



STRATEGIC PURCHASING TO SUPPORT VOLUNTARISM, INFORMED CHOICE, QUALITY AND ACCOUNTABILITY IN FAMILY PLANNING: LESSONS FROM RESULTS-BASED FINANCING

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The Health Finance and Governance Project

The Health Finance and Governance (HFG) project works to address some of the greatest challenges facing health systems today. Drawing on the latest research, the project implements strategies to help countries increase their domestic resources for health, manage those precious resources more effectively, and make wise purchasing decisions. The project also assists countries in developing robust governance systems to ensure that financial investments for health achieve their intended results.

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The Evidence Project

The Evidence project works to expand access to high quality voluntary family planning/reproductive health (FP/RH) services through strategic generation, translation, and use of new and existing evidence. The project seeks to achieve the following results: (1) Evidence generated to increase the effectiveness of FP/RH programming; (2) New and existing evidence to accelerate scale-up of evidence-informed FP/RH programming synthesized and shared; and (3) Use of evidence to improve FP/RH programming at the country level.

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I. OVERVIEW OF RESULTS-BASED FINANCING AND FAMILY PLANNING: GLOBAL TRENDS, ISSUES AND OPPORTUNITIES

The past 20 years have seen unprecedented financial commitment to family planning (FP) among governments of low- and middle-income countries (LMICs) and the donors that support them (WHO 2016). However, mobilizing government and external resources is often not enough to increase access to and voluntary use of FP services. Thus, some countries have begun to use strategic purchasing to shape the service delivery system. In these countries, the public or private purchaser(s) – for example, social health insurance funds, voucher management agencies, ministries of health (MOHs), or central procurement agencies – strategically purchase health services, sometimes from both public and private sectors, using payment systems intended to maximize value for money (Maeda et al. 2017; Tangcharoensathien et al. 2014).

This guidance document concentrates on strategic purchasing systems that conditionally link a portion of payment to health facilities and their supervisors with the attainment of pre-specified FP outputs or outcomes. Systems such as these have alternately been labeled results-based financing (RBF), performance-based financing (PBF), performance-based incentives (PBI), and pay-for-performance (P4P). These types of strategic purchasing systems aim to motivate and hold providers and supervisors accountable for providing high-quality voluntary FP services. In many cases, this performance-based payment/ performance-based incentive is a small part of the total remuneration received by healthcare facilities or their supervisors. As countries introduce this type of system, they rarely eliminate salaries and typically use the payments as an additional leverage to improve the quality of health services.

Definition of Terms

Strategic purchasing for health involves purchasing health care services from providers using deliberate mechanisms that link payment to aspects of their performance. In contrast with passive purchasing, strategic purchasing pays providers in ways that create incentives to increase specific health outputs, improve quality, or efficiently expand access to priority services.

Results-based financing (RBF) for health is defined by Musgrove (2011) as “a cash payment or non-monetary transfer made to a national or sub-national government, manager, provider, payer or consumer of health services after predefined results have been attained and verified. Payment is conditional on measurable actions being undertaken.”

Performance-based incentives (PBI), another term that captures the same meaning as RBF, was defined by the Center for Global Development Working Group (Eichler and Levine 2009) as “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.”

Pay-for-performance (P4P) is another term for RBF/PBI that typically refers to paying individual providers, health facilities, provider groups, and service delivery systems. It has also been used in the US to pay health insurance entities.

Performance-based financing (PBF) for health can be considered a subset of RBF. The term has evolved to refer to a particular model that has been supported by the Health Results Innovation Trust Fund (HRITF), managed by the World Bank and funded by Norway and the United Kingdom, and linked to International Development Association (IDA) financing in 29 countries. In most of these countries, health care facilities are paid fees for delivering specific services, often modified by performance scores on a quality checklist. These fees are often required to be reinvested in facility operations and to provide PBF payments to facility staff. These PBF payments are in addition to salary and other payments that providers receive. PBF continues to be supported through the Global Financing Facility (GFF).

The trend to implement strategic purchasing systems in LMICs in order to strengthen health systems, accelerate service utilization, and enhance quality of health interventions continues to present both an opportunity and a challenge for FP. The opportunity to enable families to voluntarily decide the number, timing, and spacing of births by stimulating quality FP counseling and increasing the availability of desired FP methods through RBF is considerable. At the same time, the challenge of designing payment systems that support voluntarism and informed choice requires careful design, thorough planning, and ongoing monitoring. When applied to FP, strategic purchasing should reflect rights-based principles of voluntarism, informed choice, quality, and accountability. In many cases, these rights-based principles are specified in policy statements and not well translated into the operational documents that govern the details of strategic purchasing – such as the services that are covered, from whom services are delivered, and the outputs or outcomes on which conditional payments are based. When considering whether rights-based principles are being applied, all of the elements of the health system must be reviewed, including the checks and balances and the monitoring system. Government policies should specify the importance of the rights-based principles and monitor the strategies employed to ensure they are being honored.

Performance-based Incentives in Family Planning: Lessons for Developing Countries, was developed in 2010 given concern over the potential for misunderstandings surrounding the trend to introduce payment systems that condition payment on delivery of FP services (Eichler et al. 2010). The document, developed by the United States Agency for International Development (USAID) -funded Health Systems 20/20 project, provides guidance on how to use RBF in ways that both support voluntary choice and enhance service utilization. This document updates the guidance produced by the original document with information from RBF programs that have since evolved and provides a more concerted focus on voluntarism, informed choice, quality, and accountability.

The need for this updated document is partly driven by commitments made by the global community at the 2012 Summit on Family Planning to bring voluntary FP services to an additional 120 million women and girls by 2020. While this goal is laudable, some civil society organizations have expressed concern that a numerical goal may violate rights-based principles of voluntarism (Hardee et al 2014). This concern gave rise to collaborative efforts among diverse stakeholders to determine a way forward that supported operationalization of rights-based principles for FP services in RBF systems.

This document identifies the opportunities for and challenges of incorporating voluntary FP into RBF systems that pay providers; offers considerations for establishing fees; describes approaches to monitoring and verification; discusses U.S. policies surrounding support for enhancing access to FP; presents what is known about how low- and middle-income countries are including FP; and provides suggestions for donors, policymakers, program implementers, and technical assistance providers about how to responsibly and effectively apply strategic purchasing to enhance FP results in LMICs.

What is a rights-based approach?

A rights-based approach to health applies a set of standards and principles to guide program assessment, planning, implementation, monitoring, and evaluation that enables individuals and couples to decide freely and responsibly the number, timing, and spacing of their children, to have the information and services to do so, and to be treated equitably and free of discrimination.

<https://www.unfpa.org/human-rights-based-approach>

Box 1: Best Practices to Consider When Including FP in Supply Side RBF Programs to Support Voluntarism, Informed Choice, Quality, and Accountability

Individual health worker level:

1. Do pay for quality counseling regardless of whether it leads to acceptance of a FP method.
2. Do construct payment levels to reduce provider bias or skewed method mix.
3. Do construct payment levels that function as reasonable compensation but not excessive. “Reasonable” implies payments that are in line with payments for other services and other sources of individual income.
4. Don’t reward health providers or individual facility staff for achieving a target number of FP users or users of a particular FP method.
5. Don’t compensate for delivery of specific FP methods with payments that are out of line with payments for other services, as this may lead to coercive behavior and should be avoided.

