



**USAID**  
FROM THE AMERICAN PEOPLE

 Evidence

# Mapping the extent to which performance-based financing (PBF) programs reflect quality, informed choice, and voluntarism and implications for family planning services

*A review of PBF operational manuals*

Marie S. Cole, PAI  
Victoria Boydell, University of Cambridge  
Ben Bellows, Population Council  
Karen Hardee, Hardee Associates

---

SEPTEMBER 2018

---

RESEARCH REPORT



## The Evidence Project

Population Council  
4301 Connecticut Avenue, NW, Suite 280  
Washington, DC 20008 USA  
tel +1 202 237 9400  
evidenceproject.popcouncil.org



**USAID**  
FROM THE AMERICAN PEOPLE

The Evidence Project is made possible by the generous support of the American people through the United States Agency for International Development (USAID) under the terms of cooperative agreement no. AID-OAA-A-13-00087.

The contents of this document are the sole responsibility of the Evidence Project and Population Council and do not necessarily reflect the views of USAID or the United States Government.



The Evidence Project uses implementation science—the strategic generation, translation, and use of evidence—to strengthen and scale up family planning and reproductive health programs to reduce unintended pregnancies worldwide. The

Evidence Project is led by the Population Council in partnership with Population Reference Bureau.

Published in September 2018.

Suggested citation: Cole, Marie S., Victoria Boydell, Ben Bellows, and Karen Hardee. 2018. “Mapping the extent to which performance-based financing (PBF) programs reflect quality, informed choice, and voluntarism and implications for family planning services: A review of PBF operational manuals,” Research Report. Washington, DC: Population Council, The Evidence Project.

Photo credit on cover page Jonathan Torgovnik

© 2018 The Population Council, Inc.



# Table of Contents

|  |            |
|--|------------|
| <b>ACKNOWLEDGMENTS</b> .....   | <b>III</b> |
| <b>EXECUTIVE SUMMARY</b> .....   | <b>1</b>   |
| <b>INTRODUCTION</b> .....  | <b>3</b>   |
| Background .....   | 3          |
| Purpose .....  | 4          |
| Results-Based Financing and the Global Financing Facility .....                            | 5          |
| <b>A RIGHTS-BASED APPROACH TO HEALTH AND FAMILY PLANNING</b> .....                         | <b>7</b>   |
| <b>REVIEW OF COUNTRY PBF OPERATIONAL DOCUMENTS</b> .....                                   | <b>9</b>   |
| Methods .....  | 9          |
| <b>FINDINGS</b> .....  | <b>10</b>  |
| Accessibility .....  | 14         |
| Acceptability .....  | 15         |
| Accountability, Transparency, and Participation .....                                      | 15         |
| Agency/Autonomy/Empowerment/Voluntarism.....   | 16         |
| Availability .....   | 17         |
| Informed choice/Informed decision-making.....  | 17         |
| Non-discrimination/Equity .....  | 18         |
| Quality, including privacy and confidentiality.....  | 19         |
| <b>DISCUSSION</b> .....  | <b>21</b>  |
| Current state of principles related to a rights-based approach in PBF implementation ..... | 21         |
| Gaps in inclusion of principles related to an RBA in PBF programs.....                     | 22         |
| <b>LIMITATIONS</b> .....   | <b>24</b>  |
| <b>RECOMMENDATIONS AND CONCLUSION</b> .....  | <b>25</b>  |
| <b>REFERENCES</b> .....  | <b>27</b>  |

# Acknowledgments

The authors of this report, Marie Cole, Victoria Boydell, Ben Bellows, and Karen Hardee, would like to acknowledge the insights from and engagement with members of communities of practice in family planning, rights, and results-based financing. From initial conversations to the documents review, the process opened up innovative perspectives on where alignment across these communities could produce a sum greater than the parts. Additionally, we would like to thank colleagues from the Evidence Project at the Population Council for facilitating the support for the study. Finally, we would like to thank Beverly Johnston, Division Chief, Bureau for Global Health, USAID; and Evidence Project AORs Mihira Karra, Erika Martin, and Erika Houghtaling of USAID for their vision to see this through.

