



CAN INCENTIVES STRENGTHEN ACCESS TO QUALITY FAMILY PLANNING SERVICES?

LESSONS FROM BURUNDI, KENYA, AND LIBERIA

August 2012

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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

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ACRONYMS

ANC	Antenatal Care
ARV	Antiretroviral
CBO	Community-Based Organization
CHT	County Health Team
CHW	Community Health Worker
CYP	Couple Years of Protection
DRC	Democratic Republic of the Congo
EC	European Commission
FP	Family Planning
GBV	Gender-Based Violence
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
IRC	International Rescue Committee
IUD	Intrauterine Device
KfW	KfW Bankengruppe
MOH	Ministry of Health
MOHSW	Ministry of Health and Social Welfare
NGO	Nongovernmental Organization
NHIF	National Hospital Insurance Fund
OBA	Output-Based Aid
P4P	Pay for Performance
PBC	Performance-Based Contracting
PBF	Performance-Based Financing
PBI	Performance-Based Incentive
PwC	PricewaterhouseCoopers
QA	Quality Assurance
RBF	Results-Based Financing
RH	Reproductive Health
RBHS	Rebuilding Basic Health Services
USAID	U.S. Agency for International Development
VD	Voucher Distributor
VMA	Voucher Management Agency
VSP	Voucher Service Provider
WB	World Bank

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EXECUTIVE SUMMARY

Can performance-based incentive (PBI) programs – programs that reward the delivery of outputs and outcomes with financial incentives – stimulate quality family planning (FP) service provision and enable women to access FP services? Or is incentivizing FP too riddled with risk, too liable to encourage providers to coerce patients or to cause patients to feel pressured to accept an FP method?

All PBI programs aim to influence the decisions that people – usually poor people – make by providing them with incentives, usually financial incentives. The idea is to encourage good behavior – to encourage patients to make decisions that lead to better health – and to motivate providers to exert the effort necessary to deliver quality care. Performance incentives also aim to constrain bad behavior, such as provider absenteeism or a focus by providers on curative care at the expense of preventive care (if, for example, they are able to earn higher reimbursement fees for those services).

The assumption behind PBI is that people are intrinsically motivated to do these things, for the most part. And in the case of providers, they are required to do these things as a part of their job. The money and other incentives that PBI brings to bear enables, motivates, and empowers people to act on the intrinsic motivation they already have, or gives them a little push if they need some extra motivation. A PBI program might pay a mother a small cash transfer on the condition that she attend health check-ups or take her children to be immunized, or a program might pay health facilities for increasing the number of facility deliveries. These kinds of incentivized actions help patients to avoid bad things, such as getting measles or dying in childbirth.

Providing incentives for FP is in some ways trickier than for other services, such as facility delivery or immunization, because of what is known as hyperbolic discounting: the phenomenon that people – especially if they are poor and vulnerable – sometimes discount a future good for an immediate reward. If a very poor person is offered money for sterilization or a long-term FP method, for example, even if the person is not sure they really want the method, they might accept it because their need for resources is so great. The same is true for providers; even if they know that quality FP provision requires explaining all the methods available to patients, along with their advantages and disadvantages, they might push patients toward a particular method if they are being paid for it. Pushing a woman towards facility delivery is less controversial because if a woman is pregnant the baby is going to deliver one way or another, and incentivizing a provider or a patient for facility delivery is meant to increase the odds of a successful delivery. But FP is a personal choice, and one associated in many countries with complicated social norms and taboos.

The point is, anxiety around FP and incentives is not unfounded. Nor is it new. Writing about reimbursement payments to sterilization acceptors in Bangladesh, the forced sterilization campaign in India in 1976, and China's one-child policy, which began in 1979-80 and continues to the present, Robinson and Ross (2007) note, "In places where socioeconomic conditions were not especially conducive to rapid and sustained fertility decline, public action to achieve lower birthrates skirted, and sometimes crossed, the line between pure voluntarism and coercion."

It was concerns such as these that prompted the U.S. Agency for International Development (USAID) in 1982 to issue an agency policy laying out guidelines on voluntary sterilization. Then, in 1998, in response to evidence of nonvoluntary practices in a Peruvian FP program, the U.S. Congress passed the Tiahrt Amendment, which elaborates standards for voluntary FP service delivery programs to protect FP acceptors.

Helping women who want to access FP services overcome the barriers for doing so, and helping providers increase coverage FP coverage in an ethical way, remain critical global health goals, particularly after decades of neglect of FP. Though there is a risk that poorly designed PBI programs could lead to distortions and damage informed choice, well-designed PBI programs can have the opposite affect: they can improve the quality of FP service provision, which necessarily respects patient choice, and can do so in ways that are compliant with U.S. government regulations.

This paper explores how PBI programs can reward quality, including the quality of FP services. There are many options for doing so, and many different indicators and payment mechanisms are being tried all over the globe. In most PBI programs, FP indicators are rewarded alongside a range of other indicators related to such things as maternal and child health and infectious disease (see Box ES-1).

Box ES-1. Incentivizing FP: What's happening ?

Incentives to health facilities for:

- New users (for any method or specific methods) – Benin, Burundi, DRC, Egypt (married women only), Rwanda, Senegal, Zambia
- Continuing users (for any method or specific methods) – Benin, Burundi, DRC, Rwanda, Zambia
- Couple years of protection – Liberia, Tanzania
- Contraceptive Prevalence Rate – South Sudan (World Bank)
- Counseling – DRC-EC
- Commodities in stock (/or minimum number of modern methods available) – Afghanistan, Haiti, South Sudan (USAID)
- Reduction in discontinuation rate – Haitiⁱ
- Staff competent to provide counseling – Liberiaⁱⁱ

Incentives for Patients:

- Vouchers sold or given for free to women, for long- and short-term methods – Cambodia (vouchers are free and also cover safe motherhood services); Pakistan (voucher also covers safe motherhood services)
- Vouchers sold or given for free to women for long-term methods only – Kenya and Uganda (these programs also sell vouchers for safe motherhood services)
- Conditional cash transfer programs, where one of the conditions includes attendance at health talks, where information about family planning is provided (Mexico)

Incentives to CHWs for:

- Providing counseling for appropriate options for family planning – Indiaⁱⁱⁱ, Philippines (in both programs, CHWs are expected to deliver a set of maternal health activities)
- % of new family planning users referred by CHW cooperatives to the health center – Rwanda
- % regular users of modern contraceptives at the health center – Rwanda^{iv}

ⁱ The commodity availability indicator was dropped in Haiti when most/all facilities had achieved it; the FP indicator related to discontinuation was dropped in Haiti after a misunderstanding about whether they were compliant with the U.S. Tiarht Amendment (both indicators are compliant).

ⁱⁱ This indicator was dropped when most facilities were deemed to have achieved it.

ⁱⁱⁱ In addition, it should be noted that the Indian National Rural Health Mission provides payments to individuals who become sterilized; to the community health worker who accompanies them; and to the service providers that perform the sterilization services. Acceptors of IUD insertion in public and private accredited health facilities also receive payments from the National Rural Health Mission. These fees are intended to cover the opportunity cost of lost wages and travel. Payment is highest for services to below-poverty-line people from high-focus states and lower for the non-high-focus states. Whether or not this practice promotes voluntary, informed choice is discussed below.

^{iv} In Rwanda, CHWs may also earn incentives for indicators related to nutrition monitoring, antenatal care and facility delivery.

In this report, we hone in on experiences in three countries:

- Burundi, which since 2010 has implemented a classic “supply-side” PBI program that offers incentives to health facilities, conditional on increases in the quantity and quality of services;
- Kenya, which since 2006 has piloted a reproductive health voucher program that sells highly subsidized vouchers for safe motherhood services and FP to poor women;
- Liberia, which since 2009 has implemented a performance-based contracting (PBC) program that contracts nongovernmental organizations (NGOs) to deliver services, manage facilities, and build the capacity of subnational levels of government, conditioning a portion of their remuneration on results.

REPORT FINDINGS AND RECOMMENDATIONS

1. There are Many Ways to Incentivize FP: Choose FP Indicators that Reflect Quality and Informed Choice

Among the chief findings of this paper is that there are many ways to encourage provision of FP services and to enable women to access those services. Burundi pays providers fees for each woman who accepts a particular method, Liberia rewards increases in couple years of protection (CYP), and Kenya sells highly subsidized vouchers for long-term methods.

But some ways of rewarding FP are better than others. Rewarding providers for increases in uptake of FP may encourage them to get the numbers up but may not encourage provision of quality counseling and thus may not result in continued use. Rewarding providers for uptake of particular methods heightens this risk, especially if the incentive for FP is significantly more than the incentives paid for other indicators in the PBI program. (In almost all PBI programs, FP is incentivized alongside a range of other health services.) A better indicator for rewarding quality FP care may be reduced discontinuation, since discontinuation is correlated with perceived low levels of quality.

For patients, providing incentives for accepting a method may limit the power they have to make decisions about what is best for their lives. A better way to help patients overcome barriers to accessing FP services is to pay for the transport and other costs associated with accessing services, as long as it is clear to patients that such assistance is not conditional on acceptance of a method. Vouchers are a potential proxy for patient choice; in schemes where they must purchase vouchers, that decision is an indicator of their desire to access FP services.

2. Reward Quality, But Take a Holistic Approach

This report also shows that there are many ways to reward improvements in quality. Kenya and Burundi reward quality through accreditation and quality checklists that gauge facility preparedness; Burundi also conditions a portion of provider payment on measures of patient satisfaction. Liberia measures facility preparedness, as well as the clinical content of care, and scores on both have an impact on the bonuses NGOs receive. Except for Liberia, the programs covered here are stronger at rewarding structural quality, mirroring a broader trend in PBI, yet many of the essential elements of quality FP service provision focus on the content of care: the technical competence of providers, information given to patients, etc.

PBI programs would do well, therefore, to take a more holistic approach to quality. Part of the power of PBI is its ability to send signals to providers about priorities, and it is important to signal that all types of quality matter – structural quality as well as process/clinical content of care and patient perceptions.

More and more programs are exploring ways to measure and reward more-complex measures of quality, including, for example, in Kenya, where the quality assurance approach is being revised to account for process and patient views.

But one of the barriers to incorporating measures of clinical care into PBI programs is that it is more complex to develop tools to measure clinical content of care, and the tools that exist tend to be hefty and detailed and do not lend themselves to the kind of regular data collection that PBI schemes need. But this is changing. More countries are following the path of Liberia and developing tools that can be used as national standards and in the context of PBI. Developing such tools is urgently needed.

Considering patient views is also important and, as Burundi shows, it is possible to directly engage patients, seek their views, and to link scores on patient surveys to a portion of provider payment. Because patient perceptions are subjective, it is important to weight the portion of provider payment affected by this quality measure carefully, so not to demotivate providers. The Burundi program also highlights the importance of how patient views are collected: Burundi contracts community-based organizations (CBOs) to survey patients, which raises patient privacy issues.

3 .Facilities Must “Own” Quality: Clear Rewards and Sanctions are Key

The country cases discussed in this report demonstrate that for PBI approaches to be effective in supporting quality improvements, facilities must understand the standards for which they are accountable; and the rules of PBI programs must be clear and consistently applied. Quality must be clearly defined, measured, and rewarded, and facilities must be supported and equipped to achieve improvements. No PBI program will motivate people if they do not understand the rules of the game or if they think what they are being asked to achieve is unfair.

At a minimum, health facility teams should be parties to performance contracts that clearly explain the indicators by which their performance will be measured – including quality measures – and targets should be negotiated and based on each facility’s own baseline performance.

4. Strengthen Family Planning Counseling – For All Who Provide It

A key aspect of quality FP service provision is ensuring that quality services, including counseling, are accessible for women and their families. Each program discussed in this report attempts to make FP counseling more accessible by bringing it closer to where women live by way of community health workers (CHWs) of various stripes. Though CHWs are on the front lines of what is essentially FP counseling (often called “promotion” or “education” when volunteer CHWs do it), because of the informality of their position in the health system, their training and capacity is often insufficient or highly variable, depending on the enthusiasm of whomever manages them. Yet encounters between CHWs and women and their families may be important determinants in women seeking provision of a method.

