



# Funding Results for Reproductive, Maternal, Newborn and Child Health

## KEY MESSAGES

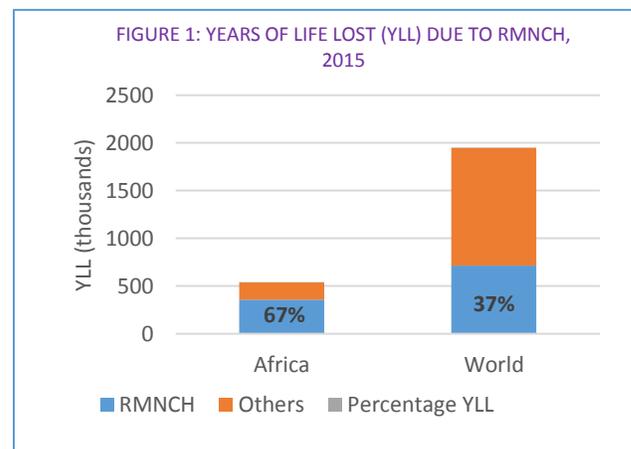
- Over the past few years, Results-Based Financing (RBF) focussed on maternal and child services has expanded rapidly. In 2015, in Africa alone, there were 34 RBF schemes either at pilot or national level.
- Key characteristics include: (i) shifting the dialogue from focusing on the execution of the budget to a dialogue on the links between resources and results; (ii) giving greater financial and managerial autonomy at the facility level; and (iii) strengthening the measurement of results.
- These changes have delivered good results in terms of improving health infrastructure, increasing health coverage and accountability.
- However, RBF schemes show mixed results, especially in terms of health outcomes for maternal care, indicating the need to take into account country initial differences and focus monitoring on the quality of care and health outcomes for maternal and neonatal health.

During the first decade of the twenty first century, many sub-Saharan African countries made substantial progress in lowering fertility rates, improving maternal health, lowering infant and children mortality and reducing HIV infections among children. Nevertheless, reproductive ill health among women remains a major contributor to mortality and morbidity in sub-Saharan Africa (SSA).

### Importance of RMNCH for SSA

Each year approximately 200,000 women in sub-Saharan Africa die from a pregnancy-related cause (WHO 2015b). Overall, the burden of disease related to reproductive, maternal, newborn and child health (RMNCH) is much higher in Africa than in other parts of the world. Globally, in 2015, 37% of the years of life lost (YLL) was due to deaths from maternal causes or deaths among those younger than 15 years. By comparison, 67% of YLL in the African Region was due to the same factors (Figure 1). The importance of reducing maternal mortality is not a new development. In the 1980s, public health specialists drew attention to the fact that most maternal and child health

programmes were almost exclusively to the benefit of the child, with little attention to the factors that were causing women to die. In 1987, the Nairobi conference marked a turning point that led to the notion of safe motherhood being a core component of reproductive health.



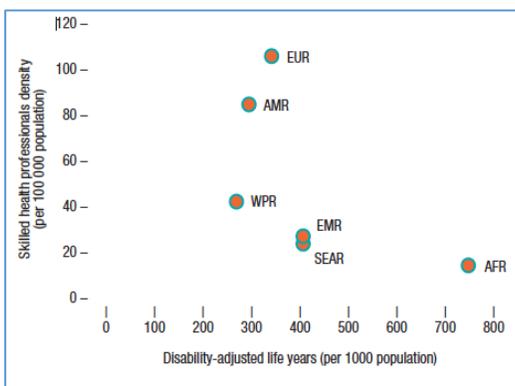
Note: RMNCH = Reproductive, maternal, neonatal and child health. The percentages of total YLL due to maternal, newborn, and children mortality are shown on top of each bar. (WHO 2016)

In 2000, the importance of maternal health was reinforced when it became one of the eight Millennium Development Goals (MDGs). In sub-Saharan Africa, the maternal mortality rate was reduced by 44% between 1990 and 2015, but the MDG goal of a three-quarter reduction was not reached. However, one factor that biased this comparison is the HIV and AIDS epidemic that increased mortality rates in a manner that could not have been anticipated.

### Lack of Adequate Infrastructure and Health Professionals

A key objective of the health programmes that were implemented during the first decade of the 21<sup>st</sup> century was to increase access to professional medical care because it was perceived to be essential for improving health outcomes. As shown by Figure 2, there is a broad association between the density of health workers and the burden of disease. Regions with high burden of disease like SSA are also the ones with the lowest density of health workers. A similar relation can be seen in the case of RMNCH. SSA countries with a high proportion of births being delivered by skilled attendants have low neonatal mortality rates (Figure 3).

