

The Contribution of the Contract and Verification Agencies in the Improvement of Health Facility Governance in Burkina Faso

Zénab K. KOUANDA¹, Moussa KABORE², Abdoulaye SOROMOYE³

¹ *Coordinator, Contract and Verification Agency, Central-East region*

² *Technical Assistant, Service for Results-Based Financing, Burkina Faso*

³ *World Bank, Burkina Faso*

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Introduction

With a view to achieving Millennium Development Goals (MDGs), Burkina Faso – supported by the World Bank – decided to pilot a results-based financing (RBF) approach to stimulate results, particularly regarding maternal and child health. Despite significant progress, mortality rates remain high in Burkina Faso, particularly among vulnerable mothers and children.¹ Also, motivated by the tangible outcomes yielded by results- and performance-based financing strategies in countries such as Rwanda, Burundi and Cameroon, Burkina Faso initiated a progressive introduction of RBF in its health sector in 2009.

Results-Based Financing in Burkina Faso

RBF involves financing health facilities per the services they provide and based on verified quantitative and qualitative indicators. The RBF pre-pilot phase was first introduced in 2011 in three health districts (Sapouy, Leo, and Boulsa). In 2014, a pilot phase expanded RBF to an additional 12 districts, thereby scaling up implementation to six health regions in all. The intervention covers 650 first line health centers, 11 medical centers with surgical wings and four regional hospitals, serving a beneficiary population of 4,450,000 people.

Governance in RBF

Governance is a relatively new concept in the health sector, referring to three strong ideas. For the World Bank, governance is translated as "the way through which power is exercised in the management of economic and social resources for national development."²

Conversely, per the European Commission, governance refers to "the rules, processes and behaviors that affect the exercise of powers, particularly in terms of openness, participation, responsibility, effectiveness and coherence. »³ These are the five "principles of good governance"³.

Health governance is based on three key dimensions⁴ :

- A management system encompassing the set of rules defining the distribution of power and responsibilities;
- An information system, including data and operating systems required to ensure intelligibility and transparency always for professionals, managers, planners, patients and the population;
- A financing system with incentives provided through specific financing modalities, budgetary mechanisms and payment arrangements.

Good governance in the health sector is therefore a concept that implies the following attributes: quality, effectiveness and efficiency, equity, participation and consensus, transparency and social accountability.⁵ Derek Luyt, reminds that the South African "Center for Social Accountability (CSA)" defines social accountability as "the right to obtain justification and explanation for the use of public assets and services by those responsible for their management and use "⁶. By this definition, providers of these health services should be accountable to citizens in general and users of those services. Accountability can therefore be understood as an element of responsibility.

¹ Burkina Faso National Health Development Plan, 2011-2020

² "Gouvernance et développement", World Bank, 1992

³ "Livre blanc sur la gouvernance européenne", European Commission, July 2001.

⁴ André-Pierre Contandriopoulos, "La gouvernance dans le domaine de la santé : une régulation orientée par la performance." Santé publique 2008, volume 20, n° 2, pp. 191-199

⁵ "Booster la gouvernance de la santé publique.", Applied Social Sciences Forum (ASSF), December 2014

⁶ "Social Accountability in Africa: Practitioners Experiences and Lessons", Affiliate network for social responsibility in Africa ([ANSA](#))

⁷ Community verification guide coupled with the RBF satisfaction survey in Burkina Faso. April 2015

Within the framework of the contracting and verification agency (CVA) interventions in RBF, governance in health systems means the management of equipment, financial and human resources, data reporting and social accountability. It also implies the involvement of health workers in the management of health structures and the organization of health services.

Contract and Verification Agencies in Burkina Faso

RBF is a strategy based on principles among which the differentiation of roles: contracting and verification on one hand, delivery and regulation on the other.

As part of the implementation of this strategy, Burkina Faso health ministry has recruited accompanying organizations from civil society to act as contract and verification agencies (CVAs). Therefore, in each of the regions involved in the implementation of RBF, a CVA has been adopted. Six CVAs have then been recruited to cover all six regions. The purpose of these CVAs is to assist health workers in the implementation of RBF. Thus, in addition to monthly quantitative services verification for the payment of subsidies, CVAs must strive to inculcate the culture of good management of health facilities to health workers through the development of a performance improvement plan (PIP), the use of the index tool and social accountability.