# List of Acronyms

|        |   |
|--------|---|
| CHW    | Community Health Workers                                      |
| FP     | Family Planning   |
| GFF    | Global Financing Facility                                     |
| HNP    | Health, nutrition, and population                             |
| HRITF  | Health Results Innovation Trust Fund                          |
| IC     | Investment case   |
| LMIC   | Low- and middle-income countries                              |
| MOH    | Ministry of health  |
| PAD    | Project appraisal document                                    |
| P4P    | Pay for performance   |
| PBF    | Performance-based financing                                   |
| PBI    | Performance-based incentives                                  |
| RBF    | Results-based financing                                       |
| RMNCAH | Reproductive, maternal, newborn, child, and adolescent health |
| SPHCDA | State Primary Healthcare Development Agency                   |
| VHW    | Village health worker   |
| WHO    | World Health Organization                                     |

# Executive Summary

Results-based financing (RBF) initiatives, which operate within the much larger financial and programming contexts of health systems, aim to expand coverage, improve quality and reduce consumer financial obligations at the country level in line with a nation's decision to progress toward universal health coverage. RBF programs have the potential to ensure that clients' needs for quality services are met through use of strategic incentives in health care provision and promoting more client-centered healthcare systems. Performance-based financing (PBF) programs are considered a specific subset of RBF initiatives and are distinguished by a focus on monetary incentives to healthcare providers for achieving agreed performance measure under certain conditions. While both PBF, which uses financial disbursements to incentivize health service delivery and quality, and rights-based programming have informed at different times efforts to strengthen and scale FP services, there is has been little done to understand the linkages between PBF and a rights-based approach (RBA) to FP services. To address this gap, a review of performance-based financing (PBF) operations manuals was undertaken together with an analysis of PBF indicators relevant to FP services. This paper reviews country-generated PBF operational documents to assess whether existing FP indicators are sensitive to the principles associated with an RBA.

As the result of an evidence mapping via consultation with the PBF community of practice, the review identified 23 PBF operational and assessed the sensitivity of FP services in those PBF programs to eight rights principles recognized by the World Health Organization. The review found that rights were not uniformly represented across the 23 PBF programs. The most commonly identified rights principles—accountability and quality—are features of most FP services in the 23 PBF programs identified in this review. Less commonly represented rights included accessibility, acceptability, and informed choice. None of the 23 programs spoke to agency / voluntarism in their FP services.

From the review of operational and implementation manuals produced in-country, this report demonstrates that current PBF programs are not designed with a rights-based approach and that PBF guidelines could better reflect the importance of patient-centered, rights-based programming. Given the mixed evidence for PBF benefits, concerns about poor country ownership of PBF programs, and a risk of perverse incentives in early versions of PBF programs that did not take have a systematic alignment with rights-based approaches, greater attention to the rights principles of acceptability, accessibility, availability, and quality; accountability; agency and empowerment; equity and non-discrimination; informed choice and decision-making; participation; and privacy and confidentiality would improve health service delivery and health system performance for all stakeholders with consumers at the center.

Key recommendations include the need to assess the rights principles gaps in current PBF programs; build consensus on integrating rights principles into PBF trainings, program design, and implementation; and launch an iterative learning agenda to improve the operationalization of rights principles in PBF programs.

From the results presented here, there is a clear opportunity for PBF programs to more explicitly and systematically address rights principles. How rights principles are incorporated into implementation will require a thoughtful, iterative approach that accounts for contextual variation. Determining the programmatic structure of a fully operational rights-based approach in any PBF program is guided by international agreement on a rights principles framework for family planning programs as well as local stakeholder contextualization in the respective health system.

Given its centrality to funding through the GFF partners, PBF for FP services will have significant implications on the abilities of women and couples to choose if, when, and how many children to bear in

their lifetimes. Placing consumers at the heart of services and ensuring they are always prioritized and protected when designing, planning, and implementing PBF programs is critical to ensuring that people are able to make their own decisions about FP use and to sustaining PBF programs, particularly in countries supported by GFF.

