

The Gambia's Community-Based RBF Scheme: Contracting Communities to Boost Demand



AUGUST 2016

TABLE OF CONTENTS

TABLE OF CONTENTS.....	2
INTRODUCTION.....	3
1. STRATEGIC CONTEXT.....	3
1.1 SECTORAL CONTEXT.....	4
1.2 BARRIER IDENTIFICATION	6
2. STRATEGIC DESIGN	7
2.1 MNCHRP: PROJECT COMPONENTS.....	7
2.2 COMMUNITY-BASED RBF: IMPLEMENTATION ARRANGEMENTS.....	8
3. PILOTING THE COMMUNITY-BASED RBF SCHEME.....	10
3.1 CONTRACTING COMMUNITIES	10
3.2 THE PERFORMANCE OF INCENTIVIZED COMMUNITY INDICATORS.....	11
3.3 LESSONS FROM THE PILOT CRBF.....	12
4. SCALING-UP THE CRBF	14
4.1 THE EXPANDED CRBF	14
4.2 REVIEW: LESSONS LEARNED AND RECOMMENDATIONS	15
ANNEX 1: COMPLEMENTARY INTERVENTIONS: CRBF, CONDITIONAL CASH TRANSFERS AND SUPPLY-SIDE PBF	18

INTRODUCTION

The Maternal and Child Nutrition and Health Results Project (MCNHRP) of The Gambia uses RBF to directly address challenges related to maternal and child nutrition and health, including sanitation and hygiene. The MCNHRP uniquely combines a supply-side performance-based financing (PBF) mechanism with a community-based RBF mechanism to foster stronger links between communities and health facilities. Its innovativeness further stems from the specific nature of its demand-side financing approach: the community-based RBF scheme in The Gambia contracts communities to create demand for services and promote the adoption of healthy behaviors – rather than contracting households as is typically done in demand side RBF interventions around the world.

The MCNHRP is jointly implemented by the National Nutrition Agency (NaNA) and the Ministry of Health and Social Welfare (MOHSW), in consultation with a wide range of national and international partners, and with the technical and financial support of the World Bank. It was initially piloted in the North Bank West region from November 2014 to December 2015. Based on lessons learned, it was subsequently extended to cover three regions, namely Central River, North Bank West and Upper River regions. The extended MCNHRP was launched in March 2015 and further expanded to two additional regions (North Bank East and Lower River Regions) in July 2016; September 2016 will mark the project's 19th month of implementation of the full package of interventions.

Figure 1: Map of The Gambia Regions



To understand how the MCNHRP seeks to create an enabling environment for social and behavior change while laying the foundations for sustainable results, this paper examines its unique community-based RBF approach. It considers its rationale, architecture as well as piloting and scaling-up processes, particularly focusing on lessons learned.

1. STRATEGIC CONTEXT

At the heart of the design of the MCNHRP is a data-driven contextual analysis, informed by a wide range of national and external surveys as well as by pre-pilot data gathered using mixed-methods.

1.1 SECTORAL CONTEXT

The Gambia's performance with regard to nutrition and health-related Millennium Development Goals (MDGs) has been modest: undernutrition persists, and under-five and maternal mortality rates remain high (Table 1).

Table 1: Trend in MDG 1c, 4 and 5 in The Gambia

	1990	2000	2010/12	MDG target
Maternal Mortality (per 100,000)	700	520	360	175
Under-5 Mortality (per 1,000)	165	116	73	57
Underweight Malnutrition (percent)	-	15	18	8

Source: Trends in Maternal Mortality 1990-2010, WHO 2012; Child Mortality Report, UNICEF 2013; WHO Global Database and SMART 2012, National Nutrition Agency, 2013

Maternal health indicators have continued to perform poorly. The total fertility rate (TFR) has increased to 5.6 children per woman while the contraceptive prevalence rate (CPR) dropped to 9 percent (Table 2) in the last decade (8 percent for modern methods). At least one antenatal care (ANC) visit by a skilled provider, nearly universal in 2005/06, has dropped to 86 percent (2013) and does not vary by level of education. The recommended four visits were completed by only 72 percent of women in 2010 (MICS 2010). Moreover, deliveries with a skilled provider have stagnated at 57 percent since 2005, and few women complete the three recommended PNC visits (DHS 2013). Furthermore, teenage pregnancies are common, resulting in a high adolescent fertility rate of 118 per 1,000 and 18 percent of adolescent girls age 15-19 having begun childbearing (DHS 2013).

Table 2: Maternal Health Indicators, 2005/06 and 2013

	2005/06	2013	Trend *
Marriage (women) before the age of 18 years	49	45	No change
Skilled attendance at delivery	57	57	No change
Antenatal care (at least one visit)	98	86	Deterioration
Contraceptive prevalence rate (any method)	13	9	Deterioration
Total fertility rate	5.1	5.6	Deterioration

**No change refers to any difference that is less than 5 percent difference of the 2005/06 value*

Source: MICS 2005/06, 2010, DHS 2013 and World Bank Development Indicator database

Despite some improvement in child health indicators, progress remains uneven. Vitamin A supplementation increased considerably between 2000 and 2005 but has since dropped (Table 3). While there is still room for further improvement, use of oral rehydration therapy with continued feeding has improved between 2005 and 2010. Similarly, the exclusive breastfeeding rate has progressed to reach 47 percent. However, the percentage of children sleeping under insecticide-treated nets has stagnated at 47 percent. Importantly, several outcome indicators are deteriorating, most notably, feeding frequency, vitamin A supplementation, and antimalarial treatment of children under five with fever.