PBI programs may want to consider ways to strengthen the role of CHWs/voucher distributors in provision of FP counseling and service delivery. It is important to ensure they are equipped to respond to questions about methods, side effects, etc., according to the quality standards that would be expected of a facility.

5. Indirectly Support Quality by Enhancing Bottom-Up Accountability

PBI aims to improve the quantity and quality of health services by giving higher-level actors (i.e., payers of health services) tools to hold providers accountable for results (and/or to incentivize actions by patients that lead to better health) through provision of financial and other incentives that are

conditional on improvements in the quantity and quality of services². Rewards for increases in the quantity of health services give providers an incentive to attract patients, an incentive which may be most powerful in settings where facilities compete with each other for patients. Such competition may lead to improvements in quality, particularly those improvements most noticeable by patients, such as friendliness, cleanliness, and attractiveness of the structure. PBI also strengthens accountability within facilities; because teams are jointly held accountable for performance (in almost all supply-side PBI schemes, the incentive is paid to the team of health workers, not to individuals), health workers hold each other accountable as the efforts of each individual team member impacts the performance payments earned.

Another way to enhance accountability is through mechanisms that strengthen “bottom-up” accountability, that is, mechanisms that give average citizens voice over their providers to hold providers accountable for delivering quality care that responds to their needs and that empowers them to shape facilities’ understanding of what constitutes quality care. Engaging communities is not new, but in the health sector it has traditionally focused on community-based provision of health services. Experiences with community engagement for the purpose of accountability have been fewer.

But in many countries, mechanisms already exist in communities, whether CHWs, community health committees, or CBOs. Engaging them can help strengthen the system and encourage the community to both support the facility to achieve results and hold them accountable – and this may provide positive pressure to improve various aspects of quality.

THE BOTTOM LINE

PBI can stimulate quality health service delivery, including quality FP services, by tackling the incentives and disincentives that providers and patients face that either enable or constrain them from making choices that lead to better health. Too many countries, driven by ideology, religion, and male opposition, have responded by doing nothing – and that, as this paper demonstrates, has been a huge missed opportunity. FP can and should be included in PBI programs that provide incentives for a package of services, and this paper offers recommendations for how.

² The “other incentives” mentioned here includes such things as increased supervision and scrutiny and verification of health data.

I. INTRODUCTION

I.1 THE CASE FOR INCENTIVES

Can performance-based incentive (PBI) programs – programs that reward the delivery of outputs and outcomes with financial incentives – stimulate quality family planning (FP) service provision and enable women to access FP services? Or is incentivizing FP too riddled with risk, too liable to encourage providers to coerce patients or to cause patients to feel pressured to accept an FP method?

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The assumption behind PBI is that people are intrinsically motivated to do these things for the most part, and in the case of providers, they are required to do these things as a part of their job. The money and other incentives that PBI brings to bear enables, motivates, and empowers people to act on the intrinsic motivation they already have, or gives them a little push if they need some extra motivation. A PBI program might pay a mother a small cash transfer on the condition that she attend health checkups or take her children to be immunized, or a program might pay health facilities for increasing the number of facility deliveries. These kinds of incentivized actions help patients avoid bad things, such as getting measles or dying in childbirth.

Providing incentives for FP is in some ways trickier than for other services, such as facility delivery or immunization, because of what is known as hyperbolic discounting: the phenomenon that people – especially if they are poor and vulnerable – sometimes discount a future good for an immediate reward. If a very poor person is offered money for sterilization or a long-term FP method, for example, even if the person is not sure they really want the method, they might accept it because their need for resources is so great. The same is true for providers; even if they know that quality FP provision requires explaining all the methods available to patients, along with their advantages and disadvantages, they might push patients toward a particular method if they are being paid for it. Pushing a woman towards facility delivery is more clearly the best thing for her; if a woman is pregnant the baby is going to deliver one way or another, and incentivizing a provider or a patient for facility delivery is meant to increase the odds of a successful delivery. But FP is a personal choice, and one associated in many countries with complicated social norms and taboos.

The point is, anxiety around FP and incentives is not unfounded. Nor is it new. Writing about reimbursement payments to sterilization acceptors in Bangladesh, the forced sterilization campaign in India in 1976, and China's one-child policy, which began in 1979-80 and continues to the present, Robinson and Ross (2007) note, "In places where socioeconomic conditions were not especially conducive to rapid and sustained fertility decline, public action to achieve lower birthrates skirted, and sometimes crossed, the line between pure voluntarism and coercion."

It was concerns such as these that prompted the U.S. Agency for International Development (USAID) in 1982 to issue an agency policy laying out guidelines on voluntary sterilization. Then, in 1998, in response to evidence of nonvoluntary practices in a Peruvian FP program, the U.S. Congress passed the Tiarht

Amendment, which elaborates standards for voluntary FP service delivery programs to protect FP acceptors.

Helping women who want to access FP services overcome the barriers for doing so, and helping providers increase coverage FP coverage in an ethical way, remain critical global health goals, particularly after decades of neglect of FP. Though there is a risk that poorly designed PBI programs could lead to distortions and damage informed choice, well-designed PBI programs can have the opposite affect: they can improve the quality of FP service provision, which necessarily respects patient choice, and can do so in ways that are compliant with U.S. government regulations.

1.2 STRUCTURE OF THIS PAPER

This report takes stock of different mechanisms being used in PBI programs – also known as pay for performance (P4P) and results-based financing (RBF)³ – to incentivize quality and FP. Quality is important for all services and all people, but it may be particularly important for FP, where evidence suggests that women provided with quality FP counseling are more likely to decide to use a method, to continue to use the method, and to recommend a method to friends. Furthermore, discontinuation rates are correlated with low levels of perceived quality (Koenig et al. 1997; Meuwissen et al. 2006; Bongaarts and Bruce 1995; Blanc et al. 2002).

Though experiences with PBI are many and growing, a clear picture of what PBI programs are doing to address the quality of services is only just emerging. Moreover, there remains much confusion and concern over whether PBI can be an effective instrument to advance quality FP service provision or if the approach is too fraught with risk for such a sensitive aspect of reproductive health.

This report examines in detail experiences in three countries that have rewarded FP and quality as part of their PBI programs:

- Burundi (performance-based financing, PBF)⁴
- Kenya (reproductive health vouchers)
- Liberia (performance-based contracting, PBC)

These countries were selected because they represent an interesting mix of approaches to incentivizing quality in PBI, as discussed in Ergo et al. (2012)⁵. They also represent a mix of mechanisms for incentivizing FP counseling and service provision.

Using a theoretical framework based on the literature on quality assurance, this report explores how quality is defined, measured and monitored, sanctioned (poor quality)/rewarded (good quality,

PBI defined

“Any program that rewards the delivery of one or more outputs or outcomes by one or more incentives, financial or otherwise, upon verification that the agreed-upon result has actually been delivered.”

–Musgrove (2010)

³ P4P and RBF are umbrella terms that describe the definition given in the sidebar above. See Musgrove (2010).

⁴ PBF is a term used to describe a particular model of PBI program most often seen in the Great Lakes region of Africa, wherein facilities receive fees for services delivered; in Burundi, subnational levels of government are also eligible to receive incentives. PBC refers to contracting NGOs, a model typically seen in post-conflict settings. Vouchers are explained below. To learn more about these and other PBI programs in Africa, see Morgan and Eichler (2011).

⁵ Ergo et al. (2012) review both developing and developed country experiences rewarding quality improvement in PBI programs.

improvements), and supported (i.e., how health facilities are supported/enabled to make improvements). We look at countries' overall quality approach, while also considering how FP quality is addressed.

The report assesses the strengths, weaknesses, and risks of different approaches, as well as how to mitigate them; explores how country approaches have evolved and why; and offers practical recommendations for countries looking to enhance quality in their PBI programs, with a special focus on ensuring the quality of FP services.

I.3 METHODOLOGY

A review of published and grey literature (i.e., external, internal, and non-reviewed reports), in English, was conducted. Evidence presented in this paper also draws from key informant interviews conducted in four districts in Kenya (Kiambu, Kisumu, Kitui, and Nairobi) between June 18 and July 1, 2011; four counties in Liberia (Bong, Cape Mount, Montserrado, and Nimba) between February 26 and March 10, 2012; and three provinces in Burundi (Bujumbura, Makamba, and Muramvya) between March 5 and March 22, 2012.

Respondents consisted of Ministry of Health (MOH), donor, and implementing nongovernmental organization (NGO) representatives; health facility staff (namely in-charges, head nurses, and/or midwives); community health workers (CHWs); and voucher distributors (VDs). Among the limitations of this assessment, the lack of interviews with patients warrants mentioning. The report does not claim to be comprehensive, which is impossible given time and resource constraints. Rather, it aims to highlight key conceptual issues and offer practical advice to PBI program designers, managers, providers of technical assistance, ministries of health, and donors. Any errors are my own.

2. PROGRESS IN FP – BUT MORE MUST BE DONE

FP is a crucial vehicle for advancing maternal and child health. Increased use of FP results in fewer unintended pregnancies, fewer maternal and newborn deaths, and healthier mothers and children. FP has been shown to be one of the most cost-effective ways to reduce maternal, infant, and child mortality (Vlassoff et al. 2004; Singh et al. 2009). It is estimated that FP could prevent as many as one in every three maternal deaths and one in every 11 child deaths by allowing women to delay motherhood, space births, avoid unintended pregnancies and abortions, and stop childbearing when they have reached their desired family size (Cleland et al. 2006).

Increased FP use can also lead to increased family savings and productivity, as well as better prospects for educating children, strengthening economies, and reducing the pressure on natural resources in developing countries (Potts and Fotso 2007; Allen 2007; Stover and Ross 2009; Guttmacher Institute and UNFPA. 2010; Rutstein 2008; Hogan et al. 2010).^{6,7}

In recent decades, there have been tremendous improvements in the reproductive health of women in the developing world, and in access to FP specifically. From 1965 to 2005, contraceptive use rose from less than 10 percent to 60 percent (Cleland et al. 2006), and between the mid 1960s and the mid 1990s, average fertility in the developing world, including China, fell from around six children per woman over her reproductive lifetime to around three, a 50 percent decline (Robinson and Ross 2007). The global total fertility rate fell from 3.7 children per woman in 1980 to 3.26 in 1990 and 2.56 in 2008, which, despite a global increase in the number of women of reproductive age, has kept the global number of births/year stable (Hogan et al. 2010).

But as Cleland et al. (2006) have noted, “Success [in FP] came at a price. The strategies used by some Asian programmes to achieve an effect on fertility were criticised as coercive and the quality of family-planning services in many countries was deemed unsatisfactory.” Responding to evidence of nonvoluntary practices (in a Peruvian FP program) in October 1998, members of the U.S. Congress introduced a statutory amendment, known as the “Tiahrt Amendment,” which affirms and elaborates standards for voluntary FP service-delivery programs to protect FP “acceptors,” who are defined as individual clients receiving services.⁸

Despite progress, more than 200 million women in developing countries do not have access to effective contraception. In addition, using estimates from 2008, Singh et al. (2009) show that 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.

⁶ UNICEF. The State of the World’s Children 2009, December 2008; and State of the World’s Children 2010, November 2009.

⁷ WHO. Maternal Mortality in 2005; 2007.

⁸ To learn more about ensuring that PBI programs are compliant with Tiahrt, see Eichler et al. (2010).

Moreover, global increases in FP coverage mask the fact that a number of countries have experienced no improvement at all (WHO and UNICEF 2010).⁹ In sub-Saharan Africa, contraceptive prevalence rates hover at around 23 percent (PLoS Medical Editors 2010). As well as having the lowest use of contraception, sub-Saharan Africa and South Asia also have the highest rates of maternal and infant mortality.

