Data Sheet (AID 1420-17)

Full CVs shall be included for the proposed long-term international personnel for the following two positions: (1) Health Care Financing Specialist; and (2) Health systems and Management specialist. Full CVs shall also be included for intermittent short-term consultants proposed (including those who would work with the Continuous Quality Improvement component). These full CVs shall be included as an annex to the Technical Proposal. Up to 10 consultant CVs may be included in the annex, in addition to those for the long-term positions. For the two long term positions, completed Contractor Employee Biographical Data Sheets should be submitted, which can be found at:

http://www.usaid.gov/procurement_bus_opp/procurement/forms/

Inclusion of Letters of Commitment for Long-term Personnel and Intermittent Consultants

Copies of signed letters of commitment demonstrating availability and commitment to take the assignment must be included for long-term personnel and intermittent consultants. These letters shall be included as an annex to the Technical Proposal.

3. Cost Proposals

The two-year base period of performance and the two-year option period of performance for this Task Order are described in Section 3. Detailed Statement of Work. In budgeting for these periods of performance, Offerors must provide two separate budgets, but should plan and budget activities to provide continuity between the two periods as follows:

Period 1: Years 1-2	(date of award through September 2007)
Period 2: Option Years 3-4	(October 2007 through September 2009)

Offerors should include the following budgets in their proposals in an “a la carte” structure:

- Indicative Two Year Work plan: A first year budget, including two long term TA positions and establishment of an office in DSS. This budget would include support of PBF at 9 pilot sites by the end of the first year. The second year budget would include support for PBF at 35 sites by the end of the second year, plus cost sharing of HIV services at selected sites, and a minimum of support for ARV at one site.
- Optional two year extension budget with Indicative Work plan to support the introduction of PBF on a national basis, including support for HIV/AIDS services, corresponding to the Emergency Plan’s Prevention, Care and Treatment targets. Approximately 30-40 additional sites to be contracted in year 3. The national model for broad implementation under GOR oversight should be tansitioned in year 4 for 50 additional sites.

The two Indicative Two-Year Workplans should reflect the Contractor's objectives and targets for each year and outline a preliminary schedule for implementation. The two Indicative Two-Year Workplans should include detail on the Contractor's estimated level of effort, commodities to be procured, and staffing, including key personnel.

The proposal should address all bulleted items described in the Statement of Work.

The proposal should also include:

- Example of indicators for Emergency Plan targets as well as indicators reflecting overall performance of basic/routine health services.
- A process for development of indicators
- A process to cost out incentives for specific indicators.
- A plan to assure that basic/routine health services do not deteriorate.
- A plan that reflects balancing the need to achieve Emergency plan targets with supporting national development of performance based financing of basic health care services.

EVALUATION CRITERIA:

Offerors must demonstrate technically, culturally, and economically sound, appropriate, cost effective and feasible approaches to contribute to the achievement of the components of the Statement of Work. Specific weighted criteria follow.

A. Technical Approach **175 pts**

1. Workability of proposed technical approach; i.e., Can the proposed technical approach reasonably be expected to achieve the Tangible Results in the Statement of Work?

2. Approach offers a realistic proposal for building Rwandan capacity and enabling targeted providers to offer an essential package of HIV/AIDS services without USG assistance over a defined period of time.

3. Innovative approaches to strengthen networks among public, NGO/FBO, and private sector (ranging from commercial to community-based) HIV/AID clinical programs

4. Innovative approaches that incorporate specific strategies to address gender in service delivery, both in terms of service providers (e.g. facility staff, health committee members, supervisors, etc.) and in terms of client groups (e.g. communities, youth, PLWHA, families, couples, etc.). 15 pts

B. Management Plan **125 pts**

1. Clarity of management plan, including explicit description of roles and responsibilities of different members of Offeror's team to achieve results.

2. Clarity of organizational plan including planned interaction between Offeror and Rwandan organizations and institutions to achieve results, as: i) members of Applicant's team; ii) collaborators in technical and management service delivery; iii) beneficiaries

3. Clear and coherent performance monitoring plan, including list of indicators for measuring the processes, the coverage and the intended impact of activities

C. Personnel **125 pts**

1. Qualifications and relevant experience of proposed technical <u>personnel</u>, including experience in developing country settings.

