

PERFORMANCE-BASED INCENTIVES: ENSURING VOLUNTARISM IN FAMILY PLANNING INITIATIVES



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DISCLAIMER

The author's views expressed in this publication do not necessarily reflect the views of the United States Agency for International Development (USAID) or the United States Government.

CONTENTS

- Acronyms..... vii**
- Acknowledgements..... ix**
- Executive Summary xi**
- 1. Overview of PBI and FP: Global Trends, Issues, and Opportunities 1**
- 2. Contribution of FP to Achieving the Health MDGs..... 5**
- 3. USAID FP Policies Related to Voluntarism and Informed Choice..... 7**
- 4. FP in PBI Schemes in Developing Countries..... 11**
 - 4.1. PBA from external funder to national or sub-national level of government 12
 - 4.2. Performance-based fiscal transfers from national to sub-national levels of government..... 14
 - 4.3. Contracting NGOs and paying partly based on documented results in fragile, low-resource settings..... 16
 - 4.4. PBI implemented in public and private sector facilities with government leadership 20
 - 4.5. Voucher schemes enable access to a package of subsidized services, reducing client financial barriers and increasing provider motivation to serve the poor 23
 - 4.6. PBI for community health workers 25
 - 4.7. CCT programs 26
- 5. Conclusion..... 29**
- Annex: Expanding Access to FP and Protecting Informed Choice in the United States 31**
- Bibliography 37**

LIST OF TABLES

- Table 1: Where is FP incorporated into a PBI scheme?..... 11

LIST OF FIGURES

Figure 1: Levels to consider: from payer to recipient.....	12
Figure 2: Afghanistan FP availability index from BSC results (2004–08)	17
Figure 3: Increases in FP utilization following introduction of a PBI pilot in Gitega Province, Burundi	22
Figure 4: Uptake of FP commodity utilization following introduction of vouchers in Pakistan (n=1,569)	24
Figure A-1: Fertility rates,* United States, 1917–1997.....	32

ACRONYMS

ASHA	Accredited Social Health Activist
BSC	Balanced Scorecard
CCT	Conditional Cash Transfer
CDC	Centers for Disease Control and Prevention
FMAP	Federal Medical Assistance Percentages
FP	Family Planning
IUD	Intrauterine Device
JSY	<i>Janani Suraksha Yojana</i>
MDG	Millennium Development Goal
MSH	Management Sciences for Health
NGO	Nongovernmental Organization
P4P	Pay for Performance
PBI	Performance-based Incentives
PBA	Performance-based Aid
PD-3	<i>Policy Determination 3 and Addendum: USAID Policy Guidelines on Voluntary Sterilization</i>
PSI	Population Services International
SIFPSA	State Innovations in Family Planning Agency
USAID	United States Agency for International Development
USG	United States Government
WHT	Women's Health Teams

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EXECUTIVE SUMMARY

The trend to implement Performance-based Incentives (PBI) in low- and middle-income countries to strengthen health systems, accelerate service utilization, and enhance quality of health interventions presents an opportunity as well as a challenge for voluntary family planning (FP) service delivery and use. There is considerable opportunity, through PBI, to stimulate quality FP counseling and increase access to and availability of voluntary FP. At the same time, the challenge of introducing incentives that support informed voluntary choice requires careful design and ongoing monitoring. This tension should not cause policymakers to shy away from incorporating FP into PBI schemes, as there is a real danger that excluding FP from the schemes may result in its neglect. Given the central role FP plays in attainment of the Millennium Development Goals, appropriate mechanisms to incorporate FP into PBI approaches are needed. This paper identifies the opportunities as well as the challenges of incorporating FP into PBI approaches; discusses U.S. policies and support for enhancing access to FP; presents what is known about how low- and middle-income countries are including FP in PBI approaches and lessons learned; and provides suggestions for donors, policymakers, program implementers, and technical assistance providers about how to responsibly and effectively integrate FP into PBI programs in the developing world.

This paper has two intended audiences:

- For those considering introduction of health PBI initiatives, it provides examples of programs that have successfully incorporated FP.
- For those implementing USAID-funded programs, it outlines the policy and legal issues that implementers of USAID programs must consider in the development, implementation, and monitoring of PBI initiatives that include FP components.

PBI approaches in health link payment to the achievement of predefined health results. We see arrangements with payers and recipients at different levels in health systems, each with implications and trade-offs regarding effectiveness and cost. Donors have incorporated PBI in the way they structure payment to countries by conditioning aid on evidence of health results and some national governments transfer funds to sub-national levels of government based partly on attainment of health or coverage targets. In some fragile state contexts, donors pay nongovernmental organizations (NGOs) for results that include FP. A number of developing countries reward health facilities for quality counseling and availability and use of modern FP methods. To reduce financial barriers to accessing FP, some programs sell to poor women vouchers at subsidized rates that provide access to FP and other services from accredited providers. Conditional cash transfer (CCT) programs provide income support to poor families if they meet health and education conditions that, in some cases, include participating in health education talks about FP.

Because FP contributes to health and broad development goals, the case is strong to include FP as one of the priorities in PBI approaches. Improvements in FP use results in fewer unintended pregnancies; fewer maternal and newborn deaths; healthier mothers and children; greater family savings and productivity; and better prospects for educating children, strengthening economies, and reducing the pressure on natural resources in developing countries.

By exploring details of a wide range of PBI schemes, this paper looks at how FP has been incorporated, how recipients are incentivized, impact when available, and lessons that hold relevance for other

settings. PBI schemes were identified through an on-line survey that was conducted in May 2009 and by schemes known to authors. The paper provides a wide range of program examples, some from countries that do not receive USAID support. Therefore, USAID-supported PBI programs should consider the applicability of the U.S. FP requirements if using these examples as a basis to develop PBI program activities. Paying for performance in FP can be introduced to incentivize actions at various levels in a health system. The decision about whether to introduce incentives for national-level recipients (e.g., a ministry of health), health facilities, or individual clients should be determined by goals; whose actions are needed to attain the goals; and relative costs, benefits, and feasibility of administering performance payments at various levels. The following cases are discussed:

- The regional **Health 2015 Mesoamerica Initiative in Central America and Mexico** and **State Innovations in Family Planning Agency in India** that describe approaches that link funding from donors to national- or state-level recipients to FP results.
- The **maternal and child health insurance program for the poor in Argentina, federal to municipal fiscal transfers in Brazil**, and incentives from national to facility levels in a **pilot in Zambia** describe approaches that link funding from national to sub-national levels linked to FP results.
- **Afghanistan, Democratic Republic of Congo, Haiti, Liberia, and Southern Sudan** incorporate FP indicators into their PBI approaches that contract NGOs to directly deliver services and/or oversee service delivery in a geographic area.
- **Burundi, Rwanda, Egypt, and Honduras** incorporate FP into their government-led PBI approaches.
- Voucher schemes in **Pakistan** and **Kenya** include coupons to access FP services and incorporate incentives on both the demand and supply side.
- PBI are used to motivate community health workers to identify pregnant women, provide counseling to women, families, and their communities, and recognize where FP demand is unmet in **India** and the **Philippines**.
- Since 1997, seven countries in Latin America and the Caribbean (**Brazil, Colombia, Ecuador, Honduras, Jamaica, Mexico, and Nicaragua**) have implemented and evaluated CCT programs with health and nutrition components, many including FP.

Many of these cases demonstrate that FP can be incorporated into PBI schemes in ways that protect voluntary choice and are in compliance with U.S. FP requirements.

Box ES-1 summarizes best practices to consider when designing a PBI scheme that incorporates FP.

This paper encourages the inclusion of voluntary FP within PBI programs supported by USAID or taking place in USAID-supported health facilities in a manner consistent with USAID FP requirements. The paper clarifies these requirements and provides examples of USAID-supported PBI programs where voluntary FP is included in a manner that is consistent with the requirements.

As donors embrace the principles of country-led health plans, complemented by increased accountability for results, linking payment to performance is likely to increase in prominence. We may see more performance-based aid, as donors condition payment to countries based on results. We may also see an increase in national to sub-national PBI as governments exercise their influence through conditions attached to intergovernmental fiscal transfers. At the national and sub-national levels, rewarding

population-level FP services coverage targets (for example, proportion of women of reproductive age in a province using FP) as well as their quality is consistent with U.S. FP requirements.

**Box ES-1: Best Practices to Consider When Including Voluntary FP in PBI Programs:
“Dos and Don’ts”**

Individual client level:

1. Do consider offering clients the opportunity to purchase coupons/vouchers (at full or subsidized prices) for a package of services that includes FP. Client payments for the purchase of vouchers promote voluntary FP choice and acceptance and can enable clients to receive services from providers they prefer, either public or private.
2. Do consider reducing financial barriers for voluntary sterilization clients to make the method readily accessible by subsidizing the cost of the procedure or offering reasonable compensation or in-kind support to those experiencing high service delivery costs, lost wages during convalescence, high transportation costs to reach a facility, or who require food during confinement.
3. Do consider offering compensation to offset the costs of transportation to enable clients to attend health education sessions and to receive FP counseling.
4. Do include attendance in health education sessions that discuss FP as one of the conditions of CCT programs.
5. Don’t pay clients or give them any benefits in exchange for accepting a method.
6. Don’t deny clients a benefit if they choose not to accept FP.

Individual health worker level:

1. Do consider paying health providers for FP services that include quality counseling as well as provision of a method. Payment should be reasonable, where “reasonable” implies payments that are in line with payments for other services. This includes compensation for services delivered to voucher clients.
2. Don’t reward health providers for achieving a target number of FP users or users of a particular FP method.
3. Don’t compensate for delivery of specific FP methods with payments that are out of line with payments for other services, as this may lead to coercive behavior.

Health facility, health team, or NGO level:

1. Do consider rewarding the availability of a wide range of methods.
2. Do consider rewarding facilities or teams to attain performance objectives. Health facility or team targets or goals should not be distributed to health care providers as individual targets. Consider rewarding facilities or teams to attain performance objectives specified as number of clients counseled, or number of new FP clients accepting FP methods. Please note: health facilities and teams have more than one health worker. For facilities with one health worker, refer to the guidelines for individual health workers.
3. Do include FP counseling as a component of antenatal and postnatal care indicators.
4. Do reward performance indicators that combine FP services provided and measures of FP quality.
5. Don’t compensate for delivery of specific FP methods with payments that are out of line with payments for other services, as this may lead to coercive behavior.

Sub-national or national level:

1. Do consider opportunities to link fiscal transfers from national to sub-national levels of government to results related to population coverage of specific methods, counseling and education, improved quality, and increased access.

I. OVERVIEW OF PBI AND FP: GLOBAL TRENDS, ISSUES, AND OPPORTUNITIES

The trend to implement Performance-based Incentives (PBI) in low- and middle-income countries to strengthen health systems, accelerate service utilization, and enhance quality of health interventions presents an opportunity as well as a challenge for voluntary family planning (FP). The opportunity, through PBI, to stimulate quality FP counseling and increase access to and availability of voluntary FP is considerable. At the same time, the challenge of introducing incentives that support informed choice requires careful design and ongoing monitoring. This tension should not cause policymakers to shy away from incorporating FP into PBI schemes, as there is a real danger that excluding FP may result in its neglect. Given the central role voluntary FP plays in attainment of the Millennium Development Goals (MDGs), appropriate mechanisms to incorporate voluntary FP into PBI approaches are needed. This paper identifies the opportunities as well as the challenges of incorporating FP into PBI approaches; discusses U.S. policies and support for enhancing access to voluntary FP; presents what is known about how low- and middle-income countries are including FP and lessons learned; and provides suggestions for donors, policymakers, program implementers, and technical assistance providers about how to responsibly and effectively integrate voluntary FP into PBI programs in the developing world.