The PIP is a quarterly business planning tool resulting from the analysis performed during monthly quantity verifications and quarterly quality verifications. It features a situation analysis leading to the identification of major issues hindering the achievement of the health facility's objectives. It also features the list of activities to be carried out *to reach the expected results in the contract*, with their monthly costs. The PIP serves as a reference for carrying out the activities contributing to the attainment of the health facility's objectives and of the staff involved in its development. A quarterly evaluation is carried out before the development of each PIP. It can therefore be viewed as the health facility's quarterly business plan, whose existence is a pre-condition for the renewal of any health facility's contract, on which financing is based. It is the product of the combined efforts of the health facility staff and members of the management committee (COGES).

In addition, the index tool (IT) is a financial management tool developed monthly. On one hand, it provides an overview of the monthly status of revenue and planned expenditure for the following month. On the other hand, it helps determine the overall incentive, but also the individual incentive of each worker to be collected after the results of the health facility (HF) performance have been verified. This overall incentive corresponds to the monthly amount generated by the HF, after deducting the planned expenditure for the following month. The criteria for establishing the incentive for individual staff include qualifications of the health worker, his/her seniority in the health district, his/her level of responsibility within the HF, the number of days absent, the rating of the worker's individual performance from his / her line manager allow to calculate the individual premiums.

It is worth mentioning that the CVA remains accountable for the quality of these two contractual tools and for all the health facilities' PIPs under its responsibility.

After nearly two years of CVA work in the field, what can be perceived as good governance outcomes in health facilities implementing RBF?

Methodology

Our analysis is based on an analysis of experiences and knowledge of the Contract and Verification Agency (CVA), the Technical Service in charge of Results-based Financing, of the World Bank in Burkina Faso (on the implementation of RBF in the country) and finally, on the data of Burkina Faso's RBF database (RBF portal).

Results

The RBF implementation strategy during the pre-pilot phase within the health facilities prior to the CVAs' intervention was affected by numerous shortcomings. Indeed, most health facilities did not have an action plan as a reference framework for carrying out activities. The few health facilities that had it did not refer to it. Similarly, the management of material and financial resources was the responsibility of the head nurse,

who would very rarely involve the members of COGES (president and treasurer) who are co-signers on the health facilities' accounts. Some health facilities did not often have a financial statement.

Since their installation, each of the CVAs in their area of intervention has worked to ensure that each health facility has planning and management tools. These include the Performance Improvement Plan (PIP) and the Index Tool.

The CVA supported the development of health facility PIPs through meticulous organization involving coordination with health workers to avoid overlaps with other activities (district level meeting, organization of national or local vaccination or medicines distribution campaigns, etc.). Indeed, a joint team of CVA staff members and a representative of the district executive team, if available, quarterly visit HFs to assist all health facilities in drafting their PIPs. This support is based on a program established for to assist all health facilities.

In this way, through those support programs, the CVA has succeeded in equipping health workers with skills to develop quality PIPs through the effective involvement of all health workers, Management Committees, along with the support of the district executive team. Health workers and COGES members were therefore given the opportunity to have quarterly frank and direct discussions on the HF management conduct, define the planning options together and take ownership of the results, each per his/her level of responsibility.

This work environment also allowed the CVA to resolve some relational tensions and conflicts between health workers themselves and between health workers and members of the management committee; relational difficulties often led to demotivation and detrimental behavior to the health facility performance.

Furthermore, CVAs have monthly supported health workers in the development and use of the Index Tool. At first this computer-based tool was not mastered by HF staff, and they were not in a hurry to make use of it. Following several support visits, health facility managers have mastered the use of the software. To achieve this, it was necessary to encourage all the HFs to acquire a computer and learn to use Excel, the software on which the Index Tool is developed. All health facility staff is involved in the development of the Index Tool and the results are published. This learning also smoothed disputes over the distribution of individual premiums because each worker was assured to participate in the accuracy of the Index Tool generated results.

In brief, because the CVA has successfully met the challenge to include and involve other health workers in the development of the two contractual tools required for an RBF contract, namely the PIP and Index Tool, it has ensured transparency in activities planning and health facilities' financial management. This transparency has undoubtedly contributed to the constant improvement of all the performance of all HFs.

The implementation of RBF in Burkina Faso includes the quarterly organization of community verifications coupled with a user satisfaction survey of health services⁷. It is organized by the CVA in collaboration with investigators recruited by local associations. The purpose of this verification is to strengthen the voice of the community; on one hand by verifying the effectiveness of the services assumed to have been delivered, and on the other hand by surveying the community on their satisfaction with health services. It makes it possible to determine the perceived quality score which accounts for 15% of each health facility's overall quality score. The user is thus at the heart of the health facility's problems analysis and his/her judgment influences the quality score and hence the amount of the quality bonus received by health workers. Through this community verification, health workers report on the quality of the services they provide to their populations. Some health facilities did not receive quality bonuses because their perceived satisfaction score was low enough to cause their overall quality score to drop below fifty percent (50%).