2. Appropriateness of the proposed technical <u>positions</u> (long and short term) to the proposed technical approach.

3. Key personnel are <u>expected</u> to possess FSI-equivalent 3/3 English and FSI-equivalent 3/3 French language capabilities as a minimum

D. Past Performance **75 pts**

1. Prior experience with performance- and/or incentive-based health services delivery in low-resource settings

2. Past performance in provision of technical assistance and training related to financing of health and/or HIV/AIDS service delivery

3. Offeror's responsiveness to past clients including responsiveness to the uniqueness of different country settings and host country counterparts' concerns.

OMB Control No. 0412-0520; Expiration Date: 9/30/2004

RFTOP No. 623-P-05-022 **CONTRACTOR EMPLOYEE BIOGRAPHICAL DATA SHEET**

AID 1420-17 (4/95)

1. Name (Last, First, Middle)		**2. Contractor's Name**	
3. Employee's Address (include ZIP code)		**4. Contract Number**	**5. Position Under Contract**
		6. Proposed Salary	**7. Duration of Assignment**
8. Telephone Number (include area code)	**9. Place of Birth**	**10. Citizenship** (*If non-U.S. citizen, give visa status*)	

1. Names, Ages, and Relationship of Dependents to Accompany Individual to Country of Assignment

12. EDUCATION (include all college or university degrees)				**13. LANGUAGE PROFICIENCY**		
NAME AND LOCATION OF INSTITUTION	MAJOR	DECREE	DATE	LANGUAGE	Proficiency Speaking	Proficiency Reading
					2/S	2/R
					2/S	2/R
					2/S	2/R

14. EMPLOYMENT HISTORY

1. Give lasts three (3) years. List salaries separate for each year. Continue on separate sheet of paper if required to list all employment related to duties of proposed assignment.

2. Salary definition – basic periodic payment for services rendered. Exclude bonuses, profit-sharing arrangements, commissions consultant fees, extra or overtime work payments, overseas differential or quarters, cost of living or dependent education allowances.

POSITION TITLE	EMPLOYER'S NAME AND ADDRESS POINT OF CONTACT &TELEPHONE #	Dates of Employment (mm/dd/yyyy)		Annual Salary
		From	To	Dollars

15. SPECIFIC CONSULTANT SERVICES (give last three (3) years)

SERVICES PERFORMED	EMPLOYER'S NAME AND ADDRESS POINT OF CONTACT &TELEPHONE #	Dates of Employment (mm/dd/yyyy)		Days at Rate	Daily Rate In Dollars
		From	To		

16. CERTIFICATION: To the best of my knowledge, the above facts as stated are true and correct.

Signature of Employee	Date

Contractor certifies in submitting this form that it has taken reasonable steps (in accordance with sound business practices) to verify the information contained in this form. Contractor understands that USAID may rely on the accuracy of such information in negotiating and reimbursing personnel under this contract. The making of certifications that are false, fictitious, or fraudulent, or that are based on inadequately verified information, may result in appropriate remedial action by USAID, taking into consideration all of the pertinent facts and circumstances,

Signature of Contractor's Representative	Date

INSTRUCTIONS

Indicate your language proficiency in block 13 using the following numeric interagency Language Roundtable levels (Foreign Service Institute levels). Also, the following provides brief descriptions of proficiency levels 2, 3, 4, and 5. "S" indicates speaking ability and "R" indicates reading ability. For more in-depth description of the levels refer to USAID Handbook 28.

2. Limited working proficiency

   S Able to satisfy routine social demands and limited work requirements.

   R Sufficient comprehension to read simple, authentic written material in a form equivalent to usual printing or typescript on familiar subjects.

3. General professional proficiency

   S Able to speak the language with sufficient structural accuracy and vocabulary to participate effectively in most formal and informal conversations.

   R Able to read within a normal range of speed and with almost complete comprehension.

4. Advanced professional proficiency

   S Able to use the language fluently and accurately on all levels.

   R Nearly native ability to read and understand extremely difficult or abstract prose, colloquialisms and slang.

5. Functional native proficiency

   S Speaking proficiency is functionally equivalent to that of a highly articulate well-educated native speaker.