A formal definition of PBI for health is: “Transfer of money or material goods conditional on taking a measurable health-related action or achieving a predetermined performance target.”¹ Essentially, PBI approaches link a payment to the achievement of predefined and agreed-upon results. This might mean providing income support to poor households with conditions that specify that they attend health education sessions that discuss FP or it might be a program that helps poor women overcome financial obstacles to seeking counseling or services by providing payment for transportation. It might mean payments to health facilities if the team working at the facility succeeds in providing quality FP counseling and services to the specified portion of the population they serve. PBI may also be incorporated into the way national governments transfer funds to sub-national levels of government, with partial links to attainment of health or coverage targets that include FP. Donors have also used PBI in the way they structure payment to countries and links to FP results can be incorporated.

Why has interest in PBI intensified recently? Global commitment to achieve the health MDGs is one of the drivers behind interest in PBI as countries recognize that current health system strengthening/health financing approaches will not produce desired results. Optimism has resulted from evaluations of conditional cash transfer (CCT) schemes in Latin America that demonstrate that linking income transfers to health and education conditions can produce encouraging results (Glassman et al. 2009, Regalia and Castro 2009). Supply-side schemes that link payment to service delivery nongovernmental organizations (NGOs) to achievement of results in Afghanistan (Sondorp et al. 2009) and Haiti (Eichler et al. 2009) are also promising. A recent rigorous evaluation of the impact of the now scaled-up national approach in Rwanda suggests that PBI contributes to improvements in service utilization and quality, including new and continuing use of FP (Basinga et al. April 2009). This growing body of evidence adds to

¹ From the Center for Global Development Performance Based Incentives Working Group, http://www.cgdev.org/section/initiatives/_active/ghprn/workinggroups/performance

the common sense appeal of PBI as a complement to the training and investment in inputs that has been much of the focus on health system strengthening in recent decades.

PBI is especially useful in health services environments where the existing incentives do not elicit hard work and where bureaucratic systems thwart individual initiative. Linking a portion of payment to achieving health results and, at the same time, allowing recipients the flexibility and autonomy to respond to incentives may catalyze actions that overcome many health system weaknesses. For example, civil service structures in many developing countries provide relatively low fixed salaries that do not vary if a health worker is a stellar performer or a bad one. Add to this that people lose their jobs only for serious misconduct and the result is a weak incentive environment for the most internally driven and an outright dysfunctional incentive environment for most others. NGOs are often paid for documented spending on inputs, rather than for producing results. A shift to accountability for results by a payment system that rewards results can stimulate changes in the behaviors of institutions and the individuals that work within them. Intergovernmental transfers can be powerful levers to catalyze accountability for results and the systems to achieve results at sub-national levels of government.

Rewarding FP results through PBI approaches involves more complex behaviors by clients and service providers than rewards for services that are more time limited and subject to less complex social, intra-household, and community dynamics, such as child immunization and vitamin A supplementation. For clients, the decision to seek counseling for FP, followed by choice of a method and its continued use, requires a complex series of behaviors and actions that include appreciation of the benefits of FP, support from families and communities, repeated actions to use the chosen method, and the ability to overcome barriers to accessing services. Incentives can overcome financial access barriers and strengthen understanding and perceived value by rewarding participation in health education talks. On the service provision side, providers need to deliver quality counseling, ensure availability of commodities, and have the technical competence to deliver chosen methods. Performance incentives can increase availability of FP counseling and methods and have the potential to improve quality.

Because incentives can be a potentially powerful tool, it is critical to consider the purpose of the incentives and monitor unintended consequences as well as those intended. Potential pitfalls of PBI programs related to voluntary FP include the following:

- Providers may focus on rewarded services and neglect other important services. PBI schemes that leave out FP may find that providers neglect provision of voluntary FP services, contributing to stagnating FP use, while the use of other rewarded services rises.
- Poorly designed PBI incentives may result in excessive attention to increasing voluntary FP use, resulting in coercive behavior by managers and providers that interferes with voluntary choice by clients.
- PBI may damage the intrinsic motivation of providers and cause them to view health care delivery, including provision of FP services, as piece work.
- The quality of information systems may be compromised as the incentives to report the FP results for which providers are rewarded may cause them to falsify reported information.
- Without clear communication, clients may incorrectly interpret the offer to cover transportation costs to access counseling or specific services (e.g., voluntary sterilization) as payment to accept a method.

These potential pitfalls can be mitigated with smart design and ongoing monitoring and assessment of both intended and unintended effects.

Many PBI schemes in developing countries, some mature and others in the early phases of design or implementation, are currently rewarding improved FP results. Evidence presented in this paper comes from the authors' knowledge of schemes and from responses to a recent on-line survey that identified eight programs (some countries have multiple approaches) that incorporate FP indicators and 17 that include low contraceptive use as a "health concern targeted by the PBI intervention" (Beith et al. 2009). A wide range of approaches are being tried such as:

- Women are sold vouchers by voucher distributors at subsidized rates that enable them to access FP services at private and/or public facilities (e.g., in Kenya, Pakistan).
- NGOs are contracted to provide services and rewarded to reduce FP discontinuation, increase FP utilization and, in some cases, improve quality of services (e.g., in Bangladesh, Burundi, Democratic Republic of Congo, Haiti, Kenya, Pakistan, Rwanda).
- Public sector providers receive money when FP measures, such as new and continuing FP use, are achieved (e.g., in Burundi, DR Congo, Egypt, Kenya, Pakistan, Rwanda, Zambia)
- Fiscal transfers from national to sub-national levels of government are linked to FP performance (Argentina, Brazil) and funding from donors to countries is partly conditioned on FP results (regional initiative in Central America and Mexico, India)
- Community health workers are rewarded for ensuring that women receive a comprehensive package of maternal health services that include FP counseling (India, Philippines).

Section 2 presents the importance of voluntary FP in health and development. Section 3 discusses U.S. FP requirements and presents a brief history of the development of both *Policy Determination 3 and Addendum: USAID Policy Guidelines on Voluntary Sterilization (PD-3)* and the Tiahrt Amendment. Section 4 presents a framework to organize PBI approaches that include voluntary FP and shares snapshots of these approaches that include program goals, indicators, payment approaches, and results, when available. Section 5 concludes the paper with a call for new measures that enable rewards for quality FP counseling and service provision as well as the quantity measures in predominant use and reiterates the call to include voluntary FP in PBI schemes. By providing clarity on the challenges and opportunities of PBI for voluntary FP, we hope to offer some strategies on how to most effectively move forward to incorporate FP indicators into PBI approaches in a manner that ensures voluntarism and informed choice. An annex is included that presents an overview of the history of support for voluntary FP in the United States with an eye toward identifying lessons relevant for FP programs in developing countries.

2. CONTRIBUTION OF FP TO ACHIEVING THE HEALTH MDGS

FP is an important vehicle for advancing maternal and child health and contributes to overall development. Evidence supporting investments in FP combined with significant global unmet need, motivated creation of MDG 5b, which calls for universal access to reproductive health and incorporates FP goals of increasing contraceptive prevalence rates, reducing adolescent birth rates, and satisfying unmet need for FP. Increased FP use results in fewer unintended pregnancies; fewer maternal and newborn deaths; healthier mothers and children; greater family savings and productivity; and better prospects for educating children, strengthening economies, and reducing the pressure on natural resources in developing countries. Because of these far-reaching benefits, increased investment in FP and maternal and newborn health services has the potential to accelerate progress toward achieving the MDGs by 2015. Using estimates from 2008, a recent report, *Adding It Up* (Singh et al. 2009) shows that:

- Despite increases in FP use in recent years, an estimated 215 million women who want to avoid a pregnancy are not using an effective method of contraception;
- About 20 million women have unsafe abortions each year, and 3 million of the estimated 8.5 million who need care for subsequent health complications, do not receive it.

The direct health benefits of meeting the need for FP and maternal and newborn health services would also be dramatic. It is estimated that, if this need were met:

- Unintended pregnancies would drop by more than two-thirds, from 75 million in 2008 to 22 million per year.
- Seventy percent of maternal deaths would be averted – a decline from 550,000 to 160,000.
- Forty-four percent of newborn deaths would be averted – a decline from 3.5 million to 1.9 million.
- Unsafe abortions would decline by 73 percent, from 20 million to 5.5 million (assuming no change in abortion laws), and the number of women needing medical care for complications of unsafe procedures would decline from 8.5 million to 2 million.
- More women would survive hemorrhage and infection, and fewer would endure needless suffering from fistula, infertility, and other health problems related to pregnancy or childbirth.

While the benefits of increasing access to FP information and services are clear, it is also clear that continuing with “business as usual” will not fill the need gap. This is true for a range of priority health interventions in addition to FP. One promising solution that a number of countries are using to strengthen health systems is PBI supply- and demand-side incentive approaches of various forms. This paper hopes to shed light on “What is PBI and how are countries, in particular developing countries, using it to increase access to FP in a way that ensures voluntarism and informed choice?”

3. USAID FP POLICIES RELATED TO VOLUNTARISM AND INFORMED CHOICE

This section covers the statutes and policies of the United States Agency for International Development (USAID) that most directly pertain to PBI schemes and the motivations behind their enactment. It begins with a bit of the history that motivated introduction of policies in 1982 that provided guidance on how USAID funding should be used to support informed consent and protect voluntarism. These policies were further elaborated within U.S. statutes in 1998 to clarify standards that protect client voluntary choice. Including voluntary FP within a USAID-supported PBI program can be acceptable if it takes care to ensure compliance with the 1998 Tiahrt Amendment and respects voluntarism and informed choice of FP services. This has been done successfully in a number of cases, many described in the pages that follow. Understanding these rules and the history behind them is relevant to all who wish to protect voluntarism.

In the early years of national FP programs, some developing countries, notably Bangladesh and India, introduced incentive payments for both providers and individuals for surgical sterilization. Payments to providers were designed to overcome provider resistance to offering FP services, especially voluntary sterilization, and encourage increases in availability of all FP services. Payments to compensate for travel costs and the value of lost wages during the recovery period were also made to individual clients who received voluntary surgical sterilization. At the time, voluntary sterilization services were offered in only a relatively few sites and, given that it was a surgical procedure, required several days of convalescence.

The practice of rewarding providers for achieving specific contraceptive targets, especially for such a permanent and provider-dependent method as sterilization, created serious concerns that payments could lead providers to coerce clients to accept specific contraceptive methods, notably sterilization. Such concerns were voiced by supporters of organized FP assistance (see Cleland and Mauldin 1991) as well as by its critics (cf. Hartman 1985; Warwick 1982). Provider payments for sterilization were also thought to bias the presentation of information about sterilization in comparison with other methods. However, there is little evidence supporting the concern that such compensation schemes have promoted reliance on sterilization. Indeed, one of the countries whose sterilization practices were most criticized, Bangladesh, has in fact seen a steady decline in sterilization use despite the persistence of both provider and client reimbursement for the service (see EngenderHealth 2002, p. 5-6).

To ensure the practice of informed consent and to protect voluntarism in the provision of sterilization services, USAID introduced agency policy in 1982: *Policy Determination 3 and Addendum: USAID Policy Guidelines on Voluntary Sterilization*.² PD-3 lays out agency guidelines on a number of issues, including payments related to voluntary sterilization. The *addendum* clarifies PD-3 and elaborates detailed program guidelines regarding acceptable practice for payment of acceptors, payment of providers of services, and “payment of referral agents.” The paper establishes that payments per case or per procedure to providers of voluntary sterilization services are acceptable if the payments are “reasonable.” While acknowledging the acceptability of the practice (given the “customary” nature of

² See http://www.usaid.gov/our_work/global_health/pop/pd3_annex.pdf

reimbursement for health procedures), the document advises USAID missions to “encourage patterns of service delivery and methods of payment which do not unduly emphasize voluntary sterilization services compared to other methods of ‘fertility control.’” PD-3 specifically mentions several measures for mitigating the risk of such payments functioning as incentives. These include separating the selection and counseling of clients from the provision of the service and structuring reimbursement for providers of FP “per counseling session” rather than for acceptance of a specific method.