Developing country governments and their donor partners are therefore looking for new ways to increase the availability of high-quality FP services and to create conditions that enable women and families to avail themselves of these services if they wish to do so.

⁹ For example, Madagascar, Rwanda, and Swaziland all witnessed increases of more than 20 percentage points, while 12 other countries saw no change or instead lived through a coverage decrease. In particular the Central African Republic and Togo saw declines of nine percentage points each and the Democratic Republic of the Congo of 11 percentage points. See WHO and UNICEF (2010).

3. WHY QUALITY (REALLY) MATTERS

Making strides in FP requires increasing availability of and access to commodities, of course, but tackling the quality of care is also key. Quality care is thought to improve health outcomes by providing patients with technically sound services, administered according to standards that are known to maximize their health impact, and by creating positive associations between patients and the health system, which may encourage patients to return to health facilities and to encourage others to do so, also. Conversely, poor quality of care may discourage patients from returning, may encourage them to put off care until their condition becomes severe, or may result in their discouraging others from seeking care.

The quality of reproductive health services may be a particularly important factor determining the degree to which women adopt and continue to use FP methods. FP is a sensitive aspect of reproductive health care. Social and relational norms and taboos – including male opposition – may work to constrain and discourage women from seeking FP counseling and services, in addition to such barriers as service availability and accessibility, the cost (direct and indirect) of accessing services, and a patient's desire to regulate fertility (RamaRao et al. 2003).

The literature demonstrates a link between quality and FP uptake, continued use, and the decision to recommend contraception to others. Notes Meuwissen et al. (2006), “quality affects the decision to use contraceptives, to continue using services ... and to recommend the services to others....”

Specialized subnational studies in Bangladesh and the Philippines examined the effects of service quality on contraceptive adoption and continued use. The largest and most rigorous analysis comes from a panel study in Bangladesh that examined the effect of women's perceptions of the quality of services provided by fieldworkers on subsequent contraceptive adoption and continuation (Koenig et al. 1997). In that study, individuals who felt they had received quality care from fieldworkers were more likely to adopt and continue use of a contraceptive method. The effect was especially strong for continuation: “Women who reported receiving moderate- or high-quality care were more likely, by 22% and 72%, respectively, to continue using a method” (RamaRao et al. 2003). A study in the Philippines (RamaRao et al. 2003) found similar evidence: receiving good-quality care at initiation of contraceptive use was positively associated with continuation of use.

Out of the evidence on the link between FP and quality, one theme of note is that the quality of FP counseling appears to be especially important: the inter-personal relationship between the provider (whether facility-based or not) and patient is noted as particularly important in influencing a woman's decision to adopt and continue to use a method. Counseling is important because, as Bongaarts and Bruce (1995:69) note, “Good counseling may encourage clients to present problems at an earlier point and lead to switching [to a different FP method], thus marginally reducing first-method continuation rates; but it may also lay the foundation for longer-term contraceptive use and greater client satisfaction.”

Koenig et al. (1997) note that the absolute number of methods at the provider-patient level may not be as important a determinant of acceptance as the trust and rapport between them.

4. WHAT IS QUALITY?

4.1 QUALITY WRIT LARGE

Quality is an all-encompassing term in health. There are elements of quality that are not directly related to FP but may nonetheless have positive spillovers effects for FP. For example, if you assure that the quality of maternal services is high, and if women have a positive experience with their health care provider, they may be more comfortable engaging in conversations about FP. For this reason, and because PBI programs should support system-wide quality (and not just the quality of one particular service area), it is important to think about how quality overall is supported in PBI programs.

Probably the best-known framework for quality in health care is Donabedian (1966), who identified three elements of quality: structure, process, and outcome. Because it is outside the scope of this report to assess the health impact of interventions (Donabedian's outcome category), and because of the importance of provider-patient relationships in FP (and thus the importance of the patient perspective and perceptions), the definition of quality adopted for this paper focuses on the following three elements: structural quality, process/content of care, and patient satisfaction or perceptions.¹⁰

Structural measures gauge the degree to which a facility is prepared to deliver care: do they have the minimum necessary inputs? An Institute of Medicine report (Donaldson 1999) says that structural measures include “the presumed capacity of the practitioner or provider to deliver quality health care. For health care professionals, this may include licensure, specialty board certification, and type of training. For facilities, they include government certification and private accreditation, physical attributes including safety, and policies and procedures.”

Process measures focus on the content of care: are services delivered according to standards known to maximize their health impact? This includes providing patients with information and answering their questions, timeliness and accuracy of diagnosis, and the appropriateness of the treatment. Interpersonal relations gauge health service delivery from the patient perspective and their satisfaction (or not) with products and services.

4.2 QUALITY IN FP

Quality can also be defined specifically as it relates to FP. Within the world of FP, there are specialized frameworks that identify essential elements of FP quality, the best known of which is probably the Bruce-Jain framework (Bruce 1990; Jain 1989), which defines quality of FP care in terms of six essential elements or dimensions:

- Choice of methods – number of contraceptive methods offered on a reliable basis.

¹⁰ Regarding patient perceptions, although some aspects of technical quality cannot be evaluated by patients, and there are circumstances in which health workers may provide a high level of technical quality but be rated poorly by patients, some research shows that satisfaction is correlated with objective measures of quality (Dasgupta et al. 2009). Patients may value many different combinations of things, including perceived or real limits to access to physicians, excessive wait times, being treated with respect and kindness, adequate privacy, or short appointment lengths in which they are not given the time to voice concerns. Bertrand et al. (1995) see value in considering both objective (structural and process) and subjective (patient satisfaction) elements.

- Technical competence – competence of clinical technique, observance of protocols.
- Information given to clients – including about the range of methods available, advantages and disadvantages, screening out unsafe options, how to use a method, side effects, and what the patient can expect in terms of sustained support from the provider.
- Interpersonal relations – personal dimensions of service.
- Mechanisms to ensure follow-up and continuity – may involve follow-up appointments to the help patients manage continuity on their own.
- Appropriate constellation of services – situating delivery of FP services so they are convenient and acceptable to clients, whether through vertical programs or in the context of MCH services, comprehensive reproductive health services, etc.

Others group these elements differently. RamaRao, for example, refers to “readiness,” the degree to which a health facility has the necessary supplies and equipment to facilitate service provision, adheres to basic standards of cleanliness, is transparent (posting fees clearly for all patients to see), and is comfortable (having chairs or benches to sit on, etc.).¹¹ Koenig et al. (1997) and Blanc et al. (2002) cite availability of methods/choice and competence of staff in providing services that adhere to national or international clinical standards and accepted procedures, and the importance of adequate counseling, comprehensive information on choices and side effects, and privacy. Scheduling follow-up is highlighted throughout the literature.

4.3 OUR FRAMEWORK: QUALITY WRIT LARGE + FP

Combining the Bruce-Jain framework for quality in FP with our simple framework for quality overall gives us the guiding framework for this assessment (below). Note that the FP quality elements may be grouped under more than one category of the overall quality.

Structural Quality/Facility Preparedness

- Choice of methods/availability of methods
- Technical competence of providers

Process/Content of Care

- Technical competence
- Information given to clients
- Interpersonal relations
- Mechanisms to ensure follow-up and continuity
- Appropriate constellation of services

Patient Satisfaction

- Interpersonal relations

It is worth noting that most of the FP quality elements fall under the “process” category, that is, they center on what happens during the encounter between provider and patient.

¹¹ RamaRao refers to readiness as including elements beyond FP per se: infrastructure, equipment, supplies, trained staff.

Once quality is defined, its delivery must be assured. Quality assurance (QA) can be defined as “all the arrangements and activities that are meant to safeguard, maintain, and promote the quality of care.”¹² For this report, we use an amalgamation of categories identified by others – including Silimperi et al. (2002),¹³ Gorter (n.d.), and Donabedian (1966) – to hone in on the following QA activities:

1. **Defining and rewarding improvements in quality:** Includes setting a clear technical standard; delineating responsibility, accountability, and oversight; and providing incentives (carrots and sticks) for improvements/progress and for stalled/stagnating progress or weakening quality.
2. **Measuring, monitoring, and supporting improvements in quality:** Includes defining indicators; developing/adapting information systems for measuring outputs and improvement; communicating changes with staff and with the community; using results to advocate for policy change; an ongoing process of building capacity through training, mentoring, peer appraisals, and supervision activities.

¹² Donabedian quoted in Gorter (n.d.). See also Donabedian (1980), Donabedian (1982), and Donabedian (1985).

¹³ Note that Silimperi et al. (2002) also identify essential activities to institutionalizing quality, which we have incorporated into the three here. These include enabling environment, organizing for quality, support functions, communication and information, and rewarding quality.

5. INCENTIVES FOR QUALITY AND FP: LESSONS FROM THREE COUNTRIES

There is considerable opportunity through PBI approaches to stimulate quality health service provision, including FP counseling, and to increase access to and the availability of voluntary FP.¹⁴ Many PBI schemes reward health facilities for quality and for providing FP counseling and services and/or providing incentives to women to enable them to access those services. This section examines how quality is defined, measured, and sanctioned/rewarded, as well as monitored and improved, in three countries and discuss the implications for FP of each approach.

Table I, at the end of this section, gives an overview of the programs discussed.

5.1 HOW IS QUALITY DEFINED AND REWARDED/SANCTIONED?

Program designers and managers in each country covered here recognize the importance of all three aspects of quality described above. However, when it comes to linking payment – reward or sanction – to quality, the definition narrows.

5.1.1 BURUNDI

In 2006, two Dutch NGOs – HealthNet TPO and Cordaid – in partnership with the MOH, began implementing PBI pilots in three provinces in Burundi. After evaluations showed positive results, in 2009, the government decided to make PBI national policy and a scale up was launched in April 2010.¹⁵

In the program, public and religiously affiliated health facilities receive monthly fees for each service delivered on a specified list of 22 services¹⁶ (for health centers) and 24 services (for district and national hospitals). The most disadvantaged health facilities (i.e., those located in poor and/or remote locations) receive unit fees that are up to 80 percent higher than the most advantaged facilities. The indicators cover curative care, preventative care, and reproductive and child health care. Facilities can also earn additional bonuses for their quality performance.

¹⁴ FP can be rewarded in PBI programs in ways that protect – and enhance – voluntary, informed choice and are compliant with U.S. regulations. To learn more about U.S. policies for supporting access to family planning see Eichler et al. (2010).

¹⁵ For analysis of the program, see Bhuwanee and Morgan (2012).

¹⁶ In April 2010, 24 indicators were contracted but two were removed following the revision of the Procedures Manual in September 2011.

Facilities have considerable autonomy in allocating the incentive payments to staff or to service quality improvements, but there is a limit on the amount that can go toward individual staff bonuses, as the MOH was concerned with potential misuse of these funds.¹⁷

In addition to incentivizing health facilities, the MOH enters into contracts with national and subnational bodies, including the national technical support unit, which is responsible for overall management and oversight of the scheme; provincial and district health teams; and the provincial verification and validation committees, known as the *Comité Provincial de Vérification et de Validation (CPVV)*. These administrative structures receive incentive payments each quarter, depending on their performance on process measures, such as how well they manage contracts, conduct audits, verify data, submit data on time, and prepare invoices.

The PBF system is managed and financed by the Burundian MOH, with technical and financial support from USAID, the World Bank (WB), the European Commission (EC), the Belgian Technical Cooperation, and GAVI, as well as from NGOs such as CORDAID, Healthnet TPO, and Gruppo Volontariato Civile.

Quality is rewarded in three ways in the Burundi program. First, the program pays fees for services delivered, and these indicators are based on clinical treatment guidelines to try to capture the provision of quality services. For example, rather than rewarding only increases in the quantity of antenatal visits, the program rewards increases in provision of tetanus toxoid vaccine administered to pregnant women during antenatal care (ANC) and for the number of HIV-positive pregnant women receiving antiretroviral (ARV) treatment. “Linking performance indicators to specific actions in the evidence-based clinical treatment guidelines represents one approach to promoting better quality in essential services” (Ergo et al. 2012).