Health facility, health team, or NGO network level:*

6. Do consider rewarding the availability of a wide range of methods.
7. Do consider rewarding facilities that attain specified performance objectives – such as number of FP clients reached with counseling. Do include FP counseling as a component of antenatal, postnatal care, HIV / STI counseling, and other indicators for clients of reproductive age seeking any clinical service.
8. Do reward performance indicators that combine FP services provided and measures of FP quality – such as availability of methods, knowledge, and client feedback on provided information of various methods and degree of voluntary choice.
9. Do construct payment levels to reduce provider bias or method skew.
10. Don’t compensate for delivery of specific FP methods with payments that are out of line with payments for other services, as this may lead to coercive behavior and should be avoided.

Sub-national or national level:

11. Do consider opportunities to link financial transfers to results related to population coverage of specific methods, counseling and education, improved quality, and increased access.
12. Do specify rights-based principles in national policy and ensure that these principles are operationalized (for definitions and examples see chapters 3 and 4 in WHO 2017).
13. Do use monitoring to identify if some populations are not being reached and to identify potential violations of rights-based principles.
14. Do use monitoring and implementation information to revise and refine.

*Health facilities and teams have more than one health worker. For facilities with one health worker, refer to the guidelines for individual health workers.

2. SHIFTING FROM PAYING FOR INPUTS TO PAYING FOR RESULTS: WHAT IS RESULTS-BASED FINANCING?

In many LMICs, health systems fund the inputs required to provide FP services, and essentially, hope that quality FP services will be available and delivered with enough information for beneficiaries to make informed and voluntary choices. These systems are focused on tracking the financing of inputs – such as salaries, FP commodities, infrastructure and equipment – and not the results the inputs produce. Health information systems that include FP registers are often unreliable and rarely used to hold those providing voluntary FP services accountable for providing voluntary FP services or to make management and policy decisions.

Using RBF systems, once outputs or outcomes are purchased, countries need systems to track and verify their delivery, to hold recipients accountable for achieving rewarded measures, and to pay for achievements. Thus, the emphasis shifts from tracking inputs to monitoring and verifying results.

RBF is much more than a change in payment. RBF should be seen as a reform that alters many parts of a health system. If well-designed and implemented, RBF has the potential to enhance efficiency and value for money by using limited resources – financial, human, infrastructure – to achieve national priorities. Management and governance can be strengthened because roles, responsibilities, and measures of accountability are clarified. Human resources can be made more effective if RBF motivates teamwork, hard work, and quality service delivery. Reliable information systems are the backbone of RBF and the generation and use of information is strengthened in a robust RBF system. Equity can be enhanced if facilities are rewarded for reaching population groups or localities traditionally under-served or in the most need of service. RBF also has the potential to enhance responsiveness to the population as health workers and facility teams have more incentives to serve their communities. In most models, facilities have the opportunity to earn payments that can be used to invest in the facility operations.

Given that all payment contains incentives, which can be a potentially powerful tool, it is critical to monitor intended and unintended consequences. Potential pitfalls of RBF programs related to FP include the following:

- Providers may focus on rewarded services and neglect other important services. RBF systems that leave out FP may find that providers neglect provision of FP services, contributing to stagnating FP use, while the use of other rewarded services rises.
- Providers may promote acceptance of FP methods that pay higher fees, which could interfere with informed choice and voluntarism.
- Poorly-designed RBF incentives may result in excessive attention to increasing FP use, resulting in coercive behavior by managers and providers that interferes with voluntary choice by clients.
- The quality of information systems may be compromised as the incentives to report the FP results for which providers are rewarded may encourage them to falsify reported information.

- Without clear communication, clients may incorrectly interpret the offer to cover transportation costs or other out-of-pocket expenses for counseling as payment to accept a method.

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

Many RBF systems in LMICs currently reward FP outputs. There is an opportunity to strengthen and reinforce emphasis on smart design and effective monitoring to better align FP services with goals of voluntarism, informed choice, quality, and accountability. This document focuses on areas of the design that merit attention to achieve these goals: indicators, payment, verification, and monitoring. Other details of design, including roles and responsibilities and operationalization, are described in other documents such as the *Performance-Based Financing Toolkit and Paying for Performance in Health: A Guide for Developing the Blueprint* (Fritsche, Soeters and Meessen 2014; Eichler and De 2008).

3. RESULTS-BASED FINANCING AND THE VALUES OF VOLUNTARISM, INFORMED CHOICE, QUALITY AND ACCOUNTABILITY

3.1 Importance of Voluntarism, Informed Choice, Quality and Accountability

The principles of **voluntarism and informed choice**, which specifies that individuals and couples have the right to decide the number, timing, and spacing of their children and to access the information and means to do so, have been integrated into all US government assistance for FP. Hardee (2013) defines these principles as:

- People have the opportunity to choose *voluntarily* whether to use FP or a specific FP method.
- Individuals have *access to information* on a wide *variety* of FP choices, including the benefits and health risks of particular methods.
- Clients are *offered*, either directly or through referral, a *broad range of methods and services*.
- The *voluntary and informed consent* of any client choosing sterilization is verified by a written consent document signed by the client.

Hardee (2013) defines the principles of **quality** in FP as:

- Service providers who are well-trained and provide safe services, treat clients with respect, provide good counseling, and protect client privacy and confidentiality.
- A reliable supply of contraceptives and equipment for services that clients want are available.

Principles of **accountability** in FP can be summarized as (Boydell, Cole, Bellows and Hardee 2018 and Cole, Boydell, Bellows and Hardee 2018):

- Mechanisms exist for community members and FP clients to provide input and feedback about services.
- Service providers and their supervisors are accountable for providing FP services in ways that preserve voluntarism, promote informed choice, and assure quality.
- Mechanisms exist for health systems to investigate and remedy allegations of/confirmed violations of rights.
- Members of the community are involved in planning and monitoring FP services.
- Health systems display good governance and effective implementation, providing an environment that facilitates the discharge of all responsibilities and the ability to readily access meaningful information, including de-identified data.

3.2 USAID Family Planning Policies Related to Voluntarism and Informed Choice¹

In the early years of national FP programs, some LMICs, notably Bangladesh (late 1980s) and India (1970s), introduced surgical sterilization payments for both providers and individuals. Payments to providers were designed to overcome provider resistance to offering FP services, especially voluntary sterilization, and encourage increased availability to all FP services. Compensation for travel costs and the value of lost wages during the recovery period were also made to individual clients who received voluntary surgical sterilization. At the time, voluntary sterilization services were offered in relatively few sites and, given that it was a surgical procedure, required several days of convalescence.

The practice of rewarding providers in national FP programs for achieving specific contraceptive targets, especially for permanent and provider-dependent methods like sterilization, created serious concerns that payments could lead providers to coerce clients to accept specific contraceptive methods, notably sterilization. These concerns were voiced by supporters of organized FP assistance (Cleland and Mauldin 1991) as well as by its critics (Hartman 1985; Warwick 1982). Provider payments for sterilization were also thought to bias the presentation of information during the counseling session and affect client decision-making. Yet, the evidence is not conclusive; one of the countries whose sterilization practices were most criticized, Bangladesh, has seen a steady decline in sterilization despite the sustained payments to both provider and client for the service (EngenderHealth 2002).

