

Helpdesk Report: Accreditation and Awards for Health Facility Standards

Date: 11 April 2011

Query: Conduct a search to find projects that supported branding and accreditation to health facilities. Where health facilities met certain quality standards they were accredited with a logo/brand that gave recognition. If possible provide details of where this was done, and for each country its scope, implementation arrangements, costs, achievements, lessons learned, and what rewards were provided to those who received accreditation.

Please provide a summary of where rewards (such as a budget increase or rewards for workers) have been provided. Include if possible the criteria and methods for selection of beneficiaries, costs of implementation, type of rewards given, and any measurable outputs or outcomes.

Enquirer: DFID Kenya

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1. Overview

Some key case studies of family planning accreditation programmes include PROQUALI, Yellow Star, Gold Star and Gold Circle.

PROQUALI, Brazil:

- A reproductive health service performance and quality improvement model funded by USAID.
- Quality was measured in five core areas – clinical services, client education, infection prevention, management systems, and environmental facilities and supplies.
- Increased service quality was observed.
- Performance improvements were most substantial in clinics that were performing at a moderate to high level at baseline, where the internal champion for the project was someone in a formal position of power, and where the least amount of staff resistance or conflict occurred.
- Financial support for commodities and staff increased as a direct result of these interventions.

- Positive changes in client satisfaction, service delivery and utilisation statistics were also observed.
- Service quality improvements were achieved but only following a considerable amount of training and technical assistance that may be impractical to implement if PROQUALI is taken to scale.

Yellow Star, Uganda:

- Established by the Ugandan Ministry of Health (MOH) with USAID and the DISH II project in 2000.
- A facility is awarded a Yellow Star from the MOH if it successfully reaches and maintains a set of 35 basic standards of care.
- It improves quality of care, encourages improved performance among health workers and promotes the utilisation of health facilities.
- Government and NGO facilities initially met 46.8% of the programmes basic standards, increased to 64.8% after 3 months.
- Key success factors were ongoing support from the MOH and a highly publicised ceremony for the first facility to receive the Yellow Star.

Gold Star, Egypt:

- Designed to increase public sector's involvement and achieve higher standards of quality of family planning services.
- The accreditation process involved 3 steps – promoting quality to providers, promoting certified clinics, and associating the certified clinics with an easily recognisable symbol.
- Success included an increase in contraceptive prevalence from 47.9 to 54.5%.
- Strategic alliance between two ministries (Health and Information) was a factor in the success.
- A multimedia campaign advertising the locations of Gold Star providers was important.

Gold Circle, West Africa:

- Initiative of the regional Family Health and AIDS in West and Central Africa Project (SFPS) that focused on quality of care.
- A mass media campaign implemented by Johns Hopkins University Center for Communication Programs (JHU/CCP) that included TV spots, radio broadcasts, and posters.
- Posters showed the Gold Circle Campaign logo (a smiling provider with outstretched hand) and the slogan, "We are here to listen to you".
- To receive the quality award the clinic was required to stock a range of family planning methods, employ competent and informative counsellors, have minimal waiting times, report clinical data regularly and practice safe infection prevention techniques.
- A significant increase in the quality of family planning services was noted within the first six months of the campaign.
- Of the 206 participating SFPS clinics in the project countries, 98 (47.6%) were accredited Gold Circle clinics.
- Exit surveys conducted when a new client completed a visit showed a great satisfaction with the performance of the accredited clinics.
- Success was due to dialogue between providers and community representatives that empowered the community to demand and maintain improvements and gave them a sense of ownership.

Literature on accreditation mostly did not explicitly mention rewards. The PROQUALI example does note that financial support was given to commodities and staff as a direct result of the scheme.

Recent literature on reward-based health schemes was found where accreditation is sometimes mentioned. This is generally known as pay-for-performance (P4P), results-based financing (RBF), performance-based financing or output-based aid. Section 8 lists and outlines some examples. Abstracts of these documents have been included but it was not possible within the scope of this study to investigate each one to draw out detailed information. Case studies are from DRC, Egypt, Uganda, Kenya, Belize and Rwanda.

2. Case studies in family planning

PROQUALI: Development and Dissemination of a Primary Care Center Accreditation Model for Performance and Quality Improvement in Reproductive Health Services in Northern Brazil

Blak, S.M. et al., *JHPIEGO*, 1999

<http://www.jhpiego.jhu.edu/resources/pubs/TR/tr9903sum.htm> (Executive Summary only)

A paper copy of the report can be ordered for free

http://www.jhpiego.org/scripts/pubs/product_detail.asp?product_id=42

PROQUALI is a comprehensive, coordinated and innovative reproductive health (RH) service performance and quality improvement accreditation model funded by USAID. PROQUALI was developed to improve performance and quality and increase access to RH services at the primary healthcare level in north-eastern Brazil. The training and technical assistance activities of the three previously independent cooperating agencies were integrated and applied during PROQUALI to help demonstration sites achieve state-approved RH service quality standards and accreditation. During the pilot demonstration phase, Phase I, the accreditation model was developed and field-tested in five primary health clinics in the states of Bahia and Ceará.

