ACHIEVING RESULTS FOR WOMEN'S AND CHILDREN'S HEALTH

Although there has been unprecedented progress made in improving the lives of women, adolescents, and children over the past two decades, there remains considerable unfinished work.

The Health Results Innovation Trust Fund supports the design and implementation of Results-Based Financing approaches in the health sector to help accelerate progress towards the millennium development goals for women's and children's health.

RBF is an umbrella term for financing mechanisms where a cash payment or nonmonetary transfer is made to a national or sub-national government, manager, provider, payer or consumer of health services after pre-agreed results are achieved and independently verified. The RBF approach shifts the focus of governments and health systems from inputs to results. It often also facilitates a level of community involvement, which acts as an accountability mechanism.

In RBF programs, various types of interventions work at different levels of the health system. For example, conditional cash transfers target the demand-side through beneficiaries, performance-based financing targets the supply-side through service providers, and cash-on-delivery intervenes at the national level by targeting governments.

While RBF designs are context-specific, they all explicitly link financing to results based on the delivery and rigorous verification of a package of reproductive, maternal, newborn, and child health services. RBF aims to increase autonomy, strengthen accountability, and empower frontline providers and health facility managers to make health service delivery decisions that best meet the needs of the women and children in the communities they serve.

This report shares lessons and results from HRITF-funded RBF projects through five country perspectives; and provides an update on the trust fund's activities over the past year.

CAMEROON

Increasing Service Provider Accountability through a Results Focus

In 2011, Cameroon launched a Performance-Based Financing pilot in Littoral with the goal to improve the utilization and quality of maternal and child health services. The pilot has expanded twice since its initial implementation, first in June of 2012 to an additional three regions (North-West, South-West and East) and again in 2015 to another three regions (Adamaoua, North, and Far-North) with new financing from IDA and HRITF. Currently, the pilot is being implemented in approximately 400 public, private and faith-based organization facilities across 26 districts in the initial four regions and will add 17 districts in the northern regions by the end of 2015 to cover approximately 5.4 million people in total across 43 districts.

Health care providers and regulatory bodies are paid based on their performance. Service providers and purchasers sign contracts formalizing the financing arrangement. The new, additional financing approved in 2014 added a community-based PBF component to address the lack of qualified health workers, demand-side barriers, and to strengthen the existing community health worker (CHW) network. CHWs will be contracted to provide preventive, promotional and curative care. In addition, the PBF project will link with the World Bank's Cameroon Social Safety Nets project, which supports the development of a basic national safety net system and a pilot conditional cash transfer program targeted to the poor and vulnerable.

"We have noticed that in the health districts where PBF has been implemented, hospitals are clean and well managed. Many people go to this hospital and the medical staff is motivated. Hospitals thus generate more resources directly and patients receive quality health care and pay a fair price for this."

ANDRÉ MAMA FOUDA
MINISTER OF PUBLIC HEALTH OF CAMEROON

EVALUATION

The ongoing impact evaluation seeks to: (i) identify the impact of PBF on maternal and child health service coverage and quality; (ii) identify key factors responsible for this impact; and (iii) assess cost-effectiveness of PBF as a strategy to improve coverage and quality. It includes a midline qualitative component, conducted in 2014, which sought to understand the key stakeholders' experiences in implementing the PBF pilot program during the first few years. In early 2014, 112 in-depth interviews and 16 focus group discussions were conducted. Respondents included health care providers and administrative/regulatory bodies such as the district and regional medical teams. At the conclusion of the pilot PBF program, an end line qualitative component will be conducted to further analyze the results of the impact evaluation.

An impact evaluation of the community PBF project will be launched in October 2015, with the baseline survey to be conducted in August 2015. This evaluation will examine whether facility-based PBF increases the quantity and quality of maternal and child health services, whether contracting community health workers through the community-based PBF model increases the quantity and quality of care at the community and facility level relative to just facility-based PBF, and whether community monitoring of community health workers and health facilities improve community health worker and health facility performance relative to CPBF and PBF without community monitoring. Public ceremonies will be conducted to randomly select facilities to be included in the evaluation.

7

regions

˅

43

districts

˅

400+

facilities

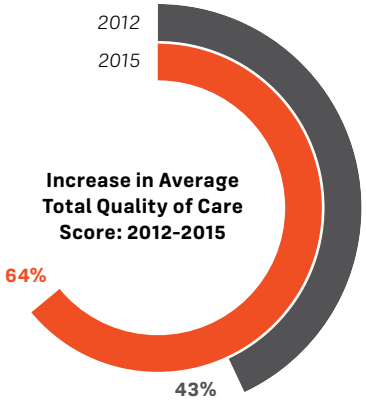
˅

5+ MILLION

people

KEY LEARNING

Trends in operational data indicate that since the RBF program was implemented in 2012, the coverage of key health services such as institutional delivery, antenatal care, family planning, and immunizations has increased. Free outpatient care for the poor and vulnerable has also increased. The quality of care, as measured by the average total quality of care score increased from 43 percent to 64 percent between 2012 and 2015.