# Introduction

## BACKGROUND

Expanding access to and use of voluntary family planning (FP) services is a well-established global health goal-- it is a specific target under the Sustainable Development Goal (SDG) of good health and well-being, an integral component of Every Woman Every Child (EWEC), and the overall objective of the Family Planning 2020 (FP2020) partnership, among other initiatives (United Nations, n.d.; Every Woman Every Child, 2016; Family Planning 2020, 2017). FP2020, the global partnership to achieve the ambitious goal of increasing access to voluntary FP for an additional 120 million users, supports and encourages voluntary FP policies and programs that focus on ensuring individuals and couples can freely and responsibly decide the number and spacing of children, with the aid of quality voluntary FP information and services and without facing discrimination (Family Planning 2020, 2018). However, significant barriers inhibit many people from using voluntary FP services to help meet their reproductive intentions. An indication of this is the estimated 214 million women who want to delay having more children or have born the children they want to have but are not using contraception (Guttmacher Institute, 2017).

One promising approach for achieving global voluntary FP goals is performance-based financing (PBF), which deploys financial incentives to the health system to improve service availability, utilization, and quality as well as addressing some public financial management bottlenecks by directly targeting resources to facilities based on performance. Described below, PBF falls under the broader and related rubric of results-based financing (RBF), which includes performance-based incentives (PBI) and pay for performance (P4P), as well as demand-side initiatives like vouchers (Musgrove, 2011). PBF is one of the financing instruments used by the recently created Global Financing Facility in support of Every Women Every Child (GFF). Housed at the World Bank, GFF is a partnership of funders, technical agencies, civil society organizations, and private sector entities focused on women and child health.

PBF programs, operating within the much larger financial contexts of health systems, aim to expand coverage, improve quality, and reduce consumer financial obligations in line with progress toward universal health coverage (Kutzin, 2013; Wagstaff et al., 2015). Although the evidence is mixed, some PBF and RBF studies have shown significant positive effects, including expanding coverage, lowering costs, increasing value for money, and increasing the overall efficiency and quality of health systems (Basinga et al., 2011; Bellows, Askew, & Bellows, 2014; Bertone, Lagarde, & Witter, 2016; Blacklock et al., 2016; Grittner, 2013; Soeters et al., 2011). At the same time, there is a move towards operationalizing rights-based approaches in health services and programs to better meet clients' needs and the state's obligations (Family Planning 2020, 2014; Hardee, Kumar, et al., 2014; WHO, 2014). PBF programs have the potential to ensure that a client-centered approach is upheld through use of strategic incentives in healthcare provision that promote quality of care, informed choice, and voluntarism, among other program attributes. Thus far, however, family planning services in PBF programs have often been supported via incentives for enrolling new contraceptive users or improving access to methods, with less attention to metrics that would reflect client empowerment or voluntarism.

### What is performance-based financing?

Performance-based financing is a health financing instrument through which payments are made for health services to healthcare providers conditional on performance on predefined and verified quantity indicators, adjusted for measures of quality.

### What is a rights-based approach to family planning?

A rights-based approach to family planning uses 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 and spacing of their children, to have the information and services to do so, and to be treated equitably and free of discrimination. (Erdman & Cook, 2008)

There are questions about the suitability of PBF for family planning services due to the potential for perverse incentivizing, e.g. offering “rewards” for achieving contracted outputs could have unanticipated or undesirable effects. These may include (a) health service actors ignoring unincentivized health interventions or cherry-picking services that pay the highest incentives, (b) inducing superfluous demand for incentivized services, and (c) fraudulent reporting although World Bank funded studies have not reported these types of adverse events to date (Chowdhury et al., 2013; Paul et al., 2018a; Kandpal, 2016).

Rewarding certain behaviors and setting certain kinds of targets can encourage actions that infringe on clients’ autonomous and informed decision-making. Financial rewards can affect how providers share information with clients, alter privacy and confidentiality protections, and induce changes in the patient-provider relationship through structural and procedural biases (Eichler, Levine, & The Performance-Based Incentives Working Group, 2009; Eichler et al., 2010). At worst under PBF, providers could pressure clients into taking any given services (Hardee, Harris, et al., 2014). The World Health Organization (WHO) has recommended that:

**“In settings where PBF occurs, a system of checks and balances should be in place, including assurance of non-coercion... If PBF occurs, research should be conducted to evaluate its effectiveness and its impact on clients in terms of increasing contraceptive availability” (WHO, 2014)**

Where family planning is concerned, significant efforts have been made to ensure that patient autonomy and protection are foremost in service delivery.

