

Knowledge Brief

Health, Nutrition and Population Global Practice

COMMUNITY RESULTS-BASED FINANCING IN HEALTH PRACTICE: REFLECTIONS ON IMPLEMENTATION FROM EXPERIENCES IN SIX COUNTRIES

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KEY MESSAGES:

The term ‘community Results-Based Financing’ (cRBF) has been used to qualify a range of schemes whereby community actors such as community organizations, community health workers (CHW), and health facility committees (HFC) are contracted to facilitate access to –and sometimes directly provide– preventative, promotional, and curative health-care services.

- It is too early to assess the effects of such experiences in the countries this brief focusses on (i.e. Benin, Cameroon, the Gambia, the Republic of Congo, and DR Congo), but comparing and discussing those schemes reveal aspects that are key in implementation, among others:
 - Pre-cRBF community engagement in health-care varies a lot; successful implementations of cRBF have built on those features and peculiarities.
 - Timely payment is crucial in a context where community actors often live in poverty; forms of pre-payment may improve retention and motivation.
 - Central to quality is the training and monitoring of community actors, which is easily undermined by low commitment of district officers and chief nurses. Certification and focus on the lower levels of ‘cascading’ training may improve quality, as well as testing the knowledge of community actors.
 - Information and Communication Technology is not a panacea for improving data collection and analysis: it requires a strong system in place, simple tools, and trained, supervised, and monitored actors—three conditions rarely met in the field. cRBF is not always well integrated into health information systems.
 - The choice of indicators and bonuses is often a top-down decision, more community engagement may be desirable but has to be accepted by the Ministry of Health. cRBF schemes are part of wider community health policy reforms and represent an entry door to re-vitalize the often neglected sector of community health.

In recent years, the emergence of ideas such as ‘close to client systems’ and ‘community accountability’ have renewed interest for community actors, and for new strategies to organize and fund them. One such strategy, whereby community actors are paid based on the activities they undertake, is ‘community-based Results-Based Financing’ (cRBF). The approach seeks to bolster demand for health-care services through the introduction of incentives for community-based actors. cRBF is regularly presented as a necessary complement to health facility-

level RBF; it is seen as helping with some of its bottlenecks such as the lack of information from and for users, issues in reaching remote populations, and difficulties in enhancing health-related behavioral change at community and household levels.

While a growing literature is analyzing the successes and shortcomings of RBF at the health-facility level, almost nothing exists regarding community RBF. This brief looks at cRBF implementation, relying on interviews,

discussions, and workshops with practitioners involved in six developing cRBF experiences in Cameroon, The Gambia, Benin, DR Congo, Rwanda, and the Republic of Congo. It seeks to shed light on success and difficulties encountered in the implementation of cRBF programs or policies.

Who is the community in ‘community RBF’? The term cRBF is used to categorize a wide variety of schemes contracting of a community actor on the basis of performance indicators –e.g. the delivery of a service. This community actor can be a group of or individual Community Health Workers (in the Republic of the Congo, Benin, Cameroon, and Rwanda), a Health Facility Committee (in DR Congo), or any other local committees (Voluntary Support Groups in The Gambia). **Do cRBF schemes work?** It is too early to say: most schemes are still in their infancy. An impact evaluation of the Rwandan scheme found mixed effects. Ongoing schemes in Cameroon, Congo, and The Gambia integrate rigorous impact evaluation mechanisms and initial results should be available in two to five years. At this stage, the main discussion we can have is around the implementation of cRBF. **What can be learnt from those new schemes?** Together with country teams, seven areas have been identified as crucial. The idea is not to provide any ‘recipe’, but to identify significant issues and questions raised in contexts that vary in terms of (c)RBF architecture and structure, health system effectiveness, and socio-economic and political environment.