Specific competencies, defined as part of the state reproductive health service guidelines (RHSGs), serve as minimal standards for service delivery point (SDP) practices, against which clinic level performance is observed and performance and quality improvements are promoted over time.

During Phase I, RH service quality was measured in five core areas as part of the accreditation process:

- clinical services
- client education
- infection prevention
- management systems
- environmental facilities and supplies

Results:

- Four of five participating clinics received accreditation at the end of an 18-month demonstration project period.
- A dramatic increase in service quality was observed within all five participating health clinics.
- Performance improvements were most substantial in clinics that were performing at a moderate to high level at baseline, where the internal champion for the project was someone in a formal position of power, and where the least amount of staff resistance or conflict occurred.
- Changes were least evident in the physical facilities and environment performance assessment areas.
- Health agency and participating clinic personnel and clients were all positive about the success of the project.

- Financial support for commodities and staff increased as a direct result of these interventions.
- Positive changes in client satisfaction, service delivery and utilisation statistics were also observed.

Conclusions and recommendations:

- Service quality improvements were achieved but only following a considerable amount of training and technical assistance that will be impractical to implement when PROQUALI is taken to scale.
- The next phase needs to strengthen infrastructure supports and improvement efficiencies to ensure model institutionalisation and sustainability beyond the USAID-funded period.
- A need to test for most effective and cost efficient strategies for the next phase.

Best Practices in Accreditation

Best Practices Update, March 2004

http://www.phishare.org/files/2252_BP_Update_Accreditation.pdf

This document outlines three case studies highlighting best practice in accreditation.

Yellow Star, Uganda:

- Established by the Ugandan Ministry of Health (MOH) with USAID and the DISH II project in 2000.
- A facility is awarded a Yellow Star from the MOH if it successfully reaches and maintains a set of 35 basic standards of care.
- It improves quality of care, encourages improved performance among health workers and promotes the utilisation of health facilities.
- Key success factors were ongoing support from the MOH and a highly publicised ceremony for the first facility to receive the Yellow Star.

Gold Star, Egypt:

- Developed in 1995 by Egypt's Ministry of Health and Population (MOHP) and Ministry of Information (MOI) to improve the quality of family planning services.
- Designed to increase public sector's involvement and achieve higher standards of quality.

The accreditation process involves three steps:

- promoting quality family planning service providers as a means of enhancing their self-image and job performance
- promoting certified clinics as sites for high-quality services
- associating these high-quality sites and services with an easily recognised symbol

Success:

- public sector involvement increased from 30-40%
- contraceptive prevalence increased from 47.9-54.5%
- strategic alliance between the MOHP and MOI to improve family planning service delivery capacity
- helped by a multimedia campaign advertising the locations of Gold Star providers and clinics.

Gold Circle; Cameroon, Burkina Faso, Côte d'Ivoire, and Togo:

- Initiative of the regional Family Health and AIDS in West and Central Africa Project (SFPS) that focused on quality of care.
- A mass media campaign implemented by Johns Hopkins University Center for Communication Programs (JHU/CCP) that included TV spots, radio broadcasts, and posters.

- Posters showed the Gold Circle Campaign logo (a smiling provider with outstretched hand) and the slogan, "We are here to listen to you".
- A significant increase in the quality of family planning services was noted within the first six months of the campaign.
- Of the 206 participating SFPS clinics in the project countries, 98 (47.6%) were accredited Gold Circle clinics.
- Success was due to dialogue between providers and community representatives that empowered the community to demand and maintain improvements and gave them a sense of ownership.

Improving Quality of Health Care: The Yellow Star Program

DISH II, 2002

<http://www.ugandadish.org/YSSuccess.doc>

This document describes the Yellow Star Program outlined in the previous document. Some additional details may be useful.

The 35 basic standards of quality required for certification fall into six categories:

- Infrastructure and Equipment
- Management Systems
- Infection Prevention
- Information, Education and Communication /Interpersonal Communication
- Clinical Skills
- Client Services

The Yellow Star is awarded to facilities that achieve and maintain 100% of these standards for a minimum of two consecutive quarters.

The programme was piloted in 12 districts during 2001 and 2002. A communication strategy with three main thrusts was launched in July 2001, and quarterly assessments began in October 2001. A Sensitisation Campaign targeting district and sub-county leaders through one-day sensitisation meetings and print materials familiarised them with the programme and enlisted their active involvement and support. A Provider Campaign encouraged health workers to change poor work practices through sensitisation meetings; training district and sub-district supervisors to conduct assessments and institute quality improvement approaches; quarterly newsletters; manuals about the Yellow Star programme; a kit of promotional materials that inspire adherence to standards; and the "Star Health Worker" award for providers with good interpersonal skills. A Community Campaign used posters, radio spots and programmes, and community meetings to educate the general public about the programme and encourage their involvement in quality improvement activities at their facilities.