Table 3: Child Health and Nutrition Indicators, 2005/06 and 2013

	2005/06	2013	Trend *
Child Health and Nutrition			
Neonatal tetanus protection	76	71	Deterioration
Exclusive breastfeeding under six months	41	47	Improvement
Minimum feeding frequency	39	58	Deterioration
Vitamin A supplementation in children 6-59 months	80	69	Deterioration
Measles immunization by age 12 months	85	88	No change
Oral rehydration treatment	48	79	Improvement
Children under age 5 sleeping under insecticide-treated bed nets	49	47	No change
Antimalarial treatment of children under 5	52	7	Deterioration
Care seeking for suspected pneumonia	69	68	No change

* No change refers to any difference that is less than 5 percent difference of the 2005/06 value

Source: MICS 2005/06, 2010, DHS 2013 and World Bank Development Indicator database

Increasing undernutrition remains an important challenge (Table 4): moderate to severe stunting, wasting and underweight affects 25 percent, 12 percent and 16 percent of children under five, respectively. This lagging performance on nutrition indicators is compounded by insufficient rain falls, limiting reliable access to sufficient quantities of affordable and nutritious food among agriculture dependent households – representing two-thirds of the population.

Nutrition and health indicators vary strongly between the rural eastern regions and urbanized western regions of The Gambia. Table 4 shows a few selected health and nutrition indicators by Region and Local Government Area (LGA) of The Gambia.

Table 4: Health and nutrition outcomes by Local Government Area

	Under-5 mortality	Infant mortality	Stunting	Institutional delivery
Upper River Region				
Basse LGA	142	98	32	31
Central River Region				
Janjanbureh LGA	115	85	35	35
Kuntaur LGA	119	86	29	33
North Bank Region				
Kerewan LGA	101	77	25	44
Lower River Region				
Mansa Konko LGA	98	74	27	55
West Coast Region				
Brikama LGA	99	74	18	68
Banjul Region				
Kanifing LGA	102	76	23	85
Banjul LGA	62	51	12	89

Source: MICS 2010, DHS 2013

1.2 BARRIER IDENTIFICATION

Moreover, quantitative and qualitative assessments conducted at the household and facility levels in preparation of this project indicate a number of concurrent demand-side and supply-side barriers to better health and nutrition outcomes¹. The majority of demand-side constraints occur at the household or community level (except for attitude of providers toward patients); they include cultural obstacles; cost; inconvenience; as well as inadequate understanding of the risks and benefits associated with the adoption of a particular behavior. On the supply-side, the reasons for poor outcomes stem from the health system experiencing insufficient financing; inconsistent infrastructure, equipment and supplies; and inadequate training and motivation of health providers. Table 5 summarizes the demand- and supply-side barriers identified by the assessments for some key indicators.

Table 5: Barriers to utilization and/or adoption of key health services and behaviors

Source: World Bank, Project Appraisal Document, 2014

Level	Demand-Side	Supply-Side
Skilled attendance at delivery (57%)		
<i>Household/ Community</i>	Cultural norms regarding childbirth	Inadequate supplies for community agents to provide services (e.g. weighing scales, sanitary materials, record books)
	Perceptions of danger/severity/need to seek care	
	Availability of or cost of transportation	
<i>Health System</i>	Attitudes of providers toward patients	Lack of consistent supply of electricity, equipment, medical drugs and commodities, fuel; Inadequately trained and poorly motivated medical personnel Inequitable distribution of trained personnel Low allocation of financial resources at PHC level
ANC, especially in 1st Trimester		
<i>Household/ Community</i>	Cultural beliefs on the importance of hiding pregnancy during the early stages	
Contraceptive Prevalence Rate (9%)		
<i>Household/ Community</i>	High desired fertility, especially of men	
	Discomfort with family planning	
	Modern family planning methods difficult to use	

¹ A Rapid Assessment of the Gambia PHC and Community Health & Nutrition Structures: a Mixed-methods approach, 2014; A Rapid Assessment of Household Health Expenditures and Health Seeking Behaviors, 2014

Health
System

Unavailability of method mix
Lack of youth-friendly services

Exclusive Breastfeeding Under 6 Months (47%)

*Household/
Community* Unawareness of the adequacy of breast
milk to keep the child hydrated

Common perception of insufficient milk
when a child cries or when a mother feels
weak, tired or hungry

Perception of spoiled milk, e.g., when
mother becomes angry or ill

Inadequate community support for the
practice of exclusive breastfeeding

Health
System

Counselling on exclusive breastfeeding not
universally provided at health centers

Vitamin A supplementation in children 6-59 months (73%)

*Household/
Community* Preference for home-based treatment with
traditional healers

The specific nature of these barriers – coupled with the poor performance of the health service delivery system with regards to maternal and child nutrition and health outcomes – points to:

- i. An operationally weakened and under-funded Primary Health Care (PHC) system;
- ii. Inadequate linkages between communities and the health sector.

2. STRATEGIC DESIGN

In light of the above mentioned conclusions, the Government of The Gambia identified Results-Based Financing (RBF) with a focus on preventive and primary health care and nutrition as a key strategic step to improve maternal and child nutrition and health outcomes.

2.1 MNCHRP: PROJECT COMPONENTS

These conclusions also informed the design of a systemic and integrated intervention simultaneously targeting individual, community, facility, regional and national levels. This intervention includes three complementary schemes:

- The supply-side PBF scheme intervenes primarily at the facility level to enhance both the quantity and the quality of services provided: it uses performance incentives to improve coverage as well as to boost the capacities and motivation of healthcare personnel. This scheme also provides financial and material start-up support for effective service delivery, including the implementation of selected health care waste management measures.
- The community-based RBF (cRBF) scheme operates at community level to create demand, boost service utilization and promote the adoption of positive health and nutrition behaviors. It provides results-based payments to both mobilize and empowers communities to partake in improving

nutrition and health outcomes. Communities are contracted to impart health information, support behavioral change (for nutrition, health, hygiene and sanitation) and refer all pregnancies to the nearest health facility.