## PURPOSE

Given the confluence of potential benefits of PBF to expand access to and improve quality of FP services, the potential risks for perverse provider incentives, and the global imperative to implement rights-based approaches to health programs, this paper reviews country-generated PBF operational documents to determine whether and the extent to which rights principles are currently considered and included in PBF program designs. The report focuses on the current state of operational and performance measures specific to FP services within PBF programs, identifying whether and how these principles are embedded in these financial schemes, now often cofinanced under the new GFF. Acknowledging that the documents that form the evidence of this review largely pre-date the GFF, the report is an opportunity to learn from what went before and iteratively improve from lessons to be drawn here.

The paper examines the structure of PBF beyond performance measures and indicators, analyzing the language used throughout the implementation manuals, including available memoranda of understanding. Additionally, this review identifies gaps where greater attention to client-centered features, most notably quality of care, informed choice, and voluntarism, all components of rights-based programming, could strengthen PBF operations and offers recommendations for improvements.

The review begins with (a) a brief overview of PBF and its new support mechanism within the World Bank followed by (b) a description of the components of a rights-based approach to FP to provide context for (c) the subsequent focus on quality, informed choice, and voluntarism. A companion paper focuses on the indicators used in PBF (Boydell et al., 2018).

The World Bank and other partners have now made extensive use of PBF to deliver FP services among a range of instruments and many countries are expanding PBF with the support of the GFF. Although most of the documents reviewed pre-date, and in a few cases draw from programs not directly supported by, the GFF, this report makes several recommendations to ensure that rights are central to the discussion among development partners and governments implementing PBF and related service purchasing strategies. The lessons from PBF will have some applicability in other investment instruments and purchasing approaches: development impact bonds, Program for Results loans, performance contracting, and national and social insurance schemes.

## RESULTS-BASED FINANCING AND THE GLOBAL FINANCING FACILITY

RBF is defined as:

**“A cash payment or nonmonetary transfer made to a national or subnational 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” (Musgrove, 2011)**

RBF programs are organized such that incentives, typically monetary, are provided to health system actors (supply-side) or healthcare consumers (demand-side) in exchange for or in anticipation of targeted behavioral changes. A contract outlines the roles of the payer and the recipient as well as the expected outcomes, and the reported outcomes are verified by an independent third party before any payments are made. With this approach, money for health systems shifts from funding inputs (e.g. salaries and commodities) to paying for verifiable outputs achieved through direct service provision or observable health-related consumer behaviors. On the supply side, health system actors may receive incentives for high performance or results, i.e. the attainment of specified healthcare outputs among the population served. Healthcare consumers, on the other hand, might receive incentives for demonstrating positive health behaviors, such as attending health education seminars or accessing health services. Consumers may receive vouchers that subsidize access to priority services and providers reimbursed for services delivered. These strategies link financial compensation to the achievement of health program priorities, with the goal of increasing the use, quality, and efficiency of health services. This review focuses on supply-side initiatives that are labeled performance-based financing (PBF), which focuses on monetary incentives to healthcare providers for performance under agreed conditions.

Since 2007, PBF for maternal and child health has been supported by the Health Results Innovation Trust Fund (HRITF), which is maintained by the governments of Norway and the United Kingdom and

administered by the World Bank. It has committed funds through 2022. In 2014, building on the success of the HRITF, the UN General Assembly launched the GFF. The GFF partnership aims to provide and coordinate additional support and funding explicitly for reproductive, maternal, newborn, child, and adolescent health (RMNCAH) in the 63 highest-burden low- and middle-income countries (LMIC) (World Bank Group, 2014). The GFF has become a flagship mechanism for supporting the provision of RMNCAH services, including voluntary FP, in many countries. Through it, PBF is one of the primary means of ensuring transparency and accountability (World Bank, 2015).