Key findings from the midline qualitative study indicate that both service providers and regulatory agents have a strong desire for the implementation of the PBF program to continue. Specifically, the study found that PBF has resulted in increased collaboration among the various stakeholders; whether it be between regional/district supervision teams and health facilities (in particular private health facilities), or between health facilities and the community members they were serving. In addition, management tools and procedures used in PBF (such as quarterly business plans, the "outil indice" for balancing expenditures and revenues, and individual performance evaluations of facility staff) led to enhanced transparency and accountability in resource management. These positive effects also contributed to increased satisfaction among both providers and patients.

The PBF program has also had a positive impact on service delivery: facilities are cleaner, more organized and better managed; staff are motivated; utilization and quality of services has increased while the price for services has reduced; drugs are more readily available, indicating that the public sector monopoly on drug provision has been broken; and the frequency of under the table payments from patients to providers have been reduced.

The study also identified obstacles. The most common obstacles encountered were (i) initial reluctance and adjustment of health facility staff to the program requirements; and (ii) obtaining initial buy-in for PBF and support of government health officials and health facility managers, particularly prior to the first payment of PBF subsidies when participants questioned if the Government would actually be able to implement the program as intended.

POLICY IMPACTS

There are several important policy impacts resulting from innovations in the design and financing of the PBF pilot in Cameroon.

- **Private sector facilities, including private for-profit and faith-based facilities, have signed PBF contracts along with the more traditionally included public sector facilities.** As a result, private facilities now offer preventive/promotional services such as vaccination, family planning, and PTMTC. In addition, the quality of care has improved in all facilities, and there is improved coordination, communication and collaboration across levels of the health system.
- **The management of the PBF contracting, verification and payment process transitioned from international NGOs to local structures** with legal authority and a positive history and relationship with the Ministry of Health (MOH). As a result, overhead costs have been reduced, and the local structures have been integrated into the national system. The transition occurred over a 12-month period through a multi-step process involving six months of training and shadowing of the international NGOs, resource transfers and signing of subsidiary agreements with the MOH, and finally, evaluation of the transfer and recommendations for a national model and scale up.
- **After two years of the pilot (2011-2013) the Government of Cameroon decided to begin financing PBF directly through domestic resources.** Starting in 2014, the MOH financed RBF through direct budget support in the Littoral region through the regional Public Treasury. Recently, the MOH requested support to explore the current budget to identify opportunities for channeling resources that are currently being wasted or poorly spent towards the RBF budget line.

preliminary results from the impact evaluation and focus on the results comparing the RBF program with control group 2. The baseline data was collected from October 20 to November, 2011. The endline data was collected from September to November 2014. Analysis on the RBF program compared to the enhanced financing arm (control group 1) is being finalized and will be included in the online version of the Annual Report to be released in October.

PRELIMINARY RESULTS

Preliminary results from the impact evaluation indicate that RBF significantly increases utilization of select MCH services, such as early antenatal care (ANC)-seeking behavior and in-facility delivery when the RBF districts are compared to the districts operating as "business as usual"—women from health facilities in the RBF districts sought ANC about three weeks earlier than women receiving care in non-RBF districts (Figure 1) and the rate of in-facility deliveries increased by almost 13 percent (Figure 2).

Performance on some post-natal care measures increased in RBF districts. PNC coverage and immediate breastfeeding increased by nearly 10 percent and 14 percent, respectively, and were statistically significant.

FIGURE 1

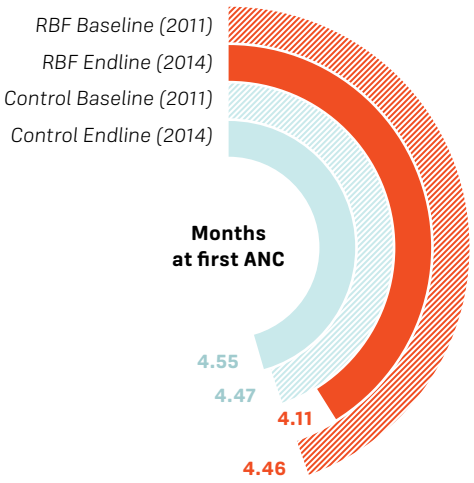
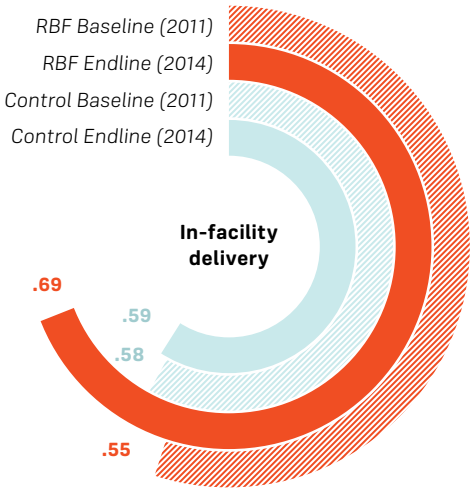
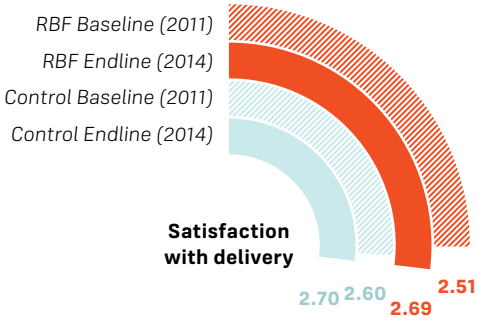


FIGURE 2



However, there were no relative gains in other MCH related measures. For example, the percent of women receiving any ANC and satisfaction with delivery increased (Figure 3) but neither improvement was statistically significant.