To ensure the practice of informed consent and to protect voluntarism in the provision of sterilization services, USAID introduced an Agency policy in 1982 titled *Policy Determination 3 (PD-3) and Addendum: USAID Policy Guidelines on Voluntary Sterilization* (USAID 1982). PD-3 lays out Agency guidelines on a number of issues, including allowable payments related to voluntary sterilization. The *addendum* clarifies PD-3 and elaborates detailed program guidelines regarding acceptable practice for "payment of acceptors," "payment of providers of services," and "payment of referral agents" where USAID is providing direct support for voluntary sterilization. The document establishes that in USAID-supported programs that receive direct support for voluntary sterilization, payments per case or per procedure to providers of voluntary sterilization services are acceptable if the payments are "reasonable relative to other medical and contraceptive services provided so that no financial incentive is created for providers to carry out voluntary sterilization procedures compared to provision of other methods of family planning." While acknowledging that this practice may be acceptable after thorough analysis (given the "customary" nature of reimbursement for health procedures), the document advises USAID Missions to "encourage patterns of service delivery and methods of payment which do not unduly emphasize voluntary sterilization services compared to other methods of fertility control." PD-3 specifically mentions several measures for mitigating the risk of such payments functioning as incentives. These include separating the selection and counseling of clients from the provision of the service and structuring reimbursement for providers of FP "per counseling session" rather than for acceptance of a specific method.

Policy and practice regarding the acceptability of payments to FP providers continued to be guided solely by PD-3 until the late 1990s. In October 1998, members of Congress responded to evidence of non-voluntary practices in the Peruvian FP program with the introduction of a statutory amendment, known

¹ The majority of this section is replicated from Eichler, Rena, Barbara Seligman, Alix Beith, and Jenna Wright. July 2010. *Performance-based Incentives in Family Planning: Lessons for Developing Countries*. Bethesda, MD: Health Systems 20/20 project, Abt Associates Inc.

as the "Tiahrt Amendment." The Tiahrt Amendment reaffirms and further elaborates standards for voluntary FP service delivery programs to protect FP "acceptors," defined as individual clients receiving services. Statute language has consistently been enacted unchanged in subsequent annual appropriations legislation to date. Two provisions of the Tiahrt Amendment are directly relevant to RBF and strategic purchasing in USAID-funded projects (USAID 1999).

1) Service providers or referral agents shall not implement or be subject to numerical targets or quotas of total number of births, number of FP acceptors, or acceptors of a particular FP method. Quantitative estimates or indicators used for budgeting or planning purposes are permissible.

2) No incentives, bribes, gratuities, or financial reward for FP program personnel for achieving targets or quotas, or for individuals in exchange for becoming a FP acceptor.

To ensure voluntarism and informed choice in its programs, including compliance with the Tiahrt Amendment, USAID has continued to focus on strengthening systems for ensuring compliance. Such activities include training for USAID and implementing partner staff on all U.S. FP requirements and enhanced monitoring of compliance with all statutes and policies that guides its FP program. To date, six Tiahrt Amendment violations have been reported to Congress by USAID. With heightened awareness of the FP requirements and strong Agency emphasis on voluntarism and informed choice, USAID has tried to address confusion and hesitancy on how to incorporate FP into RBF systems.

As global momentum continues to build to support health system strengthening interventions, including among the donor community, a number of USAID-supported programs are incorporating RBF and other strategic purchasing options to strengthen health systems and improve provider and program performance. There is also a greater understanding of how RBF initiatives can be operationalized to achieve anticipated outcomes and growing experience developing and implementing RBF programs.

U.S. FP requirements, including the Tiahrt Amendment, offer guidance when including FP with RBF systems. RBF programs funded or carried out in USAID-supported service delivery points must not include: 1) individual provider- or referral agent-level targets for number of FP acceptors or acceptors of specific FP methods; 2) program personnel cannot receive incentives or financial rewards for achieving prohibited targets; and 3) demand-side RBF initiatives must not provide benefits in exchange for accepting FP methods, but many other options remain for successfully incorporating FP indicators and activities in RBF initiatives (see Box 1). For example, incentives can be linked to ensuring availability of a choice of modern methods or for quality counseling. Fee-for-service provider payments linked to provision of FP services are also feasible, provided that they are in line with fees for other services. Rewards for provider knowledge about effective counseling and clinical practices are also possible. Subsidies to cover clients' costs of transportation are possible, as long as payment for transportation is not linked to acceptance of a method. RBF initiatives have wide latitude for including FP indicators and activities to increase demand for FP services. RBF programs often include related behavior change communication and information, education and communication activities where FP messages should be included to increase information and demand for FP. Technical assistance activities within RBF initiatives should also include modules on ensuring FP voluntarism and informed choice within high-quality, client-centered health services.

Box 2: Guidance for USAID Missions, Contractors, and Recipients of USAID FP Assistance

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

The USAID external web site also includes a link to two specific guidance documents related to the Tiahrt Amendment: “[Guidance for Implementing the ‘Tiahrt’ Requirements for Voluntary Family Planning Projects](#)” and “[Technical Guidance on the ‘Comprehensible Information’ Paragraph of the Tiahrt Clause.](#)”

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

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



4. WHAT INDICATORS ARE BEING REWARDED AND GUIDANCE

RBF programs have the potential to ensure that clients' needs for quality services are met through use of strategic purchasing and promoting more client-centered health care systems. Determining what is measured, rewarded, and purchased – *the indicators* – and whose performance is rewarded – *the recipients* – are critical components of any RBF system.

Indicators play an important role in RBF systems because they are linked to strategic purchasing and aim to incentivize certain actions and/or services. Careful selection of indicators can contribute to voluntarism, informed choice, quality, and accountability. Ensuring that incentive-linked indicators in RBF programs are grounded on rights-based principles, and most notably accountability, voluntarism, informed choice, and quality of care is critical.

This section presents information gleaned from the operational manuals of 23 PBF systems, a type of RBF.

4.1 What Family Planning Indicators Are Rewarded In Current Performance-Based Financing Systems?

Many PBF programs purchase services by paying for the delivery of a combination of quantity and quality performance indicators. Both service quantity indicators (e.g., number of new users) and quality of care measures (e.g., content of clinical care) are incentivized. In addition, a facility-level readiness or quality of care score (often generated via a checklist) is used to assess performance, and this score then modifies the quantity-based disbursement. When quantity-based performance indicators are achieved and verified, the funding disbursement is triggered. These payments are often made to a health care team (e.g. a health facility) or an administrative unit (e.g. a district health office) based on service-related or facility-related factors, not linked to a specific staff member's performance.

In a 2018 review of 23 PBF operational manuals that assessed the extent to which PBF programs incorporate quality, informed choice, voluntarism, and other rights-based principles, 21 of 23 programs were observed to incentivize FP to some extent (Cole et al. 2018). While PBF programs have the potential to promote and strengthen a human-centered approach to healthcare through strategic incentives that foster quality of care and other rights-based attributes, FP services incentivized by PBF programs have primarily focused on rewarding providers for serving new and continuing contraceptive users or users of specific methods. Quality metrics that have been rewarded tend to primarily capture contraceptive availability.

The review catalogued FP indicators used in PBF programs and assessed their sensitivity to the right-based principles of quality, informed choice, voluntarism, and accountability (Boydell et al. 2018). Three data resources were used to identify the relevant indicators. The first dataset came from 23 operational documents sourced through web searches and expert consultations. The second resource was 18 quality checklists identified through the “Multi-Country Performance Based Incentives Quality Checklist Database,” developed by ThinkWell (TRAction Project 2016), and the third resource was the Measure Evaluation database of RBF indicators (Measure Evaluation 2018).