Results:

- During initial assessments, 179 government and NGO facilities met on average only 46.8% of the programme's basic standards.
- By the second assessment, this had increased to 64.8%, an 18% increase in only 3 months.
- For individual health facilities, improvement in standard achievement ranged from 13.7 to 20.9%.

Not only did the programme improve the quality of services, it also led to more efficient and effective supervision of health facilities and greater interest in health service quality among many district leaders.

Impact of Quality Improvement Programme on Family Planning Services in Egypt

Hong, R., Misra, V. & Fronczak, N., *Eastern Mediterranean Health Journal*, 17 (1), 2011
http://www.emro.who.int/emhj/V17/01/17_1_2011_0004_0010.pdf

Egypt's Ministry of Health and Population and Ministry of Information with support from the USAID developed a national family planning quality improvement programme, called the Gold Star programme. The programme was designed to promote the supply of quality family planning services through better training and supervision of providers and to stimulate demand for family planning by promoting higher quality services to the public. The programme assessed each facility in Egypt providing family planning services on a comprehensive checklist of 101 indicators of quality, including indicators of infrastructure availability, supply of family planning methods and condition of the facility. The assessment was undertaken quarterly to ensure that quality was sustained. A facility that met all 101 quality criteria for 2 consecutive quarters was awarded a Gold Star certificate, which had to be maintained at successive quarterly evaluations to retain the status. The Gold Star programme was concluded in 2000.

Data from the 2004 Egypt Service Provision Assessment survey were used to assess whether the certified Gold Star facilities had sustained higher quality services than non-Gold Star facilities 4 years after conclusion of the programme. A nationally representative sample of 637 facilities providing family planning services were compared using several quality indicators. Gold Star facilities had significantly better availability of family planning methods, counselling and examination services than non-Gold Star facilities, independent of type, size and geographical location. Providers in Gold Star facilities were also more likely to adhere to higher quality practices in counselling and examination than in non-Gold Star facilities. The Gold Star programme was effective and could be implemented elsewhere in the region and globally.

Gold Circle Clinics Campaign - West Africa

Communication Impact Newsletter, March 2001, Number 11. Johns Hopkins University, Center for Communication Programs, 2003
<http://www.cominit.com/en/node/117475/38>

Johns Hopkins Bloomberg School of Public Health Center for Communication Programs (JHU/CCP) and Santé Familiale et Prévention du SIDA (SFPS) launched a family planning community awareness project by building new Gold Circle clinics in Cameroon, Burkina Faso, Togo and Cote d'Ivoire.

JHU/CCP promoted GO (Gold Circle) sites through the mass media by broadcasting TV and radio spots and displaying posters and sign boards with the GO logo - a smiling provider with an outstretched hand - and the GO slogan "We are here to listen to you". Community participation was a principle aspect of the GO strategy. GO quality teams consisting of providers and community representatives planned local campaigns, including open clinic days, market days and health talks. Through community participation, each new clinic attracted people in its own creative way. Apart from promotional material such as key chains, T-shirts and calendars, one site had hostesses wearing sandwich boards with family planning messages and another site featured a comedy choir of elderly women singing about GO.

In order to receive the GO quality award the clinic was required to adhere to specific standards such as stocking a range of family planning methods, employing competent and informative counsellors, minimal waiting times, report clinical data regularly and practice safe infection prevention techniques. After four phases, a total of 100 accredited GO clinics were set up across Cameroon, Burkina Faso, Togo and Cote d'Ivoire (unfortunately, the political situation in Cote d'Ivoire made it impossible to collect evaluation data).

Because the clinics were promoted to be user friendly through a wide range of media, the numbers of new clients rose significantly, even six months after the initial launch. Exit surveys conducted when a new client completed a visit showed a great satisfaction with the performance of the GO clinics.

The Impact of a Regional Family Planning Service Promotion Initiative in Sub-Saharan Africa: Evidence From Cameroon

Babalola, S. et al., *International Family Planning Perspectives*, 27 (4), 2001
<http://www.guttmacher.org/pubs/journals/2718601.html>

In 1998-9 Santé Familiale et Prévention du SIDA (SFPS) began a family planning initiative called Gold Circle (GO). It sought to reward and promote family planning quality improvements in the four target countries. Through a certification process and by using a quality-of-care diagnostic tool to determine the current quality level of services provided, 10 or more SFPS sites were selected and designated as GO sites in each country. This article documents the impact of the campaign in Cameroon, using results of a panel study supplemented with service statistics.

Findings from focus-group discussions revealed that from the clients' perspective, six criteria were important determinants of quality service: having good client-provider interactions; having a competent provider; obtaining affordable services; waiting a reasonable amount of time; having one's service needs met; and having a variety of medications and contraceptive methods available.