The GFF is a move away from traditional bilateral development assistance models towards donor pooling of financial resources to promote country-led ownership of RMNCAH. It combines domestic resources with financing from both the International Development Association and the International Bank of Reconstruction and Development, bilateral donors, other external financing, and private sector resources. The GFF Trust Fund is an additional source of funding that increases the volume of financing in order to close the estimated US\$33.3 billion resource gap for RMNCAH among the countries eligible for GFF support, allowing for scale up of priority services (World Bank, 2015). There is renewed emphasis on increasing both efficiency in funding and the value for money disbursed. As domestic financing sources increase their contributions, it is expected that the need for external grants to recipient countries will be reduced. As much as the GFF represents a financing partnership between external donors and domestic governments, it also represents a unique opportunity to prospectively strengthen rights principles in the design and implementation of GFF-supported health sector investment strategies, particularly PBF programs.

Early publications on the role of PBF in strengthening FP service provision were mostly primers, toolkits, and handbooks developed or funded by the World Bank and the U.S. Agency for International Development. These do not explicitly discuss rights-based programming in funding schemes, although the World Bank mentions other legal rights related to the receipt of FP services (Loevinsohn, 2008). Eichler and colleagues examined country-specific strategies to prevent coercion in the provision of incentivized FP services (Eichler et al., 2009). In 2010, evaluations and case studies more openly began to discuss aspects of clients' rights in FP programs under PBF, although they did not use the term "rights." Two key documents that examined the role of incentives in FP services (Eichler et al., 2009, 2010) mentioned voluntarism and informed choice as clients' rights and coincided with the World Bank's launch of its Reproductive Health Action Plan (2010-2015), an operationalization of the reproductive health component of its 2009 Health, Nutrition, and Population (HNP) Strategy. Yet, the Reproductive Health Action Plan does not explicitly mention rights-based programming. Instead, it notes that it will focus on strengthening healthcare systems to "ensure access to quality family planning and other reproductive health services, skilled birth attendance, emergency obstetric care, and postnatal care for mothers and newborns" (World Bank, 2010: 25). While access and quality are important components of a rights-based approach, they are two of many rights principles, noted in the following section of this paper. In 2013, the World Bank published an HNP paper on the ethical dimensions of FP services in RBF programs including PBF initiatives, which explored the risks and responses to incentives vis-a-vis FP services. Although it mentioned voluntarism and informed choice, other rights were not discussed (Chowdhury et al., 2013).

# A Rights-Based Approach to Health and Family Planning

A rights-based approach to FP and reproductive health advises the use of rights, rooted in consumers' reproductive desires and needs, as a set of standards and principles to guide program assessment, planning, implementation, monitoring, and evaluation. This approach underscores the importance of the individual within a broader social and cultural context for FP service delivery (Hardee, Harris, et al., 2014).

There is increasing consensus that the principles most imperative to voluntary family planning are acceptability, accessibility, availability, and quality (commonly referred to as AAAQ), as well as (a) accountability, (b) agency, autonomy, and empowerment, (c) equity and non-discrimination, (d) informed choice/informed decision-making, (e) participation, and (f) privacy and confidentiality (Family Planning 2020, 2014; WHO, 2014; UNCESCR, 2000) (table 1). Unique dimensions of voluntarism are found among these different principles as well (Kumur et al., 2017; Hardee, Harris, et al., 2014). PBF programs have the potential to ensure that clients' needs for quality services are met through the use of strategic incentives in healthcare provision and promote more client-centered healthcare systems.

| Rights Element  | Implications for family planning programs  |
|---|--|
| <b>Accessibility</b>  | Geographic, physical, financial, and policy access (i.e., absence of nonmedical eligibility criteria); information is available in the languages and terms people can understand; continuous contraceptive security; suitable hours of operation; service integration to increase access   |
| <b>Acceptability</b>  | Culturally appropriate facilities, methods, and services; community/family support for women's ability to choose, switch, or stop method of contraception; tolerance of side effects; privacy and confidentiality respected; client satisfaction with services   |
| <b>Accountability/<br/>Participation/<br/>Transparency</b>    | Mechanisms exist for community members and FP clients to provide input and feedback about services, and for the health system to investigate and remedy allegations of/confirmed violations of rights; members of the community are involved in planning and monitoring FP services; 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 |
| <b>Agency/<br/>Autonomy/<br/>Empowerment/<br/>Voluntarism</b> | Knowledge that one has the right to make decisions about healthcare; ability to make one's own decisions independent of system, spouse, family, or community pressures; informed, voluntary decision-making supported; meaningful participation of clients in program design and monitoring; client-controlled methods offered; supportive community gender norms; women/men/young people know to and ask for services based on their needs, within their rights   |
| <b>Availability</b>   | Broad choice of methods offered; sufficient and needs-based distribution at functioning service delivery points  |