FIGURE 3



A health facility survey also showed that in RBF districts, select MCH equipment was more available, there were fewer stock outs of select drugs such as DMPA, ACTs, oxytocin, and ORS, clinical protocols were displayed and adhered to with more fidelity (as assessed through patient exit interview), and health workers were more satisfied with their work conditions and operated with higher autonomy. However, the impact of RBF on worker knowledge was minimal and impacts on both staff motivation and client satisfaction were inconclusive.

Based on the experience so far, the new IDA-funded Health Services Improvement Project will continue to support a results focus for women's and children's health in Zambia.

NIGERIA

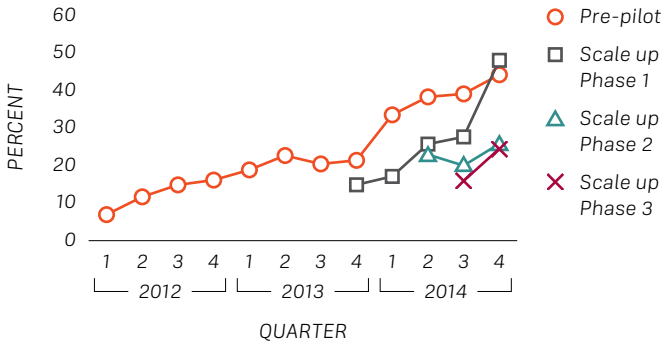
From Small Pilot to Expansion

In 2011, Nigeria launched a small Results-Based Financing pilot, covering a population of 500,000 across three Local Government Areas (LGAs). The pilot states of Adamawa in the North East, Nasarawa in the North Central region and Ondo in the South West showed early promising results. Based on the lessons learned, the full scale Nigeria State Health Investment Project (NSHIP) was developed with $150M IDA funding and a $20 million HRITF grant. Project roll out began in December 2013 and today RBF in Nigeria covers over 900 facilities in 50 LGAs with an estimated population of about 14 million as illustrated in Figure 4.

EARLY RESULTS FROM THE PILOT AND EXPANSION PHASE

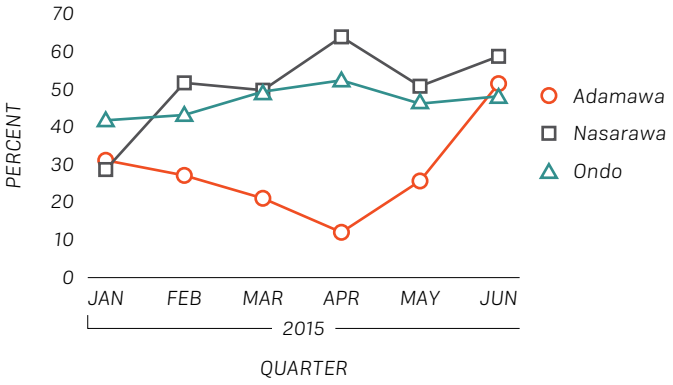
Uptake of services has been very encouraging, with utilization of core maternal and child services like immunization, deliveries in facilities, and family planning, showing much improvement. Figure 5 shows an immunization coverage increase in pre-pilot facilities from 5 percent to 44 percent; an increase from 14 percent to 44 percent in the first phase scale up facilities; and showing promise in the most recent scale up facilities.

FIGURE 5
IMMUNIZATION COVERAGE INCREASE IN PRE-PILOT FACILITIES 2012 - 2014



Similarly, at state levels, Figure 6 shows an increase in immunization coverage from 31 percent to 51 percent in Adamawa State, 29 percent to 59 percent in Nasarawa and 42 percent to 48 percent in Ondo State, since completion of scale up in December 2014.

FIGURE 6
POST-SCALE UP IMMUNIZATION COVERAGE INCREASE



Moreover, data show that quality of services also improved, along with the increases in coverage. A quality checklist applied on a quarterly basis found that structural and process quality measures saw rapid and sustained improvements. A recalibrated checklist with a stronger focus on processes of care was introduced in January 2014.

Finally, PBF facilities achieved good patient satisfaction, with ratings of 80 percent in Nasarawa State and 95 percent in Ondo State. It is worth highlighting that these results have been achieved at a marginal additional cost of $0.8per capita per year.

In February 2014, NSHIP funded the launch of an intensive internship program, implemented by the National Primary Health Care Development Agency, to increase the number of PBF Independent Verifiers in the three PBF pilot states.

FIGURE 4
NSHIP ESTIMATED POPULATION COVERAGE 2011-2015