In addition to paying fees for the quantity of services delivered, health facilities have the opportunity to earn additional bonuses of up to 30 percent of total fees earned the previous quarter, depending on composite quality scores (which are determined by an assessment of over 100 indicators in a checklist) and “community client surveys” (which are conducted every six months by community-based organizations, CBOs).¹⁸

The Quality Checklist

Sixty percent of a facility’s quality score depends on their score on a quality checklist administered each quarter. Various other countries, such as Benin, Rwanda, and (beginning in late 2012) Senegal also use checklists to measure quality in their PBI programs (see Ergo et al., 2012, for details).

In Burundi, the quarterly quality checklist primarily measures input availability and structural preparedness. It covers 15 areas, including FP, ANC, and maternal care, along with such things as hygiene, drug management, and the health management information system (HMIS). Many of the indicators in the checklist revolve around ensuring that everything is in working order, that all necessary inputs are available, that user fees are displayed, that meetings have occurred and reports submitted on time, that the structure is fenced and clean, etc.

There are 10 indicators related to FP, covering such things as ensuring confidentiality for the patient, that all methods are available and properly stored, that proper records of stocks are kept, that stocks are properly stored, and that education materials on FP are available.

¹⁷ For the provincial and district authorities, a maximum of 80 percent of the PBI bonus can be allocated to individuals. For health facilities, a tool has been developed to help calculate whether they meet the criteria for paying individual bonuses, based on certain “financial viability” conditions.

¹⁸ PBF in Burundi also includes incentive payment to national and subnational levels of government.

Some of the indicators in the checklist touch on aspects of quality that can be considered process-related or clinical. For example, there is an indicator to check that there is written justification for the FP method recommended to the patient and evidence that an examination was done before the decision was arrived at. In the maternal care standard, there is an indicator that requires the assessor to analyze 10 partograms to ensure they are properly completed and to determine the actions taken if there were complications. These indicators aim to gauge whether quality care was delivered, but they are for the most part exceptions in the Burundi checklist.

Patient Satisfaction Surveys

The other 40 percent of a facility's quality score depends on the community surveys conducted by CBOs, which is broken into two parts: 20 percent depends on patient satisfaction as measured by the survey (see Box 1), and 20 percent on confirmation by the CBO of the existence of the patient and that services were received. (It is worth questioning the value of rewarding facilities for confirmation of the existence of the patient and that the service was delivered – because this essentially means that part of why facilities receive the quality bonus is for confirmation that what they have already been paid for is real.)

Administering patient satisfaction surveys has proved challenging. First, the sample of patients selected for the surveys is fixed at 80 patients every six months for each health center (regardless of the number of patients served), which represents a small proportion of the total number of patients. (Previously, these surveys were conducted each quarter, but this proved too administratively and financially costly.) The surveys also do not capture the population who do not visit a health center to understand if perceptions of quality are one of the underlying causes. Furthermore, the lag time between receipt of a service and the survey – which can be several months – may diminish the utility of the survey if patients are less likely to remember details about their experience, something that becomes even more critical if a portion of provider payment depends on them.

Box 1. The Burundi PBI patient satisfaction survey

Having identified the patient and confirmed the type of service they last received in the health center or hospital, the questionnaires consist of the following questions (with a three-level answer scale for all but the last three questions):

- Were you satisfied with the service you received at your health center/hospital (very satisfied/reasonably satisfied/not satisfied)?
- How was the waiting time?
- Were you well greeted?
- Did the staff who treated you explain what you were suffering from, the medication that was given to you, and how to take the medication?
- Was confidentiality respected?
- In your opinion, are the personnel at the facility competent?
- Is the facility you visited open 24/7?
- Are the prices offered by the facility reasonable?
- Was the payment of the service transparent (on the basis of fixed charges displayed at the facility, provision of a receipt, children under 5 and pregnant women not charged)?
- Are the hygienic conditions of the facility acceptable (general cleanliness, clean latrines, electricity, clean water, shower)?
- Were the medications prescribed to you available at the facility?
- What were the positive aspects you observed at the health center?
- What were the negative aspects of your visit?
- What recommendations would you give to the facility to improve the services provided?

Contracting CBOs to conduct the surveys presents challenges as well. Their capacity varies widely, and in some cases is quite low. A study of CBOs across six provinces in Burundi in 2010 found that less than one-fifth of CBO members had completed primary schooling (Falisse et al. 2012). Seventy percent of the CBOs identified themselves as “self-help groups of farmers” (Falisse et al. 2012), which suggests that their engagement as part of the PBI program may be their first experience outside of subsistence farming.

Locating patients requires the CBO to visit households potentially numerous times to find the individual, and conducting the patient surveys requires some interpretation on the part of the assessor. Many CBOs interviewed during fieldwork complained that the reimbursement fees (they are paid for each survey completed) are too low, while facilities complained repeatedly about fraud (i.e., that CBOs were filling in surveys without visiting patients). The information collected by CBOs is not systematically counter-verified, yet the credibility of the program and facility remuneration depend on the accuracy and quality of the surveys.¹⁹ This is an important issue. In one district, the supporting NGO noted that they had counter-verified the CBO surveys three times because the CBOs reported they were not able to find large numbers of patients; each time, the NGO was able to find the patients and the CBOs were suspended. Linking a portion of provider payment to scores on patient satisfaction surveys might therefore demotivate providers if they are perceived as biased, unfair, or fraudulent, rather than motivating them to deliver high-quality care. (Because of this issue, a new PBI pilot in Senegal is being designed with counter-verification of CBO surveys built into the program.)

In some cases there are significant fluctuations between scores on the checklist and patient satisfaction. For instance, one health center received 96 percent for the technical quality score but zero percent for the subjective quality score. This may reflect the fact that the checklist covers mostly structural quality and has little bearing, for example, on provider responsiveness and friendliness towards patients, or it may reflect flaws in the survey instrument or influence of assessors.

Another final, critical question is whether CBOs can be considered truly independent and whether tasking community members in small, rural communities to verify the health services their neighbors receive raises confidentiality issues – particularly if the patient and service they are randomly assigned to verify is a woman who received FP services.

The Implications of Rewarding Quality Separately From Quantity

The Burundi program’s approach to rewarding quality has evolved since the program began. Initially, the maximum quality bonus was 25 percent, and facilities with scores below 70 percent received no bonus.²⁰ Beginning in 2011, facilities scoring below 50 percent stand to lose a portion of fees earned from the previous quarter (see Box 2).

This is an improvement from the days when facilities faced no penalty for low quality (i.e., they could earn bonuses for increases in quantity irrespective of the quality of those services), but facilities continue to earn quality bonuses for the most part separately from quantity since only a very low quality score results in any effect on fees for the quantity of services delivered. This may send a message to providers that quality is “extra,” since they can still receive bonuses even without improving quality. Making the quantity payment conditional on the quality score sends a stronger message to providers of the importance of quality.

¹⁹ Note that results reported by health facilities are counter-verified by an independent NGO. For a detailed look at CBO verification in Burundi, see Bhuwatee and Morgan (2012).

²⁰ As already discussed, 60 percent of a facility’s overall quality score depends on technical quality as measured by the checklist and 40 percent depends on the community surveys.

Box 2. Modifications to Burundi facility payment rules, September 2011

- Score of 90% or more = bonus of 30% of fees earned in the previous quarter * quality score
- Score between 70 and 90% = bonus of 25% of fees earned in the previous quarter * quality score
- Score between 50 and 70% = no bonus
- Score between 40 and 50% = penalty of 10% of fees earned in the previous quarter
- Score between 30 and 40% = penalty of 20% fees earned in the previous quarter
- Score less than 30% = penalty of 25% fees earned in the previous quarter

Burundi is the only one of the three countries covered here that gauges patient satisfaction in a systematic way and directly links it to a portion of facility payment, which is a marked strength of the program. Furthermore, the quality assurance mechanism, though imperfect, is institutionalized into the Burundi health system, which can create a culture of quality improvement. Burundi's quality approach could be strengthened, however, particularly by considering ways to measure and reward improvements in clinical quality and by considering ways to strengthen the system of "community client surveys."

5.1.2 KENYA

In 2006, Kenya launched a reproductive health voucher pilot in three rural districts and two Nairobi slums; two districts were added in 2012. In the program, poor women can purchase vouchers for FP and safe motherhood, which they can redeem at public and private accredited health facilities. (The program also distributes for free vouchers for gender-based violence, GBV, counseling services). The FP voucher covers counselling and provision of long-term methods. Initially removal of methods was not covered, but beginning in phase two, the voucher management agency (VMA) began paying for removal. In phase three, removal became an explicit part of the service package. Also in phase three, the program began testing a composite voucher, which offers the range of services (safe motherhood, FP, and GBV counseling) together, in part to see if doing so would reduce the stigma associated with FP. This composite voucher is also considered a possible precursor for social health insurance, to which other services could be added later.

VDs disseminate information about the program and sell vouchers. In order to target the poorest, VDs assess clients with a Poverty Grading Tool on criteria ranging from housing, water sources, and sanitation, to daily income and number of meals per day. Initially, VDs were paid a commission per voucher sold, but when it was found they were selling vouchers to ineligible women (i.e., the non-poor), their compensation was changed to a monthly salary.

A VMA identifies potential facilities, oversees means testing to determine patients eligible for subsidies through vouchers, manages contracts and voucher distributors, processes claims, and disburses reimbursements. Patient surveys are used to verify eligibility of patients, and claims are scrutinized by medics for irregularities. Once voucher claims have been verified, facilities receive fees for services delivered, which they can then use to reinvest in the facility.

Measuring Quality Through Accreditation

The quality approach in Kenya's voucher scheme has evolved during the three phases of the program: from accreditation that measured aspects of structural quality, which were not specific to reproductive health in phase one, to reproductive health-specific accreditation tools in phase two (again, focused on structural quality), to, most recently, accreditation tools that will include medical audits and measures of patient satisfaction.

The accreditation process is meant to ensure that participating facilities meet minimum quality standards, such as having a basic level of laboratory capacity, running water, and electricity during at least part of the day, among other things.

Initially, the National Hospital Insurance Fund (NHIF), a parastatal organization that accredits hospitals in Kenya, was contracted to accredit facilities. For this they developed special accreditation tools,²¹ which measured facilities using standards based on internationally recognized accreditation schemes, but these tools were not specifically focused on reproductive health services. In phase one, a number of facilities that fell slightly short of the required accreditation standards were admitted to the scheme with a plan of activities in place to improve quality over a given time frame.

In 2008, responsibility for accreditation shifted from the NHIF to a committee²² assembled by the Ministry of Public Health and Sanitation's (MOPHS) Division of Reproductive Health, composed of members from the Nursing Council of Kenya, Clinical Officers Council of Kenya, Medical Practitioners and Dentist Board, the Division of Reproductive Health, and the VMA, PricewaterhouseCoopers (PwC). The committee adapted the NHIF tools, making them specific to reproductive health. These tools gauged facilities on human resources, drugs, operating theaters, infection prevention, referral protocol, sexual violence recovery services, equipment, and infrastructure.

Gauging Patient Views

The program considered patient perceptions, another aspect of quality, but not systematically, and they were not linked to reward or sanction. For instance, field staff from the VMA visited facilities regularly to conduct exit interviews, which consisted of a two-page survey, mainly intended to ensure that patients who received voucher services were actually poor, although it also included a small portion on patient satisfaction.

Survey results were compiled by the field supervisor and shared with the main office in Nairobi. Respondents interviewed by the author during fieldwork seemed to view this primarily as a mechanism to ensure against fraudulent voucher sales and/or claims, not as a mechanism for honing in on the quality of care patients receive.