FIGURE 2: HEALTH WORKFORCE DENSITY, 2005-2015 AND ESTIMATED TOTAL BURDEN OF DISEASE, 2010 PERSONNEL (%)



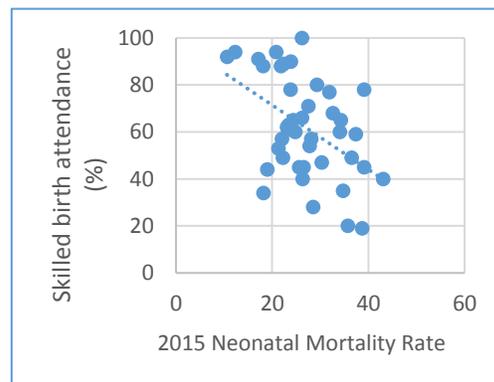
### Gap Between Access to Care and Quality of Care for RMNCH

Improving health systems was recognized, early on, as the way forward. In many countries, this led to a shift from individual health projects to Sector-Wide Approaches (SWAp) that could address more systemic issues. On average, these initiatives were found to improve health sector coordination and alignment with country objectives, but in the six countries that were evaluated, national health objectives were only modestly achieved (Vaillancourt 2009).

These findings indicated that in many countries the chain of results, from improving health inputs and personnel to better health outcomes, is often broken. A common conclusion is that the missing link is quality care. As suggested by several studies, only improving access to healthcare, without attention to quality of care, is insufficient to improve health outcomes.

Evidence to that effect comes from an analysis of facility surveys in eight countries (Haiti, Kenya, Malawi, Namibia, Rwanda, Senegal, Tanzania and Uganda) carried out between 2007 and 2015. This study reviewed the

FIGURE 3: BIRTHS ATTENDED BY SKILLED HEALTH AND NEONATAL MORTALITY RATE IN SSA



Source: The skilled birth attendance in 42 SSA countries is from World Health Statistics (WHO, 2017). The neonatal mortality rate is from the World Bank Development Indicators for the year 2015.

relationship between the level of health infrastructure and level of health care in four clinical service areas (family planning, antenatal care, sick-child care, and labour and delivery). On average, there was little correlation between health infrastructure and the quality of care (as measured by adherence to evidence-based protocols).

Similar results were found in three evaluation studies, carried out in India (Randive 2013), Malawi (Godlonton 2015) and Rwanda (Chari A.V 2014), where expanded access to formal healthcare has failed to yield survival benefits.

## The Challenge of Funding Health Systems

Due to changes in international priorities both within health and across sectors, total Development Assistance for Health (DAH) increased by only 1% per year in 2010-17, a sharp decline from the 11.2% annual growth it achieved in 2000-2010 (IHME 2018).

Within health, support shifted away from HIV/AIDS, Tuberculosis and malaria, as well as Health Sector Strengthening (HSS) and SWAp, but other sectors did not benefit from this change: they all experienced lower growth rates in recent years than in 2000-2010.

In contrast, broad support for RMNCH helped keep maternal, newborn and child health's share of funding relatively stable. Nevertheless, international funding for RMNCH has remained flat between 2013 and 2017 (IHME 2018). In 2017, the development assistance for RMNCH amounted to US\$11.6 billion, representing 31% of the total DAH.

Faced with the prospect of slow growth of international aid, it has become quite common for researchers to recommend that countries give more priority to health. In 2001, the Abuja Declaration had already asked African countries to allocate at least 15% of government expenditures to health. But few countries reached that goal. On average, the share of health expenditures for developing countries rose slightly from 10% in 2000 to 11% of public spending in 2015. For many countries, and especially those that are in the low-income group, growth in health spending has been mainly driven by increases in government resources, rather than reprioritization of health expenditures within the government budget.

Future prospects are not encouraging for SSA countries. SSA countries' per capita health spending (including domestic and international aid) is projected to increase by only 1.4% per year during the 2015-2040 period (IHME 2018). Given the usual uncertainty surrounding these type of projections, the results should be viewed as one scenario amongst many; nonetheless, they highlight the need for SSA countries to get more "value for money".

## Scope for Improving Efficiency

Estimating how much more "outcome" could be obtained with existing resources is fraught with difficulties, but there appears to be consensus that there is large potential:

- In 2010, WHO estimated that 20%–40% of all resources spent on health were wasted through leakages, inefficient combinations of interventions, and sub-optimal use of medicines and human resources (WHO 2010).
- For the US, PricewaterhouseCoopers' Health Research Institute estimated that wasteful spending amounted to up to half of all health spending in the US in 2010 (PricewaterCoopers' Health research Institute 2010).
- Looking at SSA countries, there is a wide variation in health outcomes for the same level of per capita spending, which suggests a scope for improving results without major increases in spending.