4.2 Family Planning Quantity Indicators

Cole et al. conducted a review of 23 relevant operational documents (one each from 23 countries) in English and French for inclusion in a study on the alignment of rights-based approaches and RBF. All of the documents were the most recent versions of operational or implementation manuals that were publicly available during data collection. A companion study on quantity-based FP performance indicators identified 57 indicators that were then assessed for an explicit or implicit link to one or more rights-based principles. It is important to acknowledge that PBF operational manuals are a complement to other guidelines promoted by governments and may not capture all elements of FP service delivery.

The most common quantity-based performance indicators found in the 23 operations manuals, as presented in Table 1, were: number of new and continuing users for short acting methods (pills or injectables) (n=12 of 57); number of new and continuing users of long acting methods (IUDs and implants) (n=12 of 57); and number of new users of two long acting methods (IUDs and Implants) (n=8 of 57). Less frequently mentioned indicators were: number of users of modern contraceptive methods (n=3 of 57); number of new users of modern FP (n=3 of 57); number of new users of short acting methods (pills and injectables) (n=1 of 57); and number of tubal ligations and vasectomies performed (n=6 of 57).

Table 1: Quantity-based performance indicators in 23 national PBF operational manuals.

Group	Indicator	Number of operations manuals
New & Continuing	Number of new and continuing users for short acting methods (pills or injectables)	12
New & Continuing	Number of new and continuing users of long acting methods (IUDs and implants)	12
New users	Number of new users for long acting methods (IUDs & Implants)	8
Permanent Methods	Number of tubal ligation and vasectomy performed	6
FP Users	Number of users for modern FP	5
Counselling	Number of clients counseled for FP	4
New users	Number of new users of modern FP	3
Counselling	Percent of women aged 30-60 having counseling on early detection of STIs, female cancers, FP, and preconception care.	1
Ante-natal	Number of eligible puerperal women who received counselling on sexual and reproductive health within 45 days after childbirth	1
New users	Number of new users for short acting methods (pills & injectables)	1
Ante-natal	3 home visits for ANC include FP counselling	1
Other	Couple-years of contraceptive protection (CYP) provided by facilities and community health volunteers (disaggregated by method)	1

Group	Indicator	Number of operations manuals
Other	Percent of women referred for FP by CHWs to health center (any method)	1
New & Continuing	Proportion of married, non-pregnant women of reproductive age who or whose partner are currently using at least 1 FP method (household survey) - Contraceptive prevalence rate (CPR)	1

Most indicators were applied at the health facility or dispensary level. Fewer were measured at a hospital level and the indicator that captured the number of tubal ligations and vasectomies was relevant for higher level health facilities. The majority of indicators (n=42 out of the 57) related to contraceptive service utilization. However, nine of the 23 countries used counselling as a measure of performance. The inclusion of FP as part of ante-natal care (n=1 of 57), provision or referral by community health workers (n=1 of 57), and demand (n=1 of 57) were less common measures of performance.

The quantity-based performance indicators for FP services that focus on contraceptive service utilization do not capture the nature or content of the client-provider interaction nor issues of access that are more aligned with a rights-based approach (RamaRao and Jain 2015). With a focus on measuring service use, it is unknown if users were given full information and had a full range of options to choose from, as this information would likely be captured in the quality indicators. Several PBF programs measure the number of users counseled, which is more conducive to a rights-based approach as the emphasis is on the provision of information and the interaction with the users so as to support them to make full, free and informed choice about the contraceptive method best for them.

4.3 Family Planning Quality Indicators

Research has shown that when people feel they are receiving high-quality FP services, such as positive client-provider interactions, receiving full information and their method of choice, contraceptive use and continuation is higher (Leisner et al 2017; Koenig et al. 1997; Pariani et al. 1991; Mroz et al. 1999). Measuring the quality of FP services is central to improving service delivery, managing clinical care, efficiency, and health outcomes and can guide the investment of limited resources to ensure quality improvement (Sprockett 2017). Measuring quality of care is structured around Avedis Donabedian's framework of quality of care that includes three interlinked dimensions: structure, process, and outcome (Donabedian 1966, 1988).

- Structure is the context in which healthcare is delivered including facility infrastructure, equipment, staffing, management systems, etc. This data is usually captured from routine health-facility records and surveys.
- Process is framed as the interactions between healthcare providers and clients and includes technical clinical competency of providers and the patient's experience. This tends to be captured through the assessment of provision of clinical care using clinical vignettes, medical records, simulations, and direct clinical observations.
- Outcome is understood to be the effects of care delivery on the patient or population. This can be in terms of patient satisfaction, return visits, and health status.

For more than 25 years, the FP field has been measuring quality of care using the Bruce Framework for Quality of Care (Bruce 1990). Drawing from the Donabedian framework, Bruce identified six elements of FP quality: choice of contraceptive method, information given to clients, provider technical

competence, interpersonal relations, mechanisms to encourage continuity among clients, and availability of the appropriate constellation of services. Although structure and outcomes are acknowledged, these six elements largely focus on process dimensions of quality (e.g. provider-client relations, knowledge, and delivery of care). Several assessment tools have been developed such as the Service Provision Assessment (SPA), Service Availability and Readiness Assessment (SARA), and Quick Investigation of Quality (QIQ) to operationalize the Bruce Framework. Recently, rights-based principles incorporated the availability, accessibility, acceptability, and quality framework to broaden the understanding of quality in FP programs (Jain 2017).

A recent review of quality of care assessment tools for FP in LMICs found there are still no widely accepted tools to assess the quality of clinic-based FP (Sprockett 2017). Existing tools, moreover, do not measure all the dimensions of quality of care, rather they focus on structure over the process dimensions and none assess clinical or health outcomes. Within the structural dimensions there is a tendency to focus on equipment, supplies, medicines and physical facilities and patient experience was the most common aspect of process quality captured (Sprockett 2017). Of the 20 existing tools to assess clinic-based FP service delivery, none were easy-to-use, standardized, or comparable.

PBF operational manuals were found to address availability (n = 193), quality (including privacy and confidentiality) (n = 128), and informed choice (n = 51). Voluntarism was not explicitly referenced in operational manuals. The majority of questions in the quality checklists measured more tangible material items that can be physically counted and assessed (records, display materials, and stocks in place). Only one question obtained information from the provider and one set of questions assessed users' perspectives (10 client exit interview questions on informed choice). Fifty-one questions were linked to informed choice, the majority related to the provision of FP information and a few related to sharing information about client rights. Ten questions captured informed choice through client exit interviews, the same questions were asked at different levels from a quality checklist in Tanzania.

Table 2: FP relevant questions in quality checklists

Rights/Rights Principle	Questions currently used to capture (total out of 396 questions)
Voluntarism	N/A
Availability	Availability of specific methods (e.g. IUD, implants, injectables, condoms etc.) (n=103)
	Staff available to provide specific methods (e.g. IUDs, implants, Norplant etc.) (n=32)
	Range of contraceptive commodities available (n=17)
	Staff trained in FP (n=17)
	Equipment available (n=23)
Informed choice	Display of client rights (n=2)
	Availability of wall posters or box to demonstrate FP methods (n=39)
	Conduct exit interview about informed choice of FP methods (n=10)
Quality	Consultation by qualified staff (n=4) (technical competency)
	Justification of recommendation method documented in patient records (technical competency) (n=13)
	Complete FP consultation with justification of method, history, questions and examination complete (technical competency) (n=6)
	Adequacy of method chosen (n=1)