Policy and practice regarding the acceptability of payments to FP providers continued to be guided solely by PD-3 until the late 1990s. In October 1998, members of Congress responded to evidence of non-voluntary practices in the Peruvian FP program with the introduction of a statutory amendment, known as the “Tiahrt Amendment.” The Tiahrt Amendment reaffirms and further elaborates standards for voluntary FP service delivery programs to protect FP “acceptors,” defined as individual clients receiving services. Statute language has consistently been enacted unchanged in subsequent annual appropriations legislation to date. Two provisions of the Tiahrt Amendment are directly relevant to PBI in USAID-funded projects:³

- 1) Service providers or referral agents shall not implement or be subject to numerical targets or quotas of total number of births, number of FP acceptors, or acceptors of a particular FP method. Quantitative estimates or indicators used for budgeting or planning purposes are permissible.
- 2) No incentives, bribes, gratuities, or financial reward for FP program personnel for achieving targets or quotas, or for individuals in exchange for becoming a FP acceptor.

The amendment requires that, within 60 days after the USAID Administrator determines that a single violation of either of these requirements has occurred, the Administrator must submit a report to Congress describing the violation and corrective actions taken to address it.⁴

The Tiahrt Amendment enjoys bipartisan support. To ensure voluntarism in its programs, including compliance with the Tiahrt Amendment, USAID stepped up its internal training on all U.S. FP requirements and enhanced monitoring of compliance with all statutes and policies that guide its FP program. To date, three Tiahrt Amendment violations have been reported to Congress by USAID. Heightened awareness of the statutes and policies, including the Tiahrt Amendment, strong Agency emphasis on voluntarism, and limited knowledge of PBI as a new way of doing business have initially combined to create hesitation to include FP in such schemes by those who want to ensure voluntarism within USAID’s FP programs and compliance with the Tiahrt Amendment requirements.

More recently, momentum is building to support health system strengthening interventions that enhance priority health programs. A number of USAID-supported programs are incorporating innovative financing approaches such as PBI to strengthen health systems and improve provider and program performance. There is also a greater understanding of how PBI initiatives can be operationalized and potential results, building on recent (yet limited) evaluations and reporting of results of PBI initiatives, growing experience developing PBI programs, greater support for health system strengthening, and new openness to innovation.

U.S. FP requirements, including the Tiahrt Amendment, offer wide opportunities for including voluntary FP with PBI initiatives. PBI programs funded or carried out in USAID-supported service delivery projects must not include provider- or referral-level targets for number of FP acceptors or acceptors of specific FP methods and demand-side PBI initiatives must not provide benefits in exchange for accepting FP

³ The full text of the Tiahrt Amendment appears in http://www.usaid.gov/our_work/global_health/pop/fy99lang.pdf

⁴ See http://www.usaid.gov/our_work/global_health/pop/voluntariness.html.

methods, but many other options remain for successfully incorporating FP indicators and activities in PBI initiatives. For example, incentives can be linked to ensuring availability of a choice of modern methods or for quality counseling. Fee-for-service provider payments linked to provision of voluntary FP services are also feasible, provided that they are in line with fees for other services. Subsidies to cover clients' costs of transportation are possible, as long as payment for transportation is not linked to acceptance of a method and free services can be provided. PBI initiatives have wide latitude for including FP indicators and activities to increase demand for voluntary FP services. PBI programs often include related behavior change communication and information, education and communication activities where FP messages should be included to increase information and demand for voluntary FP. Technical assistance activities within PBI initiatives should also include modules on ensuring FP voluntarism and informed choice within high-quality, client-centered health services

Box 1: Guidance for USAID Missions, Contractors, and Recipients of USAID FP Assistance

Familiarization with current U.S. FP requirements and related guidance is easy and should be the first step in building compliance into PBI program design. The USAID external web site provides links to the policy language that governs the use of FP assistance and outlines USAID's guiding principles:
http://www.usaid.gov/our_work/global_health/pop/index.html#.

The USAID external web site also includes a link to two specific guidance documents related to the Tiahrt Amendment: "Guidance for Implementing the 'Tiahrt' Requirements for Voluntary Family Planning Projects" and "Technical Guidance on the 'Comprehensible Information' Paragraph of the Tiahrt Clause."

In addition, USAID's Global Health E-Learning Center, www.globalhealthlearning.org, includes an e-learning course on the U.S. FP requirements. This publicly available course includes information on all the U.S. FP requirements, including the Tiahrt Amendment.

USAID Missions should keep communication lines open with implementing partners in order to address questions or issues that may arise during PBI program development or implementation. USAID Mission staff are strongly encouraged to contact their Regional Legal Advisor (RLA), and/or the Senior Policy Advisor (GH/PRH) at USAID/Washington, for further assistance addressing compliance or other policy-related questions.

4. FP IN PBI SCHEMES IN DEVELOPING COUNTRIES

The authors are aware of many developing country health PBI schemes that include FP as an important element, often within a package of maternal health services. We see schemes that are fully private, fully public, and those that involve partnerships between public and private sectors. While most have been introduced within the past few years, some have been implemented for much longer. And while many begin with pilots, others are being introduced at scale, and still others have expanded to scale after promising pilot results. The vast majority involve supply-side incentives and a few also incorporate demand-side incentives aimed at overcoming financial obstacles poor women face or increasing understanding of FP benefits. This section will describe how these schemes work and, where available, present impact on measures of FP. Also highlighted are pitfalls, challenges, and lessons that can be of interest to others planning to introduce a FP component to an already existing or planned health sector PBI scheme.

While this section presents descriptions of how FP is being incorporated in PBI schemes, these examples should not be considered examples of “best practices,” nor are they intended to be used to guide programs that USAID Missions may adopt. They present evidence of “what is” and not necessarily “what should be.” As programs evolve, we can expect to continue to learn about new innovative approaches.

Table I presents a snapshot of PBI programs in developing countries that incorporate FP, by region. A more detailed discussion of schemes by category follows.

TABLE I: WHERE IS FP INCORPORATED INTO A PBI SCHEME?

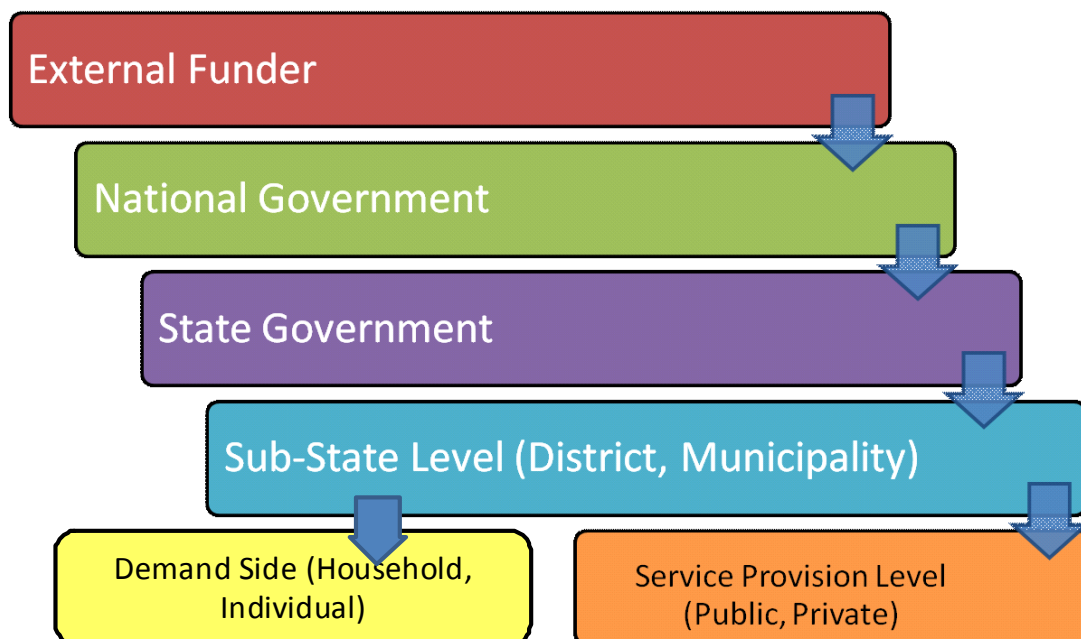
Region	Country Applications
Sub-Saharan Africa	Benin, DR Congo, Burundi, Kenya, Liberia, Rwanda, Southern Sudan, Zambia
Asia	Afghanistan, Bangladesh, India, Pakistan, Philippines
Latin America and Caribbean	Argentina, Belize, Brazil, El Salvador, Guatemala, Haití, Honduras, México, Nicaragua, Panamá
Middle East	Egypt

Note: Table lists PBI schemes covering FP that are known to authors.

The following discussion categorizes developing-country PBI schemes that include FP by type of payer and primary recipient of the performance-based payment. This structure provides a way to organize the evidence as well as provides a menu of options to consider. There are cases of external donors funding countries, sub-national levels of government, and NGOs based on performance related to a package of services that includes FP. We also see transfers from national to sub-national levels of government partly linked to FP results. There are a number of examples of payment from a government or health insurer to health facilities and to community health workers linked to attainment of health results that include FP. We also see a few examples of demand-side PBI, in which funds are provided to clients to

overcome financial barriers to accessing care, to enable choice of provider, and to improve understanding of FP. Figure 1 shows a number of the options.

FIGURE 1: LEVELS TO CONSIDER: FROM PAYER TO RECIPIENT



Within each category, we provide as much information as we have about the goals of the program including the justification for paying incentives to the chosen recipients. We describe features of the design such as indicators, payment rules, and how performance is monitored and validated. Following discussion of the design elements, we describe what we know about implementation arrangements: the “how” and “who.” When available, we also include results and lessons learned.

4.1. PBA FROM EXTERNAL FUNDER TO NATIONAL OR SUB-NATIONAL LEVEL OF GOVERNMENT

Performance-based Aid (PBA), which provides funding from an external donor to a national or sub-national level of government conditional on achieved results, embodies assumptions that incentives at this “higher” level will catalyze changes in leadership, planning, management, and systems that will result in improved health and, specifically, FP results. The evidence on the effectiveness of PBA, however, is far from clear, partly because incentives provided at this higher level do not appear to trickle down to affect behaviors of providers and clients (Eichler and Glassman 2008).

A new initiative that will include FP was in the design stage when this paper was being written. **Health 2015 Mesoamerica**, funded by the Bill & Melinda Gates Foundation and Instituto Carlos Slim de la Salud and managed by the Inter-American Development Bank, aims to avoid weaknesses observed with other examples of PBA that failed to ensure that incentives change behaviors where change is most

needed – at the level of the service delivery-client interface.⁵ Payments to governments in Central America and poor states of Mexico will be linked partly to results that will include FP if FP is a selected priority of the national or state government that is the potential recipient of performance awards. Contracts between Health 2015 Mesoamerica and country and state governments intend to specify that incentives must be transferred to lower levels of the system. While contract terms and actual indicators are not yet determined, this approach has the potential for much cross-country learning within the Central American region and beyond. It is also planned to be an interesting model of donor funding linked to country-level performance that incorporates a contractual requirement that specifies that incentives reach the service delivery-client interface.

SNAPSHOT: Health 2015 Mesoamerica

FP indicators: Availability of at least six modern FP methods

Recipient: National governments in Central America and state governments in Mexico

FP-linked payment mechanism: Combination of predictable investment funding, complemented by government matched funds, and a portion linked to attainment of results

In **India**, USAID has implemented a form of PBA termed “performance-based disbursement,” which provides funding to a state-level registered society (Indian parastatal) linked to attainment of specified benchmarks. The State Innovations in Family Planning Agency (SIFPSA) was formed to receive USAID funding (\$325 million over the first 10 years beginning in 1994) and to implement state-level FP activities in Uttar Pradesh aimed at reducing fertility by expanding access to and improving quality of FP services (Rowan 2009). In 2002, SIFPSA grew to serve Uttarakhand and Jharkhand and to cover a broader set of maternal and child health activities. SIFPSA’s responsibility is to develop plans to increase FP access, use, and quality and to contract a range of public and private entities to implement activities.