It should be noted that, considering budgetary restrictions, only two community verifications could be organized.

With CVAs, the data sent by health facilities to the SNIS are more reliable since the data are verified before the payment of incentives. This verification process made sure that all data collection tools for both quantity and quality data are available; This was not necessarily the case before (example of a missing healthy newborn health record, and the existence of non-compliant healthy newborn vaccination records). A system

of penalties has been instituted and applied by CVAs to sanction data reporting discrepancies to the national health information system by health facilities. This rapidly made it possible in the field to correct negligence in the counting of indicators. The quality of quantity verification ensures that indicators are paid according to actual achievement.

These results were possible because the CVAs organized detailed and effective coaching of primary level health facilities, which enabled the implementation and use of planning and management tools, through in-service training of health staff on the RBF strategy. The organization of periodic systematic assessments of health facility quality and the performance of the supervisory structures, the volume of the financial flow injected into the health system, certainly contributed to the achievement of these results in health facilities.

After over 2 years of working, CVAs have certainly contributed to:

- The establishment and use of planning and management tools such as PIP and index tools;
- Transparency in HFs financial management with the development of the monthly index tools with all health workers; this allows to take stock of the monthly financial statement and to plan the expenses to be carried out the following month in compliance with the business plan (PIP) initially developed;
- Find a consensus with the whole staff on strategies to be implemented to achieve health objectives;
- Achieve a form of social accountability by strengthening the community's voice;
- Have a better consideration of health services users' satisfaction.

Challenges

However, CVAs have experienced some challenges in achieving their mission. These challenges were mainly institutional, regulatory and financial. Indeed, one of the pitfalls in achieving CVAs' objectives has been the structural organization of CVAs as defined in the RBF design in Burkina. There are only three members to be designated as CVA regional staff: the coordinator, the deputy coordinator and the clerk, irrespective of the region's population size or the number of HFs under the CVA's responsibility. In addition, only the CVA staff is responsible for ensuring all health facilities have a PIP and Index Tool. This contractual obligation led to have three or sometimes only two staff members (the coordinator and the deputy coordinator) quarterly visit and support all the health facilities in a region under RBF (from fifteen to one hundred and fifty health facilities by region).

On the other hand, CVAs were officially established in most of the regions by governors or their representatives, however, this introduction was mostly ceremonial and the CVAs institutional mission went unrealized. A formal action was taken to endorse the presence of CVAs alongside the state's sovereign structures. CVAs' role has thus not been sufficiently understood and accepted by some supervisory structures. Consequently, these structures have sometimes not systematically invited the CVA when they should have done so, such as in the quality verifications of primary-level health facilities or during facilities' performance evaluation in which the CVA participates as an observer. District health authorities and CVAs have not always been systematically invited to work together by the first district officials except sometimes under pressure from CVAs. These inadequacies in the collaboration between public administrators and CVAs have resulted in a lack of synergy and meant that there is not always total transparency in the health facilities financial management, and the accountability that these workers owe to the communities has not always been observable.

Delays in the availability of funds to allocate to CVAs throughout their activities have had a negative impact on the effectiveness of certain activities such as the organization of community verifications. Only two community verifications could be organized by the CVA in two years of operation. It goes without saying that the community's opinion has not been sufficiently taken into consideration in the improvement of health services.

Finally, the CVA was confronted with the inadequacy of preparation of health workers for the RBF approach, in its notion of contracting and inherent obligations and even in the oversight structures. Indeed, prior to the

implementation of the CVAs, all public health facilities were systematically under the RBF strategy without any condition, without any form of contract. As such, there were sometimes high tensions at the beginning of the PIPs and index tools development, as there were no provisions to ensure the availability of tools (information of COGES members, financial report, PIP draft) which could facilitate the development of PIPs and Index Tools. Moreover, the contractual breaches by certain HFs, due to the absence of PIPs, created dissatisfaction within these HFs, which hurt the CVAs.

While it is true that CVAs intervention has contributed to improving governance in primary health facilities, the following recommendations can be made to improve their actions: (i) increase CVAs' legitimacy by taking official measures endorsing their actions on the ground; (ii) allocate more human, material and financial resources to the CVAs to enable them to carry out their missions more effectively.

However, in view of the generalization of this financing method to the whole country, and especially because of the reduction in the amount of funding allocated to the strategy, it would be wise to think of a change in the CVAs' current structural form. Indeed, one of the criticisms of RBF is the significant financial resources allocated to CVAs. Other alternatives have been proposed, admittedly less costly, but they must meet the challenge of efficiency and respect for the separation of functions to guarantee the purchased results' credibility.