Rights/Rights Principle	Questions currently used to capture (total out of 396 questions)
	Advantages and disadvantages of methods know (technical competency) (n=1)
	FP register available and completed (Offering a range of services and continuity of care) (n=18)
	FP record/cards filled correctly (Sample) (Offering a range of services and continuity of care) (n=21)
	Staff correctly calculates the number of women expected every month for FP method(s) offering a range of services and continuity of care (n=22)
	Staff correctly calculates the number of women expected every month for specific FP method, offering a range of services and continuity of care (n=16)
	Presence of FP flowcharts and job aids, offering a range of services and continuity of care) (n=1)
	Questioning during consultation undertaken (Information exchange in counselling) (n=2)
	Control and monitoring meeting established (Follow-up) (n=1)
	Appointments made for follow-up (Follow-up) (n=3)
	Check if follow-up was undertaken (Follow-up) (n=1)
	Follow-up visits with FP side-effect and discontinuation (follow-up) (n=1)
	Strategy in place for couples seeking permanent methods (referrals) (n=7)
	Privacy ensured in consultation room (e.g. curtains of windows, no transparent glass, no through passage, closed door) (n=24)

4.4 Opportunities to Strengthen What is Measured in Performance-Based Financing Systems

PBF indicators to date capture some key elements of quality, informed choice, and availability in FP services. This trend is not unique to quality checklists in health-focused PBF programs but is a characteristic of assessing quality of FP more broadly. Though measuring and tracking quality is critical to improving service delivery and health outcomes, standardized tools to assess the quality of FP services remain incomplete (Sprockett 2017). Most existing measures currently assess the structural aspects of quality – measurable attributes that can be assessed without seeking patient informed consent, can be directly linked to supply chain management and input-based procurement systems, and do not involve costly community-based follow-up beyond the facility. This focus does not directly measure performance (Sprockett 2017). Quality measures in PBF ought to consider the clinical processes and patients’ own assessments of services as well their health outcomes (Akachi and Kruk, 2017). By directly understanding patients’ experiences we can better learn how to operationalize quality in the context of patient care and FP services (Akachi and Kruk, 2017). There are several promising efforts underway to measure patients’ experience of quality of care for FP services that could potentially improve existing quality measurements (Holt et al. 2017; Sudhinaraset et al. 2017).

In both the quality and quantity assessments of FP in PBF programs there is a strong focus on FP methods – whether the number of users or methods available. This could reflect a desire to increase the number of options available for users to choose, particularly those that are historically less available (e.g. LARCs). It may also reflect a focus on the uptake of specific methods. PBF measures, therefore,

need to move beyond service provision and method uptake to include both the client's self-perceived experience and client interactions with providers.

The majority of quantity and quality indicators found in this review are commonly used in FP (see Measure Evaluation 2017). Recent reviews of commonly used FP indicators that assessed their sensitivity to rights found limited explicit reference to rights-based principles and many dimensions of rights were absent (Wright & Hardee, 2015; Gruskin et al 2017). Given the complex nature of rights, no one indicator could capture the multi-dimensionality of rights-based principles. Several indicators for specific dimensions of rights are well developed, and with slight adaptation could be considered for use in PBF programs. Yet some dimensions of rights, namely non-discrimination, voluntarism, and agency, are less commonly found in FP indicators, perhaps due to the difficulty in measurement and verification.

In addition to the quantity and quality indicators for FP services in PBF programs, program-wide RBF indicators may strengthen the implementation of a rights-based approach to FP services. For instance, several PBF program documents detail how equity is incentivized with 'equity bonuses' (e.g. Afghanistan, Mozambique, Burkina Faso, Cameroon) or incentivize reaching specific underserved populations— such as indigenous or indigent populations. There are also measures and incentives for service provision in remote health centers (e.g. Zambia). In addition to the service performance indicators, there are a set of administrative indicators, usually at local health offices and above, related to the performance of program activities (e.g. regular reporting, budgeting, planning etc.) as part of the program's own internal accountability systems. In Cameroon, the percentage of facilities with a health committee meeting three times in a quarter is also incentivized as a way to measure participation and accountability. These wider RBF program indicators have elements that likely support the effective delivery of FP services.

5. PAYMENT DESIGN

Determining the portion of payment that will be conditional on performance and the fees associated with attainment is a critical design decision that directly impacts rights-based principles such as voluntarism, informed choice, quality, and accountability. Effective payment design involves understanding the universe of other ways the rewarded recipient gets paid and considering how payment for FP results will interact with and impact recipient behavior. This implies that attention be given to payment systems for non-FP services, in addition to direct payment systems for FP performance. This is especially important when payment is given to providers that deliver a range of non-FP services in addition to FP services.

5.1 The Importance of Results-Based Payment Systems

Whether RBF is between an external donor and a national government, to subnational levels of government, health facilities, NGOs or supply system entities, the terms and conditions of payment are a critical part of any RBF system. Because RBF systems are rarely designed to compensate for the entire cost of delivering a service or achieving a result, payment levels are **not** determined by the costs of delivering services. RBF payments function more as *signals* to recipients (e.g. national, subnational, health facilities, NGOs, supply chain actors) about what is important and what they will be held accountable for achieving, than as a means of reimbursing service delivery costs. Because of this strong signaling function, the terms of payment can promote voluntarism, informed choice, quality, and accountability if thoughtfully designed to achieve these goals. If, however, careful attention is not paid to the potential for unintended consequences, the payment system may impede attainment of FP goals. Also note that as countries begin to introduce strategic purchasing through social insurance, insurance payments rarely cover the entire cost of delivering services, public providers continue to earn salaries, and other inputs continue to be funded.

5.2 Results-Based Payment Mechanism Options

Once a decision is made to move from a complete input-based financing model to a model that overlays payment for outputs or outcomes on top of the otherwise funded inputs, the specific payment mechanism needs to be determined. There are a number of options, each with benefits and challenges that need to be considered. What follows is a series of descriptions of payment mechanisms that have been used to reward FP-related indicators and a discussion of the benefits and challenges with each. Note that it is possible to combine mechanisms.

Payment mechanisms can be effective at promoting voluntarism, informed choice, quality, and accountability if designed with a clear-eyed assessment of how the payment recipient's behavior is likely to change in response to the payment rules and complemented with monitoring to identify potential unintended effects (see section on monitoring and verification).

To guard against providers promoting some methods over others, fees should be established that reduce provider bias or method skew.

- I. **Fee-for-service:** A number of PBF initiatives pay health facilities unit fees for a list of services. For example, facilities may earn a fee for each new user of FP they serve. Some PBF systems

specify different fees for different methods. To guard against providers promoting some methods over others, fees should be established so that they reduce provider bias or method skew. For example, the PD-3 requires USAID-funded programs to ensure that payments to providers are “reasonable relative to other medical and contraceptive services provided so that no financial incentive is created for providers to carry out voluntary sterilization procedures compared to provision of other methods of family planning.” This principle can be applied when setting a fee for any FP service or other type of health service in a fee-for-service payment model. Note that this does not mean that fees should be identical. Fees for methods that require more time and effort to deliver or that may result in fewer clinic visits in a given time frame may need to be higher than fees for simpler-to-deliver or routinely administered methods.

Pure fee-for-service models incorporate incentives to stimulate service delivery because individual providers and health facilities earn an additional fee for each additional service provided. However, in PBF systems, fees paid to the facility are layered on top of salaries and are, therefore, a small proportion of earnings. They serve as a signal of what is valued, a means to improve quality, ensure accountability, and a way to strengthen information systems and their use, in addition to providing a financial incentive to deliver services.