1. CONTRACTING COMMUNITY STRUCTURES

Different rationales underpin the architecture of the different cRBF schemes; they are intimately linked to local contexts. Understanding the existing community structures and collaborating with them has been crucial to the design and implementation of most cRBF schemes. For example, the Republic of Congo barely had households visits and CHWs prior to cRBF, hence, in consultation with the different stakeholders, the rainbow programme (the local cRBF scheme) set up a system of household visits by newly trained CHWs. Conversely, in Benin and Cameroon, CHWs have existed for a long time but their activities have often been inconsistent, the approach has therefore been to train them on a package of activities and sub-contract them through their local health centers. In The Gambia, community meetings helped decide that the best option would be to contract the existing, and already well-functioning, village Voluntary Development Committees.

Clear and simple contracts have helped implementation in the various cases: they entail being explicit with the community about the phasing out or discontinuation of programs. What is more, a good communication should also be sensitive to the characteristics of the local communities. Good examples of this include the case of The Gambia where the premium is adjusted to the size of the community and DR Congo where equity criteria (for

example, distance from health facility) inform the payment of an extra bonus. In other countries, neglecting the variance in efforts to perform the contracted activities has, reportedly, led to unease with contracted community actors.

cRBF systems are recent but the question of their resilience to emergency situations –such as epidemics– is already being raised. Part of the answer may lie in mechanisms discussed below: fluid payment systems, integration of cRBF into national health policies, and strong quality assurance mechanisms.

2. TIMELY INCENTIVES AND PAYMENTS

With community actors often living in situations close to poverty, the timeliness of payment is fundamental. In their first months, most schemes have experienced important delays that led not only to discontent but also attrition of the (often trained) community actors willing to participate in cRBF. Slight changes in the cRBF architecture and increased experience of the implementers have usually led to resorbing those delays. Pre-payment mechanisms also help. In Benin, health facilities reluctantly accepted to pre-pay CHWs monthly but, eventually, the pre-payment improved the motivation and retention of CHWs.

Whether there should be a fixed, non-results based, part in the remuneration of the cRBF community actor is debated. Most countries have suppressed this fixed part because it was not providing strong enough incentives. A fixed part may, however, help with retention. The experience of Cameroon has showed higher attrition of CHWs after the fixed part was suppressed. At the same time, it may make community actors a de facto part of the MoH payroll –a problem in some countries. The issue of the fixed part ties into two other important issues.

First is the question of the ‘amount’ of indicators contracted actors routinely achieve: in Benin it was estimated that, at the end of the day, payment does not vary hugely between CHWs (but it varies between health zones), while in Cameroon it was reported that what varies most is the bonus based on technical quality. Second is whether being a contracted cRBF actor is, in practice, a full-time activity. The amount of money cRBF actors can expect to earn varies hugely between countries. In Cameroon, many consider the price of indicators too low, but being a contracted CHW can nonetheless provide a sizeable complementary income to people living in situations close to poverty. This is less the case in Benin or with the HFC members of DR Congo and the Committee members in The Gambia. It is important to note that the living conditions of community actors does not seem to play too important a role when deciding the price of indicators. In most cases, the price of an indicator is set according to (1) the total available budget and (2) the potential positive and cumulative externalities of the activity (in The Gambia, a pricing consultant helped the exercise).

3. PARTICIPATORY SELECTION OF INDICATORS

The choice of indicators is a clear policy tool used to set health-care priorities, a responsibility of the Ministry of Health (MoH). Since a smooth and successful implementation of cRBF requires the collaboration of many actors, most schemes include discussion mechanisms that bring together different divisions within the MoH as well as financial and technical partners. In most cases, this process is consultative rather than deliberative but ultimately, because a series of cRBF schemes are, at least partly, externally funded, donors have a decisive influence on the choice and pricing of indicators. The community and local-level actors who lack representation in regional and national fora are the ones who face most difficulties having their voice heard.

All schemes except Cameroon's cRBF have deliberately chosen to operate with less than ten indicators to reduce costs, increase the monetary incentive attached to individual indicators, improve data quality and verification but also to set clear policy priorities and maintain the focus, and thereby quality, of the work of the community actors.