**A useful way of analyzing inefficient spending is to view it as the result of three different types of factors:**

- **Behavioural factors:** Behaviours that lead to health problems that could be avoided through non-medical interventions (e.g. providing financial incentives for HIV testing or providing cash transfers for keeping girls in schools which has been found to have protective health benefits).
- **Operational factors:** Administrative or other processes that add costs without creating value (e.g. ineffective use of IT, errors in claims processing leading to fraud, etc.)
- **Clinical factors:** Medical care that is poor and results in additional treatment costs.

## Result-Based Financing (RBF)

Recent efforts to address individual behaviours, and clinical and operational deficiencies have followed various approaches under the general term of **Results-Based Financing (RBF)**. In 2015, in Africa alone, there were 34 RBF schemes either at pilot or national level. RBF encompasses a variety of demand- and supply-side incentives:

- The first type consists of demand-side incentives provided in the form of **conditional or unconditional cash transfers** with the objective of changing behaviours and/or increasing the demand for health services.
- The second type, often referred to as **pay-for-performance (P4P)** in high income countries, aims to improve the supply of health services by providing financial incentives to hospitals, physicians and other healthcare providers.
- A similar approach is the **Performance-Based Financing (PBF)** which has been widely used in low- and middle-income countries. It is also a supply-side intervention that has been used to increase the coverage and quality of essential services, often with a focus on maternal and child health.

### Key characteristics of PBF are:

- Linking payments and results,
- Independent verification of results,
- Managerial autonomy to facilities and,
- Enhanced systematic supervision and coaching of facilities.

These characteristics set PBF apart from the traditional health programme, under which international aid is received by the Ministry of Health, and which, in turn, hires health professionals and procures the needed supplies. In that type of programme, health care services are paid for by government, sometimes irrespective of whether the right services are being delivered.

In many countries, such a system of funding has resulted in an unbalanced allocation of funds with most of the resources being used for funding central-level administration and few funds reaching decentralised levels of public health facilities.

## Key Results of PBF

The initial impetus for PBF in SSA countries arose from an early impact evaluation in Rwanda that found positive impacts on institutional deliveries and preventive care visits for young children and also on the quality of prenatal care (Basinga 2010). After this promising start, other quasi-experimental studies have also shown some positive results for many, but not all, of the outcomes that were evaluated, as indicated by a World Bank review of seven completed evaluations of RBF in Afghanistan, Argentina, Cameroon, RDC, Rwanda, Zambia and Zimbabwe (Kandpal 2016).

### Overall, the main advantages of PBF is that it has helped to:

- Shift the dialogue between government and donors from a focus on the execution of budgets to discussing results.
- Ensure that health facilities at the local level received a larger share of resources. This has conferred greater financial autonomy at the local facility level, including the authority to make decisions on staffing.
- Strengthen the focus on measurements. Due to its link between performance and payments, PBF creates a strong demand for health information systems to provide timely information and allow verification.

However, evaluations also indicate that the effects of PBF are heterogeneous, varying both within and across countries. Few studies have examined in detail the reasons for this result, but three broad factors seem to stand out:

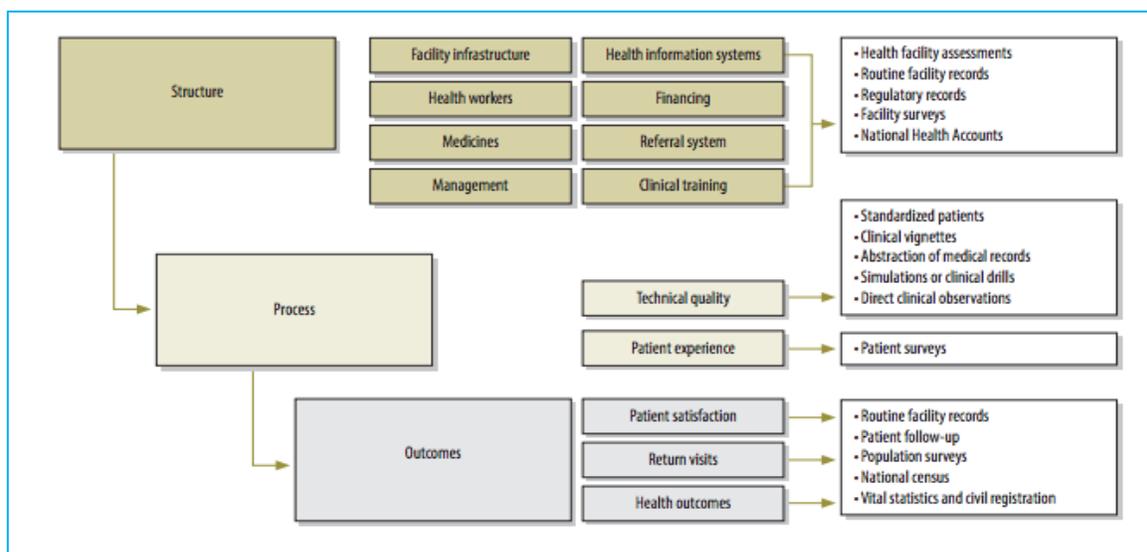
- First, **contextual factors that may affect the sustainability of reforms**. As found by a review of 23 PBF, most PBF were implemented in fragile and conflict-affected countries (Bertone MP 2018). Such contexts are bound to create implementation challenges as occurred in Afghanistan.
- Second, **country-specific bottlenecks** were not always identified prior to implementation. These included:

- Demand-side barriers (e.g. payments at point of use) that constrain the uptake of certain services,
  - Legal constraints on the autonomy of health facilities that conflict with the autonomy granted to facilities under the PBF,
  - The complexity of the PBF approach which can impede understanding of the incentive mechanism, and more generally,
  - The readiness of the health system for a relatively complex health system reform.
- Third, shortcomings in the **measurement of results**. So far, most of the monitoring indicators are focused on inputs and processes, but very few measure the quality of care. As a result, incentives to improve quality are often lacking.

### Bridging the Quality Chasm in Maternal, Newborn and Child Healthcare

Efforts to operationalize the meaning of quality can best be understood by following Donabedian’s theory of quality of care (Donabedian 1988). Donabedian proposes three dimensions of care that needs to be tracked and linked: (i) structure (e.g. facility infrastructure, management and staffing), (ii) processes (contents of clinical encounter and patient experience) and (iii) outcomes (patient satisfaction, return visits and health outcomes) (Figure 4).

FIGURE 4: DOMAINS OF QUALITY OF CARE AND DATA MEASUREMENT



Source: (Akachi 2017)

Each area has advantages and disadvantages for monitoring: inputs are a necessary component of health care, but they do not provide much information beyond that; process indicators provide more information on the type of care that is provided, but are more difficult to collect, and outcome indicators measure the ultimate goal of health care, but they also reflect the impact of factors that are beyond the health system itself.

Applying that typology to PBF leads to the conclusion that PBF has improved the structural elements of quality of service delivery (e.g. availability of equipment and drugs) but has been much less successful in improving processes and health outcomes. One reason (in addition to the others previously mentioned) is that most of the efforts to monitor results have been concentrated on measuring inputs. Much more effort is needed to measure the content of care and outcomes.

In a recent analysis of 68 checklists (at primary, secondary and tertiary levels) used in 32 PBF programmes across 28 countries, the indicators were found to focus mainly on infrastructure and availability of resources (Josephson 2017). On average, checklists covered 125 indicators of which 80% were structure-type indicators, 19% process-type and less than 1% outcome-type. Looking at the indicators in more detail show that structural indicators measure mainly resource availability (57%) and/or are management-focused (24%) rather than being related to the clinician-patient interaction, which suggests a rather ineffective blend of indicators to assess the quality of care.

## Way Forward

Since most of the SSA countries lack the health information systems to collect outcome measures of health care, it is reasonable for PBF to start first with information on inputs. Its main purpose, so far, is to provide the information needed for (i) verifying payments and (ii) measuring the extent to which the necessary infrastructure for health care exists.

However, improving health outcomes also depends on what happens once people reach the clinic. As shown by several surveys of providers, there is a gap between what clinicians know and what they actually do in practice. In most cases, clinicians have the knowledge to improve care, but they do not have incentive to do so. Linking financial incentives to indicators of process and content could thus offer a way to close the gap and improve health care.

In practice, information systems will need to be developed and data collected. The areas of focus have been recently delineated by WHO which defined standards for improving the quality of maternal and newborn care (WHO 2016). However, this work needs to be operationalized by identifying corresponding indicators and how information could be collected. In the past, gathering such information was costly, but there is now scope for new technologies, such as phone surveys or using email to collect more clinical and patient-based metrics, including patient satisfaction.

In the final analysis, PBF needs to evolve further. On the one hand, there is a need to implement reforms that act on the demand side of health (such as social insurance or reducing out-of-pocket payments) as well as on the supply side. Improved quality of health services is often the missing link. Policy changes that boost demand only fail to improve health outcomes if the supply of services is of low quality. And conversely, policy that acts to increase the supply of services may fail to have a substantial impact on outcomes if there are strong constraints on the demand side that are preventing people from accessing health services.

Overall, PBF needs to evolve. Because of the many links it has with the rest of the health system, it cannot remain a project in isolation to the greater of the health system, but it can be used as a testing ground for promising innovations and provide substantial evidence concerning the need to improve the efficiency of current health systems.

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