The GO initiative consisted of a two-pronged strategy that focused on service delivery improvements (the supply side) and the promotion of these improvements (the demand side).

The service statistics indicate that the campaign led to a significant increase in the demand for family planning services at Gold Circle clinics, with the number of new clients more than doubling immediately after the campaign launch.

4. Current family planning accreditation in Uganda and IPPF

The Family Planning Association of Uganda, FPAU

Reproductive Health Uganda, site access: 5/4/2011
http://www.rhu.or.ug/index.php?option=com_content&view=article&id=66&Itemid=76

In 2005, FPAU was accredited to International Planned Parenthood Federation (IPPF) and was awarded the Quality of Care Certificate by the IPPF Africa Region (IPPFAR). This was an indication of the strides the Association had made in improving its services. FPAU Executive Director, Elly Mugumya, attributes this success to improved image, technical competence, confidence and ability to deliver, account and share best practices with other stakeholders.

IPPF Accreditation

Site accessed: 5/4/2011
<http://www.ippf.org/en/About/Accreditation.htm>

A Member Association is accredited if they meet IPPF membership standards. IPPF is a federation of 153 Member Associations, each making a contribution to sexual and reproductive health in its country in its own way.

IPPF Accreditation System, Upholding our Values and Principles

IPPF, 2010

<http://www.ippf.org/NR/rdonlyres/3A46DB15-8722-41A0-974D-0BE18A4D415F/0/accreditation.pdf>

IPPF introduced an accreditation system in 2003 which was revised in 2009. The system is a formalised peer review that aims to ensure that all Members meet and comply with 49 essential standards. This demonstrates its commitment, as well as showing how it adheres to these commitments. This is checked and verified through an accreditation review process which takes place every five years.

The process:

- Each association assesses how well it meets the membership standards by replying to questions and supplying evidence.
- The assessment is then analysed by a review team of IPPF staff and a volunteer from another member association, during a desk review and then on-site visit.
- Once the assessment is complete the review team will work with the Association to agree on areas in need of improvement.
- Once an Association complies with all the membership standards, the IPPF Governing Council awards an accreditation certificate.

IPPF's 10 principles of membership are, to be:

- open and democratic
- well-governed
- strategic and progressive
- transparent and accountable
- well-managed
- financially healthy
- a good employer
- committed to results
- committed to quality
- a leading NGO in the country

IPPF Standards and Responsibilities of Membership

<http://www.ippf.org/NR/rdonlyres/9041F7E1-3FC0-486D-BDFC-F24B8D3D473F/0/StandardsMembership2009.pdf>

Details of the 10 principles of membership as outlined in the previous document.

4. General information on accreditation

Quality and Accreditation in Health Care Services, a Global Review

WHO, 2003

http://www.who.int/hrh/documents/en/quality_accreditation.pdf

This report has sections on:

- International structures and national structures and activities for improving healthcare
- Quality concepts and tools
- Health service accreditation programmes in different countries including South Africa and Zambia

Accreditation and Other External Quality Assessment Systems for Healthcare, Review of Experience and Lessons Learned

Montagu, D., *DFID HSRC*, 2003

http://collections.europarchive.org/tna/20100918075642/http://www.dfidhealthrc.org/publications/health_service_delivery/Accreditation.pdf

This document contains the following sections:

- Theories of external quality assessment (EQA) and healthcare quality management
- Experience in international accreditation / EQA
- Public-private interaction in quality management
- Application in developing countries

An appendix lists major accreditation organisations based in developed countries.

African International Quality & Accreditation in Healthcare Conference: 10 & 11 May, 2011, South Africa

<http://www.africahealthexhibition.com/Site-Root/Conference-Centre/Conferences1/International-Quality--Accreditation-in-Healthcare-Conference/>

This upcoming conference might be of use.

5. Case studies for other healthcare facilities

Adolescent Health Service in South Africa, NAFCI - The National Adolescent Friendly Clinic Initiative

Mabitsela, O., *Partners in Population and Development Africa Regional Office*

<http://ppdafrica.org/index.php/en/programs/goodpractices/46-southafricaadolescent>

The National Adolescent Friendly Clinic Initiative (NAFCI) is an accreditation programme designed to improve the quality of adolescent health services at the primary-care level and strengthen the public sectors ability to respond to adolescent health needs. NAFCI is implementing an innovative approach to improving adolescent health services by making health services more accessible and acceptable to young people, establishing national standards and criteria for adolescent healthcare in clinics throughout the country, and building the capacity of healthcare workers to provide quality services.

Implementation:

- Implemented through provincially based co-ordinators who work closely with all categories of clinic based staff and department of health managers to ensure compliance with NAFCI standards.
- Has developed a recognition system where clinics are assessed according to NAFCI standards and criteria. Clinics are awarded bronze, silver, or gold depending on how well they meet the standards.
- There is no direct chargeable cost to the clinics as the programme is funded by the Henry J. Kaiser Family Foundation and the National Department of Health.