   R Reading proficiency is functionally equivalent to that of the well-educated native reader.

PAPERWORK REDUCTION ACT INFORMATION

The information requested by this form is necessary for prudent management and administration of public funds under USAID contracts. The information helps USAID estimate overseas logistic support and allowances; the educational information provides an indication of qualifications; the salary information is used as a means of cost monitoring and to
help determine reasonableness of proposed salary.

PAPERWORK REDUCTION ACT NOTICE

Public reporting burden for this collection of information is estimated to average thirty minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any otheraspect of this collection of information, including suggestions for reducing this burden, to:

United States Agency for International Development
Procurement Policy Division (M/OP/P)
Washington, DC 20523-1435;
and
Office of Management and Budget
Paperwork Reduction Project (0412-0520)
Washington, DC 20503

DISCLOSURE OF LOBBYING ACTIVITIES

Approved by OMB
0348-0046

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure.)

1. Type of Federal Action:

☐ a. contract
b. grant
c. cooperative agreement
d. loan
e. loan guarantee
f. loan insurance

2. Status of Federal Action:

☐ a. bid/offer/application
b. initial award
c. post-award

3. Report Type:

☐ a. initial filing
b. material change

For Material Change Only:
year ______ quarter ____
date of last report ________

4. Name and Address of Reporting Entity:

☐ Prime ☐ Subawardee
Tier _____, *if known*:

Congressional District, *if known*:

5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime:

Congressional District, *if known*:

6. Federal Department/Agency:

7. Federal Program Name/Description:

CFDA Number, *if applicable*: ____________

8. Federal Action Number, ***if known*****:**

9. Award Amount, ***if known*****:**
$

10. a. Name and Address of Lobbying Entity
(if individual, last name, first name, MI):

b. Individuals Performing Services *(including address if different from No. 10a)*
(last name, first name, MI):

(attach Continuation Sheet(s) SF-LLL-A, if necessary)

11. Amount of Payment *(check all that apply)*:

$ ______________ ☐ actual ☐ planned

12. Form of Payment *(check all that apply)*:

☐ a. cash
☐ b. in-kind; specify: nature ______________
value ______________

13. Type of Payment *(check all that apply)*:

☐ a. retainer
☐ b. one-time fee
☐ c. commission
☐ d. contingent fee
☐ e. deferred
☐ f. other; specify: ______________

14. Brief Description of Services Performed or to be Performed and Date(s) of Service, including officer(s), employee(s), or Member(s) contacted, for Payment Indicated in Item 11:

(attach Continuation Sheet(s) SF-LLL-A, if necessary)

15. Continuation Sheet(s) SF-LLL-A attached: ☐ Yes ☐ No

16. Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be reported to the Congress semi-annually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than

Signature: ______________

Print Name: ______________

Title: ______________

Telephone No.: Date:

INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

his disclosure form shall be completed by the reporting entity, whether subawardee or prime Federal recipient, at the itiation or receipt of a covered Federal action, or a material change to a previous filing, pursuant to title 31 U.S.C. ection 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for fluencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or mployee of Congress, or an employee of a Member of Congress in connection with a covered Federal action. Use the F-LLL-A Continuation Sheet for additional information if the space on the form is inadequate. Complete all items that pply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of lanagement and Budget for additional information.

1. Identify the type of covered Federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered Federal action.
2. Identify the status of the covered Federal action.
3. Identify the appropriate classification of this report. If this is a followup report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered Federal action.
4. Enter the full name, address, city, state and zip code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants and contract awards under grants.
5. If the organization filing the report in item 4 checks "Subawardee", then enter the full name, address, city, state and zip code of the prime Federal recipient. Include Congressional District, if known.
6. Enter the name of the Federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation, United States Coast Guard.
7. Enter the Federal program name or description for the covered Federal action (item 1). If known, enter the full Catalog of Federal Domestic Assistance (CFDA) number for grants, cooperative agreements, loans, and loan commitments.
8. Enter the most appropriate Federal identifying number available for the Federal action identified in item 1 (e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract, grant, or loan award number; the application/proposal control number assigned by the Federal agency). Include prefixes, e.g., "RFP-DE-90-001."
9. For a covered Federal action where there has been an award or loan commitment by the Federal agency, enter the Federal amount of the award/loan commitment for the prime entity identified in item 4 or 5.
10. (a) Enter the full name, address, city, state and zip code of the lobbying entity engaged by the reporting entity identified in item 4 to influence the covered Federal action.

