



**Results-Based Financing in The Gambia:
Innovatively Contracting Communities and Health Facilities**



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As the proverb goes, “necessity is the mother of invention” and Results-Based Financing (RBF) makes such “invention” possible. By shifting the focus of governments and health systems from inputs to results, it provides a fertile ground to change the way business is carried out in the health sector: it facilitates a path from bottlenecks to effective and efficient solutions. Context-specific in nature, RBF has been devised in many shapes and forms to respond to the specific needs of countries, regions, communities and peoples. Typically, RBF interventions target beneficiaries (e.g. conditional cash transfers), providers (e.g. performance-based financing) or country governments (e.g. cash on delivery). Most World Bank-financed RBF projects have generally focused on supply-side incentives, leaving stimulation of demand to health facilities. RBF interventions have, however, rarely been as systemic as in The Gambia.



Community meeting, Samba

The Maternal and Child Nutrition and Health Results Project (MCNHRP) of The Gambia uses RBF to directly address challenges linked to maternal and child nutrition and health, including sanitation and hygiene. The MCNHRP uniquely combines a supply-side performance-based financing mechanism with a community-based RBF mechanism, thereby fostering stronger links between communities and health facilities. Its innovativeness further stems from the specific nature of its demand-side financing approach: the community-based RBF scheme in The Gambia implies contracting communities to create demand – rather than contracting households as is typically done in demand side RBF interventions around the world. This approach strengthens social cohesion and community ownership in The Gambia as well as creates an enabling environment for social and behavioral change particularly among women, laying the foundations for the sustainability of results.

The MCNHRP was initially piloted in the North Bank Region West of The Gambia from November 2013 to December 2014. It was subsequently extended – based on lessons learned – to two additional regions in January 2015, namely Central River and Upper River Regions of The Gambia. Its implementation is jointly led by the National Nutrition Agency (NaNA) and the Ministry of Health and Social Welfare (MOHSW), with the financial and technical support of the World Bank.

1. Data-Driven Design

At the heart of the design of the MCNHRP is a data-driven process of barrier identification, building on the 2013 Demographic and health Survey (DHS) as well as on qualitative and quantitative rapid assessments implemented during project preparation. This process was further informed by pre-pilot data gathered through assessments using mixed-methods, focusing on process evaluation data and baseline impact evaluation data.

Specifically, DHS results highlighted persistent undernutrition among children under five (16 percent) and stunting among children (25 percent); high rates of infant mortality (34 deaths per 1,000 live births), under five mortality (54 deaths per 1,000 live births) and maternal mortality (433 per 100,000 live births); stagnant skilled deliveries (57 percent since 2000); regressing antenatal care attendance (at least one visit by a skilled provider regressing from nearly universal in 2005-2006 to 86 percent) and 18 percent of adolescent girls aged 15-19 beginning childbearing (DHS, 2013). Conversely, rapid assessments carried out at household and facility levels to understand barriers to better outcomes underlined concurrent supply-side and demand-side barriers. On the supply-side, insufficient health funding, inconsistent infrastructure, equipment and supplies as well as poor training and motivation among health providers figured as major impediments to service delivery. On the demand side, the cost of care and transportation, inadequate

knowledge of appropriate nutritional practices and healthy behaviors as well as cultural constraints emerged as obstacles to service uptake. The specific nature of these barriers, affecting both service delivery and service utilization, – coupled with poor performance of maternal and child nutrition and health indicators (DHS, 2013) – highlighted the need to intervene in a systemic and integrated manner, concurrently endeavoring to improve nutrition and health outcomes at individual, community, facility, regional and national levels.

2. Community-Based RBF

At individual and community levels, the MCNHRP seeks to create demand and boost service utilization: it provides conditional cash transfers (CCTs) to both mobilize and empower individual women and communities to partake in improving nutrition and health outcomes. At community level, these CCTs imply contracting the community to impart health information, support behavioral change and refer all pregnancies to the nearest health facility. At individual level, CCTs are provided for timely and complete antenatal care (ANC) visits with a skilled provider, starting with the first trimester of pregnancy. These incentives seek to induce adherence to recommended health practices among pregnant women. Conversely, community level CCTs simultaneously raise awareness about the existence of individual CCTs and provide the knowledge, support and enabling environment required for informed health decision-making and timely utilization of primary health care (PHC) services.



Member of a Voluntary
Support Group

Community-level CCTs are rolled out through existing Baby Friendly Community Initiative (BFCl) and PHC structures. Primarily focused on promoting exclusive breastfeeding, Village Support Groups (VSGs) are readily operational as well as formed and led by the community. Their unique access to and knowledge of target populations is used to increase the outreach and effectiveness of social and behavioral change communication (SBCC), particularly focusing on the promotion of personal and environmental hygiene, skilled delivery in a health facility, timely and complete antenatal care, postnatal care as well as birth spacing. In parallel, Village Development Committees (VDCs) and VSGs are used to further scale up BFCIs and further address persisting maternal and child undernutrition as well as food insecurity: they advocate for exclusive breastfeeding and appropriate infant and young child feeding, as well as help identify women and children in food and nutrition insecure households and communities. Qualitative evidence indicates that these community structures concurrently helped increase health knowledge and wide-spread hand washing and other hygiene practices in many communities.