2. **Rewards for population coverage:** National and subnational governments, NGOs, and health facilities with teams of health workers can be rewarded for improving the proportion of a target population that has been counseled for FP. Note that rewards should not be for acceptance of FP but for counseling regardless of whether clients choose to adopt a method. Complementary monitoring can determine whether counseling is effective. In these models, there may be payment associated with indicators such as an increase in the percentage of postpartum women who were counseled according to the country’s guidelines or an increase in the percentage of women of a specific age that were effectively counseled. Payment might be a fixed amount for attaining the defined level of coverage or there may be series of payments for different levels of performance. The MesoAmerican Health Initiative uses indicators of population coverage to reward the national governments of Central America (Iriarte et al 2017; Regalia et al 2017; Mokdad et al. 2018). USAID paid NGOs in Haiti based on results using this model (Eichler et al. 2009).
3. **Scores on a quality tool that deflates or inflates other payments:** As discussed in the section on indicators, most of the PBF models include a quality check list that contains structural, process, and some clinical content-of-care indicators. Application of this quality tool results in a score which is then used to alter the amount of unit fees received by a facility. For example, if the score is 79%, the facility earns 79% of the unit fees it would have earned if its score were perfect. In some cases, quality scores have been used to provide additional funding to facilities (Rudasingwa 2017), while in other cases (TRAction 2016) quality scores have been applied to only a fraction of the fees as a way to motive facilities to both improve quality and to deliver a higher quantity of services.
4. **Hybrid models:** Many countries adopt models that are a hybrid. For example, Tanzania is combining direct facility financing with fees-for-services that are then modified by performance on a quality score. Indonesia’s national social insurance program pays primary care facilities by per capita payments to deliver a defined package of services that includes FP, plus fees for specified

Payment mechanisms can be combined into hybrid models that balance the advantages and disadvantages of particular payment mechanisms.

services – such as deliveries, plus performance payments based on contact rates and effective management of chronic conditions. In these cases, health workers continue to receive their salaries and inputs, such as commodities, are procured using input-based budgets.

Hybrid models can combine payment systems so that the disadvantages of one payment system can be offset with the advantages of another. One example is the practice of paying a per capita payment to facilities to provide a package of services that include FP to enrolled beneficiaries. The per capita or “capitation” payments are made at regular intervals regardless of whether the services in the covered package are delivered, which gives the provider the financial incentive to underprovide. If capitation payments are complemented with fees for specified services and/or rewards for achieving population coverage, the incentive to underprovide can be counteracted.

6. MONITORING AND VERIFICATION

Monitoring and verification play integral roles in any payment system in which payments are linked to predefined results. These two types of activities have a shared objective to ensure the RBF system works as intended, but they also have distinct purposes. This section discusses why monitoring and verification are important activities and presents key considerations when designing monitoring and verification activities so as to promote voluntarism, informed choice, accountability, and quality.

6.1 What is Monitoring and Why is It Important?

Monitoring is an activity that enables interested stakeholders – such as civil society, the funding agency, the government, or others – to frequently check whether the RBF system is producing *intended* effects and is **not** producing *unacceptable, unintended* outcomes (sometimes referred to as unintended consequences or perverse incentives) and then make refinements to the system as necessary. The activity can also provide a check-in about whether the RBF system is operating as intended.

Although often undervalued, monitoring is an extremely important element of an RBF system. When budgeting and staffing an RBF system, the costs of and staffing for proper monitoring should be included.

To underscore why monitoring the intended and unintended outcomes of the RBF system is important, consider RBF as a reform. A reform aims to improve outcomes over time. By definition, a reform creates behavioral and systemic changes and reactions (i.e. effects) across the health system. The goal of the RBF system is to engineer changes and reactions that deliver improvement without unacceptable, unintended effects. Some effects are predictable, while some may not be anticipated ahead of time. Monitoring helps stakeholders identify and measure such anticipated and unanticipated effects. Stakeholders can also leverage monitoring resources to monitor that implementation and system processes are functioning smoothly.

Monitor how introduction of the RBF system affected voluntarism, informed choice, accountability, and quality

Information gleaned from monitoring allows policy makers and managers to refine design elements and address challenges around adherence to rights-based principles. Such opportunities for system refinements can be built into the system as a formal process. One example of a formal process might be a bi-annual review meeting by a technical working group to propose revisions to FP indicators, FP quality indicators, verification methods, or key operational processes. Another example of a formal process for refinement is peer-to-peer learning meetings, where facilities, districts, or other stakeholders are invited together to share experiences and learn from one another. The information available as a result of the monitoring activity may also be applied for RBF system refinements to improve rights-based principles in less-formal ways, such as holding a meeting with a particular district health team in a district with lackluster performance.

6.2 How Monitoring Links to the Theory of Change

The monitoring process should be informed by a theory of change. The designers of an RBF program theorize how the changes introduced by RBF will affect the health system. This theory of change considers the *theoretical effects* (those expected to occur), as well as any *potential negative effects or risks* (the outcomes not expected to occur but that cannot be ruled out completely). The examples in Table 3 demonstrate how theoretical and potential effects might be both positive and negative. For example, one positive theoretical effect of the RBF system is that health workers conduct FP counseling with more clients. One potential negative effect or risk is that some clients are coerced into a particular method. By inviting a diverse array of stakeholders to help develop the theory of change and identify the potential effects and risks up front, potential issues can be actively avoided or mitigated.

Appropriate monitoring is especially important in the early years when the RBF system theory of change is still being tested

The design of the RBF system and how it is operationalized determines the system's effects and risks. In systems in which facilities earn payments linked to results, many of the effects will be related to actions taken at that level. However, because these systems often involve other actors performing management, oversight and verification, the effects are not exclusively related to health worker behavior. One example of a positive theoretical effect is that local governments and civil society organizations improve the management and oversight of health facilities. One example of a potential negative effect is that verifiers use their position to help facilities report inaccurate information because strong performance might reflect well on the verifiers.

With a well-developed theory of change in mind, decision makers can then make an informed decision about whether to implement an RBF system.

6.3 Conducting Meaningful Monitoring

The changes predicted in the theory of change remain *theoretical* until *actually observed* through monitoring.

Conducting meaningful monitoring involves four steps:

1. Decide what *theoretical* and *potential effects/risks*, and implementation and system processes, to monitor
2. Gather relevant information
3. Use the information to identify, or quantify, those effects or processes
4. Enable decision makers, managers, and implementers to act on the findings

The potential effects to monitor vary with the stakeholders. Table 3 shows illustrative examples of effects to monitor and how one might do so. This table does not include every potential effect to monitor for, or every potential monitoring method. Stakeholders need to develop a list based on the particular context and considering the specific RBF system design.

Table 3: Illustrative examples of theoretical and potential effects of an RBF system

Theoretical/potential effect identified in the theory of change	Illustrative monitoring technique for that effect
More clients receive FP counseling	Review health management information system database and/or survey data
FP method mix increased	Review facility inventory management system data
More clients initiate and continue a FP method	Review FP registers or health management information system database
Clients experience FP method selection as voluntary and informed (or involuntary and uninformed)	Review Method Information Index results or other confidential client feedback mechanism
Non-incentivized services have been de-prioritized by staff (potential unintended effect)	Review health management information system database and/or survey of health staff or clients
Performance-based payments are distributed accurately and timely (or there are delays)	Review financial accounting systems
Health workers' behavior changed (positively or negatively)	Review feedback from staff, facility records or client surveys
Facilities are following guidelines for reinvesting RBF earnings in infrastructure, equipment, outreach, commodities, or supplies at the facility to improve quality (or they don't fully understand guidelines or use funds inappropriately)	Review data from quality assessments of facilities
Verified data are accurate (or data discrepancies are identified)	Compare verified data and with data from an independent source (e.g. counter verification)

Monitoring may require gathering and use of multiple data or information sources. Each additional source of data or information adds to the complexity in the monitoring process. Therefore, it is important to develop a monitoring plan during the RBF design phase and determine the resource needs for its implementation. It may only be necessary to prioritize a few key effects for monitoring, or alternatively, it may be possible to assign monitoring activities to multiple stakeholders. For example, an NGO already operating a FP hotline in the country may agree to collect additional information from callers to help monitor voluntarism and informed choice from RBF and non-RBF regions, while other entities can conduct separate monitoring activities. If monitoring responsibilities fall to multiple entities, it is helpful to have clear expectations about how often and with whom findings will be shared. The more robust the monitoring activity, the more informative it can be. But there is a trade-off between robustness and sustainability.