SNAPSHOT: State Innovations in Family Planning Agency in India

FP indicators: Capacity development measures that relate to development of the parastatal agency such as “development of management systems and procedures”; process measures such as “number of people trained” and “development of a media campaign”; and results-oriented measures such as “introduction of quality improvement systems” and “FP use through social franchises”

Recipient: SIFPSA, a parastatal entity established to oversee FP in the state of Uttar Pradesh, India

FP-linked payment mechanism: Disbursements based on achievement of predefined benchmarks

During the initial phase of development, SIFPSA received support to establish itself as a functioning organization. Early benchmarks were related to priorities such as development of management systems and procedures, planning, and staffing. Ongoing benchmarks related to process measures such as “number of people trained,” “NGO contracted and funds disbursed,” “development of a media campaign,” and “introduce quality improvement systems” as well as to measures of FP use through mechanisms such as social franchising. Each benchmark in the annual plan is costed and associated funds are disbursed after the benchmark is achieved. The majority of the measures are process oriented. In some contracts, SIFPSA incorporates financial incentives to reward the results the subcontracted entity is accountable to achieve.

⁵ Discussion with Maria Fernanda Merino of the Inter-American Development Bank on May 12, 2010.

4.2. PERFORMANCE-BASED FISCAL TRANSFERS FROM NATIONAL TO SUB-NATIONAL LEVELS OF GOVERNMENT

National governments can incorporate PBI into the methods used to determine transfers of federal funds to states and municipalities. This may be especially useful in settings where top-down approaches to health are not feasible due to factors such as sheer size of countries (e.g., India) or decentralization that transfers responsibility for health to sub-national levels of government. By linking federal-to-state fiscal transfers to results, national governments can exert influence by providing incentives to hold lower levels of government accountable while preserving the principle of direct management of health at the state level. Effective performance-based fiscal transfers can stimulate state health leaders to identify and fix systemic weaknesses and bottlenecks. If not carefully designed and implemented, however, performance-based transfers can have the same challenges as PBA described above. If the incentives do not translate into health-improving actions at the interface between providers and clients, performance-based inter-governmental transfers will have little impact.

In **Argentina**, the federal government transfers funds to provinces partly based on enrollment in a maternal and child health insurance program, *Plan Nacer*, and partly based on achievement of 10 tracer indicators, one of which is counseling for sexual and reproductive health. The goals of this program are to reduce the infant and maternal mortality rate; strengthen the incentive framework for efficiency and enhance focus on results between the national level and participating provinces and between provinces and service providers; and strengthen the stewardship capacity of national and provincial ministries of health. *Plan Nacer* began as a World Bank project in 2002 with intentions to transition to full government funding.

SNAPSHOT: Maternal and child health insurance program for the poor in Argentina
FP indicator: Proportion of reproductive age women who receive counseling for sexual and reproductive health
Recipients: Province-level governments
FP-linked payment mechanism: 4 percent of per capita payment linked to attainment of target

After signing an annual performance agreement with the National Ministry of Health, provinces implement a system to enroll beneficiaries, and design and implement a health service purchasing function in the Provincial Ministry of Health. Annual performance agreements specify yearly results and enrollment goals, targets for tracers, prices for services, annual work programs, and yearly projected budgets. Provinces negotiate quarterly targets, expressed as a proportion of the total eligible population, with the National Ministry of Health. Each province sets up a “provincial purchasing unit” to oversee implementation of *Plan Nacer* at the province level. The responsibilities of the provincial purchasing unit are to (i) identify and enroll beneficiaries; (ii) identify, authorize, and contract with service providers, (iii) control the technical quality of services, financial management, and procurement, and (iv) obtain technical financial and administrative support.

Plan Nacer covers a benefits package that includes 80 health services that improve maternal and child health. Of the per capita payment of roughly \$10 per person/per month (the average cost of providing the defined package of benefits), 60 percent is transferred based on submission of enrollment lists that show numbers of poor women and children enrolled in the scheme and the remaining 40 percent is linked to evidence of achievement on 10 performance targets, with the FP-related target “proportion of reproductive age women that receive sexual and reproductive care consultations.” Achievement of each target is linked to 4 percent ($4 * 10 = 40\%$).

As in all approaches that link funding to evidence of results, an effective system to monitor and validate reported results is critical. In Argentina's *Plan Nacer* program, enrollment of the target population is crosschecked by examining enrollment registers of other social insurance schemes. Penalties for misreporting enrollment are return of the per capita transfer plus an additional 20 percent penalty.

Provinces collect and report output information for each tracer, following explicit guidelines from the national program (and assistance to build the required information, verification, and reporting systems). An external auditor examines a sample of registrations (enrollment and tracers) for verification. The National Ministry of Health also conducts a concurrent audit using internal staff.

By 2009, *Plan Nacer* enrolled 80 percent of the target population in five states (1 million enrollees in 2009). Performance on tracers surpassed targets for six out of 10 indicators.

Plan Nacer is an exciting and innovative program that expands coverage and access to services by poor women and children by subsidizing premiums in a targeted social insurance program, specifying the rules for transfers of funds from national to province level, and creating health purchasers at the province level who negotiate with and pay providers for a defined list of services. However, the devil is in the details and the implementation "machinery" needs attention. The details to validate data and hold provinces accountable are critical: The 60 percent transfer upon enrollment ended up building up large pools of funds in the provincial account. This growing pool then became a source of political pressure as the national government, the press, and civil society organizations quickly began pressuring provinces to spend this money on services for enrolled beneficiaries.⁶ In addition, this strategy enables the central government to have influence over health in provinces that are decentralized providing a clear oversight and guidance role for the Ministry of Health while still transferring control over resources and local-level decisions to the provinces. Perhaps most important is that *Plan Nacer* profoundly changed the roles of key actors and shifted focus to results, strengthening the long-term capacity of the health system.

In **Brazil**, the federal government has incorporated performance-based transfers to municipalities since 1998 to stimulate expansion of a Family Health Program that provides maternal health and FP services. As population coverage by Family Health Teams increases, municipalities receive higher transfers per team per year, providing incentives to expand the program and serve the poorest Brazilians.

Between 1994 and 2008, the proportion of the population covered by Family Health Teams expanded from zero to 31 percent.

SNAPSHOT: Federal to municipal transfers in Brazil

FP indicators: Not explicit, but included in the package of services provided by Family Health Teams.

Recipients: Municipalities

FP-linked payment mechanism: Rewards increase as the proportion of the population living in the municipality is covered by Family Health Teams.

Beginning in 2009, Brazil is piloting an enhanced incentive scheme that links funding to performance on eight indicators that cover effectiveness (health outputs), efficiency (reduced hospital admissions), and management. FP is not explicitly incentivized; however, it continues to be included in the package of services provided by Family Health Teams.

⁶ Many insights throughout come from discussion with Cristian Baeza, then lead health specialist of the World Bank, who designed this Adaptable Program Loan (APL).

In **Zambia**, a pilot has been designed and will soon be implemented that establishes performance incentives for regional health teams and district health teams that are aligned with performance incentives for health facilities. Facilities will have the opportunity to earn fees for each new FP acceptor. In addition, a quality assessment tool is being developed to incentivize quality counseling as part of the full package of services. This approach is designed to motivate health actors at each level of the system to resolve bottlenecks, work hard, and strengthen the performance of the health system, with a focus on maternal and newborn health, including FP.

This pilot, supported by Norway and the U.K. Department for International Development (DFID) through a World Bank-managed “Health Results Innovation Trust Fund,” will examine the impact of PBI in nine districts of Zambia as compared with two groups of controls (nine districts receive the same funding as the PBI districts but with no performance conditions and nine other districts continue with “business as usual”). Regional health teams and district health teams will also be rewarded with incentives to provide the supervision and technical support to help facilities achieve performance goals. Facilities will earn fees for a list of services in addition to the fixed budget and health worker salaries. Performance fees earned by facilities will be partly used to invest in the facility and in community outreach activities and will be partly shared by facility workers.

SNAPSHOT: Results-based financing pilot in Zambia
FP indicator: Number of new FP acceptors
Recipients: Health facilities, district teams, regional teams
FP-linked payment mechanism: Monthly fee for each new FP acceptor

4.3. CONTRACTING NGOS AND PAYING PARTLY BASED ON DOCUMENTED RESULTS IN FRAGILE, LOW-RESOURCE SETTINGS

In low-resource settings with limited health infrastructure, increasing access to FP commodities may be one of the most effective strategies to reduce both maternal and child mortality. Many FP commodities can be distributed by community health workers and through other product distribution channels that already exist at village level, making scale-up easier and faster than, for example, investing in infrastructure to manage emergency deliveries and in training highly skilled health workers. In **Afghanistan** (with World Bank support), **DR Congo** (World Bank), **Haiti** (USAID), **Liberia** (USAID), and **Southern Sudan** (USAID and World Bank), NGOs are contracted to directly deliver services and/or oversee service delivery in a geographic area. This sometimes includes paying incentives and providing support to public health teams and public facilities as well as second-tier contracts to service delivery NGOs. These settings have in common a relatively weak public service delivery system and a history of relatively strong NGOs delivering services in the context of fragility from conflict or lack of government leadership. Contracting NGOs and paying based on results has proven to be an effective strategy to ensure that services reach the population in fragile contexts. In some settings (Afghanistan and Liberia), NGO contracting has also been effectively used to bolster the steering role of the national Ministry of Health. What follows is a brief description of each of these models with emphasis on the role of voluntary FP.

In 2002, donors and the nascent **Afghanistan** Ministry of Public Health decided to contract NGOs to provide access to a package of essential health services that includes increasing access to FP. Distinct contractual approaches were adopted by three donors (European Union, World Bank, and USAID), enabling comparison across approaches (Sondorp et al., 2009). The World Bank incorporated a true PBI approach that provided the opportunity for NGOs that received contracts to deliver services in an entire province to earn a performance bonus based on how they performed on a “balanced scorecard”

(BSC). The BSC considers 28 indicators along six domains. In the “capacity for service delivery” domain is one indicator termed the “FP availability index.” NGOs are paid based on a fixed and reliable budget with a small portion linked to results. Original architects of this model now question whether putting more funding at risk might generate larger results.⁷ Confounders such as variations in security make it difficult to unambiguously conclude the PBI approach was more effective than the approaches adopted by the European Union and USAID. However, the major donors are converging on a unified approach that incorporates rewards for results.

SNAPSHOT: NGO performance-based contracting in Afghanistan

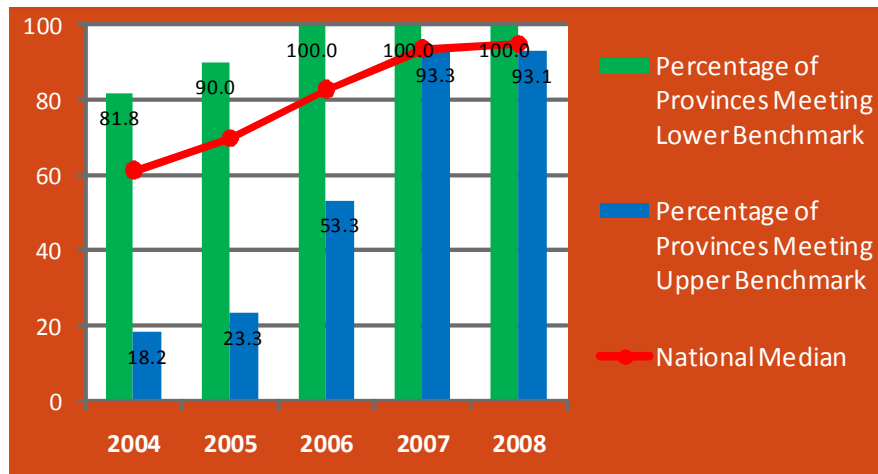
FP indicator: FP availability index

Recipients: NGOs with province-level contracts

FP-linked payment mechanism: NGOs receive bonuses linked to scores on a BSC that incorporates the FP availability index.