|   |   |
|---|---|
| <p><b>Informed choice/<br/>Informed decision-making</b></p>   | <p>Women and youth make own decisions about whether and what method of FP to use, without pressure from anyone, with free access to accurate information they can understand and a range of options to choose from</p>  |
| <p><b>Non-discrimination/Equity</b></p>                       | <p>Everyone, no matter what group they come from, age, or any other circumstance, has the same access to quality information and services; everyone is treated fairly and the same</p>  |
| <p><b>Quality (including privacy and confidentiality)</b></p> | <p>Service providers are well trained and provide safe services, treat clients with respect, provide good counseling, and protect client privacy and confidentiality (ensuring client information cannot be observed or heard by anyone else without the client’s consent; ensuring client records are not shared with anyone and information is not disclosed); and have a regular supply of contraceptives and all necessary equipment to provide the services clients want</p> |

# Review of Country PBF Operational Documents

## METHODS

An evidence mapping of PBF operational documents was undertaken through web search and consultation with experts. The aim was to collect and summarize as much evidence as possible and to map results to general concepts or research areas (Arksey and O'Malley 2005; Dijkers 2011). Acknowledging that the documents were drawn from programs that largely pre-date the GFF, the value of evidence mapping is that it is a systematic search extracting from a wide range of materials on specific questions of interest for policy and program implementation.

A review of PBF operational documents was undertaken from November to December 2017. These operational documents have programming guidance and tend not to be discoverable through professional literature databases and not uniformly available via search engines. The search focused on the World Bank Group's results-based financing website (<https://www.rbhealth.org>), which served as a repository for PBF documentation, followed by a request to experts at the PBF Community of Practice Google and Collectivity groups to share other documentation of PBF guidance that were not housed on the World Bank website. It was not possible to source all expected operational manuals as they were not readily available in the public domain. The exploration identified 23 relevant documents (one each from 23 countries) in English and French.

All the documents are the most recent, publicly available versions of operational or implementation manuals. From these, we extracted concepts, procedures, and performance measures that specify or reflect the principles presented in Table 1. While the paper focuses on FP-related PBF elements, the extracted data was not exclusively focused on FP-specific elements in the documents. For example, the availability of commodities is not necessarily specific to contraceptives but potentially inclusive of them. Some of the connections between content in the documents and the rights principles are intuited; this reflects the lack of clear intent on which some activities or procedures are based, but also provides a foundation for further operationalization of a rights-based approach that can ensure high quality services, informed choice, and voluntarism in PBF programs. Information from the documents was sorted by the eight principles, or groupings thereof, per country, with an additional section for relevant but miscellaneous findings.

# Findings

The manuals reviewed were produced between 2009 and 2015, the majority before the creation of the GFF. Of the 23 PBF program implementation documents reviewed, 21 manuals mention or include FP. All the documents reviewed focused largely on the implementation of quality and accountability mechanisms for the financing programs. A few program documents attempted to address issues of accessibility, availability, informed choice, acceptability, and non-discrimination/equity. There was no operational inclusion of agency, autonomy, empowerment, or voluntarism of healthcare consumers. Table 2 provides an overview of the principles that were included in each of the reviewed country PBF operational and implementation manuals.