Box 3: The role of monitoring in supporting voluntarism and informed choice

Within any output-based FP payment system is the potential that the system produces *too strong* an incentive for a provider to increase uptake of one or more FP methods among his or her clients. If the financial incentive is too strong it could, in theory, dissuade a provider from respecting voluntarism and informed choice.

The two major ways to address this concern are to **design** the system in a way that minimizes this risk and to conduct robust **monitoring** that would quickly identify any adverse effects on voluntarism and informed choice so that action can be taken.

Monitoring for signs of coercive practices and practices that compromise voluntarism is challenging in any setting due to the imperative to respect individuals' privacy. One method may be to set up a hotline or mobile reporting system that enables individuals to voluntarily and anonymously provide tips to a third party in a safe and secure way. Another method may be to request information from people in the community who are likely to hear about cases of coercion, such as teachers or role models (in a way that assures client privacy).

For USAID-supported FP programs, monitoring around the voluntarism and informed choice requirements is expected to be regular and ongoing.

6.4 What Is Verification and Why Is It Important?

Verification is an activity during which interested stakeholders – usually coordinated by the system administrators – check the accuracy of the quantitative data reported by the intended payment recipients. In the PBF Toolkit published by the World Bank in 2014, Fritsche et al. also categorize quality assessments as verification but advise that different actors conduct each (Fritsche et al. 2014). The PBF Toolkit advises that PBF quantity verification be conducted by the purchasing agency (system administrators), whereby the quality assessment is usually delegated to the regulator (such as a district health team). However, potential conflicts of interest should be considered. For example, if district health teams are rewarded for the aggregate performance of the facilities they supervise they would not be unbiased verifiers of facility data.

Verification assures credibility of the RBF system and accuracy of FP indicators

FP indicators reported by payment recipients may be inaccurate due to unintentional mistakes or intentional misleading. Verification provides an opportunity to correct mistakes in the reported data as well as to deter fraud. Similar to monitoring, investments must be made to design, develop, and implement verification. When budgeting and staffing any system that pays for outputs or outcomes, the costs of and staffing for proper verification should be included.

Verification is also critical in an RBF system because it assures that the system is credible. Credibility and trust are pillars of an RBF system. In their technical report on verification in performance-based incentive schemes, Ergo and Paina explain how “the different stakeholders need to trust that the performance that is being reported and rewarded is real. This credibility needs to be safeguarded at all times. If stakeholders start doubting the validity of the performance data, the whole scheme is in danger.” Verification builds trust among payment recipients that their peers are playing by the rules. It also assures the funding agency that funds are being distributed appropriately.

Finally, the verification activity can be an opportunity for providing feedback to RBF payment recipients on quality of FP services provided and readiness to provide quality FP services. As discussed in Section 4, many countries have opted to incorporate FP quality indicators as part of the RBF system. A quality assessment can be conducted during the verification visit and the resulting quality score can be incorporated in the payment formula to motivate the facility to continue to invest in realizing improvements.

There are many ways to design verification in an RBF system. Verification activities vary within or across RBF systems in the following ways:

- *When* to do verification (before or after payments made)
- *How frequently* to do verification (examples: with every payment; routinely but less frequently than every payment; at random times)
- *On whom* to do verification (verify every payment recipient, or verify a random selection of payment recipients)
- *Who* does verification (examples: peers of the payment recipient; health system managers; civil society organization; contracted firms)
- *What* to verify
- *Consequences* when inaccuracies are identified

Box 4: Three key lessons on verification

Ergo and Paina (2012) identified the following lessons in their study of the six PBI schemes:

- Although verification is set up to catch and deter fraud and that fraud does exist, inconsistencies in data – especially in the beginning – tend to be due more to poor data entry and lack of local capacity to fulfill the requirements of the system. Therefore, the first few rounds of verification can be expected to be less about fraud and more about identifying the weaknesses of PBI implementation – such as unclear indicator definitions, wrongly classified cases, incorrect use of data collection tools – and fine-tuning the PBI instruments, as well as ensuring that participants fully understand the new system.
- Verification can be carried out in many different ways, but it was generally agreed that stakeholder engagement in verification is important - whether through mixed verification or through peer review. The role of the community, however, was often debated. Engaging communities in order to ensure the veracity of the data and to strengthen community engagement can come at the price of some independence and rigor.
- The degree of rigor of verification can vary considerably, both across PBI schemes and over time within a given scheme. Pilots usually place significant emphasis on high levels of credibility and rigor. As verification schemes evolve and move to scale, verification designers have to master the art of maintaining a good balance between affordable costs and adequate degrees of independence, integration, and rigor, so as to ensure sufficient levels of credibility without compromising long-term sustainability.

The design of the verification, and its implementation, may vary in different contexts. For example, verification within an RBF system may need to be more robust in contexts where the RBF payments represent a large proportion of health workers' overall pay, or when the RBF system is introduced into a health system that lacks other quality controls on data reporting. Consequences of data inaccuracies found during verification may need to change over time. Certain problems found through verification may evoke stricter consequences than others. For example, *over-reporting* of services may evoke stricter consequences than *under-reporting* services.

How and what to verify depends on the indicator itself. An indicator related to stock of FP commodities at the facility may require verifiers to count the facility's current stock at the time of the visit (including reviewing expiration dates). In countries with reliable logistics management information systems, review of electronic data may suffice. For an indicator of total number of clients that received FP counseling at the facility during the performance period, verification may involve reviewing patient-level entries in the registers to ensure the number of entries matches the reported total. An FP indicator of total number of FP outreach services provided by a community health worker in the performance period may be verified by reviewing the worker's daily notebook. Some countries implementing RBF systems have gone further than reviewing patient registers and include patient tracing to ensure that data in register books are accurate (see section 6.5 below for more discussion on this method).

6.5 Common Challenges and Solutions for Monitoring and Verification

Despite the fact that monitoring and verification have distinct objectives, in many RBF systems they tend to share resources (staff, funding, and attention) because they both deal with data. Because verification must happen on a pre-determined schedule in order to pay RBF recipients, there is a risk that verification might monopolize these shared resources leaving few resources for much needed monitoring. Routine monitoring is important for identifying elements of the system that might impact on voluntarism, informed choice, accountability, and quality because these effects may not be measured through verification.

One way to avoid this situation is to clearly separate the resources. Some people should be devoted to overseeing the operations of verification, while others should be devoted to reviewing data to monitor system processes, effects, and outcomes. It should be made transparent to all stakeholders what will be verified, what will be monitored, who will do each of these activities, and how. Once these activities are defined, financial and human resources should be devoted to carrying them out.