Moreover, the Nairobi field supervisor estimated that most of the patients surveyed during this exercise were those recovering after deliveries, which makes sense given the high uptake of the safe motherhood

²¹ OBA-RH & NHIF Accreditation Manual 1st Edition (2006) for Level I and II Hospitals and the NHIF Accreditation Manual for GOK & Faith-Based Level III Facilities 1st Edition (2006).

²² Composed of representatives from the MOPHS reproductive health office, the medical and nursing councils, the NHIF, PwC, and the project management unit.

voucher²³ and the fact that safe motherhood services imply more visits and longer time spent at the facility than FP services. To the extent that the questionnaires were useful for gauging quality (which is unclear), they were probably not capturing sufficient data on FP clients to draw conclusions.

In addition, once a year, voucher distributors (drawing from the list of patients who had participated in exit interviews) made home visits to administer client satisfaction surveys. How results from the survey were assessed and shared with health facilities is unclear. If facilities scored below 50, they received a warning, which would prompt the VMA to return to check for improvements. At what point follow-up occurred, however, and whether it was done systematically, is unclear. Furthermore, the lag time between when the patient received the service and when they were surveyed could in some cases be significant such that it called into question the utility of the survey generally, although a VMA representative expressed the view that the a time lag (versus immediate exit interviews) may be advantageous in that it “allows the clients to objectively rate the level of quality of care without fear of intimidation from the providers.”²⁴

An Evolution in Kenya’s Approach

In summary, during phases one and two of the program, only structural quality/facility preparedness, as measured through accreditation tools, was subject to reward/sanction, the reward being the ability to participate in the program and thereby benefit from reimbursement fees for seeing voucher patients. The accreditation tools gauged such things as whether the facilities offered the services required by the voucher program, whether the structure itself met national standards, whether the necessary inputs were available and in operating condition, whether basic standards of cleanliness and privacy existed, and whether human resources were sufficient, but they did not measure the clinical content of care.

The VMA would hire medics to scrutinize claims for “clinical issues” – for example, was the type of medicine used appropriate or was the procedure necessary – but there is a significant amount about clinical quality that cannot be captured by reviewing insurance claims. Contracts between the VMA and facilities did state that facilities had to comply with national quality standards for reproductive health and FP services, but this was insufficiently enforced. (With enforcement, this contractual obligation is potentially powerful, particularly for holding private providers accountable; in the private sector, doctors sometimes develop their own guidelines, which do not always reflect best practice.)

It should be noted that one of the theories behind vouchers (and other supply-side PBI programs that reward increases in the quantity of services provided) is that the desire to attract patients gives health facilities an incentive to improve quality, since more patients results in more income. There is evidence, for example, that facilities in Kenya often use the additional funds earned from voucher reimbursement to make improvements noticeable to patients, such as painting the walls, repairing roofs, buying more chairs for the waiting rooms, etc. This incentive to compete to attract patients may be weak, however, in remote and underserved areas where providers are scarce and competition is limited. Furthermore,

²³ Uptake of the safe motherhood voucher exceeded expectations, with more than 60,000 women delivering using the safe motherhood voucher during the first two years of the program and around 120,000 at the end of phase two (October 2011). It should be noted, however, that in the initial phase of the program, VDs were paid a commission on each voucher sold, and it was found that they were selling vouchers to ineligible women (i.e., the non-poor), which may partly explain the high uptake. This was corrected, and VDs are now paid a monthly salary. Uptake of the FP voucher fell short of anticipated levels in the first several years, although uptake increased starting in 2010, nearly tripling from what was observed in Phase I.

²⁴ Personal correspondence with a PwC staff member, May 23, 2012.

competition alone may not be sufficient to ensure the provision of care according to evidence-based guidelines.²⁵

Recognizing the limitations of the quality approach, in the third phase of the voucher program medical audits will be introduced, along with a new accreditation system that places a strong emphasis on patient satisfaction. At the time of this writing, the contracting process was being launched for an organization to conduct quality improvement/accreditation using the newly developed accreditation manual.

5.1.3 LIBERIA

In 2009, the USAID-funded Rebuilding Basic Health Services (RBHS²⁶) project launched a performance-based contracting scheme that contracted NGOs to manage and support the Ministry of Health and Social Welfare (MOHSW) health facilities (over 100 facilities in seven counties) and to help build the capacity of County Health Teams (CHT), with counties being the equivalent of districts. Through performance-based contracting of NGOs, the program aims to motivate the health workforce, focus attention on (and provide demonstrable evidence of) measurable results, strengthen information systems, build local capacity to manage and deliver health services, and, of course, improve health outcomes.

NGOs can earn quarterly bonuses conditional on achievement of targets on 12 service delivery indicators (one of which is increases in couple years of protection, CYP), based on the aggregate score for the entire county. In the first phase of the program, the bonus was also linked to increases in the number of facilities with staff competent to provide FP counseling, but this was removed when it was felt that most/all facilities had achieved this.

As in Burundi, Liberia rewards achievement of targets on indicators that are drawn from clinical-treatment guidelines. For example, the program rewards increases in the percent of pregnant women provided with a second dose of intermittent preventive treatment (IPT) for malaria, which is one way to reward provision of quality care.

In addition to bonuses, there are potential penalties. Poor performance on five administrative and management indicators (such as the number of facilities submitting a timely, accurate, and complete HMIS report to the CHT during the quarter) can lead to quarterly penalties.

The bonus is distributed by the NGO to facility staff, as well as to NGO field staff, county health teams, and, in some cases, CHWs. Initially, there were no consistent rules among NGO partners for how to allocate the bonuses, as RBHS wanted to give NGOs as much freedom as possible to determine how to use funds. This was good in theory, but in practice it led to confusion among facility staff and other local partners and diminished the power of PBI to motivate frontline actors who did not understand the rules. Beginning in 2011, RBHS became more prescriptive, and now 80 percent of the bonus must go to facilities and 20 percent must go to local NGO staff and the CHT. Of the amount for facilities, roughly half is supposed to be given as cash bonuses for staff and half spent on facility management and

²⁵ Some suggest that even in areas with few or only one facility, voucher programs still spur providers to improve clients: “Even where competition is limited, the push to make the facility more attractive for potential clients is still observed as facilities compete for the market. Even with no competition providers will still organize their services so as to convince potential clients of the benefits of using the services – this could be called competition for the market (as opposed to within the market). The result is that clients, who otherwise would not use the services, start to use them, e.g. delivering a baby in a health facility.” (Personal correspondence with Anna Gorter, May 18, 2012.)

²⁶ RBHS is a USAID project implemented by John Snow Inc.

community mobilization, however field visits revealed that this policy is not yet being implemented consistently.

Results are verified each quarter by a mixed team consisting of representatives from RBHS and the MOHSW.

Quality: From Structure to Structure and Process

The approach to rewarding quality has evolved in Liberia. From the beginning of the Liberia's PBC program, NGO bonuses were partly contingent on the aggregate score on accreditation of the facilities they manage (facilities must earn at least one star on accreditation).²⁷ The accreditation tool was developed and administered by the MOHSW, with support from the Clinton Health Access Initiative (CHAI), and it focused on structural measures of quality, similar to what has been described above for Burundi and Kenya. After several years of implementation, it was realized that though accreditation was effective at capturing structural/input aspects of quality, clinical quality was missing. So with support from RBHS, the MOHSW developed QA tools to gauge the clinical content of care. Both tools (accreditation and QA) are administered once a year and aggregate facility performance for both is linked to the NGO incentive payment. (As of 2012, the tools were to be implemented together as one activity.)

Of the countries covered in this report, only Liberia measures and links incentives to improvements in clinical quality, in addition to structural quality, a notable strength of the program. However, the relationship between performance on quality indicators and targets and the incentive payment is not well understood among facility staff. As noted above, information about how the PBI program works – indicators, targets, incentives, and verification of results – is not clearly defined for facilities, thus knowledge about the rules of the program is weak. This may diminish the effectiveness of the Liberia performance incentive scheme, since facility staff are unlikely to be motivated by a program they do not understand. Furthermore, the process for setting targets for facilities is unclear and appears inconsistent among NGOs. Where facilities are being asked to achieve target increases on the service delivery indicators, targets are not set against each facility's own baseline but rather against a county-wide baseline, meaning that facilities that are already performing well benefit more than those starting at lower baselines, even if the former actually made less improvement.

Patient satisfaction is not currently measured in a systematic way in Liberia's PBC program, nor is it linked to a reward or sanction. At the time of this writing, the program was being redesigned, as responsibility for managing the performance contracts shifted from RBHS to the MOHSW. As part of the redesign, the government and its partners are considering ways to measure and reward patient perceptions of quality and to strengthen facility understanding of the program.

5.2 HOW IS QUALITY MONITORED AND HOW ARE FACILITIES SUPPORTED TO IMPROVE?

5.2.1 BURUNDI

In Burundi, quality checklists are conducted each quarter by a team composed of representatives from the Provincial Health Management Team and District Health Management Team (for health centers), and by peer teams with observers from the PBF National Technical Unit (for hospitals). Facility staff receive feedback and recommendations on the same day, which are supposed to inform facility action plans.

²⁷ During accreditation, facilities received either two stars: 95-100 percent; One star: 85-94.9 percent; Half star: 75-84.9 percent; No star: less than 74.9 percent.

The patient satisfaction surveys are done every six months, with results fed back to the provincial PBF committee, which then shares province-wide results at a large feedback meeting. There, results of both the technical quality evaluation and the community surveys are shared with a wide range of stakeholders, including the contracted CBOs, facilities, village health committees, governors, and district and provincial authorities.

It is left up to the facilities to respond to findings from the patient surveys. Sometimes facilities are able to respond by, for instance, reducing wait times for patients, but often (according to informants) patients lodge complaints about or make suggestions for things not in a facility's control. As one example, a health facility cited a patient who complained that the facility did not have an optician on staff, without knowing that health centers are not supposed to offer specialized care of that sort.

Facilities are supported by supervision visits from district-level authorities, who use ministry guidelines (developed in conjunction with the EC's Santé Plus program) to check on structural and process measures of quality.

5.2.2 KENYA

Once a facility is accredited, the accreditation entity is supposed to conduct quality checks after six months, plus annual quality reviews and reaccreditation. A July 2010 report notes that the results from QA and reaccreditation are supposed to be formally communicated to the voucher service providers (VSPs) – that is, health facilities – and if results show that there is an immediate danger to the health of potential clients, the voucher program will be halted and the facility will face remedial actions (Gorter et al. 2010).

VSPs that did not meet accreditation criteria, but were nonetheless allowed to participate in the program, were expected to improve quality during the program period, but there was no systematic follow-up of the quality of these VSPs. However, as Gorter et al. (2010) notes, there were nonetheless efforts to improve quality: “Quality assurance tools were used by the RH-OBA [reproductive health-output-based aid] Technical Committee to collect data and generate reports, and most of the accredited health facilities had functional quality improvement teams. ... However, the supervision, monitoring and evaluation system was weak.”

Furthermore, the phase-two contract with VSPs states, “The VMA shall regularly monitor compliance of the VSP to the standards set by the Ministry of Medical Services and Ministry of Public Health and Sanitation on provision of quality reproductive health services on FP long-term methods.” But according to respondents, follow-up by the accreditation committee was weak. The VMA produced few detailed reports about accreditation, and because the committee lacked the capacity to visit all voucher facilities twice a year, follow-up was scant; it proved difficult to assemble the committee on a sufficiently regular basis, and the reporting back was particularly weak.

Facilities that do not already have quality committees are required to establish them. Typically, they are headed by a nurse and composed of department representatives, lab technicians, and/or even cooks and cleaners. Quality committees meet periodically with the hospital or facility management team to discuss any range of quality issues. The committees are not required to report to the VMA, but the VMA collects meeting minutes to ensure that the committee meets. Informants notes that though many facilities are excited to form committees, their functioning often falls off when things get busy or interest wanes. A key question: to what extent does simply forming committees and ensuring that they meet lead to better quality services in health facilities?