Most schemes focus on indicators related to health promotion and patient referral, with apparent success in some areas such as the community detection and referral of tuberculosis in Benin. In countries like Cameroon and Benin, there is an interest for potentially integrating more service delivery (including curative activities in Cameroon) in the cRBF package of activities. This is seen as potentially beneficial for the population that is not in frequent contact with health facilities but would also overstretch the role of the CHWs and begs questions about their level of training and qualification. It also risks to exacerbate a real challenge in the field: to ensure that the CHWs do not overstep their assigned role and only provide the services they are meant to provide and are trained for. That indicators should be SMART (Specific, Measurable, Accepted, Relevant and Time-bound) appears obvious to most practitioners involved in cRBF who called for indicators to be as specific as possible. However, at the same time, arises the question of what is left apart, not contracted because it is hard to measure.

4. ENSURING FEASIBILITY AND QUALITY

Quality comes, first and foremost, from the appropriate training of the contracted community actors. This has been raised as a possible issue in many of the schemes. Indeed, the 'cascading' or 'snowball' training model that is used, and understandably so given the high number of actors involved, has too often meant that training at the community level is of poor quality –when it is precisely that level that is in contact with the users. Solutions to this problem include (1) proper certification by third-party (Benin) and badge schemes that signal quality training and (2) supervision mechanisms and re-cap session (yearly

session in Cameroon). District teams are a prime candidate to take on this type of role and to provide additional training and refreshers, and they have been supported in that sense in DR Congo. However, in other contexts, local governments have high turnover, limited capacity for supervision and have displayed very little enthusiasm to monitor CHWs, leading cRBF implementers to consider alternative channels such as municipalities.

Quality is hard to check given (1) the often high number of community actors and (2) the fact that most activities are scattered across the health center's responsibility areas. This does not mean that it is impossible: district assessment exists in all schemes and community monitoring is being experimented in Cameroon and Benin with local Community-Based Organizations (CBOs), who check entries in CHW registers used by the CHWs and assess user satisfaction (the same surveys have been, reportedly, used to identify areas of improvement for health facility staff). This system requires well-trained and literate CBOs that are not always in high supply in rural areas. Testing the knowledge CHWs have of the different activities they are supposed to undertake is another possible –and interesting– way to monitor quality and is an option that is being tested in Cameroon. High caliber CHWs would, then, be those who are, for instance, able to correctly identify an illness in the community and refer the patient to the health center.

5. SIMPLE DATA SYSTEMS

In a perfectly functioning cRBF scheme, quality issues would be identified in real time, by an efficient data-based monitoring system. This, however, appears to be quite challenging. Too often, (data collection) tools are too complex to be meaningfully used at the community-level and there is little and sometimes no integration between cRBF data collection and other health information systems –with some notable exceptions such as Benin and The Gambia where cRBF data collection is fully integrated into DHIS II.

The Gambia cRBF scheme has innovated in data collection and verification with the use of survey-based Lot Quality Assurance Sampling (LQAS). The model is quite appealing at first glance but the solution may not fit other cases: it does not provide detailed community-level data; it is costly, and it is technically complicated to implement (population size is needed, for instance). For most cases, this will not be a panacea. Conversely, the belief that Information and Communication Technologies (ICT) automatically improve data collection and quality seems often misplaced. For this to happen, the data collection mechanism in place must be strong and simple enough to be accessible for people with potentially low technological literacy. Training is also required as shown by the examples of The Gambia and Benin. These conditions are simply not met in many cases, making the use of ICTs at best a waste of energy –and at

worst creating more problems by adding another layer of complexity in a system many already find complicated.

Ultimately, practitioners are still exploring ways to best use community-level data to inform and influence activities and policies. At the micro-level of a health facility, a huge, largely untapped, potential is the use of data analysis by local nurses and CHWs to identify and act upon local problems. This, however, requires additional training and may require skills that are simply not available at that level.