Lessons learned:

- Developing a system that is sustainable and can be maintained by the district and provincial health systems with minimum resources is challenging.
- It can be difficult to keep healthcare providers motivated and interested in implementing NAFCI in light of the many other primary healthcare programmes and initiatives that are being introduced.

- Even though NAFCI focuses on adolescents, it will contribute to improved quality of care at all levels, thus supporting other initiatives.

The ten NAFCI standards for accreditation of clinics are as follows:

- Management systems are in place to support effective provision of the essential service package for adolescent-friendly services.
- The clinic has policies and processes that support the sexual and reproductive rights of adolescents.
- Clinic services appropriate to the needs of adolescents are available and accessible.
- The clinic has a physical environment conducive to the provision of adolescent health services.
- The clinic has drugs, supplies, and equipment to provide the essential service package.
- Systems are in place to train staff to provide adolescent-friendly services.
- Information, education, and communication consistent with the essential service package is provided.
- Adolescents receive an accurate physical assessment.
- Adolescents receive individualised care based on standard service delivery guidelines.
- The clinic provides continuity of supplies and services for adolescents.

Clinics are accredited with a Bronze star for a 30-60% score, Silver for 61-90% and a Gold star for greater than 90%.

Results:

- 5 were clinics accredited.
- 36 clinics are implementing standards.
- There was a change in staff responsiveness to youth.
- There is increased participation of youth at clinics, average monthly utilisation by 10-19 year olds increased from 340 in 2002 to 420 in 2004.
- There is increased participation of the community in clinic activities.

The Nicaragua Mother and Baby Friendly Health Units Initiative: Factors Influencing its Success and Sustainability

Quality Assurance Project & United Nations Children's Fund, *USAID*, 2006
<http://www.hciproject.org/sites/default/files/NicMotherBabyFriend.pdf>

The Baby Friendly Hospital Initiative launched by United Nations Children's Fund (UNICEF) and the World Health Organization (WHO) in 1993 has become the world's largest focused accreditation programme, with over 19,000 hospitals in 150 countries certified as having complied with the "Ten Steps to Successful Breastfeeding." Yet, for all its success, the initiative is having problems with sustainability.

Too frequently, well-trained staff move on, hospitals lose their initial enthusiasm and commitment, and hospitals that once met certification standards no longer do so. However, the Mother and Baby Friendly Health Units Initiative (MBFHI) in Nicaragua, a program of the Ministry of Health in cooperation with UNICEF, appears to be the exception.

Quality assurance has been important to success. Certification uses rigorous, quantitative measurements by a multi-disciplinary team of external experts selected by UNICEF/Nicaragua and the Ministry of Health. The certification criteria differ for different types of health units, appropriately so. Direct care units (hospitals, health centres, and health posts) must meet the 10 (or 11) steps for successful breastfeeding, while health systems

(SILAIS and municipalities) must have a minimum percentage of the health units in their jurisdiction certified.

The certification process is initiated by the health unit itself and may take a year or more, but during that time, the health unit discovers its shortcomings and corrects them; learns to carry out and appreciate the value of good standards and rigorous measurements; and generally develops a culture that supports measurement, planning, and improvement. The long certification process is usually intense and emotionally charged. The greatest learning usually occurs during the self-assessment and improvement phase that precedes the official certification visit.

The estimated cost of certifying one typical municipality (one health centre and five health posts), based on average certification costs incurred by the Ministry of Health in the past year (05/06), is US\$ 4,686. This includes training, evaluation and certification costs (see p28 for a breakdown of costs).

Safe Motherhood Studies - Timeliness of In-Hospital Care for Treating Obstetric Emergencies

Edson. W et al., *Operations Research Results*, USAID 2006

<http://www.hciproject.org/sites/default/files/Timeliness%20of%20in-hospital%20care%20for%20obstetric%20emergencies.pdf>

The Joint Commission for Hospital Accreditation developed a framework in 1993 for improving healthcare provider performance, defining nine aspects of performance. One aspect was timeliness, defined as, "the degree to which care is provided to the patient at the most beneficial or necessary time." Since then, timeliness has emerged as a key component of monitoring the quality of healthcare. The Institute of Medicine in 2001 brought it into sharper focus by discussing the consequences of a lack of timeliness, ranging from long waiting times that patients may interpret as lack of respect from providers to delay in the diagnosis or treatment of an illness. The National Health Care Quality report card included a conceptual framework for quality of healthcare with four dimensions: safety, effectiveness, patient centeredness, and timeliness.

The report defines timeliness as "obtaining needed care and minimizing unnecessary delays in getting that care." It also defines three sub-categories of timeliness (1) access to the system of care, (2) timeliness in getting to care for a particular problem, and (3) timeliness within and across episodes of care. In developing countries, timeliness relating to safe motherhood was brought to the fore by the three-delay model, which specifies three types of delays that contribute to the likelihood of maternal death in the event of a complication: (1) delay in deciding to seek care, (2) delay in reaching a treatment facility, and (3) delay in receiving adequate treatment at the facility.