In addition to forming quality committees, some facilities administer patient satisfaction surveys, which are also required by the NHIF, but, in practice, are done irregularly (according to most facility representatives).²⁸ The VMA is also supposed to provide training for the VSPs on the voucher policy, process and, procedure and facilitate the provision of refresher trainings on FP services. But again, these have been irregular.

5.2.3 LIBERIA

In Liberia, both the accreditation and the QA are done annually. The QA assessors directly observe delivery of services, and if certain services are not being conducted at the time of the visit, the assessors ask the health worker to simulate the service. Facilities receive feedback on the same day for both exercises (shortcomings and strengths for each module); they are also asked to evaluate the assessors.

Facility knowledge of their accreditation scores was strong, but knowledge of QA scores appeared weaker during field visits. Furthermore, not all facility staff fully understood the differences between the two tools (accreditation focuses on what you have, QA focuses on what you do). This is illustrative of what appeared to be a lack of ownership of the quality tools and quality assurance process by many facility representatives. Quality seemed to be viewed as something that happened to them, rather than a process they are responsible for assessing themselves and “owning.”

After the QA baseline assessment was completed, RBHS worked with the CHTs and NGOs, training them in QA and mentored CHT staff at some facilities to help them develop action plans. But this activity was not ongoing or routine. In 2012, the MOHSW planned to combine the accreditation and quality assurance surveys, eventually improving the feedback loop.

As with Burundi and Kenya, facilities are supported through regular supportive supervision, mentoring, coaching, and training.

²⁸ Some facilities (e.g., Nyanza District Hospital) described doing patient satisfaction surveys more systematically, each quarter, over the course of a week to 10 days, with a sample size of approximately 60 to 120 patients, depending on admissions levels, but this was an exception.

TABLE I. OVERVIEW OF PROGRAMS

	Overview of the PBI Program	FP Indicators that Are Rewarded	Type of Quality Tool Used	FP Elements Captured in the Quality Tool	How Are Quality Improvements Rewarded?
Burundi	<p><u>Dates:</u> Pilots began in 2006. Nationwide scale-up commenced in 2010.</p> <p><u>Coverage:</u> All 17 provinces in the country.</p> <p><u>Type of PBI program:</u> Classic “supply-side” program. Public and religious facilities can receive monthly fees for each service delivered in a list of 22/24 services (for health centers and hospitals, respectively). The most disadvantaged health facilities (i.e., those located in poor and/or remote locations) receive unit fees that are up to 80% higher than the most-advantaged facilities. Facilities can also earn additional quality bonuses of up to 30% of total fees earned the previous quarter.</p> <p><u>Main players:</u> The program is managed and financed by the Burundian MOH, with technical and financial support from USAID, WB, EC, Belgian Technical Cooperation, and GAVI, as well as NGOs such as CORDAID, Healthnet TPO and Gruppo Volontariato Civile.</p>	<ul style="list-style-type: none"> • Each new and old user of a modern method (excluding condoms, intrauterine devices (IUDs), implants – i.e., pills and injectables) – FBR 2,500 (US\$1.95) health center/FBR 3,250 (US\$2.50) hospital. • Each woman receiving an implant or IUD – FBR 8,500 (US\$6.60) / FBR 10,000 (US\$7.70), respectively. • For hospitals, fees per vasectomy/Bilateral tubal ligation – FBR 44,000 (US\$34). 	<ul style="list-style-type: none"> • Quarterly checklist (focuses mainly on structure and inputs, with some content on care indicators) • Patient satisfaction surveys 	<p>Quarterly checklist consists of 15 areas, including FP, which is worth 110/2,500 points. Ten indicators in the FP category:</p> <ul style="list-style-type: none"> • FP stored properly. • FP register up to date. • Education material on FP methods available. • All methods available, with what is recorded in inventory matching what is actually available. • Consultation room is confidential. • Consultation done by qualified personnel. • Justification exists for method recommended and evidence that examination was done before arriving at decision • Next appointment with patient scheduled. • Health center reaches at least 90% of its quarterly target for oral and injectable contraceptives (delineated in facility action plans). • Health chats conducted on FP. 	<p>Facilities can earn a quality bonus each quarter of up to 30% of fees earned the previous quarter.</p> <p>60% quality score determined by quality checklist, 20% determined by patient satisfaction surveys, and 20% on confirmation of existence of patient and that services were delivered.</p> <p>A facility’s quality bonus hinges mostly on structural quality measures, some content, and some patient satisfaction.</p> <p>The bonus is in addition to bonuses facilities already receive for delivering services, irrespective of quality.</p>

	Overview of the PBI Program	FP Indicators that Are Rewarded	Type of Quality Tool Used	FP Elements Captured in the Quality Tool	How Are Quality Improvements Rewarded?
				The patient satisfaction survey asks patient to explain experience with service. May or may not be FP service.	
Liberia	<p><u>Dates:</u> Launched in 2009 in seven counties. Scale-up and direct MOHSW management of performance contracts began in 2011.</p> <p><u>Coverage:</u> Seven of 15 counties since 2009 managed by RBHS, two of which were turned over the MOH management in January 2012 (the others were to be turned over in July 2012). Of remaining eight counties, seven signed performance contracts with MOHSW in July 2011.</p> <p><u>Type of PBI program:</u> NGOs contracted to deliver services in public facilities and to help build the capacity of CHTs. Achievement of targets on 12 service delivery indicators are linked to a potential 6% bonus, while poor performance on five administrative and management indicators are linked to potential quarterly penalties.</p> <p>The bonus is distributed by the NGO to facility staff, NGO field staff, and CHTs, and in some cases CHWs.</p> <p><u>Main players:</u> Initially managed by USAID-funded RBHS project. Now management being turned over to the MOHSW with technical support from RBHS. Accreditation tool developed</p>	<ul style="list-style-type: none"> Increases in CYP aggregate score for the entire county. 	<ul style="list-style-type: none"> Initially, improved scores on accreditation were linked to NGO bonuses (focus on structure and inputs). Subsequently, MOHSW developed QA tools, and RBHS began linking NGO bonuses to improvements in QA scores, in addition to accreditation, in 2011. QA checklist focuses on content of care; covers 15 areas, including FP. 	<p>The QA tool (as of June 2011) on FP contains 15 standards – each of which is accompanied by detailed verification criteria – such as:</p> <ul style="list-style-type: none"> FP counseling and information is targeted to the needs of the client. Current pregnancy is ruled out prior to the provision of FP. Other RH needs addressed during FP encounter. Thorough, safe, hygienic IUD services are provided to eligible clients. Client satisfaction with their current method of contraception is assessed and managed. Side effects, complications, complaints, and concerns related to the use of their contraceptive method are addressed/manage. <p>The accreditation tool covers availability of methods and supplies.</p>	Improvements in score on accreditation and QA impact NGO bonuses.

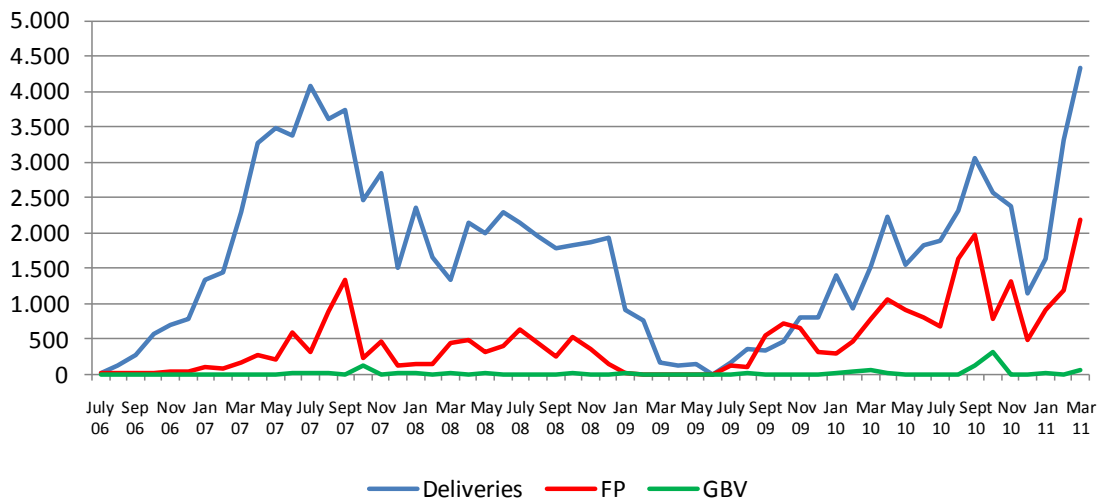
	Overview of the PBI Program	FP Indicators that Are Rewarded	Type of Quality Tool Used	FP Elements Captured in the Quality Tool	How Are Quality Improvements Rewarded?
	with technical assistance from CHAI and QA tools developed with assistance from Jhpiego.				
Kenya	<p><u>Dates/Coverage:</u> Launched in 2006 in three rural districts and two Nairobi slums. Two districts added in 2012.</p> <p><u>Type of PBI program:</u> Reproductive health voucher program sells vouchers (at a highly subsidized rate) for FP and safe motherhood to poor women, who can then use the vouchers to access services at public and private accredited facilities. Providers are reimbursed for the cost of provision, plus a reasonable profit.</p> <p><u>Main players:</u> PwC is the voucher management agency. Initially, the NHIF accredited facilities and the National Coordinating Agency for Population and Development was responsible for program oversight, with support from a steering committee composed of representatives from the MOH and German Development Bank (KfW). Beginning in 2011, program oversight transferred to the Ministry of Public Health and Sanitation. The program is financed by KfW.</p>	<ul style="list-style-type: none"> • FP counselling and provision of long-term methods for poor women who purchase a highly subsidized voucher. • Health care providers are reimbursed for provision of those services to voucher clients. 	<ul style="list-style-type: none"> • Accreditation checklist. • Focus on structure and inputs during phases one and two. • In phase three, medical audits will be introduced, along with a new accreditation system that places a strong emphasis on patient satisfaction. At the time of this writing, the quality tools were being revised. 	The tools used for accreditation included such things as: availability of supplies and teaching aids; presence of qualified medical personnel; maintenance of proper records; and mechanisms to gauge patient satisfaction.	Facilities must be accredited to participate in the program, the reward being the ability (or not) to participate in the program and thereby benefit from reimbursement fees for seeing voucher patients.

6. A QUICK LOOK AT IMPACT

What follows is a presentation of performance on FP and quality indicators for the three schemes over time. Unfortunately, data showing changes from before and after introduction of the schemes were not available, nor were comparison data from facilities that did not participate in PBI. These data are presented, however, to show that there is a progressive improvement on most indicators, although it is not possible to fully attribute those improvements to PBI.

In Kenya, uptake of the FP voucher proved complex and fell far short of anticipated levels in the first several years, but as Gorter (2011) shows, uptake of long-term FP methods increased considerably in 2010, nearly tripling from what was observed in phase one. (See Figure I.) The increase was probably driven by a combination of things, including providing education on the benefits of FP to providers and community education and marketing. In many cases, facilities were purchasing FP vouchers and giving them away for free to women during outreach activities. This was done in close collaboration with the VMA. (When facilities implement outreach activities to promote FP, they invite a VD to attend and sell vouchers. If a woman is unable to pay, the health facility pays on her behalf.) According to one key informant, the VMA put several measures in place to prevent facilities from misusing these vouchers and submitting fake claims, however this raises serious concerns about the potential for fraud. Furthermore, facilities purchasing vouchers for women to use at their facility goes against the notion of vouchers enabling women to choose which facility to access for services. Fewer than 400 GBV vouchers – which are distributed free at health facilities and police offices – were redeemed in the first three years of the program.