The FP availability index measures the availability of FP supplies in health facilities. The index assigns one point for each of the following items if they were in stock “throughout the last month”: condoms; oral contraceptive pills; Depot Medroxy Progesterone Acetate (DMPA), an injectable contraceptive; and intrauterine devices (IUDs). The range of scores possible for each facility is 0-4. Figure 2 shows a steady increase in availability of modern methods from 2004 to 2008 as measured by the FP availability index.

FIGURE 2: AFGHANISTAN FP AVAILABILITY INDEX FROM BSC RESULTS (2004–08)



Source: Johns Hopkins School of Public Health et al. (2008)

The **DR Congo** has a relatively long history of contracting out management of health in geographic regions. Currently (in 2010) the European Union, the World Bank, and Cordaid are supporting PBI programs in different parts of the country through various NGOs that include FP.

SNAPSHOT: L’approche contractuelle in the DR Congo

FP indicators: New FP user, continuing FP user, tubal ligation, vasectomy, implants, IUDs

Recipients: Provincial and zonal health teams, health facilities

FP-linked payment mechanism: Bonuses for achieving targets at provincial and zonal levels; fees for specific services at health facility level

⁷ Discussion with Benjamin Loevinsohn of the World Bank, December 2009.

Since 2007, the European Union is funding a PBI program in North Kivu, Kasai Orientale, Kasai Occidentale, and Orientale provinces of DR Congo. The program contracts seven NGOs to oversee delivery of health services that includes FP. PBI in DR Congo, known as *l'approche contractuelle*, was designed to address maternal health including FP, child health, infectious diseases, and chronic conditions. Incentives target three levels in the health system: zonal health teams and provincial health teams, health centers, and reference hospitals. Zonal and provincial health teams can earn bonuses linked to attainment of targets. Health centers and hospitals receive fees for each service provided on a list. Fees are included for the following FP services: tubal ligation and vasectomies, new and continuing FP users, and IUDs and implants. Funds for these services are transferred to the facility level and are used for facility costs, transportation, and bonus payments for health workers (Kwete and Hsi 2010). This approach suffers from payment delays, problems with verification of data, and tensions between health teams and facility staff. One design challenge is the conflict of interest that exists when health teams are responsible for verifying the health facility results that they also are paid for achieving. The project has funding through 2010.

In 1999, USAID shifted its approach, in a long-running project managed by Management Sciences for Health (MSH), to contracting NGOs in **Haiti** from paying for documented spending on inputs to paying for achievement of output and performance results. In the initial phase, FP indicators were rewarded. However, in subsequent years, FP was dropped from the list of rewarded indicators because of a misunderstanding that PBI of any type linked to indicators of FP would violate the Tiahrt Amendment and a concern that FP indicators might be misinterpreted and inappropriately implemented in the local context. The PBI approach in Haiti, and how it evolved, contains lessons for PBI programs as well as insight into what may happen if FP is left off the list of rewarded services (Eichler et al. 2009).

SNAPSHOT: Performance-based contracting of NGOs in Haiti

FP indicators: Availability of at least five modern methods, reduce FP discontinuation rate

Recipients: NGOs

FP-linked payment mechanism: Reward for attainment of annual target

PBI in Haiti began with a pilot with three NGOs that provided services to roughly 500,000 people. Additional NGOs were progressively graduated into a PBI payment regime until 2005, when all health service delivery NGOs supported by USAID were paid based on results. This approach continued and PBI with the public sector was planned until the devastation brought by the earthquake in January 2010.

Payment consists of a portion that is regular and reliable and paid in four lump sum quarterly payments, and an annual award fee that is based on whether targets that were established at contract signing are achieved. Through 2005, roughly 95 percent of an NGO's historical budget was regular and reliable with the opportunity to earn the 5 percent withheld amount plus an additional 5 percent bonus linked to attainment of performance targets. After 2005, the withheld amount increased to 6 percent (94 percent regular and reliable) and up to an additional 6 percent could be earned if all targets were reached. Targets are established relative to each NGO's baseline level from the previous contract period. Each target has a performance payment associated with it and payment for attainment of each target is "all or nothing."

Two FP indicators were included in the pilot phase in Haiti: (i) all service delivery points have availability of at least five modern FP methods (measured by facility stock audit), and (ii) reduced FP discontinuation rate (measured by FP register review). The first indicator was reached by all the NGOs and, for this reason, was not included in future years. The second indicator was designed to motivate better client communication and more effective counseling with the goal of reducing FP discontinuation. It provided incentives to deliver quality services to women who had already chosen to use a modern method and

aimed to reduce the drop-out rate slightly (and by no means eliminate discontinuation when women wanted to get pregnant). As explained above, FP was dropped from the list of rewarded indicators after the pilot year because of a misunderstanding that PBI of any type linked to indicators of FP would violate the Tiahrt Amendment and a concern that incentivizing FP might be inappropriately implemented in the local context. Ongoing tracking of a more comprehensive list of indicators than the ones connected with performance awards enabled examination of performance trends for FP. Because FP was eliminated from the list of rewarded services, this analysis shows increases for rewarded health indicators while FP performance remained stagnant. This suggests that providers focused efforts on improving performance of rewarded services and possibly neglected FP. The experience in Haiti suggests that failure to include voluntary FP was a missed opportunity and that identifying indicators of FP that can be responsibly incorporated into PBI programs is a priority – especially in environments where incentives are also linked to other services.

Liberia and **Southern Sudan** are the newest examples of governments that are contracting NGOs to deliver health services that include incentives linked to FP. Both are using an approach with some similarities to what is used in Haiti. **Liberia** awarded contracts to NGOs to oversee delivery of services at the county level. A full package of services that includes FP is funded with a subset linked to a performance payment. USAID contracts in Liberia provide full funding for the activities in each contract (as compared with including a “withheld” amount as is done in Haiti) and use the performance payment as an added sweetener. A potential performance payment is linked to the FP indicator, “number of sites with staff member competent to provide counseling on informed choice for family planning.”⁸ As the contracts had not completed the first full year at the time of writing this report, no results are available on the effectiveness of this indicator and approach.

SNAPSHOT: Contracting NGOs to oversee service delivery in counties in Liberia
FP indicator: Number of sites with staff member competent to provide counseling on informed choice for FP
Recipients: NGOs with county-level contracts
FP-linked payment mechanism: Award fee linked to attainment of performance target

In 2009, USAID awarded a project to MSH to support performance-based provision of health services in **Southern Sudan** by paying NGOs to deliver services that include FP to a geographic region of Southern Sudan. The approach is to establish performance targets for a package of primary health services and to reward NGOs each quarter for attainment of performance targets. NGOs will have a fixed price contract that is based on reasonable costs of providing the full package of services in the regions they serve. This fixed price portion will be provided in regular and reliable quarterly payments conditional on certain deliverables such as reporting. In addition, NGOs will have the opportunity to earn up to an additional 6 percent of the value of the annual fixed price budget if they attain or surpass their performance targets. Performance payments are at the level of an NGO that has multiple service delivery points.

SNAPSHOT: Performance-based contracting of NGOs in Southern Sudan
FP indicators: Number of women using a modern FP method; percentage of women using a modern FP method; compliance with FP clinical standards; number of doses of each method distributed; number of counseling visits for FP/reproductive health
Recipients: NGOs
FP-linked payment mechanism: Award fee in addition to annual budget if targets are met or exceeded.

⁸ Discussion with Beverly Johnston of USAID.

In addition to a range of child health, maternal health, malaria, nutrition, hygiene and sanitation, HIV/AIDS prevention, and health systems strengthening indicators, the following five FP/birth spacing indicators are included:

- Percentage of women using a modern FP method in areas currently assisted by USAID
- Number of women using a modern FP method in areas currently assisted by USAID
- Assessment of U.S. government (USG)-assisted clinic facilities' compliance with clinical standards (in Southern Sudan, must have at least four methods available)
- Number of doses of each method of contraceptive distributed (methods to be identified)
- Number of counseling visits for FP/reproductive health as a result of USG assistance

NGOs have responsibility for delivering services in a geographic region of Southern Sudan and indicators and targets are set for a large geographic area. NGOs will report achievement on the full list of indicators each quarter. However, to manage the logistical and financing costs of ongoing validation, a subset of indicators will be randomly selected each quarter for verification. *Readers should note that these indicators would be inappropriate if used to incentivize individual health workers.*

A number of challenges, which are likely relevant for other post-conflict and fragile states, have delayed final agreement on the terms of contracts with NGOs.⁹ The first is that it is difficult to derive robust estimates of the cost of delivering services in challenging environments with limited infrastructure (e.g., few roads), few trained health workers, weak management capacity, rudimentary information systems, etc. Information to reliably determine budgets is more important when paying lump-sum fixed-price contracts than in environments where reimbursement is for documented spending. A second challenge is that some NGOs are reluctant to commit to achieving performance targets when they do not control the supply of inputs that are essential for achieving targets, such as bednets and vitamin A. A third challenge is that seasonal variation makes access and delivery of health services almost impossible during some parts of the year, causing NGOs to be reluctant to commit to quarterly targets that are not feasible to achieve during the period. A fourth challenge is that reliable population figures (denominators) required for obtaining intervention coverage estimates do not exist and baseline performance data are unreliable.

4.4. PBI IMPLEMENTED IN PUBLIC AND PRIVATE SECTOR FACILITIES WITH GOVERNMENT LEADERSHIP

Driven by the desire to improve health results that includes FP, often with a focus on the health MDGs, a number of national governments are scaling up PBI approaches in their public systems. In some settings, private providers, including NGOs and faith-based organizations, are also incorporated. Before PBI is introduced, public health facility staff in most public settings receive a fixed salary that does not vary by whether they do a good or poor job and, in many cases, is not impacted if they work less than their full shift or are frequently absent. This dysfunctional incentive environment predictably does not generate intensive efforts to provide quality FP and other health services. To address this poor performance, some governments are implementing performance incentives. In many cases, countries begin with pilots and revise and refine as they evaluate and learn before scaling up.

⁹ Discussion with Dan Kraushaar, MSH, February 18, 2010.

In **Rwanda** and **Burundi** national governments (or donors following a standardized national approach) pay additional fees to health facilities (per service delivered) linked to delivery of a list of priority services that include new and continuing FP users and, in Burundi, specified methods. In Rwanda, the fees are discounted by quality assessment scores and in Burundi facilities have the opportunity to earn an additional bonus for performance on quality assessments. In all settings, facility-level payments are partly used to reward health workers. In **Egypt**, as part of the strategy to roll out a new family health model, health facilities providing this integrated care model have the opportunity to earn performance bonuses linked to attainment of health targets (including FP) and these performance payments are distributed partly to individual staff. **Honduras** has implemented a PBI strategy aimed at improving quality in public hospitals that incorporates FP indicators.

Perhaps most well known because of the recent impact evaluation that has been widely disseminated, **Rwanda** has scaled up a unified national PBI model that pays health facilities (public and private) fees for a list of services and then assesses quality and applies the quality score to discount fees (Basinga and Vermeesch 2009, Basinga et al. 2009). Increasing access to FP is a government priority reflected in how district political leaders are accountable to the national level as well as inclusion of FP in the package of services rewarded with performance-based financing fees in health facilities. Included in the list of rewarded services at the health center level are fees for new FP acceptors and additional fees for resupply of FP. In addition, a measure of quality of FP is assessed that assigns weights to both a structural component of FP (such as commodity availability) and a process component assessed through medical record review.