    (b) Enter the full names of the individual(s) performing services, and include full address if different from 10 (a). Enter Last Name, First Name, and Middle Initial (MI).
11. Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (item 4) to the lobbying entity (item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.
12. Check the appropriate box(es). Check all boxes that apply. If payment is made through an in-kind contribution, specify the nature and value of the in-kind payment.
13. Check the appropriate box(es). Check all boxes that apply. If other, specify nature.
14. Provide a specific and detailed description of the services that the lobbyist has performed, or will be expected to perform, and the date(s) of any services rendered. Include all preparatory and related activity, not just time spent in actual contact with Federal officials. Identify the Federal official(s) or employee(s) contacted or the officer(s), employee(s), or Member(s) of Congress that were contacted.
15. Check whether or not a SF-LLL-A Continuation Sheet(s) is attached.
16. The certifying official shall sign and date the form, print his/her name, title, and telephone number.

Public reporting burden for this collection of information is estimated to average 30 mintues per response, including time for reviewing

FAR 52.209-5 CERTIFICATION REGARDING DEBARMENT, SUSPENSION, PROPOSED DEBARMENT, AND OTHER RESPONSIBILITY MATTERS (DEC 2001)

(a)(1) The Offeror certifies, to the best of its knowledge and belief, that -

(i) The Offeror and/or any of its Principals -

(A) Are [ ] are not [ ] presently debarred, suspended, proposed for debarment, or declared ineligible for the award of contracts by any Federal agency;

(B) Have [ ] have not [ ], within a three-year period preceding this offer, been convicted of or had a civil judgment rendered against them for: commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, state, or local) contract or subcontract; violation of Federal or state antitrust statutes relating to the submission of offers; or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, tax evasion or receiving stolen property; and

(C) Are [ ] are not [ ] presently indicted for, or otherwise criminally or civilly charged by a governmental entity with, commission of any of the offenses enumerated in subdivision (a)(1)(i)(B) of this provision.

(ii) The Offeror has [ ] has not [ ], within a 3-year period preceding this offer, had one or more contracts terminated for default by any Federal agency.

(2) "Principals," for the purposes of this certification, means officers; directors; owners; partners; and, persons having primary management or supervisory responsibilities within a business entity (e.g., general manager; plant manager; head of a subsidiary, division, or business segment, and similar positions).

THIS CERTIFICATION CONCERNS A MATTER WITHIN THE JURISDICTION OF AN AGENCY OF THE UNITED STATES AND THE MAKING OF A FALSE, FICTITIOUS, OR FRAUDULENT CERTIFICATION MAY RENDER THE MAKER SUBJECT TO PROSECUTION UNDER SECTION 1001, TITLE 18, UNITED STATES CODE.

(b) The Offeror shall provide immediate written notice to the Contracting Officer if, at any time prior to contract award, the Offeror learns that its certification was erroneous when submitted or has become erroneous by reason of changed circumstances.

(c) A certification that any of the items in paragraph (a) of this provision exists will not necessarily result in withholding of an award under this solicitation. However, the certification will be considered in connection with a determination of the Offeror's
responsibility. Failure of the Offeror to furnish a certification or provide such additional information as requested by the Contracting Officer may render the Offeror nonresponsible.

(d) Nothing contained in the foregoing shall be construed to require establishment of a system of records in order to render, in good faith, the certification required by paragraph (a) of this provision. The knowledge and information of an Offeror is not required to exceed that which is normally possessed by a prudent person in the ordinary course of business dealings.

(e) The certification in paragraph (a) of this provision is a material representation of fact upon which reliance was placed when making award. If it is later determined that the Offeror knowingly rendered an erroneous certification, in addition to other remedies
available to the Government, the Contracting Officer may terminate the contract resulting from this solicitation for default.

52.203-7 ANTI-KICKBACK PROCEDURES (JUL 1995)

(a) Definitions.