- The conditional cash transfers scheme provides incentives to individual pregnant women for timely and complete antenatal care (ANC) visits with a skilled provider, starting with the first trimester of pregnancy. These incentives seek to induce adherence to recommended health practices among pregnant women.

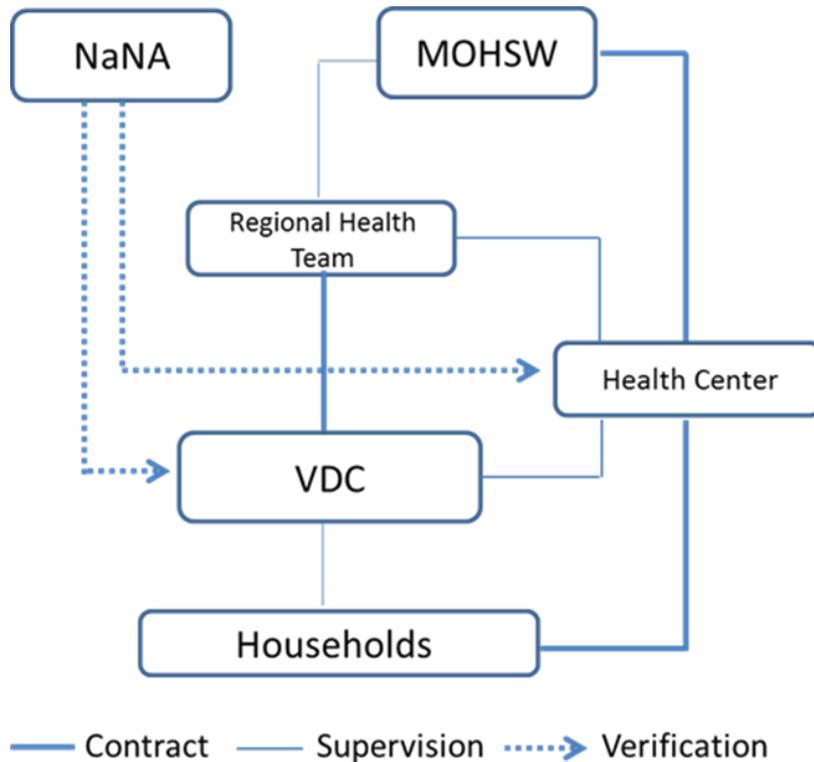
These schemes are supplemented by social and behavior change communication and by continuous capacity building activities focusing on the provision of technical advisory services, training, and goods to key implementing entities, service providers, and community structures.

The MCNHRP is also designed to enable learning and capture the effect, efficiency and implementation challenges of its three-tier intervention with respect to health and nutrition outcomes, ownership, cost-effectiveness, and other aspects of community mobilization and health system strengthening.

2.2 COMMUNITY-BASED RBF: IMPLEMENTATION ARRANGEMENTS

The architecture of the MCNHRP was designed to ensure contextual relevance as well as compliance with both national policies and core RBF principles. The following section will describe the implementation arrangements specific to the cRBF scheme.

Figure 2: MNCHRP Implementation Arrangements



Source: World Bank, Project Appraisal Document, 2014

Delivery Mechanism

The cRBF scheme directly contracts communities for the achievement of community level results. This contracting is formally carried out through Village Development Committees (VDCs) – already possessing bank accounts as existing community level government structures²– and voluntary Village Support Groups (VSGs)³, composed of community members including the Community Birth Companion formerly the Traditional Birth Attendant.

RBF payments are disbursed quarterly and transferred to community bank accounts upon verification of reported results. Once these payments are verified and disbursed, they are shared between VDCs and VSGs: 80 percent is used by VDCs to invest in village development activities based on a commonly agreed quarterly village business plan; and 20 percent is used to provide VSGs with performance-based incentives.

RBF Purchasing Function

To capitalize on this potential, the RBF Committee – created within the MOHSW to act as the RBF purchaser – contracts the VDC to coordinate and oversee the achievement of predefined performance thresholds as agreed upon in the quarterly community business plan.

In turn, the VDC subcontracts VSG members to (i) promote personal and environmental hygiene, skilled deliveries in a health facility, timely and complete antenatal care, postnatal care and family planning; (ii) provide counselling and referral services at the household and community levels; and (iii) promote recommended infant and young child feeding practices, thereby participating in the scale-up of the Baby-Friendly Community Initiative (BFCl).

RBF Regulation Function

The implementation of activities is regulated by the MOHSW, which ensures compliance with RBF principles as well as alignment with national health promotion norms and guidelines. This regulation function is realized through:

- RBF sensitization organized by the Regional Health Directorate (RHD) – composed of regional and local MOHSW and NaNA officers – to foster a better understanding of results oriented activities and requirements, including reporting and incentive payments.
- Social and Behavior Change Communication (SBCC) trainings, organized by the RHT to ensure effective and efficient health promotion activities aligned with national policies and norms.
- Monthly health-related community visits, carried out by the RHD to supervise and coach VDCs and VSGs. Using a community monitoring check-list to score overall community management and implementation performance, the RHD also coaches VDCs and VSGs, advising and guiding them throughout the project’s lifecycle. This coaching is supplemented by the Community Health Nurse (CHN) who works closely with communities, providing timely problem resolution and “on the job” guidance, including in the context of report preparation and submission.
- Monthly nutrition and food security-related coaching dispensed, respectively by NaNA and the Regional Agriculture Directorate to support and oversee the coherent and effective implementation of BFCl and food security measures.