Setting Up a National Hospital Accreditation Program: the Zambian Experience

The Quality Project, *USAID*, 2000

http://www.hciproject.org/sites/default/files/Setting%20up%20a%20national%20hospital%20accreditation%20program%20The%20Zambian%20experience_0.pdf

This paper describes the Zambia accreditation programme including:

- Recognising the need to improve hospital quality and choosing accreditation to address this need
- Choosing the appropriate accreditation model
- Setting up the formal structure to advise and manage the programme
- Developing and testing standards and designing the survey process
- Recruiting, hiring and training surveyors

- Conducting educational campaigns and consultative surveys
- Refining policies, procedures and rules for accreditation
- Developing the accreditation database format
- Conducting full accreditation surveys
- Interpreting survey data and making accreditation decisions.

Review of Health Services Accreditation Programs in South Africa

Salmon, J.W. et al., *USAID*, 2003

<http://www.hciproject.org/sites/default/files/Summary.%20The%20Impact%20of%20Accreditation%20on%20the%20Quality%20of%20Hospital%20Care.%20KwaZulu-Natal%20Province,%20Republic%20of%20South%20Africa.pdf>

There is growing evidence of the impact of quality assurance methods on the quality of care in resource-constrained environments like South Africa's, where simple solutions such as re-training of staff or the supply of additional resources have failed. The wealth of quality assurance experience in South Africa thus far can provide lessons that will benefit not only the health sector reform locally but also other quality improvement efforts worldwide.

Urgently needed are guidelines for the interested national stakeholders to use in developing quality initiatives. The review team hopes that the findings and recommendations here will shed light on the status of accreditation in South Africa and pave the way for the establishment of a national framework for ensuring quality—especially equitable—healthcare.

6. Rewards

Dealing with difficult design decisions: The experience of an RBF pilot program in Haut-Katanga District of Democratic Republic of Congo (DRC)

Brendenkamp, C., *RBF*, 2011

<http://www.rbfhealth.org/rbfhealth/system/files/PBF%20pilot%20in%20Haut-Katanga%20DRC.pdf>

Criteria for selection of beneficiaries:

- the facilities are considered part of the national health system
- the facilities are able to deliver the basic package of health services
- they agree to a reduction in the user fees according to a defined schedule

The project is funded by World Bank-financed Health Sector Rehabilitation and Support project (HSRSP) which involves contracting NGOs to provide support to health services.

There are two dimensions to the size of the incentive that is associated with each service, i.e. the "price". One is the absolute price and the other is the price relative to other services.

At best, however, the "appropriate" price is a guess. There is uncertainty as to how service delivery will respond to changes in incentives/prices. There is uncertainty about how reductions in user fee revenue may be offset by payments under the scheme (which depend both on changes in utilisation and on the prices). It is also not known what perverse incentives may be created. Therefore, the design needs to remain flexible. Based on reviews of facility performance and budget execution, prices need to be periodically reviewed, and if need be revised upwards or downwards. Periodic consideration also needs to be given to shifting the incentive payments to alternative types of health services.

Evaluation of the scheme is being undertaken with results expected in November 2011.

Overall support to health services in the district by the HSRSP, including infrastructure and equipment investments, drugs and consumables (including anti-malarial bednets), technical supervision and support (and incentives for health administrators and hospitals not included in the experiment) is approximately US\$ 3.50 per capita annually. Added to this are the incentives to health facilities included in the intervention and comparison groups, equivalent to US\$0.75 per capita per year. Compared to results-based financing interventions elsewhere in DRC and in Central Africa region, this is a small incentive. The performance-based payment allocated to health centres in the results-based financing schemes in the provinces of Kasai Oriental, Kasai Occidental, South Kivu and North Kivu range from about US\$ 1 to US\$ 1.50 per capita per year, with still higher figures in Rwanda and Burundi. Yet, this small incentive would still count for a large proportion of the total income of the facilities, and is expected to be sufficient to modify staff behaviour. Implementation cost, including establishing systems, technical supervision and community verification, totals an additional US\$ 0.22 per capita annually.

Additional cost, unique to the experimental pilot nature of the programme, is external technical assistance to the design and implementation of the pilot and the impact evaluation, as well as data collection and analysis, totalling approximately US\$0.50 per capita annually.

Pay for Performance for Improved Health in Egypt

El-Saharty, S. et al., *Health Systems 2020 Project*, 2010

http://www.healthsystems2020.org/files/2763_file_Egypt_Brief_Format_FIN_REV_10.pdf

Annex on accreditation

http://www.healthsystems2020.org/files/2783_file_Egypt_Annex_B.pdf

This scheme made payments to healthcare facilities and providers linked to specific and measurable performance indicators. After several years of trying to improve the quality of healthcare solely through improvements in infrastructure and management, pay-for-performance (P4P) would pay providers for actual results achieved, and in the process, give them more autonomy over how funds (i.e., bonuses) were spent.