Table 2: Indication of Principles associated with a Rights-based Approach in PBF Operational/Implementation Manuals from 23 LMICs

|                     | Accessibility | Acceptability | Accountability/<br>Transparency/<br>Participation | Agency/<br>Autonomy/<br>Empowerment/<br>Voluntarism | Availability | Informed<br>Choice/<br>Informed<br>decision-<br>making | Non-<br>discrimination/<br>Equity | Quality<br>(including<br>privacy &<br>confidentiality) | PBF<br>program<br>has FP<br>incentive | Manual  |
|---------------------|---------------|---------------|---|---|--------------|--|-----------------------------------|--|---------------------------------------|---|
| <b>Afghanistan</b>  |               |               | x   |   |              |  | x                                 | x  | x                                     | <i>(Operations Manual: Results Based Financing Intervention in BPHS Facilities and Hospitals in Afghanistan, n.d.)</i>                          |
| <b>Argentina</b>    | x             |               | x   |   |              |  | x                                 | x  |                                       | <i>(Cortez, Romero Vanina Camporeale, &amp; Perez, 2012)</i>  |
| <b>Armenia</b>      |               |               | x   |   |              |  |                                   |  | x                                     | <i>(Republic of Armenia Ministry of Health, 2014)</i>   |
| <b>Benin</b>        |               |               | x   |   | x            |  |                                   | x  | x                                     | <i>(République du Bénin Ministère de la Santé, Secrétariat Général du Ministère, &amp; Programme de Renforcement du Système de Santé, 2014)</i> |
| <b>Burkina Faso</b> |               |               | x   |   |              |  |                                   |  | x                                     | <i>(Burkina Faso Ministère de la Santé, 2013)</i>   |
| <b>Burundi</b>      |               |               | x   |   |              |  |                                   | x  | x                                     | <i>(Republique du Burundi Ministère de la Santé Publique, 2010)</i>   |
| <b>Cameroon</b>     |               | x             | x   |   |              | x  |                                   | x  | x                                     | <i>(Consortium AEDES/IRESKO, 2012)</i>  |

|             |   |   |   |  |  |   |   |   |   |  |
|-------------|---|---|---|--|--|---|---|---|---|--|
| Djibouti    |   |   | x |  |  |   |   | x |   | (Republique de Djibouti Ministère de la Santé, 2014)                                       |
| DRC         |   |   | x |  |  |   |   | x | x | (Republique Democratique du Congo Ministère de la Santé Publique Secérariat Général, 2015) |
| Haiti       |   |   | x |  |  |   |   | x | x | (République d’Haiti Ministère de la Santé Publique et de la Population, 2013)              |
| Ivory Coast |   |   | x |  |  |   |   |   | x | (République de Cote D’Ivoire Ministère de la Santé et de la Lutte contre le Sida, 2014)    |
| Kenya       | x |   | x |  |  | x |   | x | x | (The Government of Kenya The Ministry of Health, 2013)                                     |
| Lesotho     | x | x | x |  |  | x | x | x | x | (Lesotho Ministry of Health, 2013)   |
| Liberia     |   |   | x |  |  |   |   |   | x | (Republic of Liberia Ministry of Health and Social Welfare, 2012)                          |
| Mali        |   |   | x |  |  |   |   | x | x | (Republique du Mali Ministère de la Santé, 2011)   |
| Mozambique  | x |   | x |  |  |   | x | x | x | (Institute for Collaborative Development, 2015)  |

|                      |          |          |           |          |          |          |          |           |           |   |
|----------------------|----------|----------|-----------|----------|----------|----------|----------|-----------|-----------|---|
| Nigeria              |          |          | x         |          | x        |          | x        | x         | x         | (Federal Ministry of Health, Ondo Nasarawa and Adamawa State Ministries of Health, National Primary Healthcare Development Agency, Ondo State Primary Healthcare Development Board, & Nasarawa and Adamawa State Primary Healthcare Development Agencies, 2013) |
| Rwanda               |          | x        | x         |          |          |          |          | x         | x         | (Republic of Rwanda Ministry of Health, 2009)   |
| Senegal              |          |          | x         |          |          |          | x        | x         | x         | (Republique du Senegal Ministere de la Sante de l'Hygiene Publique et de la Prevention, 2012)   |
| Sierra Leone         |          |          | x         |          | x        | x        |          | x         | x         | (Government of Sierra Leone, 2012)  |
| Tajikistan           |          |          | x         |          |          |          | x        | x         | x         | (Republic of Tajikistan Ministry of Health and Social Protection, 2014)   |
| Tanzania             | x        | x        | x         |          | x        | x        | x        | x         | x         | (The United Republic of Tanzania Ministry of Health and Social Welfare, 2015)   |
| Zambia               | x        |          | x         |          |          |          |          | x         | x         | (Zambia Ministry of Health & The World Bank, 2011)  |
| <b>TOTAL (of 23)</b> | <b>6</b> | <b>4</b> | <b>23</b> | <b>0</b> | <b>6</b> | <b>4</b> | <b>7</b> | <b>19</b> | <b>21</b> |   |

A summary of how each of the principles is reflected in the manuals follows. Each subsection begins with the definition of the principle, also provided in Table 1, followed by a description of what was captured in the operational documents across countries.