²VDCs are the lowest level of governance in The Gambia, concentrating on village level development activities.

³ VSGs were originally established to roll out the Baby-Friendly Community Initiative (BFCl) and promote breastfeeding

These concurrent mechanisms enable tracking progress and ensuring timely problem resolution.

RBF Fund Holding Function

At the heart of direct community contracting is the provision of RBF incentives to support engagement, increase the feasibility of information dissemination and realize change. These incentives are disbursed by NaNA which leads the fund holding function and ensures financial accountability and transparency in the context of the MCNHRP.

RBF payments are transferred quarterly to community bank accounts (i.e. VDC) upon verification of reported results. These disbursements are shared between VDCs and VSGs: 80 percent is used by VDCs to cover operating costs, support community mobilization and invest in community development projects, and 20 percent is used to provide VSGs with performance-based incentives.

RBF Verification Function

NaNA leads the verification of results as well as the ensuing disbursement and management of RBF payments. Specifically, the verification of quantity is carried out through monthly surveys, using lot quality assurance sampling (LQAS) survey – a random sampling methodology – which is then compared to target proportions set in the contract. The LQAS is implemented by Community Based Organizations (CBOs) contracted by NaNA. Verification also builds on community registers and reports which detail the number of outreach activities carried out and the number of “at risk” patients referred to the nearest health facility. Once results are verified, quarterly RBF payments are disbursed and transferred by NaNA into VDC bank accounts.

Counter-Verification Function

Furthermore, an external verification agent (EVA) is contracted to perform biannual random technical and quality spot checks to ensure the validity and accuracy of verifications. This counter-verification is carried out on a sample of beneficiaries. This sample includes individuals having used PBF services at the health facility level; respondents previously surveyed by CBOs, and women having accessed ANC services through the ANC CCT. The EVA also conducts this review for the cRBF scheme.

3. PILOTING THE COMMUNITY-BASED RBF SCHEME

The pilot MCNHRP was implemented from November 2013 to December 2014, to assess and maximize the viability and functionality of the project’s design and architecture. It was implemented in ten communities located within one of the catchment areas of one of the facilities incentivized by the PBF scheme in the North Bank West Region of The Gambia.

3.1 CONTRACTING COMMUNITIES⁴

Using the implementation arrangements highlighted above, the pilot cRBF directly contracted communities, which were randomly selected among communities classified as Primary Health Care and Baby-Friendly Community Initiative communities. These communities received quarterly RBF payments based on their performance on predefined indicators (Table 6).

⁴Jos Dusseljee, 2016, Review of the Application and Pricing of the Performance Based Components in the MCNHRP.

Table 6: Project indicators and verification mechanisms

Indicators	Indicator definition	Action being paid for	Verified how and by whom	Sources: records/data available
Children (0-6 months) being breastfed exclusively	Breastfeeding children age 0 - 6 months who were not fed with any food or drink other than breast milk over the last 24 hours	Reaching a minimum predefined level (proportion)	During the day prior to the verification (LQAS)	LQAS Survey
At risk pregnant women and those with complications identified and referred	Any pregnant woman who has a risk condition and/or develops a complication and referred by the VSG to the nearest health facility	Number of women identified with a risk condition or complication and referred by VSG members	NaNA verifies	VSG referral register and returns

Source: World Bank, Project Appraisal Document, 2014

To achieve these objectives and as part of the RBF contracting cycle, quarterly performance targets were laid out in a quarterly business plan developed collectively with the support of the RHD. Based on locally identified needs and priorities, these business plans both guided the implementation of activities and the use of RBF payments.

These commonly agreed upon quarterly village business plans also served as a basis to score performance and determine the level of payment received by communities, with:

- Exclusive breastfeeding scores inferior to 50 percent resulting in no payment
- Exclusive breastfeeding scores over 50 percent receiving a full payment based on a fixed percentage
- Each woman with complications referred leading to a RBF payment

Once RBF payments were disbursed in the VDC bank account, they were shared between VSGs (30%) and VDCs (70%), with VDCs typically using their payments for operating costs, community mobilization and community health and development activities; and VSGs dividing incentives among members. Guided by their quarterly business plans, communities typically invested in community-specific solutions to service utilization impediments. For instance, communities purchased motorbike ambulances to help pregnant women reach health facilities and deliver with a skilled provider; another community bought a milling machine to sustainably generate income and further invest in development ventures, including the creation of communal gardens.

3.2 THE PERFORMANCE OF INCENTIVIZED COMMUNITY INDICATORS

Piloted for 12 months, the cRBF was assessed through a Process Evaluation to maximize the viability and functionality of the project’s design and architecture. Qualitative data resulting from this evaluation indicated that the project was yielding positive outcomes with regard to incentivized indicators.

Some communities have mobilized to use RBF payments to help women – for example, one community has been saving multiple rounds of RBF payments to purchase a donkey cart to transport women to health facilities for delivery.

Exclusive breastfeeding

Qualitative data highlighted that most communities met exclusive breastfeeding targets. They further suggest that the health benefits of exclusive breastfeeding were understood and accepted: “now, we are

practicing exclusive breastfeeding and this is giving our children good health – no more frequent incidence of diarrhea, vomiting and high body temperature”⁵.