Targets were established for each indicator based on previous trends and achievements. Some targets, such as those that relate to family planning, vary by facility based on current utilisation data and demographic indicators (e.g., the number of married women of reproductive age in the catchment area).

A combination of provider payment mechanisms is used for paying contracted healthcare facilities. The basic mechanism is fee-for-service in combination with an adjusted payment aiming at controlling associated moral hazards, achieving efficiency, and enhancing quality of services provided. This necessitates using a hybrid payment mechanism with various monetary values for different levels of utilisation and performance-based incentives.

There have been four major assessments of the Egyptian Health Sector Reform Program, all of which show positive results. Although it is difficult to attribute improvements directly to P4P, it is unlikely that such results could have been achieved without the incentive payments.

Vouchers for Health: Increasing Utilization of Facility-Based STI and Safe Motherhood Services in Uganda

Bellows, B. & Hamilton, M., *Health Systems 2020 Project*, 2009

http://www.healthsystems2020.org/files/2576_file_Uganda_Brief_FIN_Small.pdf

This case study shares the experience of Uganda using vouchers to stimulate uptake of services for sexually transmitted infections (STIs) and safe deliveries. P4P was first

introduced to increase treatment of STIs; later a safe motherhood component was added to augment the number of facility-based deliveries. Specific vulnerable groups are targeted and receive subsidised vouchers, which they can use to access services at accredited private clinics.

Findings reveal that STI symptom knowledge increased and that the reduction in syphilis prevalence was greater among respondents who lived closer to contracted private facilities. Yet STI treatment utilisation did not increase significantly and the programme experienced a handful of challenges (for example, with claims management). This case study provides an example of how a government can regulate the private health sector through use of financial incentives and offers lessons for countries wishing to expand service access to safe motherhood and STI treatment through P4P engagement of private sector providers.

Vouchers for Health: Increasing Utilization of Facility-based Family Planning and Safe Motherhood Services in Kenya

Bellows, B., Hamilton, M. & Kundu, F., *Health Systems 2020 Project*, 2010

http://www.healthsystems2020.org/files/2563_file_Kenya_Brief_Format_FIN_15_Sept.pdf

This case study describes a Kenyan demand- and supply- side pay-for performance (P4P) scheme that uses vouchers as a means to reduce maternal and child mortality. Subsidised vouchers are targeted to poor women, enabling increased access to a range of safe motherhood and family planning services. Accredited public and private health service providers are reimbursed for voucher-supported services provided. Findings show that uptake of safe motherhood vouchers was very successful; however uptake of family planning vouchers proved more complex. This case study provides an example of a Government-led programme to increase service utilisation and offers lessons for countries considering implementing similar voucher-driven schemes.

Using Supply-side Pay for Performance to Strengthen Health Prevention Activities and Improve Efficiency: The Case of Belize

Vanzie, M., *Health Systems 2020 Project*, 2010

http://www.healthsystems2020.org/files/2620_file_Belize_Brief_Format_FIN_3.pdf

Supply-side pay for performance (P4P) in Belize consists of monthly capitation payments, discounted based on achievement of monthly performance indicators by contracted public and private primary healthcare clinics, plus annual performance awards to the clinics. The goal of the scheme is to increase access, improve the quality of services, and enhance the productivity of healthcare workers. The scheme specifically focuses on pre- and postnatal care and deliveries, and primary care for chronic illnesses such as diabetes, hypertension, and asthma. Belize's National Health Insurance (NHI) administers the P4P scheme and the Ministry of Health determines policies that include defining the packages of services and licensing and accrediting health facilities. The programme started as a pilot in 2001 and currently covers 40 percent of the population. Scheme managers are considering a shift from rewarding process and some output measures to rewarding output and outcome measures.

About OBA (output-based aid) and Output-based Healthcare in Uganda

Output-based Healthcare, trials and successes of contracted patient care in Uganda, Site accessed 11/04/2011

<http://oba-uganda.net/about/>

The growth of output-based aid (OBA) in the Ugandan health sector is based on the conviction that public health goals can be achieved with contracted incentives to healthcare providers. In Uganda the OBA approach is built on a performance-based contract and patient

vouchers that entitles the bearer to choose care from any contracted health centre. Healthcare providers must meet accreditation standards and then compete to diagnose and treat patients in exchange for the voucher. The vouchers' cost to the patient is heavily subsidised. The provider is reimbursed at a negotiated rate that reflects the cost of service provision and a reasonable profit. Service providers are reimbursed only after verification of contractually delivered services. The Uganda OBA programmes are designed to give patients the economic power to demand high quality healthcare delivery, to target high risk or low income patients for critical services, to augment general population utilisation rates, and to contain per-unit costs.