In turn, such gains reportedly helped reduce the incidence of diarrhea: *“We used to give them all kinds of water and we have noticed that is what was causing problems but since the project was introduced, children now have good health.”*¹

Specifically, individual VDCs sign a performance contract with the Regional Health Directorate (RHD) of the MOHSW for the coordination and oversight of outreach and community development activities. In turn, they contract a VSG – including the Community Birth Companion – to organize and carry out health promotion and counselling activities. Both entities are paid quarterly by NaNA for achieved and verified results: 80 percent is used by the VDC to cover operating costs, community mobilization and community development projects, and 20 percent is used to provide performance-based incentives to individual members of the VSG.

¹ Woman who delivered in the previous 6 months, MCNHRP Pilot Process evaluation, 2015.

Performance contracts – and especially community level CCTs coupled with capacity building – engage and empower community stakeholders to devise and invest into their own tailored solutions to health service utilization impediments. For example, in Samba – a community located in the Central River Region of The Gambia – the VDC used CCTs to purchase two donkeys and a cart to help pregnant women easily access skilled deliveries in health facilities. Moreover, in Kaur Health Center in the Central River Region, anecdotal evidence indicates that the concurrency and interdependency of individual and community CCTs helped increase first trimester ANC attendance by a skilled provider from 26 in 2014 to approximately 46 in 2015. They also reportedly contributed to reducing the occurrence of pregnancy-related complications – such as hypertension, anemia, preeclampsia, etc. – thereby contributing to increased mother and child survival.

In this context, individual and community CCTs concurrently helped enhance demand for nutrition and primary maternal and child health services while building momentum and strongholds for community-owned, community-led and context-specific interventions. These community CCTs contribute to placing the achievement of nutrition and health outcomes at the center of individual and community interests.

3. Supply-Side PBF

At facility level, the MCNHRP intervenes to enhance both the quantity and the quality of services provided: it uses performance incentives to improve coverage as well as boost the capacities and motivation of healthcare personnel. It is based on a contractual arrangement between individual health facilities and the MOHSW RBF Committee² for the achievement of verified results. Sixty percent of inherent PBF payments are typically used to improve infrastructure, procure equipment and supplies, increase outreach activities as well as cover operating costs. Supplemented by financial and material start-up support for effective service delivery, these payments help enhance health facilities' autonomy, providing them with the opportunity to set their own priorities and develop tailored solutions to existing bottlenecks.



Review of business plan with NaNA, Samba



Kaur health team, VSG and CAC

The realization of these solutions (i.e. investments) is guided by business plans, developed by each contracted health facility with the support of the RHD. For example, in Dankunku – located in the Central River Region of The Gambia – the health center invested in the renovation of staff quarters to both improve staff living conditions and heighten the facility's potential to attract as well as retain personnel. Conversely, Kaur health center dedicated a portion of received incentives to purchasing essential drugs, thereby bolstering its pharmacy as well as remedying drug supply delays and shortages. Such

investments simultaneously improve health facilities' capacity to deliver services and also boost provider satisfaction. This is further reinforced by performance rewards for health care personnel, representing 40 percent of overall incentives.

² The MOHSW RBF Committee is the unit created within the Ministry of Health and Social Welfare to lead regulatory mechanism inherent to the MCNHRP.

Seeking to both mobilize and motivate provider participation for the delivery of quality community nutrition and primary maternal and child health services, the use of bonuses has been observed – during RHD supervisory visits – to be effective in enhancing provider attitudes: regular and timely attendance, timely provision of care, greater willingness to work, regular and quality reporting and information management as well as motivation are becoming increasingly customary. Similarly, representatives of Bansang Hospital – a referral hospital in the Central River Region – underlined improved referrals as well as heightened interest in patients’ well-being and satisfaction: “an increasing number of primary health care providers ask for medical advice and follow up on referred patients”. Conversely, qualitative evidence suggests that improved provider attitudes and satisfaction are influencing the perceived quality of service as well as patient satisfaction: “[Nurses] are more caring and friendlier. In the past, you would be sitting there and they wouldn’t care, just going about their own businesses. But now they would talk to you, assist you and give you all that you need until you deliver and make sure that you are ok before they release you to go home.”³

In parallel, PBF payments also contribute to expanding the availability of skilled providers, by engaging and incentivizing community health nurses and community health workers to extend service coverage to communities, especially to “hard to reach” and vulnerable households. Focusing on providing selected outreach activities to enhance appropriate nutrition, health diagnosis and referral, community health nurses and community health workers also monitor, support and closely collaborate with community structures (i.e. VDCs and VSGs). Notably, they coach incentivized Community Birth Companions in counseling and accompanying pregnant women for skilled deliveries. By operating within the community and with the community, they contribute to bridging the critical gap between health facilities and communities while enhancing health coverage and equity.