In addition, data show that there is a potential to improve behavior in this regard, with women increasingly implementing imparted knowledge: *“the other day I was testing one woman whose baby was sick. I told her why don’t you dissolve the baby’s medicine in water and give it to her to drink. The woman quickly said ‘Oh no, not water, I cannot do that may be I will use my breast milk to dissolve the medicine but definitely not water.”⁶*

Nevertheless, qualitative data also stressed the need to mitigate the unintended effects of incentives, particularly for lactating women: *“I think there is high uptake of exclusive breastfeeding because this is what the communities are paid against, and there is competition. If you go to the “Fanafana” (a local Wolof dialect) communities, like Kerr Gumbo the subsidies are higher compared to others because the more children you have under exclusive breastfeeding the more money you get, there is that high uptake. In Kerr Gumbo, they lost a baby, the entire village was mad because it means their number of children is reducing.”⁷*

- The Process Evaluation thus recommended ensuring close monitoring to reduce unintended impacts of incentivized indicators as the project is scaled-up.

Referral of women with complications during pregnancy or delivery

Qualitative data highlighted that VSGs routinely reported referring women to attend early ANC, delivery and post-natal care at the health facility, and referring women who display any signs of complications during or after pregnancy. Data however also suggested that the definition of “complications” was not well understood among some VSGs, and that this might have led to referral and reporting disparities.

- The Process Evaluation thus recommended planning for additional training on what constitutes pregnancy-related complications to increase the efficiency of referrals and the accuracy of reporting.

These promising results point to an opportunity to: (i) expand the approach beyond the current expansion to CRR and URR to include other priority Regions including NBR East and LRR; and (ii) build on the experience of working with Village Support Groups (VSG) and Village Development Committees (VDC) to broaden the scope of community action for improved health and nutrition outcomes by including household food security concerns.

3.3 LESSONS FROM THE PILOT CRBF

The piloting phase of the cRBF in The Gambia enabled to maximize design and improve its potential for better maternal and child nutrition and health results. Providing lessons learned and recommendations, it helped identified factors affecting performance and areas requiring further refinement. These factors and areas are summarized below, based on the conclusions of the 2015 Process Evaluation, and the findings of semi-structured interviews conducted in December 2015.

Capacity Building

The performance of incentivized indicators is dependent on the capacity of community structures to effectively and efficiently implement project activities. Provided at the project’s onset, training has

⁵ Mother who delivered in the past 6 months, MCNHRP Pilot Process Evaluation, 2015

⁶Traditional Birth Attendant, MCNHRP Pilot Process Evaluation, 2015

⁷Regional Health Team Member, MCNHRP Pilot Process Evaluation, 2015

reportedly been instrumental in motivating as well as in capacitating VDCs and VSGs to foster sustainable behavioral change. By strengthening these community structures, training has also galvanized collaboration and development: [the project] “has built trust and confidence between the community and the VSG”⁸, thereby further contributing to the creation of an enabling environment for social and behavioral change.

Additional training was however requested by VSGs and VDCs to better impart nutrition and health knowledge. When asked what needed to be improved, one VSG member stated: “*more training to help us do our work effectively*”. Conversely, during semi-structured interviews carried out in December 2015, stakeholders reiterated the need for training to better reduce misconceptions pertaining to the frequency of ANC visits and enhance people’s understanding of pregnancies and deliveries, including risks associated to them.

- Demand for additional knowledge across a variety of areas is addressed in the design of the MCNHRP: the national strategy for Social and Behavior Change Communication (SBCC) has been developed by the MOHSW and NaNA; manuals and tools have been prepared; and trainings have been both planned and implemented.

Further, a variety of stakeholders indicated the need to simplify RBF reporting standards to mitigate potential issues of literacy among VDCs and VSGs. As a result, the scale-up MCNHRP endeavored to:

- Create a simplified and generic reporting template.
- Increase reporting supervision by incentivizing community health nurses for the accuracy and timeliness of community reports.

To clarify RBF concepts and indicators, the MCNHRP also included additional training to ensure that community selection, indicator pricing, RBF payment and disbursement mechanisms are well understood at all levels.

Community Norms

As local cultural contexts play a key role in the cRBF – particularly with regard to SBCC, additional attention as given to the specific nature and the underlying societal dynamics that shape community norms to both better reinforce positive norms and address negative norms. The national SBCC strategy and accompanying tools were developed with that in mind.

Gender

With prevailing gender norms placing women as primary caregivers and men as primary family decision-makers, male access and adherence to new knowledge is perceived to be crucial: it directly determines the likelihood of information being translated into action. As underlined by a woman who delivered in the past 6 months: “*if a woman wants to have a certain number of children she has to discuss it with her husband and if he doesn’t agree, then leave it. Some may decide not to have children even though but for me I will not stop delivering if I don’t have the consent of my husband.*”⁹

Male involvement was particularly deemed important in the context of family planning, where misconceptions appear to remain strong: “*with family planning, the issue of misconception is there, some are with the belief that family planning is for sterilization, once you use family planning you will never bear children again*”¹⁰. These misconceptions often result in women either not embracing healthy

⁸VSG Member, MCNHRP Pilot Process Evaluation, 2015

⁹ MCNHRP Pilot Process Evaluation, 2015

¹⁰ VDC/VSG member, MCNHRP Pilot Process Evaluation, 2015

behaviors or hiding contraceptive use at the risk of marital conflict and/or family stigma. On the other hand, although men have been traditionally excluded from reproductive and maternal health matters, they often expressed the desire to benefit from the MCNHRP, specifically wanting to enhance their capacity to make informed decisions and better care for their families: *“we are not against family planning. We simply want to understand.”*¹¹

To further involve men and increase the project’s impact, stakeholders at community, regional and national levels recommended targeting men in a tailored fashion. They also recommended targeting spouses to ensure common understanding and open dialogue. Specifically, such targeting could be realized through:

- The identification, mobilization and training of male champions of change. In this regard, religious leaders were particularly identified as important role models capable of helping overcome perceived cultural and religious impediments to family planning uptake.
- The inclusion of more men in VSGs to enhance male receptivity to new concepts, behaviors and practices. Male-provided counselling is also thought to be instrumental in further reinforcing SBCC messages at household level. Such counselling could be supplemented by the creation of male peer counselling groups.
- The inclusion of household counseling for all spouses, provided by both a male and a female VSG member.