There is a trade-off between robustness of monitoring and verification, and cost. Monitoring for voluntarism and informed choice can potentially be done in a relatively cost-efficient manner using centralized mechanisms such as hotlines or mobile reporting, but even those systems require financial investment to operate them and communication to ensure intended beneficiaries are aware of them. Monitoring the RBF system for adherence to rights-based principles may be costly if the method requires a representative household survey. In some countries with weak facility-based data systems and unreliable reporting accuracy, verification of FP indicators might require more cost-intensive verification activities such as in-person visits, direct review of patient registers or patient tracing. Many RBF systems start as donor-financed with medium-term plans to transition to domestic financing. While administration is a large cost driver, funders should recognize that RBF is working to enhance the effectiveness of the health system in multiple ways and investments in strengthening monitoring and verification systems have benefits for the entire health system.

In many RBF systems, administrators verify data from every health facility before payments are made to health facilities, which is a costly effort. This means that verification teams travel to every participating

facility every payment cycle (often quarterly). The intensity of such verification may be necessary in cases where supportive supervision and data reporting on quality assurance systems are dysfunctional. RBF verification has provided the means for district managers to routinely visit facilities in their district, and the means to assure quality of data reported by facilities. In those cases, RBF verification is not a function simply for the new payment system; it is strengthening a formerly dysfunctional process of the existing health system. In their toolkit, Fritsche et al. (2014) acknowledge that these functions “can be seen as the equivalent of a systemic data-quality audit on all data elements.” In these cases, RBF verification has greater significance than its name implies. It may have spillover effects for the rest of the health system that should be acknowledged when a funder considers its price tag.

However, sustainability of an intensive monitoring and verification system deserves consideration. Inherent in FP rights-based principles is the goal of sustaining long-term availability of counseling, commodities, and services for both new and continuing FP users. An expensive system will be more difficult for national governments to take over and may introduce economic distortions. Monitors and verifiers often receive per diem payments and transportation subsidies to conduct monitoring and verification activities. This influx of funding to keep RBF running can create a dependence on these additional payments by those who receive them, and create vested interests in maintaining intensive processes in the long-term. The government and financing agencies need to consider the downstream effects of these activities so that it does not introduce unacceptable distortions that will be difficult to roll-back later. One way to mitigate these challenges is to develop a medium-term plan for monitoring and verification activities.

One option for reducing verification costs builds on the experience of financial auditing systems that use various strategies that reduce risks of errors and fraud to an acceptable level. For example, auditing organizations use simple algorithms to identify outliers in the reported data. The auditors then audit the organizations that reported the outliers more intensively. Alternatively, the auditors could conduct more intensive audits on a random sample of reporting organizations. These financial auditing designs could be applied to verification in an RBF system. By reducing the numbers of sites verified in each cycle, costs would be reduced.

Monitoring, on the other hand, is necessary in any context because it is important to monitor the ripple effects of a new system and test the theory of change. As the system matures and the intended and unintended outcomes become better understood, the intensity of monitoring can decrease.

In many RBF systems, both verification and monitoring activities involve verifiers or monitors reviewing patient-level data, which poses a risk to protecting patient privacy. Additionally, many systems go a step further to do “client-tracing” – that is, selecting a few clients recorded in facilities’ registers to confirm they received the recorded service. Patient rights advocates have raised concerns about some of these practices and have recommended ways to improve these practices (Rajkotia 2018). An individual’s decision to use FP, or their choice of FP method, is personal health information. Protecting an individual’s privacy should be a consideration when designing monitoring and verification activities.

7. INNOVATIONS AND CONSIDERATIONS FOR THE FUTURE

Governments are increasingly adopting various forms of strategic purchasing to obtain more value for their health funds. FP services that are grounded in respecting the needs of clients must be part of any package of services that are purchased and must be provided in a way that assures voluntarism, informed choice, quality, and accountability. Systems to keep track of delivered services and to submit claims to the payer will be needed and systems of checks and balances to check the veracity of claims and to monitor whether systems are achieving what is intended without negative effects will be required. These systemic changes will be needed for RBF or for any model of strategic purchasing. The challenge is to determine systems that are cost effective to manage and implement and can be eventually funded with domestic resources as countries make progress on the path toward self-reliance.

Because strategic purchasing systems such as RBF interact with and rely on many aspects of health systems, assuring that FP is included in a way that respects and protects voluntarism, informed choice, quality, and accountability needs to be driven by leadership and policy and to be reflected in operational documents and processes. While review of operational documents of PBF programs did not identify voluntarism as a priority, this does not mean that voluntarism is not emphasized through policy and other guidance provided by ministries of health to service providers. When designing and assessing strategic purchasing systems such as RBF for adherence to rights-based principles, people should consider how policies, regulations, clinical guidance, and operational manuals work in concert to assure rights.

There is scope for increasing understanding and appreciation of the importance of voluntarism and informed choice among health financing and system strengthening experts. For example, in a September 2017 meeting that brought FP experts together with PBF experts to consider how to revise PBF systems to support quality FP services, it became clear that the concept of a rights-approach was unfamiliar to PBF experts (PBF and Family Planning Working Group 2018).

There is also an opportunity to strengthen the focus on informed choice in PBF systems as a measure of the quality of FP counseling, in addition to structural and process measures that are typically included in PBF system checklists. FP2020 promotes the use of the Method Information Index (MII), a short questionnaire delivered to FP clients after FP counseling to measure informed choice. The MII is composed of the following three questions that assess the effectiveness of counseling: 1) Were you informed about other methods? 2) Were you informed about side effects? 3) Were you told what to do if you experienced side effects? (Measure Evaluation 2018).

RBF systems generate high-quality service-level data that can be used wisely to bolster the effectiveness of the country's routine supervision and management system and improve the country's adherence to rights-based principles. District-level managers, for example, may review service-provision indicators or quality assessment data from facilities in their district to more efficiently identify facilities that could benefit from additional resources, training or supportive supervision, and pinpoint the specific clinical areas requiring attention.

In addition to rewarding providers for doing what they know, RBF has the potential to reward acquisition of knowledge. Rewarding clinical knowledge has the potential to encourage providers to be up-to-date on new technologies and practice guidelines. The World Bank has been testing the use of clinical vignettes in Cambodia and Democratic Republic of Congo as a measure of provider knowledge of appropriate counseling for different age groups, client examination, and provision of methods. Individual health providers are randomly selected from a facility and asked to complete a vignette (Gyuri Fritsche, conversation with author, April 2018). The score the individual achieves is used to modify the payment the entire facility receives, which provides incentives for health workers to pressure colleagues to know guidelines and to therefore be up to date on knowledge and clinical practices.

Privacy can only be assured in an RBF scheme by carefully designing verification and monitoring activities with patient privacy in mind. The sensitivity of FP, therefore, warrants careful handling of private health information from FP clients. Consulting with or co-designing verification and monitoring with patient organizations is one strategy for assuring that these activities do not conflict with social norms, law or regulations in the country. Allowing voluntary or anonymous client feedback through a hotline, for example, or surveying a wide range people in the community to avoid targeting the specific patients you are seeking, are methods to be considered. Drawing lessons from verification of services to HIV patients that questions all households in a geographic area is another.

FP services can and must be included in strategic purchasing systems in ways that assure voluntarism, informed choice, quality, and accountability. Countries are increasingly utilizing strategic purchasing tools, including RBF, to obtain more value for their health money and failure to include FP may result in its neglect. Thoughtful design that anticipates reactions in health systems and potential impact on voluntary FP, combined with ongoing monitoring to identify potential unintended effects, can steer countries toward systems that achieve multiple health system goals that lead them on the path toward self-reliance.

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