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RESULTS-BASED FINANCING IN SENEGAL

POLICY BRIEF: OPENING THE BLACK BOX: PROVIDER RESPONSE TO RBF INCENTIVES FOR QUALITY IN SENEGAL

BACKGROUND

In 2012, Senegal's Ministry of Health and Social Action, through the Programme National de Financement Basé sur les Résultats (PNFBR) and with support from the United States Agency for International Development (USAID), began piloting a results-based financing (RBF) program for health in all health centers and health posts in two regions: Kaffrine and Kolda. The RBF program awards payments to providers and facilities based on achievement of pre-determined quantity and quality targets. Quality assessment checklists are used to score facility-based service quality (see box at right). One year into implementation, it became clear that understanding how provider personnel respond to quality incentives was essential to the long-term success of the program. In 2015, USAID's Translating Research into Action (TRAction) project launched the Black Box Study, implemented by Results for Development (R4D) and the Netherlands Royal Tropical Institute (KIT), to explore this question.

Through questionnaire-based individual interviews and focus group discussions with health center and health post workers, the study team collected qualitative data in the two initial pilot RBF regions (Kaffrine and Kolda) and one comparison region (Kaolack). The study results showed that providers exposed to RBF quality incentives had different definitions of quality, approaches to achieving quality, and perceived barriers to quality compared to providers in the comparison group.

The **"Black Box"** refers to provider response and behavior towards quality incentives through RBF program implementation.

How (if at all) do providers change their behavior when quality checklists are introduced? Checklist scores capture performance on these quality metrics but not how their behaviors change to attain the scores. Hence, the behavior behind quality scores has been a "black box".

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RBF CHECKLIST SCORE CATEGORIES

- General activities (i.e., reception, fee schedules, assuring patient confidentiality, etc.)
- Hygiene
- Management
- Monitoring and Evaluation/Health Information System
- Maternity
- Family Planning
- Vaccines and Newborn follow-up
- Infectious Disease (TB, HIV)
- Laboratory (Health centers only)

FINDINGS

The qualitative findings from this study indicate that RBF has had a positive impact on provider behavior and approaches to quality of care and has begun to shift provider attention and transform the performance culture within facilities towards more responsive care with strategic and collaborative use of resources. Findings are detailed below in three main categories—how providers in RBF and in comparison facilities define quality, how they work to achieve quality, and how providers perceive access to supportive resources.

1. Providers in RBF Programs Define Quality Differently

Given the focus of the quality checklist, it was expected that RBF providers would generally define quality differently from their comparison region counterparts. In fact, study results showed that those respondents working within RBF facilities included multiple dimensions in their definition of quality while comparison facilities typically cited only one or two components of quality in their definitions.

When asked how they defined quality of care, beyond having adequate structural resources (e.g. equipment, supplies, personnel, facilities), respondents from all participant groups cited the need to engage with and focus on patients in order to provide quality services. Comparison region respondents, however, generally provided non-specific statements such as "respond to client needs" and "satisfaction of patients." The responses suggest that in RBF regions there is an effort to go beyond responding to individual patient needs, to plan and carry out specific strategies of active engagement with the community to improve the quality of care they can provide (see Table 1). The data also suggest that providers in RBF facilities consider more specific patient needs or activities, such as ensuring that "the sick do not have a long wait" at the facility. As one respondent said:

> *" When patients arrive at the facility, we have a conversation with them. We get them settled and make them comfortable so that they can explain their concerns to us. If you don't welcome them as you should, you will not get the results you want. For patients to be able to explain their health issues, they must have confidence in you."*
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> – Nurse Assistant, RBF Region

2. Providers in RBF Programs Work to Achieve Quality Differently

When asked broadly about efforts they undertake to improve the quality of care, respondents spoke about internal capacity building, external stakeholder engagement (patients, health committees, organizations/projects, etc.), or seeking out additional resources. Internal capacity building included provision of trainings, establishment of additional supervision activities, improved management practices, community mobilization. Examples of the types of responses by participant group are detailed in Table 1.

All health posts, both in the comparison and RBF regions, focused heavily on external engagement activities as a source of improving quality. None of the comparison health posts, however, cited seeking additional resources, whereas RBF respondents did. Most RBF respondents from both health centers and health posts provided multi-faceted responses that included both internal and external aspects and many even elicited elements of all three themes in their responses. These more holistic and integrated approaches to quality were further reinforced by the insistence demonstrated by many RBF providers on the importance of a greater sense of teamwork in raising quality. Particularly in focus group discussions, RBF participants were animated and engaged with each other in discussions of the

Table 1. Illustrative responses by participant group to the question, "what activities do you undertake in an effort to improve the quality of care?"