4. SCALING-UP THE CRBF

In March 2015, the MCNHRP was extended to three additional regions (i.e. Upper River, the Central River and the North Bank West Regions). It was further expanded to two additional regions (i.e. North Bank East and Lower River Regions) in July 2016. In September 2016, the project will mark its 19th month of implementation with its full package of interventions.

4.1 THE EXPANDED CRBF

In-keeping with these lessons, the scaled-up cRBF scheme extended its incentivization to further address demand-side barriers – including cultural and traditional norms – to better maternal and child nutrition and health results. Indicators include food and nutrition security as well as water and hygiene-related indicators (Table 8).

Table 8: Main Project indicators

Incentivized Indicators
Proportion of children aged 6-23 months who consumed foods from at least 4 recommended food groups during the previous day
Proportion of mothers with children aged 6-23 months who can cite at least 3 good complementary feeding practices
Proportion of women aged 15-49 who can cite at least three danger signs related to pregnancy
Proportion of women aged 15-49 who can cite at least four advantages of exclusive breastfeeding
Proportion of women aged 15-49 who consumed foods from at least 4 of the recommended food groups during the previous day

¹¹Interview Respondent, Kaur, Central River Region, December 2015

- Proportion of women aged 15-49 with improved sanitation (i.e. availability of a toilet)
- Proportion of women aged 15-49 with a designated hand washing station where water and soap are present
- Community having at least one properly managed dump site
- Number of pregnant women, postpartum mothers and neonates with complications who were referred, evacuated or escorted by the VSG to the nearest health facility
- Number of pregnant women referred to a health facility for delivery

Source: MOHSW and NaNA, Maternal and Child Nutrition and Health Results Project Operations Manual, June 2015

The implementation arrangements inherent to the extended cRBF remain similar to that of the pilot cRBF (Table 7).

Table 7: RBF functions and responsible entities

Function/Role	Responsible Entity
Purchaser and Regulator	MOHSW (RBF Committee), RHT
Contracted entity	Health centers, communities (VDCs and VSGs), pregnant women
Fund holder, Payer, Quantity Verifier	NaNA, CBOs for cRBF (through LQAS)
Quality Verifier	RHTs, CBOs
External Verifier	IVA, CBOs

Source: MOHSW and NaNA, Maternal and Child Nutrition and Health Results Project Operations Manual, June 2015

4.2 REVIEW: LESSONS LEARNED AND RECOMMENDATIONS

To capture the effect, efficiency and implementation challenges of the cRBF with respect to health and nutrition outcomes, an annual review was conducted after one year of scaled-up implementation. This review draws on quantitative data gathered during routine performance monitoring and retrieved from the project’s database. It is also informed by qualitative data – specifically secondary documentation such as the 2014 Process Evaluation; the 2016 MCNHRP Indicator Pricing Report; and World Bank Mission Aide Memoires. The recommendations of the Annual Project Review are summarized below.

RBF Knowledge and Learning

- Ensure continuous documentation of the cRBF to enhance knowledge and learning on cRBF approaches.

Target Setting

The overall performance of community structures indicates that communities took serious steps to improve community knowledge and action linked to incentivized indicators. One important

observation¹², however, was that community performance targets were set relatively low, causing performance scores to reach an average of 155 percent. Communities appear to be insufficiently challenged, despite their commitment and high levels of motivation. For instance, in the village of Sambang in Central River Region, the VDC and the VSG stated that they would welcome additional and more ambitious targets. They specifically indicated that they would be willing to work at improving family planning uptake to improve maternal and child health.

Recommendations

- Review performance contracts and payment mechanisms to ensure focus on project priorities and on enhancing intended benefits.
- Review incentivized community indicators and performance targets to improve community performance and motivation, and accelerate the attainment of results.
- Ensure the uniformity of the methodology used to set community targets to facilitate a comparative analysis between performing and non-performing communities.

Verification

The survey-based nature of the verification mechanism used in The Gambia and the frequency of its implementation (i.e. monthly) have constituted a challenge: together they heighten data collection cost and complexity as well as increase the risk of over-reporting as data is self-reported and typically linked to behaviors and knowledge.

Recommendations

- Review the LQAS questionnaire to reflect respondents' knowledge on SBCC components, ensuring that respondents' progression is captured.
- Review CBO contracts and establish standards for the selection of interviewers.
- Strengthen the feedback mechanism inherent to the LQAS for continuous improvement.

Capacity Building

Recommendations

- The second round of trainings should be more targeted and practical, less theoretical, and geared to address the existing deficiency gaps.
- Prioritization of the trainings needs to be done, and avenues of trainings or mentoring and coaching explored. Priorities include:
 - Organizing refresher trainings for cashiers of Village Development Committees to improve the quality of financial reporting.
 - Providing additional technical support and training to Community Birth Companions to help them enhance their capacity to conduct health promotion activities.
 - Strengthen and further support nutrition counselling during pregnancy, delivery and in postpartum.
- Review monitoring and provide training for appropriate use.
- The RHDs (including Regional Accountants) should ensure adequate supportive supervision and coaching to all communities on periodic basis, with quality.