Mother and child at Dankuku Health Center

This critical gap is further bridged by using existing structures of the *Bamako Initiative*, namely Catchment Area Committees (CAC) now being referred to as Health Center Management Committees (HCMC). Including representatives of the catchment area – with the District I Chief acting as Chairman and the Officer in Charge of the health center as Secretary – these structures are contracted by the MOHSW RBF Committee to oversee the day to day management of the health center, monitor PBF funds and individual CCTs as well as play a role in determining individual provider performance rewards.

As such, the HCMCs further strengthened community-centered nutrition and health interventions: they concomitantly ensure that the health facility is accountable, operationally and financially transparent as well as responsive to community needs. In turn, HCMCs are monitored and supervised by the RHD.

Supervision and coaching – alongside incentives – is reportedly also a determinant of improved motivation and performance among incentivized primary health service providers. This is highlighted by a HCMC member who commented: “It gives a feeling of motivation when supervisors [the RHD] come and see what is happening and are aware of your situation and can make changes or corrections where applicable.”⁴ As underlined by a health worker, it also heightens collaboration and team work: “Before, meetings were happening but not frequently like during the RBF... It encourages all the members to participate [...] and involves the CHN village health services. They are part of the health service and

³ Comment from a woman who delivered in the past six months, MCNHRP Pilot Process evaluation, 2015.

⁴ Comment from a CAC member, MCNHRP Pilot Process evaluation, 2015.

the community. Their influence in the community gives great dividends towards service. So without team work, those team people would have been independent in their areas and not interested in what is happening at the healthy facility.”⁵ Supervision further places the achievement of results at the center of the primary health care system, linking, harmonizing and aligning activities implemented by stakeholders.

Despite its concurrent effects on provider performance and on the quality of care, the MCNHRP also constitutes a strain for health care providers as new RBF imperatives coupled with routine activities and continued inadequate human resources have increased provider workloads: *“with the RBF you are to record, be an accountant, entrepreneur, business is not as usual... We are the ones who conduct deliveries, book antenatal mothers, family planning services, looking for invoices and doing all financial transactions, doing our best for services to continue and for the health facility to have drugs at any time so that the patients can get their satisfaction. My role in this project or the health facility is very tedious.”*⁶

4. MCNHRP: National and Systemic Reach

Such overarching constraints are addressed at the national level, particularly by the National Nutrition Agency (NaNA) and the MOHSW RBF Committee who are contracted to ensure RBF management functions, respectively leading the RBF internal verification mechanism and the RBF purchasing functions – validating and paying for results. Collaborating under the aegis of the Project Implementation Committee (PIC), they also coordinate systemic activities: *“Through this RBF we are trying to see how that whole gambit of what constitutes a perfectly working health system is included. Starting from making sure that the right staff are there, making sure that the drugs are available, making sure that the working environment is conducive enough because whatever health education you may give if you don’t facilitate the enabling environment for the people it might not have that impact.”*⁷

Acting as a national platform, the PIC is notably strengthening the health management information system (HMIS) to make it more effective and efficient to support evidence-based decision-making. Building on RBF reporting processes implemented at community, facility and regional levels, the HMIS is being strengthened at all levels to facilitate timely barrier identification, progress monitoring and strategy development. The PIC also intervenes to strengthen national SBCC tools and national health and nutrition policies and guidelines to ensure appropriate training, standardized quality information dissemination and clinically sound service delivery practices. It also engages stakeholders for cross-sectoral change, for example by disseminating the results of the MCNHRP’s impact evaluation baseline assessment. Highlighting human resource and drug availability-related impediments, these results, in turn, motivated joint planning, and assessments of human resources for health and drug supply chains, thereby addressing systemic challenges to improved health and nutrition results. The readiness and willingness of national stakeholders to quickly seek further information and devise solutions is a testimony to the PIC’s mobilization of and collaboration with national partners.



Community birth companions, Central River Region

⁵ MCNHRP Pilot Process evaluation, 2015.

⁶ Comment from a health worker, MCNHRP Pilot Process evaluation, 2015.

⁷ Comment from a PIC member, MCNHRP Pilot Process Evaluation, 2015.

The effective and interdependent collaboration, motivation and commitment of the PIC – supplemented by that of individuals, communities, health workers, Regional Health Directorates, the MOHSW and NaNA, and other national and international stakeholders, including the World Bank – are gradually establishing a strategic and operational culture focused on sustainability and results: “business NOT as usual” is indeed increasingly becoming a leitmotiv in The Gambia across all levels of the health and community nutrition system, boding well for the achievement of better and lasting nutrition and health outcomes.

“This project is very innovative in that it combines the purchase of health and nutrition results from health facilities as well as communities through results-based financing,” said Rifat Hasan, World Bank Task Team Leader for this Project. “Through this reform, health facilities and communities are motivated to work harder and more closely together to not only increase the use of better quality maternal and child health and nutrition services but also improve the adoption of healthy behaviors at community level. By simultaneously addressing supply-side and demand-side barriers, the Maternal and Child Nutrition and Health Results Project will go a long way towards improving health and nutrition of vulnerable families, and we are already starting to see positive changes.”