6. OUTREACH AND ACCESS

CHWs systems that have been 'revitalized' through cRBF may help reach populations that were not reached in the past. In Cameroon for instance, newly incentivized CHWs started visiting nomadic people when they pass in the health centres' area of responsibility, reportedly improving vaccination coverage among that population. Further, cRBF schemes are said to be open to the entire community –and few of them have chosen to devote energies to targeting specific vulnerable groups, this despite cRBF being a potentially powerful tool to doing exactly this. One exception is Benin, where CHWs receive a higher premium when they visit indigents in their home. Home visits are known to be an opportunity for increasing health awareness among the most vulnerable.

7. HEALTH SYSTEM INTEGRATION

The cases of Benin, the Republic of Congo, and Cameroon illustrate how cRBF can be an opportunity to 'rationalize' the CHWs and HFC members in terms of clarifying their roles and ensuring that they have adequate skills, but also bringing them closer to health centers. cRBF approaches are generally horizontal, in the sense of an integration in the local health system. It remains unclear how new vertical programs would fit in such a model but cRBF could be a platform for interventions relying on CHWs.

The Gambia and Rwanda cRBF cases also present interesting features in terms of integrating traditional actors into the health system through the contracting of 'cooperatives' of birth-attendants (Rwanda) or groups that include them (The Gambia).

Further Learning

Community engagement is crucial for expanding the coverage of essential health services in a cost-efficient manner, especially in situations with limited fiscal space for health. cRBF schemes are an eclectic mix of approaches that attempt to bring in more funding to community actors through various incentive systems. It is too early to tell whether the different approaches covered in this brief are effective. What seems clear at this stage is that cRBF approaches lead to re-thinking, and possibly re-vitalizing, a

community health sector that is often neglected. By doing so, cRBF also asks questions about the health (and RBF) system, among others in terms of roles of the community actors or quality insurance.

There is no one-size-fits all and successful implementations have built on local realities and institutions and adjusted and learned from the field. There remain many more questions and unknowns than answers about cRBF and it will be crucial that experiences are well documented and researched in order to push the global reflection on the topic forward. In addition to the need to soundly evaluate the impact of cRBF schemes, further research is required to better understand a series of key issues, among others: (1) the link between cRBF and other demand-side approaches (including vouchers); (2) the links between cRBF and primary health-care approaches, also in terms of coordination of the different stakeholders (and in terms of community participation in cRBF verification); (3) the role of non-monetary incentives for CHWs; (4) community feedback mechanisms, including those enabling vulnerable and marginalized groups to be heard in the public sphere; as well as the mechanisms that empower communities and make them recognized; (5) the extent to which CHWs can be used as frontline providers, especially for family planning (for example, distributing pills); (6) the mechanisms capable of compelling households into action following a CHW's household visits, and more broadly, the best ways to incentivize behavioral change and community action; (7) potential systems for regular community-level data collection, monitoring, and quality control –and the role of technology in them; (8) the effects and sustainability of projects undertaken with or support by community subsidies; and (9) the medium and long-run viability of cRBF schemes, both within communities and as national schemes, and in terms of both community financing and support from local actors.

Several ongoing studies on CRBF schemes are being implemented in the context of the portfolio of impact evaluations funded through the Health Results Innovation Trust Fund. In the Republic of Congo and the Democratic Republic of Congo, the research will focus on incentivizing health facilities to conduct home visits. A study in Cameroon will evaluate a mechanism through which health centers subcontract community health workers. In The Gambia, a model of performance payments to community organizations will be studied. The studies employ both quantitative and qualitative methods and are expected to be completed in the next three years.

This HNP Knowledge Brief is based on the 2016 report 'Community-based Results-based Financing in Practice: A Discussion Piece'; the cRBF workshop held in Harare 18-20 September 2016; an online workshop held with country teams on 19 January 2017, and a series of individual consultations with and between country team.

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