¹²Jos Dusseljee, 2016, Review of the Application and Pricing of the Performance Based Components in the MCNHRP.

Social and Behavior and Change Communication

To ensure effective and efficient health promotion activities aligned with national policies and norms as well as strengthen and further support nutrition counselling during pregnancy, delivery and in postpartum.

Recommendations

- Strengthen SBCC efforts on all MCNH indicators, both incentivized and non-incentivized.
- Develop and implement a community mobilization strategy for increased impact.
- Develop a regional SBCC action plan based on the national SBCC strategy.
- Develop and implement a SBCC roll-out plan.
- Conduct aggressive awareness campaign focusing on maternal child nutrition and health services.

ANNEX 1

COMPLEMENTARY INTERVENTIONS: CRBF, CONDITIONAL CASH TRANSFERS AND SUPPLY-SIDE PBF

With the technical and financial support of the World Bank and in consultation with national and international stakeholders, the Government of The Gambia designed an innovative RBF approach to complement improvements in service utilization with improvements in service delivery: the community-based RBF scheme is thus combined with a supply-side performance-based financing (PBF) scheme and a conditional cash transfer scheme endeavoring to concurrently improve nutrition and health outcomes at individual, community, facility, regional and national levels.

At individual and community levels, the MCNHRP seeks to create demand and boost service utilization: it provides incentives to both mobilize and empower individual women and communities to partake in improving nutrition and health outcomes. At community level, communities are contracted to impart health and nutrition information, support behavioral change and refer all pregnancies to the nearest health facility. At individual level, conditional cash transfers (CCTs) are provided for timely and complete antenatal care (ANC) visits with a skilled provider, starting with the first trimester of pregnancy. These incentives seek to induce adherence to recommended health practices among pregnant women. Conversely, RBF payments help mobilize communities to simultaneously raise awareness about the existence of individual CCTs and provide the knowledge, support and enabling environment required for informed health decision-making and timely utilization of primary health care (PHC) services.

Community-level RBF payments are rolled out through existing Baby Friendly Community Initiative (BFCl) and PHC structures. Primarily focused on promoting exclusive breastfeeding, Village Support Groups (VSGs) are readily operational as well as formed and led by the community. Their unique access to and knowledge of target populations is used to increase the outreach and effectiveness of social and behavioral change communication (SBCC), particularly focusing on the promotion of personal and environmental hygiene, skilled delivery in a health facility, timely and complete antenatal care, postnatal care as well as birth spacing. In parallel, Village Development Committees (VDCs) and VSGs are used to further scale up BFCl and further address persisting maternal and child undernutrition as well as food insecurity: they advocate for exclusive breastfeeding and appropriate infant and young child feeding, as well as help identify women and children in food and nutrition insecure households and communities. Qualitative evidence indicates that these community structures concurrently helped increase health knowledge and wide-spread hand washing and other hygiene practices in many communities. In turn, such gains reportedly helped reduce the incidence of diarrhea: “We used to give them all kinds of water and we have noticed that is what was causing problems but since the project was introduced, children now have good health.”¹

Specifically, individual VDCs sign a performance contract with the Regional Health Directorate (RHD) of the MOHSW for the coordination and oversight of outreach and community development activities. In turn, they contract a VSG – including the Community Birth Companion – to organize and carry out health promotion and counselling activities. Both entities are paid quarterly by NaNA for achieved and verified results: 80 percent is used by the VDC to cover operating costs, community mobilization and community development projects, and 20 percent is used to provide performance-based incentives to individual members of the VSG.

Performance contracts –coupled with capacity building – engage and empower community stakeholders to devise and invest into their own tailored solutions to health service utilization impediments. For example, in Sambang – a community located in the Central River Region of The Gambia – the VDC used RBF payments to purchase two donkeys and a cart to help pregnant women easily access skilled

deliveries in health facilities. Moreover, in Kaur Health Center in the Central River Region, anecdotal evidence indicates that the concurrency and interdependency of individual and community helped increase first trimester ANC attendance by a skilled provider from 26 in 2014 to approximately 46 in 2015. They also reportedly contributed to reducing the occurrence of pregnancy-related complications – such as hypertension, anemia, preeclampsia, etc. – thereby contributing to increased mother and child survival.

In this context, individual and community incentives concurrently helped enhance demand for nutrition and primary maternal and child health services while building momentum and strongholds for community-owned, community-led and context-specific interventions. These RBF payments contribute to placing the achievement of nutrition and health outcomes at the center of individual and community interests.

At facility level, the MCNHRP intervenes to enhance both the quantity and the quality of services provided: it uses performance incentives to improve coverage as well as boost the capacities and motivation of healthcare personnel. It is based on a contractual arrangement between individual health facilities and the MOHSW RBF Committee for the achievement of verified results. Sixty percent of inherent PBF payments are typically used to improve infrastructure, procure equipment and supplies, increase outreach activities as well as cover operating costs. Supplemented by financial and material start-up support for effective service delivery, these payments help enhance health facilities' autonomy, providing them with the opportunity to set their own priorities and develop tailored solutions to existing bottlenecks. The realization of these solutions (i.e. investments) is guided by business plans, developed by each contracted health facility with the support of the RHD. For example, in Dankunku – located in the Central River Region of The Gambia – the health center invested in the renovation of staff quarters to both improve staff living conditions and heighten the facility's potential to attract as well as retain personnel. Conversely, Kaur health center dedicated a portion of the received incentives to purchasing essential drugs, thereby bolstering its pharmacy as well as remedying drug supply delays and shortages. Such investments simultaneously improve health facilities' capacity to deliver services and also boost provider satisfaction. This is further reinforced by performance rewards for health care personnel, representing 40 percent of overall incentives.