SNAPSHOT: National PBI in Rwanda

FP indicators: New FP acceptors and continuing FP users

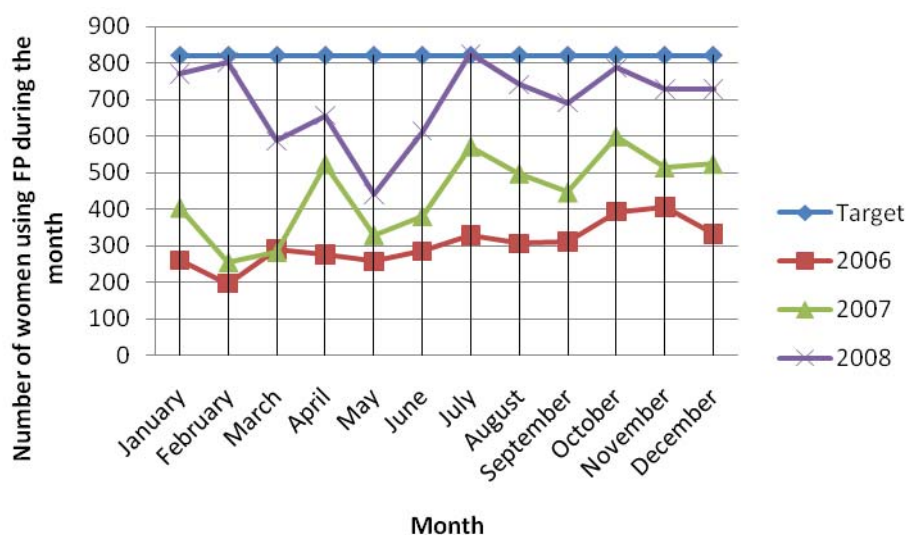
Recipients: Health facilities

FP-linked payment mechanism: Monthly fees for each new and continuing user, discounted by facility performance on quality assessment that includes availability of FP methods as a quality measure

PBI in Rwanda began in 2002 with two donor-funded and NGO-implemented pilots with different design and implementation arrangements. After both models showed better results than in comparable districts without PBI, and after promising results from a third pilot that began in 2005, the Ministry of Health decided to scale up a common national model that incorporated features of each of the pilots. This is an interesting example of a case of where pilots informed and led to national scale-up (Rusa et al. 2009).

Inspired by strong results in neighboring Rwanda, in 2006 **Burundi** began with pilots of its own supply-side PBI model that includes FP, which it now intends to expand to scale (Busogoro and Beith 2010). With this scheme, Burundi hopes to reduce adolescent pregnancy and increase the contraceptive prevalence rate, as well as improve maternal and child health. Payments are based partly on quality of care delivered, measured by patient and community satisfaction, and partly on use of quantity-related incentive payments determined by multiplying fees for specified services by the quantities provided. As in Rwanda, public health centers receive monthly fees for a list of services that include FP indicators, which in Burundi are fees for new FP acceptors and for insertion of IUDs and implants. In addition to fees paid monthly, quality is assessed quarterly and facilities have the opportunity to earn a bonus of up to an additional 15 percent of the revenues earned during the quarter determined by how the facility scores on a quality assessment. Monthly fees and quarterly quality bonuses are earned at the facility level; a portion is used for facility upgrades and the rest is shared among facility staff. In Gitega Province, for example, FP utilization levels rose from an annual average of around 300 women consultations per month to just over 800 per month in two years (see Figure 3).

FIGURE 3: INCREASES IN FP UTILIZATION FOLLOWING INTRODUCTION OF A PBI PILOT IN GITEGA PROVINCE, BURUNDI



Source: Busogoro and Beith (2010)

SNAPSHOT: From pilot to scale of PBI in Burundi

FP indicators: New FP acceptors, insertion of IUDs, implants

Recipients: Health facilities

FP-linked payment mechanism: Monthly payment of fees to facilities, quarterly quality bonus of up to 15 percent of fee revenue linked to performance on facility-wide quality assessment

During the pilots, health facility quality was assessed quarterly using 154 service-specific composite indicators. Contracts were established between Provincial Purchasing Agencies and local associations that are responsible for validating health services received at the community level, to determine satisfaction with services used, and to assess the extent of patient/community knowledge. Patients are asked how they were treated by providers, what medicines were prescribed (if any), and what follow-up took place. Findings from these quarterly community surveys are fed back to the respective health care providers. Part of the quality payment that facilities receive depends on the results of these surveys conducted by the local associations. Each facility can earn a bonus of up to 15 percent of the total amount obtained on quantitative results during the same time period. The Ministry of Health intends to raise this bonus to 25 percent during nationwide scale-up.

In 2001, **Egypt** introduced PBI into their family physicians approach to primary health care in the public health delivery system in five governorates. Through PBI, facilities receive a financial incentive when they attain health targets. Two FP targets are established using the following indicators: (i) the percentage of females of reproductive age (ages 15–45) using FP by method, and (ii) the percentage of females of reproductive age using FP relative to the total number in the catchment area. These indicators are reported monthly to the health district and validated by examining the primary health care logbook maintained at each facility. This financial incentive is then distributed to the health care staff within the facility according to a point system that is based on variables such as qualifications, experience, number of days worked, and efforts made to achieve the indicators in each area. Financial value of each point is determined by dividing total payment by total points and each staff member receives this value multiplied by the points they earned. This approach has succeeded in increasing utilization of key services including FP (El Hayatmy et al. 2010).

SNAPSHOT: PBI in a Family Physician Model in Egypt

FP indicators: (i) Target percentage of reproductive age females (15–45) using FP methods, and (ii) target percentage of reproductive age females using FP relative to total number in catchment area

Recipients: Family health primary health care facilities

FP-linked payment mechanism: Facility-level rewards for reaching targets

The opportunity to earn significant performance bonuses (roughly a 250 percent increase in salary) has drawn medical specialists into family medicine. However, a significant challenge confronting Egypt is that it is not clear how to continue to finance this scheme. One of the architects of the scheme now believes that donor funding should be used to help design and implement PBI schemes, but should not be used to pay financial incentives. If this advice had been followed in Egypt, it is likely that the magnitude of the incentive payments would have been lower and financial sustainability more feasible.¹⁰

With support from USAID, the Health Care Improvement (HCI) Project, and MSH, the Government of **Honduras** has introduced PBI that consists of monetary payments to hospitals based on their execution of quality improvement plans. These plans emphasize appropriate and effective implementation of a package of maternal and newborn services that includes FP, in that payment depends partially on the percentage of post-obstetric event patients who received information about and were offered FP methods. The level of funding that a hospital can receive depends on the degree to which each indicator is met. Targets are set by the central Ministry of Health and each hospital. A small portion of the hospital incentive payment goes directly to members of the quality improvement teams. PBI introduction has resulted in significant improvements in quality of care indicators. Additionally, other programs outside of maternal/newborn health have become motivated to adopt quality improvement methods.

SNAPSHOT: Performance incentives for quality improvement in Honduras

FP indicator: Percentage of post-obstetric event patients who received information about and were offered FP methods

Recipients: Public hospitals

FP-linked payment: Financial rewards for implementing quality improvement plans

4.5. VOUCHER SCHEMES ENABLE ACCESS TO A PACKAGE OF SUBSIDIZED SERVICES, REDUCING CLIENT FINANCIAL BARRIERS AND INCREASING PROVIDER MOTIVATION TO SERVE THE POOR

A number of countries are implementing voucher models that either provide at no charge, or sell for a small fee, books of coupons that enable access to services that include FP. In some settings, voucher holders have a choice of provider that can include public and private options, while in other settings voucher holders are assigned to specific providers. Some voucher schemes are run by the government, while others are purely private. Voucher approaches are most often used to target poor and marginalized populations. We know of voucher schemes in **Pakistan** and **Kenya** that include coupons to access FP services. Several other countries (Bangladesh, Cambodia, Myanmar, Nepal, Nicaragua, Uganda) are using some form of vouchers but they either do not include FP or we were not able to verify the specific contents of the subsidized package. Voucher approaches incorporate incentives on both the demand and supply side.

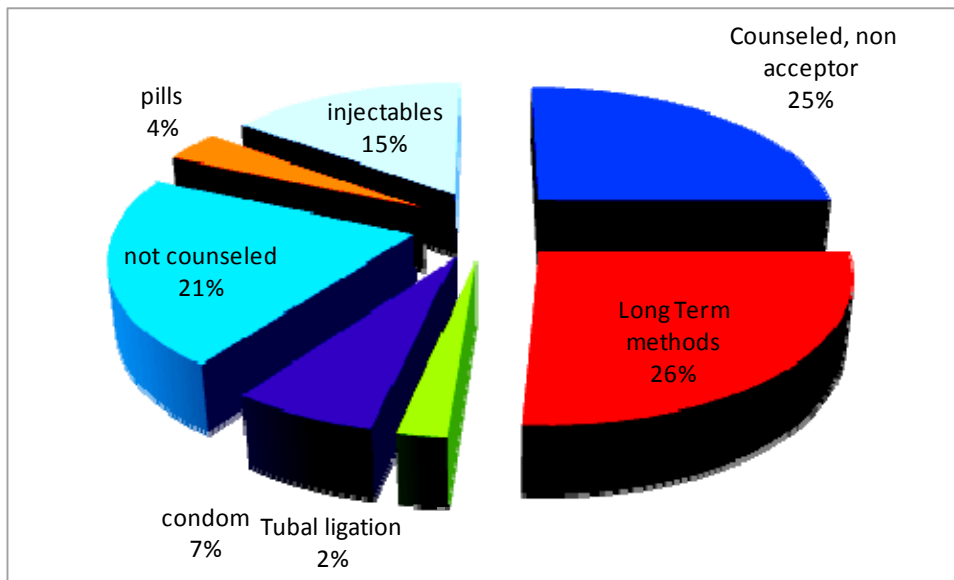
¹⁰ Discussion with Sameh el Saharty, December 2009.

In **Pakistan**, Population Services International (PSI) has enhanced the capabilities of the Greenstar social franchise and formed another franchise called “GoodLife” to pilot a voucher program in the Dera Ghazi Khan district that provides access to a full package of maternal health services from network private providers. The package comprises prenatal care, delivery, postnatal care, and FP. Poor pregnant women who have previously given birth at home are visited by Lady Health Workers, a form of community health worker, and educated about the benefits of delivering in a health facility. In addition to financial barriers, there are significant social and cultural barriers to overcome – men and mothers-in-law are decision makers and community tradition is to deliver at home. It may take multiple visits for the woman and her family to elect to purchase a voucher book for a small fee that enables access to a package of services from a GoodLife Provider. When the woman presents for services, the provider gives her funds to cover the cost of transportation. After services are provided, providers submit the vouchers to a voucher management agency managed by PSI and receive payment for the services provided; the payment includes fees for each FP counseling session and for provision of modern methods. This process enables PSI to track actual utilization of services by each voucher recipient by verifying voucher serial numbers against client names (Bashir et al. 2010).

SNAPSHOT: FP services as part of a maternal health package delivered through a social franchise in Pakistan
FP indicator: Vouchers redeemed for post delivery FP counseling
Recipients: Voucher holder (woman) and service provider
FP-linked payment mechanism: Voucher holder receives free services and transport subsidies; service provider receives a fee for providing FP counseling.

In this pilot, 78 percent (1,569) of voucher recipients returned to a contracted provider after delivering to receive FP counseling. Of these, 32 percent chose not to adopt a FP method, while the others chose methods as shown in Figure 4.

FIGURE 4: UPTAKE OF FP COMMODITY UTILIZATION FOLLOWING INTRODUCTION OF VOUCHERS IN PAKISTAN (N=1,569)



Source: Bashir et al. (2010)

It is important to note that women paying a fee for the voucher book indicates that they were convinced of the value of the services and suggests that accessing FP counseling and use of a modern method was chosen voluntarily. Interestingly, in Pakistan there is also evidence of a positive spillover effect as many voucher recipients brought 3–4 pregnant women from their family or neighborhood for care at the health facility. This suggests that the voucher scheme may have resulted in changed behavior of other community members, most striking given that these women had to pay fully for services out of pocket.