FIGURE I. TREND IN MONTHLY NUMBER OF SERVICES PROVIDED FOR JULY 2006 THROUGH MARCH 2011 (PHASES ONE AND TWO) FOR THE KENYA VOUCHER SCHEME²⁹



²⁹ From Gorter (2011). During the first one and half years of the program, NGO distributors sold vouchers to non-eligible women, therefore the numbers using vouchers were relatively high during that period. The low service uptake during the months January 2009 up to December 2009 was due to an interruption in voucher distribution; due to administrative problems with renewing the contract with the VMA, no vouchers were distributed from November 2008 up to June 2009.

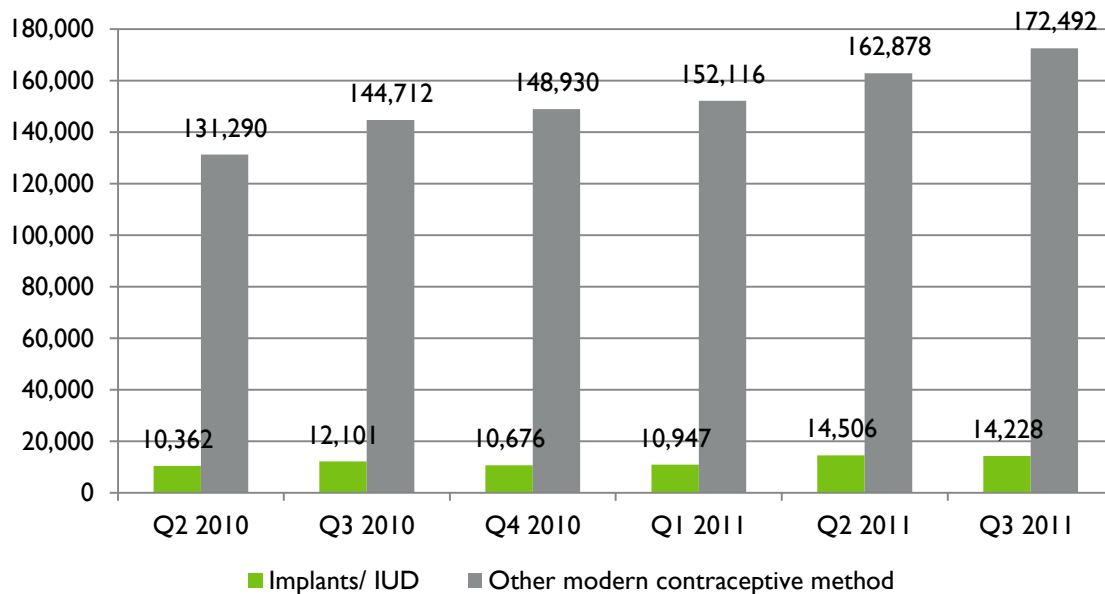
In Burundi, FP use has increased modestly since the PBF program was scaled up nationally, as have health center quality scores (see Figures 2 and 3). (“Subjective quality” refers to scores on the twice-yearly patient satisfaction surveys, while “technical quality” refers to the quarterly assessments of mainly structural quality.)

FIGURE 2. BURUNDI QUALITY SCORES FOR HEALTH CENTERS (NATIONAL AVERAGES)



Source: Government of Burundi PBF Database

FIGURE 3. UTILIZATION OF FP AT THE HEALTH CENTER LEVEL IN BURUNDI (NATIONAL AVERAGES)



Source: Government of Burundi PBF Database

In Liberia, the average score of RBHS facilities on accreditation has increased modestly, from 84 percent in 2010 to 88 percent in 2011. (Detailed comparison results are shown in Table 2.) RBHS facilities, on average, scored 12 percent higher on the accreditation than MOHSW facilities. The scores of IRC-Nimba and MERCI,³⁰ which were the top performers in 2010, dropped considerably in 2011, illustrating the difficulty in maintaining a consistently high level of performance over time.³¹

TABLE 2. CHANGES IN NUMBER OF ACCREDITED FACILITIES IN LIBERIA (2010-2011)

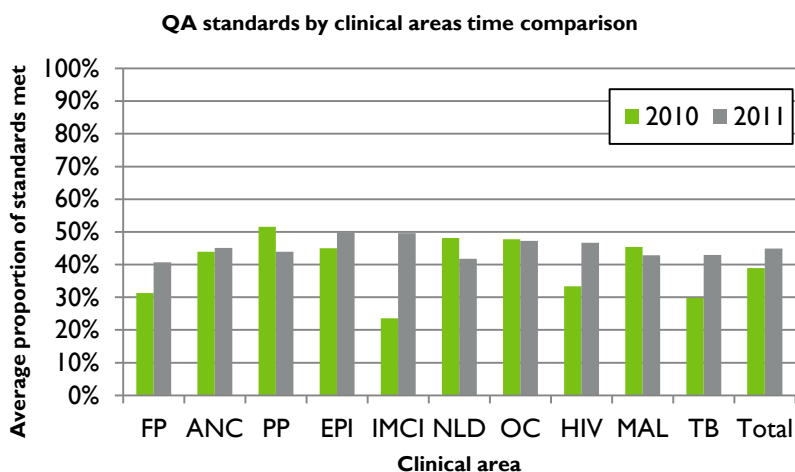
Partner	2010		2011		Improvement	# Increase	# no change	# Decrease
	Facilities	1 and 2 Stars	Facilities	1 and 2 Stars				
Africare	16	50%	16	88%	38%	13	1	2
EQUIP	22	77%	23	87%	10%	15	1	6
IRC-Lofa	19	58%	19	84%	26%	18	0	1
IRC-Nimba	10	100%	12	58%	-42%	2	0	8
MERCI	15	80%	15	33%	-47%	2	2	11
MTI	25	12%	25	96%	84%	25	0	0
RBHS Total	107	57%	110	78%	21%	75	4	28

Source: RBHS.

Most facilities captured in this table are health clinics or health centers.

The quality of clinical care has also improved. Figure 4 shows the quality of care measured by the average percentage of clinical standards met by facilities. Between 2010 to 2011, overall quality increased from 39 percent to 45 percent. There have been modest quality improvements in most clinical areas; for example, the aggregate FP quality scores improved from 31 percent to 41 percent.

FIGURE 4. QA STANDARDS BY CLINICAL AREA (2010 AND 2011)



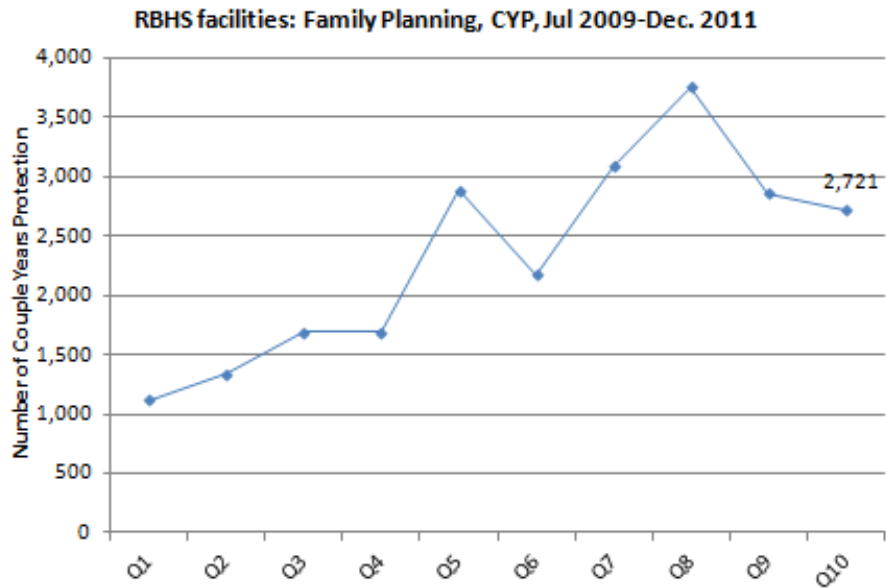
Source: RBHS. These figures are for RBHS facilities only and are not national averages.

³⁰ IRC (International Rescue Committee) and MERCI are NGOs contracted by RBHS. Nimba is a county in Liberia.

³¹ This was partly due to shortages in long-acting methods.

Finally, Figure 5 shows the progress made in Liberia on FP. The number of CYP more than doubled in two years in the areas where the PBI program was implemented, driven in part by the introduction of long-lasting methods.

FIGURE 5. RBHS FACILITIES: FP, CYP (JULY 2009 THROUGH DECEMBER 2011)



Source: RBHS.

7. ANALYSIS AND RECOMMENDATIONS

The programs discussed here illustrate the challenges and potentials of PBI approaches to stimulate quality FP and other reproductive health services by providing stronger incentives to providers to deliver quality care, and to patients to enable them to access services. Each program also illustrates the iterative learning process at the heart of PBI, of monitoring performance and making revisions to strengthen the approach.

There remain important and persistent question around incentivizing FP and quality: What are the risks? How can they be mitigated? What is the way forward?

7.1 GETTING IT RIGHT: CHOOSING FP INDICATORS THAT REFLECT QUALITY AND INFORMED CHOICE

In each country covered here, the picture around quality and FP is imperfect but increasingly positive. Demand for FP appears high, long-lasting methods are being introduced, provider confidence in administering the new methods is growing, and community-based distribution is being tried.

Despite progress, unmet need remains high. In each country, informants highlighted the range of persistent barriers to accessing (for women) and providing (for providers) quality FP services, including:

- Lack of knowledge /appreciation of the benefit of FP among women, families, and communities.
- Rumors and misinformation about FP side effects (e.g., that FP will cause cancer or that using FP will make future children infertile or the woman infertile).
- Lack of support from husbands, and taboos in the community (e.g., strong cultural proclivities towards having as many children as possible and an association between FP and sex workers).
- Costs – financial, transportation, opportunity.
- Religious barriers.

The problem of discontinuation was also highlighted by respondents. All this points to the importance of commodities, supply chains, and training, certainly, but also to the importance of ensuring the quality of care, especially the quality of encounters between providers and patients.

During field work in Liberia, I asked health facility staff what they think those encounters should be like. Box 3 shows some of the things they said.

**Box 3. How do you define high-quality FP care?" –
Sample responses from health care providers in Liberia**

- "Giving FP to the right person with instructions."
- "Allowing women to choose what method they want and telling them all the options."
- "It's about helping them [women] make a choice. Patients can be overloaded with information and just choose the last method you mention. You have to help them make an informed choice."
- "A friendly attitude is important."
- "They [women] need to like you and trust you."
- "Confidentiality: they may already be hiding it from their husband and friends but they are coming to you [to help them]."

The Tiahrt Amendment, mentioned earlier, also elaborates quality standards by delineating behaviors deemed incompatible with quality FP service provision. Tiarht contains two provisions that relate to PBI:

- 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 and planning purposes are permissible.
- No incentives, bribes, gratuities, or financial reward for FP personnel for achieving targets or quotas, or for individuals in exchange for becoming a FP acceptor.

So when is it okay to provide incentives for FP?

Probably the greatest risk, or the clearest example of coercion, is when patients are paid to accept a particular method, especially a permanent method. Paying people for particular methods necessarily implies limiting their choices. A government or donor or program paying a person for sterilization strikes as particularly unethical given the power dynamics heavily skewed in the payer's favor, the patient's need for resources, and the patient's inability to ever go back on the decision.

We have seen programs like this, for example in India, where the Indian National Rural Health Mission provides payments to individuals who become sterilized, to the CHWs who accompanies them, to facilities, and to the service providers who perform the sterilization services. Acceptors of intrauterine device (IUD) insertion in public and private accredited health facilities also receive payments from the National Rural Health Mission. These fees are intended to cover the opportunity cost of lost wages and travel, and payment is highest for services to below-poverty-line people from high-focus states and lower for the non-high-focus states.

This type of scheme is unallowable by USAID rules and should be questioned by any donor and any program interested in promoting quality FP.

A better approach is to pay individuals or offer them at a discounted rate (as in voucher programs) for reaching a facility or for receiving counseling, without conditioning payment on a requirement to accept a method. This helps the patient overcome the real financial, transport, and opportunity costs associated with seeking care, while also empowering them to make the decision about what method is best for their life, if any.