"Kickback," as used in this clause, means any money, fee, commission, credit, gift, gratuity, thing of value, or compensation of any kind which is provided, directly or indirectly, to any prime Contractor, prime Contractor employee, subcontractor, or
subcontractor employee for the purpose of improperly obtaining or rewarding favorable treatment in connection with a prime contract or in connection with a subcontract relating to a prime contract.

"Person," as used in this clause, means a corporation, partnership, business association of any kind, trust, joint-stock company, or individual.

"Prime contract," as used in this clause, means a contract or contractual action entered into by the United States for the purpose of obtaining supplies, materials, equipment, or services of any kind.

"Prime Contractor" as used in this clause, means a person who has entered into a prime contract with the United States.

"Prime Contractor employee," as used in this clause, means any officer, partner, employee, or agent of a prime Contractor.

"Subcontract," as used in this clause, means a contract or contractual action entered into by a prime Contractor or subcontractor for the purpose of obtaining supplies, materials, equipment, or services of any kind under a prime contract.

"Subcontractor," as used in this clause, (1) means any person, other than the prime contractor, who offers to furnish or furnishes any supplies, materials, equipment, or services of any kind under a prime contract or a subcontract entered into in connection with such prime contract, and (2) includes any person who offers to furnish or furnishes general supplies to the prime Contractor or a higher tier subcontractor.

"Subcontractor employee," as used in this clause, means any officer, partner, employee, or agent of a subcontractor.

(b) The Anti-Kickback Act of 1986 (41 U.S.C. 51-58) (the Act), prohibits any person from--

(1) Providing or attempting to provide or offering to provide any kickback;

(2) Soliciting, accepting, or attempting to accept any kickback; or

(3) Including, directly or indirectly, the amount of any kickback in the contract price charged by a prime Contractor to the United States or in the contract price charged by a subcontractor to a prime Contractor or higher tier subcontractor.

(c) (1) The Contractor shall have in place and follow reasonable procedures designed to prevent and detect possible violations described in paragraph (b) of this clause in its own operations and direct business relationships.

(2) When the Contractor has reasonable grounds to believe that a violation described in paragraph (b) of this clause may have occurred, the Contractor shall promptly report in writing the possible violation. Such reports shall be made to the inspector general of the contracting agency,

the head of the contracting agency if the agency does not have an inspector general, or the Department of Justice.

(3) The Contractor shall cooperate fully with any Federal agency investigating a possible violation described in paragraph (b) of this clause.

(4) The Contracting Officer may (i) offset the amount of the kickback against any monies owed by the United States under the prime contract and/or (ii) direct that the Prime Contractor withhold from sums owed a subcontractor under the prime contract, monies withheld, the amount of the kickback. The Contracting Officer may order that
monies withheld under subdivision (c)(4)(ii) of this clause be paid over to the Government unless the Government has already offset those monies under subdivision (c)(4)(i) of this clause. In either case, the Prime Contractor shall notify the Contracting Officer when the monies are withheld.

(5) The Contractor agrees to incorporate the substance of this clause, including subparagraph (c)(5) but excepting subparagraph (c)(1), in all subcontracts under this contract which exceed $100,000.

SPECIAL PROVISION

USAID Disability Policy - Acquisition (December 2004)

(a) The objectives of the USAID Disability Policy are (1) to enhance the attainment of United States foreign assistance program goals by promoting the participation and equalization of opportunities of individuals with disabilities in USAID policy, country and sector strategies, activity designs and implementation; (2) to increase awareness of issues of people with disabilities both within USAID programs and in host countries; (3) to engage other U.S. government agencies, host country counterparts, governments, implementing organizations and other donors in fostering a climate of nondiscrimination against people with disabilities; and (4) to support international advocacy for people with disabilities. The full text of the policy paper can be found at the following website: http://www.usaid.gov/about/disability/DISABPOL.FIN.html.

(b) USAID therefore requires that the contractor not discriminate against people with disabilities in the implementation of USAID programs and that it make every effort to comply with the objectives of the USAID Disability Policy in performing this contract. To that end and within the scope of the contract, the contractor's actions must demonstrate a comprehensive and consistent approach for including men, women and children with disabilities.