A maternal health voucher scheme that includes FP has also been implemented in **Kenya**, where uptake of delivery services exceeded expectations but FP utilization fell far short. Voucher distributors are contracted by a voucher management agency, funded by KFW, to sell subsidized FP vouchers within (currently five) pilot sites. Voucher distributors receive a monthly salary and are trained in how to apply a standardized poverty assessment tool, adapted by Marie Stopes International for the Kenya context, to grade potential clients on criteria including housing, access to health sources, water sources and sanitation, daily income, and number of meals per day. Voucher distributors must also conduct home visits to verify the poverty grading tool responses. Sometimes informal arrangements are made between the distributors and the clients if clients cannot pay the full voucher fee upfront. For example, they can arrange to pay the distributor in installments. Voucher holders provide the purchased vouchers to their preferred accredited service provider to receive the services linked to the particular type of voucher.

SNAPSHOT: Maternal health and FP voucher program in Kenya

FP indicator: FP vouchers redeemed

Recipients: Service providers

FP-linked payment mechanism: Service provider (public and accredited private) is paid to provide FP services to voucher holders who are poor women who purchased FP vouchers for a subsidized fee.

One lesson from the Kenya experience is that vouchers reduce financial barriers to accessing FP services, but they do not alone address other determinants of the choice to use FP. Other reasons inhibiting use of FP in Kenya are concerns about safety, religious prohibition, personal opposition, and a desired family size of many children. Identifying outlets for FP commodities and access are not major issues for any age group. This highlights the need to take into account local attitudes towards FP and to consider developing appropriate marketing and educational outreach components when designing a voluntary FP PBI intervention (Bellows et al. 2009). The next phase of this pilot intends to address these complementary components.

4.6. PBI FOR COMMUNITY HEALTH WORKERS

PBI can also be used to motivate community health workers. These workers play an important role in identifying pregnant women, in counseling women, families, and their communities, and in recognizing where FP demand is unmet. Examples of this include both **India** and the **Philippines**, where community health workers receive financial incentives dependent on completion of a package of services. In both cases, payment to the workers is accompanied by demand-side payments to overcome financial and social obstacles poor women face.

In **India**, the government-supported *Janani Suraksha Yojana* (JSY) program provides PBI to individual female village-level community health workers, called Accredited Social Health Activists (ASHA), who serve as a liaison between the community and government health systems. ASHAs are responsible for implementation of a full package of care composed of a number of activities that assist a woman through pregnancy and delivery and that are important to both the woman and the newborn's health directly

following birth. Payment to ASHAs from the JSY is conditional on their completing all of these activities, which includes FP counseling. The JSY program also provides demand-side payments to women, which are linked to facility-based delivery, not specifically to FP.¹¹ Eligibility criteria differ by state.¹² In what are called “low-performing states” all pregnant women of any caste, age, or income group who deliver in a government or accredited private health facility qualify for the JSY program and receive the financial incentive. In “high performing states” all pregnant women who are members of scheduled caste/schedule tribe communities and pregnant women who are below the poverty line and older than 19 years qualify for the program.

In addition, the National Rural Health Mission in **India** provides payments to individuals who choose sterilization, to the community health worker who accompanies them, and to the service provider who performs the sterilization services (Government of India 2007). In low-performing states, below poverty line women who receive tubectomies receive 600 rupees, below poverty line men receive 1100 rupees for vasectomies, and ASHAs receive 150-200 rupees when they accompany women for tubectomies and men for vasectomies. These fees are intended to cover the opportunity costs of lost wages and travel. In addition to fees paid to ASHAs and individuals, there are fees for the service providers who provide sterilization services.

The **Philippines** is currently piloting a performance-based payment scheme with the goal of supporting facility-based childbirth and increasing the role of skilled attendance at delivery among disadvantaged women. FP is included as part of the package of maternal health services, but it is not explicitly rewarded. As in India, the scheme includes both supply- and demand-side payments. On the supply side, payment goes to Women’s Health Teams (WHTs), which are composed of a rural health unit midwife, one *barangay* health worker,¹³ and one traditional birth attendant. On the demand side, women delivering in an appropriate health facility also receive a payment to offset childbirth-related expenses, such as transportation to reach the facility, and medicines, medical supplies, and food required during the stay. Funded through the Department of Health and Municipal Local Government Units, this scheme is designed to encourage WHTs to track and counsel all women within their catchment area and to encourage pregnant women to have facility-based deliveries. Like the India JSY program’s ASHAs, WHTs are responsible for implementing a full package of care. However, while FP is part of this package (WHTs organize outreach activities for FP and provide counseling), FP itself is not explicitly incentivized, as both supply- and demand-side payments are tied only to facility-based delivery.

4.7. CCT PROGRAMS

CCT programs are large-scale social protection programs that link income transfers to poor households if specified conditions are met, usually related to utilization of health, education, and nutrition services. Since 1997, seven countries in Latin America and the Caribbean (**Brazil, Colombia, Ecuador,**

¹¹ Acceptors of sterilization and IUD insertion in public and private accredited health facilities receive payments from the National Rural Health Mission meant to compensate for lost wages. ASHAs who refer people receive fees and the facilities receive payments.

¹² The government of India has divided states into two categories based on rates of institutional delivery. The 10 states with the lowest rates of institutional delivery are classified as “low-performing states”; they are Assam, Bihar, Chattisgarh, Jharkhand, Madhya Pradesh, Orissa, Rajasthan, Uttar Pradesh, Uttaranchal, and Jammu and Kashmir. The remaining 18 states are “high-performing states”; they are Andhra Pradesh, Arunachal Pradesh, Goa, Gujarat, Haryana, Himachal Pradesh, Karnataka, Kerala, Maharashtra, Manipur, Meghalaya, Mizoram, Nagaland, Punjab, Sikkim, Tamil Nadu, Tripura, and West Bengal.

¹³ Barangay health workers are individuals who have undergone training programs under any accredited governmental or nongovernmental organization program and who provide primarily health care services in their community after having been accredited to function as such by the local health board in accordance with the guidelines promulgated by the Philippines Department of Health.

Honduras, Jamaica, Mexico, Nicaragua have implemented and evaluated CCT programs with health and nutrition components (Glassman et al. 2009). Health and nutrition components of CCTs aim to stimulate demand for health services by transferring cash to mothers conditional on their seeking services for themselves and their children at health clinics and attending health education talks that cover FP, among other topics. CCTs may influence use of FP by improving understanding of FP benefits through health education talks, increasing access to FP commodities by incentivizing more frequent contact with the formal service delivery system, and by intensifying the focus on investing in their children's health and education.

SNAPSHOT: CCTs in Latin America

FP indicator: Attendance at health education talks that include FP

Recipients: Poor households

FP-linked payment mechanism: Monthly income transfers to poor households linked to a series of conditions that include attendance at health education talks that include FP, in some settings

CCTs may also have the perverse effect of stimulating an increase in fertility if cash transfers are linked to family size or numbers of children in school. Unintended effects of the CCT program in **Honduras** may have contributed to a 2–4 percent increase in fertility – a possible result of providing income transfers that vary with the number of children and pregnant women in a household (Stecklov et al. 2006). This effect was not observed in **Mexico** and **Nicaragua**, where income transfers do not vary with family size. CCTs in Mexico appear to have delayed the onset of premarital sex, age of marriage, and age at first and second birth (Gulemetova-Swan 2009).

5. CONCLUSION

As health programs throughout the developing world incorporate demand- and supply-side PBI, there is a real danger that voluntary FP will be neglected if not included. Progress in voluntary FP might stall or decline if FP is left out and with it the missed opportunity to contribute to broader development goals. By building on ways voluntary FP has been included in developing-country PBI approaches, identifying challenges and gaps, and contributing to a future agenda to fill these gaps, FP can be incorporated in ways that are effective as well as responsible and can protect voluntary choice and be in compliance with USAID FP requirements. The cases described in this paper can inform those operating in the USG-funded context as well as others who value voluntarism about relevant PBI options. There is some evidence that some countries are choosing not to include FP at least partially due to concerns about the Tiahrt Amendment; as one PBI survey respondent shared, “*the indicators for this scheme have not been designed yet. However, the indicators will not target a number of family planning acceptors due to Tiahrt amendment concerns.*” We wish to reassure program designers and implementers that voluntary FP can be included in PBI programs in ways that comply with U.S. FP requirements.

There is a need, however, to develop indicators of *quality*, in addition to the quantity measures that are in current use. The majority of FP indicators currently included in developing-country PBI programs focus on quantities of commodities or services delivered rather than quality of counseling or clinical care. They reward availability of needed inputs (e.g., availability of commodities, availability of trained staff) or numbers of FP services delivered (e.g., new acceptors). Few programs reward provision of quality counseling or FP services, partly because quality is harder to specify, measure, and verify than is quantity. This challenge is not unique to FP, as early PBI programs usually begin by rewarding the “low hanging fruit” of relatively simple to measure, countable services that can be reported through existing information systems.

As donors embrace the principles of country-led health plans and this is complemented by increased accountability for results, linking payment to performance is likely to increase in prominence. We may see more PBA, as donors condition payment to countries on achieved results. We may also see an increase in national to sub-national PBI as governments exercise their influence through conditions attached to intergovernmental fiscal transfers. At the national and sub-national levels, rewarding population coverage of voluntary FP services as well as their quality is consistent with U.S. FP requirements.

Because true impact occurs at the interface between users and service providers, any incentive approach has to strengthen the systems needed to reach clients and ensure delivery of voluntary, quality FP counseling and services. Rewarding population-based targets is consistent with U.S. FP requirements if the level being rewarded is a facility or team, as long as facilities have more than one person on staff. Payment for each service is acceptable at the facility/team or individual provider level, as long as payments are reasonable and in line with payments for other services. FP users can receive payments to offset transportation costs to overcome this often significant barrier to access. Rewards for quality counseling and service delivery, if feasible metrics are developed, can be used at each level.

In settings with service delivery NGOs and private providers, contracts can incorporate conditions that require achievement of specified results, and payment can be linked to this achievement. This is true in weak state settings as well as stable contexts. Governments, donors, and social insurance entities can incorporate PBI for voluntary FP counseling and services into the payment terms with NGOs, FBOs, and

private providers. Payment can reward attainment of population coverage or pay for each FP service delivered, provided that the per service payment is in line with payments for other services. Rewarding quality FP counseling and service provision is a priority with private providers as discussed above. In some settings, voucher schemes may help create a “market” for providing FP counseling and services, increasing both supply of quality services and demand. By reducing prices paid by the poor and complementing these subsidized prices with top ups that pay providers competitive fees, financial access barriers for poor households can be partially overcome and willingness to serve the poor can increase. When users pay even small fees to purchase vouchers, it is an indication of voluntary choice. Rewarding availability of modern methods may be a strong indicator during the early stages of a PBI scheme, especially in low-resource environments. However, this indicator appears to respond quickly and may need to be replaced with measures of counseling, use, or quality as systems develop and commodities become more reliably available. Once information systems are in place to report on counseling and acceptance of methods, countries are able to incorporate measures of quantity into performance incentive programs. The coming challenge is to develop measures of quality counseling and quality service provision that can be measured and validated in a routine and cost-effective way to be able to link to performance payments.

To support development of PBI approaches that incorporate voluntary FP, countries may request technical assistance to help structure the terms of payment agreements; to define rewarded performance measures; to establish the administrative functions needed to contract, monitor, verify, and pay; and to train recipients of PBI arrangements to understand new rules and how to effectively respond to them to achieve results. Countries may also appreciate help with strategies to consult with stakeholders during the design phase to assess what will work and refine the approach. Input to develop advocacy strategies to identify challenges and build support for a feasible PBI approach may also be appreciated.

Paying for FP results has potential to contribute to reducing unwanted and mistimed pregnancies and, by doing so, contribute to reducing maternal and newborn mortality. For countries already implementing PBI, including voluntary FP in the package of rewarded services will help to motivate providers to counsel couples about the benefits of FP and the choices available and will help to ensure that voluntary FP is not neglected. This paper describes a number of approaches that can be considered that incorporate FP into PBI schemes responsibly and in accordance with U.S. FP requirements. As PBI is evolving and learning and innovation is a dynamic process, we can expect to continue to learn about effective approaches to incorporate voluntary FP.