What about payments to providers? Paying providers to increase uptake of FP services may not directly impinge on patient voluntary choice, but it may lead providers to push patients to accept a method and so may indirectly diminish informed choice. Whether programs pay fees for services or reward attainment of targets (both send a signal to provider to increase uptake), the risk is greatest when providers are paid to increase uptake of particular services, since this increases the likelihood that they

will push acceptance of the methods that their payment depends on. This is especially harmful when the payment for these indicators is significantly higher than payment for other indicators.

The best way to protect informed choice is in programs where providers are rewarded for uptake (to pay for increases for any method) and where the fees paid to providers for the FP indicator are not significantly higher (or lower) than the fees paid for other indicators (for example, facility delivery or provision of ARV).

Countries may also want to consider indicators that are better proxies for the quality of care than simple uptake measures, since in the majority of countries assessed in Blanc et al. (2002), more users quit/discontinued using a method for quality-related reasons rather than a desire to get pregnant. A good example of such a proxy is the discontinuation rate. This indicator was rewarded in Haiti's PBC program and is compliant under the Tiahrt Amendment.

Box 4. "Dos" and "don'ts" of incentivizing patients and providers for FP

Do...

1. Consider offering patients the opportunity to purchase coupons or vouchers for a package of services that includes FP.
2. Consider offering compensation to offset the cost of transportation, etc., to enable clients to attend health education that includes FP and/or FP counseling.
3. Include attendance in health education sessions that discuss FP as one of the conditions in conditional cash transfer programs.
4. Pay health providers for FP services that include quality counseling, as well as provision of a method. Consider indicators such as reductions in discontinuation, increases in the number of FP clients counseled, and/or number of new acceptors of any method. Payment should be reasonable in the sense that it should be in line with payments for other services. (Note that this includes compensation to providers for services delivered to voucher patients.)
5. Consider rewarding availability of a wide range of methods.
6. Include FP counseling as a component of antenatal and postnatal performance indicators.

Don't...

1. Pay clients or give them any benefits in exchange for accepting a method.
2. Deny clients a benefit if they choose not to accept FP.
3. Reward individual health providers for achieving a target number of FP users or users of a particular method. (Note that it is acceptable to establish targets for FP uptake for facilities and to pay the facility as a team for meeting that target.)
4. Compensate providers for delivery of specific methods, especially when payments are out of line with payments for other services.

Source: See Eichler et al. (2010).

7.2 REWARDING QUALITY: TAKE A HOLISTIC APPROACH

Each country program discussed in this report makes efforts to reward, at some level, key aspects of quality. Burundi and Kenya, through accreditation and a quality checklist, gauge facility preparedness and both programs aim to capture patient satisfaction, with facility bonuses linked partially to this measure of quality in Burundi. Liberia measures facility preparedness and clinical content of care, and scores on both have an impact on the bonus the NGOs receive, which indirectly affects health facility bonuses.

Except for Liberia, these programs are clearly stronger at rewarding structural quality, yet, many FP quality elements fall into the process/content category of quality: they focus on what happens during that encounter between patient and provider.

It is therefore especially important for FP, but also for any quality improvement system, to consider a holistic approach to quality. One of the powerful things about PBI is its ability to send signals to providers about priorities, and it is important to send a strong signal that all aspects of what constitutes quality care matter. Over the long term, a holistic approach can help assure that patients have quality interactions with providers, which may in turn help build positive associations with the health system and lead to patients being more open and more willing to visit health centers.

7.2.1 TACKLING PROCESS/CLINICAL QUALITY

Tackling clinical quality is less straightforward than structural quality, as it is more complex to develop and define the tools that measure content of care. In countries where such tools already exist, PBI can support and reinforce national government quality standards; as the Liberia program shows, PBI can also support and provide added impetus for the development of such tools and can provide a platform for rolling them out (since the elements of quality assurance – defining a quality indicator and means for measuring achievement/progress, establishing systems to monitor progress, reward improvements, sanction poor quality, and support facilities to improve – mirror the elements of most PBI programs).

Even in very-low-capacity settings, where there is concern about facilities not having all the necessary inputs to deliver quality care, there are nonetheless many things within provider control that enhance care. For example, hand washing, explaining all information to patients, and allowing patients to ask questions are all possible and ought to be emphasized, even as a country builds supply chains and other systems necessary for ensuring all the necessary inputs are in place. Clinical practices must also be learned over time, and good habits must be formed, which is another reason why it is important to build a holistic approach to quality assurance into PBI programs. Countries may, however, consider a stepped approach to rewarding clinical content of care, where there are concerns about capacity. For example, in the first year of a PBI program, the weight for clinical quality (that is, the portion of a facility's bonus affected by its clinical quality score) could be less but could increase over time.

7.2.2 TACKLING PATIENT PERCEPTIONS OF QUALITY

All three programs work in multiple ways to increase provider incentives to “please” patients through provision of quality care. In Kenya, for example, voucher income is often used to make the facility more attractive to patients, and in Burundi, the drive to increase patient load to earn more fees has led to increased outreach by facilities.

It is also important to understand patient perceptions and expectations about care. Burundi shows that it is possible to directly engage patients, seek their views, and link scores on patient satisfaction surveys to a portion of provider payment, but the Burundi experience also demonstrates the need to develop such mechanisms carefully, first by developing robust tools to measure patient satisfaction and then to

test and revise them based on lessons learned. Surveys are also likely to be more useful the closer they are to the time the actual service was received.

But another key lesson is that because patient perceptions are inherently subjective, it is important not to condition too high a portion of provider payment on them, since it could have the opposite of the intended affect: demotivating providers (if they view the system as unfair), rather than motivating them to respond to patient needs.

The mechanism for collecting patient views is also important. The independence of the assessor is critical. Contracting CBOs, for example, raises questions about patient privacy. To mitigate the risk of a violation of patient privacy, some countries that contract CBOs to verify results are considering informed consent forms at the point of services in which the patient says that they are willing to be surveyed later by a CBO. This sends a signal to patients that they have a choice and may also result in their giving more consideration to the quality of the service they receive.

Additionally, in Senegal, which at the time of this writing was finalizing the design of a PBI pilot in which CBOs will be contracted to verify facility results and conduct patient satisfaction surveys, one better-equipped CBO will be responsible for an entire district, rather than contracting many very local CBOs (such as the farmer co-ops in Burundi) to verify the results of the facility in their locale, which virtually guarantees they will know some of the people they visit.

Programs may want to consider methods such as “partnership defined quality,” which actively engage communities in defining, implementing, and monitoring quality improvement process.³²

7.3 STRENGTHEN FP COUNSELING – FOR ALL THOSE WHO PROVIDE IT

A key aspect of quality FP service provision, as the Bruce-Jain framework highlights, is the “appropriate constellation of services” dimension of quality, ensuring that quality services, including counseling, are accessible for women and their families.

Each program discussed here is attempting to make FP counseling more accessible by bringing it closer to where women live by way of CHWs of various stripes – volunteer CHWs in Burundi, VDs in Kenya, and the various cadres of volunteer CHWs in Liberia. These CHWs are on the front lines of what is essentially FP counseling (often called “promotion” or “education” when volunteer CHWs do it). Yet because of the informality of their position in the health system, their training and capacity is often insufficient or highly variable, depending on the enthusiasm of whomever manages them. Nevertheless, encounters between CHWs and women and their families may be an important determinant in her seeking provision of a method.

Therefore, PBI programs may want to consider ways to strengthen the role of CHWs/VDs in providing FP counseling and service delivery. It is important to ensure they are equipped to respond to questions about methods, side effects, etc., according to the quality standards that would be expected of a facility.

³² <http://www.coregroup.org/our-technical-work/initiatives/diffusion-of-innovations/83>

7.4 FACILITIES MUST “OWN” QUALITY – CLEAR REWARDS AND SANCTIONS ARE KEY

For PBI approaches to be effective in supporting quality improvements, facilities must understand the standards for which they are accountable, and the rules of the PBI program must be clear and consistently applied.

Burundi is probably the strongest in this regard: the PBI system is firmly in place, with scores on quality directly tied to a substantial facility bonus. A significant drawback to the Burundi approach, however, is that quality is rewarded separately from increases in quantity, signaling to providers that quality is “extra.”

In Kenya, after the initial accreditation, there is no real, practical, carrot or stick imposed by the VMA for improving quality. If quality, as defined by facility preparedness, was to significantly change, the facility might be dropped from the program, but in practice this has been rare. Moreover, any irregularities/negative feedback from patient satisfaction surveys result only in infrequent follow-up visits by the VMA, with few implications (i.e., they are not tied to any systematic bonus or penalty, although they may result in fewer voucher patients, and hence less income). Finally, in Kenya, facility reimbursement fees are not dependent on quality; rather providers are reimbursed for the quantity of services delivered. This may be affected by quality – facility preparedness has been improved in many facilities – but it remains unclear how or if it spurs improvements in process of care.

In Liberia, as discussed earlier, the rules used by NGOs to distribute performance payments to facilities are not clear. While the NGO bonus depends directly on the aggregate quality scores of the facilities they manage, confusion remains about how health facility bonuses relate to their performance on quality measures.

Facilities must understand the rules of the PBI system, including clearly understanding how quality is defined, measured, and rewarded, if it is to be motivating. Nor will they be motivated if they do not feel supported/equipped to achieve improvements, or if they think that what they are being asked to achieve is unfair.

At a minimum, health facility teams should be parties to performance contracts that clearly explain the indicators by which their performance will be measured – including quality measures – and targets should be negotiated and based on each facility’s own baseline performance. In voucher programs, a stronger signal on the importance of clinical quality could be sent by conditioning a portion of provider reimbursement on scores obtained on quality assurance tools that gauge the content of care.

7.5 INDIRECTLY SUPPORT QUALITY BY ENHANCING BOTTOM-UP ACCOUNTABILITY

One of the theories behind PBI is that increasing accountability – between payers of health services and health providers, and between health providers and patients – will improve both the quantity and quality of health services. PBI programs attempt to enhance accountability in a number of ways. First, the programs give higher-level actors (i.e., payers for health services) tools to hold providers accountable for results (and/or to incentivize actions by patients that lead to better health) through the provision of financial and other incentives that are conditional on improvements in the quantity and quality of

services.³³ Rewards for increases in the quantity of health services give providers an incentive to attract patients, an incentive that may be most powerful in settings where facilities compete with each other for patients. Such competition may lead to improvements in quality, particularly those improvements most noticeable by patients, such as friendliness, cleanliness, and attractiveness of the structure. PBI also strengthens accountability within facilities because teams are jointly held accountable for performance (in almost all supply-side PBI schemes, the incentive is paid to the team of health workers, not to individuals), and they hold each other accountable, as the efforts of each individual team member impacts the performance payments earned.

Another way to enhance accountability is through mechanisms that strengthen “bottom-up” accountability, that is, mechanisms that give average citizens voice over their providers to hold providers accountable for delivering quality care that responds to their needs and that empower them to shape facilities’ understanding of what constitutes quality care.

Engaging communities is not new, but in the health sector it has traditionally focused on community-based provision of health services. Experiences with community engagement for the purpose of accountability have been fewer.

But in many countries, mechanisms already exist in communities, whether CHWs, community health committees, or CBOs, and engaging them can help strengthen the system and encourage the community to both support the facility to achieve results and hold them accountable – and this may provide positive pressure to improve various aspects of quality. In this regard, the Burundi model of contracting CBOs to verify results may hold promise, but innovation, experimentation, and evaluation of such approaches is needed.

³³ The “other incentives” mentioned here includes such things as increased supervision and scrutiny and verification of health data.

8. CONCLUSION

So what is the verdict? Can PBI programs improve quality and enable women to access quality FP services? This paper shows that they can but that implementing such programs requires careful design and the flexibility to learn and revise as you go. Importantly, by tackling incentives there is significant potential to enable and empower patients and providers to take actions that lead to better health.

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