Rwanda: Performance-Based Financing in Health

Rusa, L. & Fritsche, G., in: Sourcebook on Emerging Good Practice, *Managing for Development Results*, 2007

<http://www.mfdr.org/sourcebook/2ndEdition/4-3RwandaPBF.pdf>

This report introduces performance-based-pay in Rwandan health services and discusses application the scheme and problem solving for all levels of the health system.

Results include increases in new users, institutional deliveries, vaccinated children and contraceptive prevalence rates (CPRs). One model reported an increase in CPR from 0.44% in 2002 to 7% in 2005.

Innovative Financing Partnerships Help Uganda Meet the Unmet Need for Family Planning

News Bureau, *Management Sciences for Health*, January 2011

<http://www.msh.org/news-bureau/innovative-financing-partnerships-help-uganda-meet-the-unmet-need-for-family-planning.cfm>

A performance-based financing (PBF) grant has helped the Kamuli VSC (Voluntary Surgical Contraception) health clinic in Kamuli District, Uganda drastically increase the quantity of family planning services provided to clients. In September 2010, the clinic saw 10 family planning clients per week; now nearly 80 clients receive family planning services each week. Kamuli VSC health clinic is supported by Family Life Education Program (FLEP), and a local private sector organization 'STRIDES for Family Health' has assisted with a PBF contract since September 2010. The new grant allowed Kamuli health clinic the opportunity to provide additional family planning services, including Long-Acting and Permanent Methods (LAPM) which were previously unavailable.

A Vision for Health: Performance-Based Financing in Rwanda, End-of-Project Report for the Rwanda HIV/PBF Project

Rwanda HIV/Performance-Based Financing Project, 2009

http://www.msh.org/resource-center/publications/upload/Rwanda-EOP-11-10-09_spreads.pdf

Performance-based financing is a contracting mechanism that is rooted in a simple premise: rewarding health service providers for positive results leads to even more positive results, which contributes to improved health outcomes. The Rwanda HIV/PBF Project started in 2005 with the objective of improving the access, quality, and efficiency of HIV clinical services while ensuring that incentives for HIV services did not negatively affect primary care services.

The project not only achieved that objective, but also contributed to overall improvement in the quality and delivery of basic health care services and the strengthening of the Rwandan health system. Although simultaneous introduction of several reforms makes it difficult to single out any one cause for improvement, results from a 2008 World Bank-sponsored PBF

impact evaluation revealed that overall clinical care improved significantly in districts where PBF had been introduced.

According to data from the Interim Demographic and Health Survey (2007–08) and other sources, indicators measured by the HIV/PBF Project showed the following improvements in primary health care:

- an increase in the contraceptive prevalence rate among married women from 10 percent in 2005 to 36 percent in 2007–08
- an increase in the percentage of births attended by skilled health personnel from 31 percent in 2005 to 52 percent in 2007
- a reduction in childhood mortality from 152 per 1,000 live births in 2005 to 103 per 1,000 live births in 2007
- almost 100 percent increase in the average number of women per health centre (re)vaccinated against tetanus, an avoidable and often fatal disease

Performance-based Financing and Changing the District Health System: Experience from Rwanda

Soeters, R., Habineza, C. & Peerenboom, P.B., *WHO Bulletin*, 84(11), 2006
<http://www.who.int/bulletin/volumes/84/11/06-029991.pdf>

Evidence from low-income Asian countries shows that performance-based financing (as a specific form of contracting) can improve health service delivery more successfully than traditional input financing mechanisms. We report a field experience from Rwanda demonstrating that performance-based financing is a feasible strategy in sub-Saharan Africa too. Performance-based financing requires at least one new actor, an independent well equipped fundholder organisation in the district health system separating the purchasing, service delivery as well as regulatory roles of local health authorities from the technical role of contract negotiation and fund disbursement.

In Rwanda, local community groups, through patient surveys, verified the performance of health facilities and monitored consumer satisfaction. A precondition for the success of performance-based financing is that authorities must respect the autonomous management of health facilities competing for public subsidies. These changes are an opportunity to redistribute roles within the health district in a more transparent and efficient fashion.

Performance-based Financing for Health, Lessons from Sub-Saharan Africa

Toonen, J. et al., *Royal Tropical Institute of the Netherlands (KIT)*, 2009
http://www.kit.nl/net/KIT_Publicaties_output/ShowFile2.aspx?e=1593

This report includes:

- An introduction with a literature review of lessons learned from PBF approaches
- Determinants for success of PBF
- The effects of PBF on health service productivity
- Monitoring and managing PBF

7. Additional information

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About Helpdesk reports: The HDRC Helpdesk is funded by the DFID Human Development Group. Helpdesk Reports are based on up to 2 days of desk-based research per query and are designed to provide a brief overview of the key issues, and a summary of some of the best literature available. Experts may be contacted during the course of the research, and those able to provide input within the short time-frame are acknowledged.

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