Seeking to both mobilize and motivate provider participation in the delivery of quality community nutrition and primary maternal and child health services, the use of bonuses has been observed – during RHD supervisory visits – to be effective in enhancing provider attitudes: regular and timely attendance, timely provision of care, greater willingness to work, regular and quality reporting and information management as well as motivation are becoming increasingly customary. Similarly, representatives of Bansang Hospital – a referral hospital in the Central River Region – underlined improved referrals as well as heightened interest in patients' well-being and satisfaction: “an increasing number of primary health care providers ask for medical advice and follow up on referred patients”. Conversely, qualitative evidence suggests that improved provider attitudes and satisfaction are influencing the perceived quality of service as well as patient satisfaction: “[Nurses] are more caring and friendlier. In the past, you would be sitting there and they wouldn't care, just going about their own businesses. But now they would talk to you, assist you and give you all that you need until you deliver and make sure that you are ok before they release you to go home”.

In parallel, PBF payments also contribute to expanding the availability of skilled providers, by engaging and incentivizing community health nurses and community health workers to extend service coverage to communities, especially to “hard to reach” and vulnerable households. Focusing on providing selected outreach activities to enhance appropriate nutrition, health diagnosis and referral, community health

nurses and community health workers also monitor, support and closely collaborate with community structures (i.e. VDCs and VSGs). Notably, they coach incentivized Community Birth Companions in counselling and accompanying pregnant women for skilled deliveries. By operating within the community and with the community, they contribute to bridging the critical gap between health facilities and communities while enhancing health coverage and equity.

This critical gap is further bridged by using existing structures of the Bamako Initiative, namely Catchment Area Committees (CAC) now being referred to as Health Centre Management Committees (HCMC). Including representatives of the catchment area – with the District Chief acting as Chairman and the Officer in Charge of the health center as Secretary – these structures are contracted by the MOHSW RBF Committee to oversee the day to day management of the health center, monitor PBF funds and individual CCTs as well as play a role in determining individual provider performance rewards.

As such, the HCMCs further strengthened community-centered nutrition and health interventions: they concomitantly ensure that the health facility is accountable, operationally and financially transparent as well as responsive to community needs. In turn, HCMCs are monitored and supervised by the RHD.

Supervision and coaching – alongside incentives – is reportedly also a determinant of improved motivation and performance among incentivized primary health service providers. This is highlighted by a HCMC member who commented: “It gives a feeling of motivation when supervisors [the RHD] come and see what is happening and are aware of your situation and can make changes or corrections where applicable.” As underlined by a health worker, it also heightens collaboration and team work: “Before, meetings were happening but not frequently like during the RBF... It encourages all the members to participate [...] and involves the CHN village health services. They are part of the health service and the community. Their influence in the community gives great dividends towards service. So without team work, those team people would have been independent in their areas and not interested in what is happening at the healthy facility.” Supervision further places the achievement of results at the center of the primary health care system, linking, harmonizing and aligning activities implemented by stakeholders.

Despite its concurrent effects on provider performance and on the quality of care, the MCNHRP also constitutes a strain for health care providers as new RBF imperatives coupled with routine activities and continued inadequate human resources have increased provider workloads: “with the RBF you are to record, be an accountant, entrepreneur, business is not as usual... We are the ones who conduct deliveries, book antenatal mothers, family planning services, looking for invoices and doing all financial transactions, doing our best for services to continue and for the health facility to have drugs at any time so that the patients can get their satisfaction. My role in this project or the health facility is very tedious”.

Such overarching constraints are addressed at the national level, particularly by the National Nutrition Agency (NaNA) and the MOHSW RBF Committee who are contracted to ensure RBF management functions, respectively leading the RBF internal verification mechanism and the RBF purchasing functions – validating and paying for results. Collaborating under the aegis of the Project Implementation Committee (PIC), they also coordinate systemic activities: “Through this RBF we are trying to see how that whole gambit of what constitutes a perfectly working health system is included. Starting from making sure that the right staff are there, making sure that the drugs are available, making sure that the working environment is conducive enough because whatever health education you may give if you don’t facilitate the enabling environment for the people it might not have that impact.”

Acting as a national platform, the PIC is notably strengthening the health management information system (HMIS) to make it more effective and efficient to support evidence-based decision-making. Building on RBF reporting processes implemented at community, facility and regional levels, the HMIS is being strengthened at all levels to facilitate timely barrier identification, progress monitoring and strategy development. The PIC also intervenes to strengthen national SBCC tools and national health and nutrition policies and guidelines to ensure appropriate training, standardized quality information dissemination and clinically sound service delivery practices. It also engages stakeholders for cross-sectoral change, for example by disseminating the results of the MCNHRP's impact evaluation baseline assessment. Highlighting human resource and drug availability-related impediments, these results, in turn, motivated joint planning, and assessments of human resources for health and drug supply chains, thereby addressing systemic challenges to improved health and nutrition results. The readiness and willingness of national stakeholders to quickly seek further information and devise solutions is a testimony to the PIC's mobilization of and collaboration with national partners.

The effective and interdependent collaboration, motivation and commitment of the PIC – supplemented by that of individuals, communities, health workers, Regional Health Directorates, the MOHSW and NaNA, and other national and international stakeholders, including the World Bank – are gradually establishing a strategic and operational culture focused on sustainability and results: “business NOT as usual” is indeed increasingly becoming a leitmotiv in The Gambia across all levels of the health and community nutrition system, boding well for the achievement of better and lasting nutrition and health outcomes.