	RBF HEALTH CENTERS	RBF HEALTH POSTS	COMPARISON HEALTH CENTERS	COMPARISON HEALTH POSTS
Internal capacity building	"Monthly coordination meetings and regular intersectoral meetings" "Motivation of staff" "Advanced integrated strategies"	"Keeping management tools up to date" "Training health workers"	"Good organization of services" "Supervision of staff in their work to see what they are doing and how they do it"	"Supervision of health workers" "Managing monthly data transmissions"
External engagement	"Interpersonal communication and home visits in the population"	"Raising awareness among women to start their antenatal care visits early" "Community mobilization activities and coordination with community health workers"	"Be empathetic towards the patients" "Awareness raising"	"Communication between the personnel and the population" "Counseling and consultations" "Information, education, and communication"
Seeking additional resources	"Recruiting qualified personnel" "Availability of necessary supplies"	"Recruiting qualified staff" "Availability of adequate material"	"More technical equipment"	No responses within this category

increased communication and coordination across departments/units and overall collaboration that RBF participation had fostered. As one respondent stated:

> *"RBF let us know what each one must do. We all respect the norms put forth with RBF by being conscious of them and talking to each other. It's a manner of working together that we have adopted to be able to respect the RBF standards."*
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> – Nurse Assistant, RBF Region

3. Providers in RBF and Comparison Regions Alike Reported the Need for More Supportive Supervision and Training Support

Both RBF and comparison regions consistently echoed the need for engaged and effective supervision in order to improve quality of care. Study findings indicated that current supervision across all three regions tends to be more of a routine monitoring exercise rather than an active and supportive improvement process. While no respondents saw poor supervision as an impediment to improved quality services, many provided specific feedback on how supervision could be improved. Although RBF respondents demonstrated an overall more favorable appreciation of supervision, there was little evidence that supervision was addressing the quality improvement needs made explicit through low RBF checklist scores according to providers.

The need for additional support such as trainings and tools was also consistently noted across all groups of respondents. With incentives in place to motivate improved outcomes, the study team expected that RBF facilities would likely be more innovative in their problem-solving skills and would utilize new or adapted tools, external advice, or additional financing to close any gaps. Both groups of providers, however, expressed difficulty accessing resources they might use to achieve their quality targets, as well as the absence of effective mechanisms for connecting with higher levels of the system to communicate needs and derive support in RBF and non-RBF contexts.

POLICY RECOMMENDATIONS

In light of the findings presented in this brief, the research team recommends the following in order to help build on the positive changes RBF has supported to date and to facilitate sustained improvement:

1. **Prioritize interactive routine supervision:** More interactive and dynamic supervisory interactions between providers and their supervisors will allow facility workers to engage more fully with the performance data and information they are being provided while also facilitating a dialogue on any training or material needs. With trainings often organized at the regional and/or national levels, establishing or strengthening lines of communication is important so that perceived training needs at facility-level can inform decisions at those higher levels.
2. **Increase motivation, not just with financial rewards, but through improved data availability:** As they begin to understand the competitive and status-related factors that lead to increased teamwork, district and regional health teams can create feedback mechanisms to systematize this motivation. By making facility scores transparent and publicly available (or at least available to facility personnel), facilities would regularly be aware of not only their own scores, but how their performance compares to their peers. Mid- and high-level performers would be continually motivated to work as a team to achieve higher results, and district-level managers would be able to provide targeted support to lower performers to provide guidance, tools, or training to address specific needs. Study results showed that respondents are not just motivated by financial incentives, but already driven by a sense of pride in improved performance under RBF. In providing scoring information to providers, the health system could leverage non-financial motivators for worker engagement.
3. **Establish and map peer and resource networks:** Given that facilities were not apt to report seeking out additional support or guidance, creating peer networks for providers and managers would promote the sharing of best practices and lessons learned while also creating a collaborative space for discussion and innovation. In addition, mapping of partners and resources could help providers match their needs with existing resources and opportunities. These could be existing partnerships or mechanisms for identifying new opportunities for facility, district, or even regional support.
4. **Support district-level leadership and management training:** District-level managers are key players in facilitating provider behavior shifts as well as in creating the environments that promote and support those changes over time. As noted during the study, tools and trainings can have little impact if the management support is not there to foster change. Ensuring that district and facility managers are cognizant of key leadership principles will allow more systematic improvements.
5. **Consider the limits of RBF in achieving quality:** It is important in moving forward to understand the limits of RBF on improving quality and where other health system initiatives must intervene. Human resource shortages, for example, were a critical concern among both RBF and comparison groups. However, recruitment and placement of staff are decisions taken at higher levels, with limited, if any, input from the facility-level. In promoting, implementing, or supporting RBF programs, Ministries of Health, funding agencies, development partners and local providers must be mindful of these limitations.

TRACTION PROJECT OVERVIEW

The Translating Research Into Action (TRAction) Project, funded by the U.S. Agency for International Development, focuses on implementation and delivery science—which seeks to develop, test, and compare approaches to more effectively deliver health interventions, increase utilization, achieve coverage, and scale-up evidence-based interventions. TRAction supports implementation research to provide critically-needed evidence to program implementers and policy-makers addressing maternal and child health issues.

For more information on the TRAction Project:
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