ANNEX: EXPANDING ACCESS TO FP AND PROTECTING INFORMED CHOICE IN THE UNITED STATES

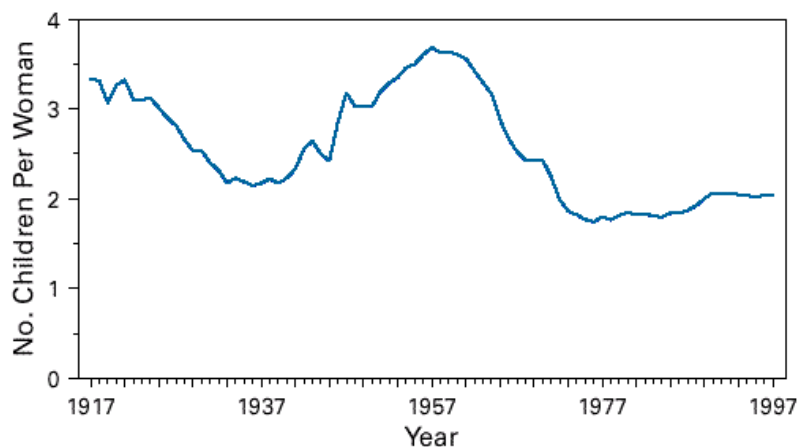
We have chosen to highlight the U.S. experience with FP to share one example of how the tension between using payments to reward providers for the provision of services that are adopted voluntarily and safeguarding the voluntarism of clients' adoption of the service can be minimized. In addition to presenting an opportunity for reproductive control, prevention of health and social consequences of mistimed or unwanted pregnancies, and prevention of the spread of sexually transmitted diseases, a FP visit can also serve as a woman's entry into the health system (Institute of Medicine [IOM] 2009). These opportunities are joined with unique challenges in delivering FP as a health service.

Despite being one of the Centers for Disease Control and Prevention's (CDC's) top-10 great public health achievements during the 20th century (see Figure A-1), FP was not always available to those seeking to have smaller families or longer birth intervals (CDC April 1999). To meet the rising demand for contraception, the U.S. Congress passed several laws designed to expand access to FP. Title X ("Title Ten") of the Public Health Service Act of 1970 authorized the Department of Health and Human Service's Office of Family Planning to give grants to public and nonprofit entities to establish and operate FP clinics, train service providers, conduct research, and engage in community outreach (IOM 2009). The program is hereafter referred to as the Title X program. The state/federal Medicaid program was amended in 1972 to require states to cover FP services. To incentivize states to expand these services further, the federal government has paid for a larger proportion of FP services than it does other health services on average since 1966.¹⁴ Overall, the late 20th century was characterized by initiatives to allow patients and their physicians to access FP, as well as generate more demand for FP through education and outreach.

Contemporary views on FP are that individuals have the right to practice FP if desired, but the practice must be voluntary and providers must ensure informed consent. In the past, there have been cases in the United States where today's standards for voluntarism in FP programs have not been upheld. In some cases, FP was forced on non-consenting women by powerful institutions (Schoen 2005). As a response to allegations of forced sterilizations, state legislatures have created laws and regulatory agencies to ensure that voluntarism is unequivocally protected.

¹⁴ The Federal Medical Assistance Percentages (FMAPs) are percentages of the total cost of a Medicaid health service that the federal government pays. The remainder is paid by the state in which the recipient resides. Generally, FMAPs are at least 50 percent and vary by state depending on the state's per capita income relative to the national average. FP enjoys a special status among covered services. The federal government pays 90 percent of services and supplies for Medicaid beneficiaries in all states, as per Section 1903 [42 U.S.C. 1396b] of the Social Security Act, amended in 1965.

FIGURE A-1: FERTILITY RATES,* UNITED STATES, 1917–1997



*The total fertility rate is the sum of age-specific birth rates for single years of age for women aged 14–49 years. The birth rates for single years of age used to compute total fertility rates are based on births adjusted for underregistration for all years and on population estimates adjusted for underenumeration; therefore, they cannot be compared with birth rates and fertility rates.

Source: CDC (December 1999)

PBI, called Pay for Performance (P4P) in the U.S. context, started in the United States in the 1980s, in private health care. More recently, P4P programs have expanded into public provision of health care.¹⁵ Performance measures have been designed, critiqued, and amended through the participation of a rich array of experts and stakeholders. The U.S. health system is different from those of low- and middle-income countries, with its mix of private and public payers (such as Medicare and Medicaid), private and public providers, and a dizzying mix of payment mechanisms, incentives, and initiatives to control costs and improve quality. This diversity contains important lessons for other contexts; however, this incentive “soup” is murkier in the United States than in most developing-country contexts, making the potential impact of a P4P scheme in a developing country potentially even more powerful.

We found no evidence of direct use of P4P to improve FP procurement and delivery in the United States. This may reflect an absence of need to incentivize providers to offer FP services. The P4P movement entered health care practice long after the advent of successful nationwide federally funded FP programs. Most counties in the United States now have at least one provider offering comprehensive FP services regardless of the patient’s ability to pay (Frost et al. 2004). This widespread availability may have been a factor in allowing Congress to exempt FP from Medicaid managed care programs as Medicaid moved away from fee-for-service in the 1990s (Lindberg et al. 2006).

Characteristics of American society fostered growth in demand for contraception and other FP services in the 20th century and eventually contributed to changes in the way health care was delivered in the United States. Civil society groups and women’s rights advocates helped to spread awareness of FP and

¹⁵ Some large P4P programs currently operating in the private sector include The Leapfrog Group’s Hospital Rewards Program (www.leapfroggroup.org), Bridges to Excellence programs and PROMETHEUS payment schemes (<http://bridgestoexcellence.org>), and Integrated Healthcare Association’s PBI program in California (http://www.ihc.org/pay_performance.html). The USG has also started PBI programs in the public health sector through The Centers for Medicare and Medicaid’s Premier Hospital Quality Incentive Demonstration and Physician Group Practice Demonstration (www.cms.hhs.gov).

empower women to demand reproductive rights. Patient demand for FP was high and the health system had to expand to meet that demand. Additionally, providers became early advocates of FP for their patients. Fee-for-service provider reimbursement encouraged delivery of high quantities of health services, thus provider motivation was not a large issue in the United States, unlike in poorer countries with salaried physicians. Availability of funding, good infrastructure, and relatively low entry barriers to the private health care sector allowed the health care system to expand and for Medicaid and the Title X program to be implemented nationwide.

While developing country contexts differ, popular and political recognition of the importance of FP warranted the creation of these U.S.-based domestic programs for many of the same reasons FP merits consideration in P4P programs abroad. Aside from provider motivation and patient demand, there are issues that seem to transcend national income levels and populations. Medicaid and the Title X program were created to expand access to FP to vulnerable populations such as low-income people. These programs were intended to address health care equity, protect voluntarism and informed choice, and balance competing forces.

FP indicators that have been used in domestic programs have been designed with those goals in mind, and may be helpful in guiding designs for FP indicators in P4P programs in those settings. Box A-1 contains a list of indicators currently used to evaluate the Title X program and new ones proposed by the IOM that further emphasize quality of services and patient-centered care (see IOM 2009).

Some aspects of the Title X program in the United States have elicited discussion that may be relevant in P4P programs that include FP indicators. The first discussion centers around balancing informed choice with effectiveness and efficiency. To protect informed choice, providers who receive funding from the program must discuss the entire range of FP options with new patients. While it is thought that many providers and commentators believe an emphasis on education and counseling is important for protecting informed choice and contributes to more satisfied patients (Gold 2008), the IOM offers that excessive information could interfere with the patient's retention of knowledge and is counterproductive when patients come in for a visit with a method preference (IOM 2009). These two demands can compete and must be balanced when designing P4P indicators that protect informed choice.

The second discussion surrounds balancing opportunities to provide comprehensive care with the goal of attracting as many patients as possible. Health-seeking behavior may be reinforced if patients feel that they can seek any service unconditionally. If women visit a health center to obtain contraception, it is tempting to take advantage of the woman's presence by providing her other health services. The woman's visit for FP may be her only visit to a health center. However, women may be intimidated by other tests, shots, or services and may choose not to visit the health center for FP purposes if she knows that obtaining other services are preconditions. Potential patients of Title X clinics reportedly avoided a visit when the Title X program required that all new patients receive a Pap smear at their first visit. To ensure that the clinics could attract as many women as possible, the program modified this provision by allowing the woman six months after her first visit to receive a Pap smear (IOM 2009). While public health experts wanted as many women as possible to be screened for cervical cancer, provision of contraception may have been compromised as an unintended consequence.

Box A-1: “Title X” Program Evaluation Indicators (annotated)

Client characteristics	1	Socioeconomic characteristics
	2	Client knowledge, intendedness, visit agenda*
	3	Number of clients
System characteristics	1	Funding
	2	Program requirements
	3	Ratio of staffing to patient encounters
		a. Number of full-time equivalents who are medical versus other clinical service providers
		b. Nonclinical service providers
	4	Interpreters
	5	Number of delegates supported by Title X
	6	Service planning sites supported by Title X
	7	Number of clinic sites
	8	Compliance with administrative requirements, having written goals and evaluation plan, etc.
	9	Personnel and clinic management systems
	10	Client care protocols
	11	Training and technical assistance
12	Financial management system	
13	Systems to involve the community	
Process of care: client-provider encounter	1	Mandated care is state of the art
	2	Range of client services offered by qualified staff
	3	Written plan for client education
	4	Report that counseling, history and exam services comply with Title X requirements
	5	Quality assurance program ongoing
	6	Evaluate monthly the range of contraceptive products available*
	7	Wait time for scheduling visit by reason for visit*
	8	Continuity of care at the same site if needed*
	9	Care is patient-centered and respectful*
	10	Clear information is offered, and bilingual*
	11	Patients feel welcomed by reception and clinical staff*
	12	Services are perceived as confidential*
Service use performance indicators for Title 10 priority areas	1	Enumeration of services provided
	2	Number of users receiving testing and other services; number of positive test results
	3	Increased FP services to low-income clients to decrease number of unintended pregnancies **
		a. 80% of contracepting male and female clients who return to clinic continue any method for 10-14 months unless seeking a pregnancy**
		b. 90% of female clients seeking contraception do not report a positive pregnancy test within 15 months of receiving contraception**
	4	Increased screening of females aged 15-24 for Chlamydia infection**
		a. 75% of female clients under 25 receive at least one test for Chlamydia within 14 months**
	b. 100% of all female clients with a positive test for Chlamydia are retested at the first visit that takes place 90 days or longer after treatment; 95% of those who are retested test negative**	
5	Increased services to reduce invasive cervical cancer**	
6	Increased screening for HIV/AIDS**	
Modeled improved clinical outcomes	1	Low-income women achieve their FP goals*
	2	Decreased number of unintended pregnancies, particularly among low-income women
	3	Reduced infertility among women
	4	Reduced invasive cervical cancer

*New indicator proposed by the Institute of Medicine

**Example of a service use performance indicator defined by Family Planning Councils of America

A final issue that has been discussed in the U.S. domestic context is voluntarism. For example, the Medicaid program tried to balance convenience and maximum services provided with attention to voluntarism. However, it is often possible for physicians to perform sterilization at the time of a woman's delivery and while many women ask for this service voluntarily, there is potential for abuse given that the physician is in a position of power. After 1978, the Medicaid program no longer reimbursed physicians for sterilizations performed at the time of delivery; instead, women must have given informed consent 30 days prior to the service in most cases (Kaiser Family Foundation 2005). Some critics argue that this law is harmful to public health because some women never return for the service, but others argue it is necessary to protect voluntarism.

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