## ACCESSIBILITY

*Definition: Geographic, physical, financial, and policy access (i.e., absence of nonmedical eligibility criteria); information is available in the languages and terms people can understand; continuous contraceptive security; suitable hours of operation; service integration to increase access*

The most forward-looking PBF programs fostered greater access by (a) integrating community health extension services, (b) testing financial subsidies, and (c) insisting on a greater customer experience. Six of the PBF documents reviewed included issues of accessibility to family planning services or the larger incentivized health program. The main dimensions that frame healthcare access in these manuals are physical and geographic. Five of the 23 PBF programs included incentives to increase physical access to family planning services. In Mozambique's scheme, not financed by World Bank, health facilities selected for participation in its PBF program include peripheral health centers, referral hospitals, and mobile clinics (Institute for Collaborative Development, 2015). Lesotho's health system utilizes village health workers (VHW) as the fourth tier of service provision. Under the country's PBF program, VHWs are trained and used as extensions of health centers, conducting services from the Essential Services Package, which includes FP, and reporting back to health centers. A component of their health center contracts is that they hire and make use of VHWs and VHWs complete their responsibilities. The VHW and health center are considered a unit to which incentives are made; payments to VHWs are made based on both their performances and that of their respective health centers. The training and deployment of VHWs brings services to more remote areas, increasing physical and geographic accessibility of services for hard-to-reach communities (Lesotho Ministry of Health, 2013). Similarly, one of Tanzania's health facility quantity indicators on the country's PBF performance agreement is the number of households visited by community health workers (CHW) (The United Republic of Tanzania Ministry of Health and Social Welfare, 2015). Additionally, health providers based at more remote health centers in Zambia are incentivized with higher monthly PBF incentives for the provision of FP services (Zambia Ministry of Health & World Bank, 2011). Kenya's PBF operational manual for scale up lists an indicator for the number of counties with defined strategies for increasing access and utilization of RMNCAH services as a measure tied to incentives, but it does not define a good strategy (Government of Kenya Ministry of Health, 2013).

Two country manuals address economic barriers to accessing healthcare services in their PBF programs. In Argentina, there are no client premiums at the points of service, so healthcare is "free" for consumers (Cortez et al., 2012). Tanzania's PBF program seeks information directly from clients regarding the costs of services received and whether the client was receiving benefits from the Tanzania Social Action Fund (TASAF). Its PBF Client Satisfaction Questionnaire asks, "Did you find the cost of care/services financially reasonable and affordable to you?" gauging the user's ability to pay for services (accessibility).

Information access for healthcare users is not directly incentivized or accounted for in any of the PBF documents reviewed.

In summary, findings were mostly around performance measures used to assess and reward geographic reach, and a couple of programs accounted for financial access. These are generally related to expansion of service delivery points rather than the recruitment of consumers in those localities. No measures were in place for information access for healthcare users, but there are some related indicators captured under "Acceptability".

## ACCEPTABILITY

*Definition: Culturally appropriate facilities, methods, and services; community/family support for women's ability to choose, switch, or stop method of contraception; tolerance of side effects; privacy and confidentiality respected; client satisfaction with services.*

Four out of the 23 manuals addressed issues of acceptability. Cameroon's implementation manual has several indicators that reflect the desire and need for, and the tolerability of, various FP services among the recipient populations. For instance, it counts the total number of old and new FP acceptors currently on oral pills or injection, a fairly common FP output indicator that appears across programs, although programs may quantify acceptors for different contraceptive methods. Cameroon also collects the number of new cases of implants and/or IUDs, post-abortive curettage, and tubal ligation or vasectomies (Consortium AEDES/IRESKO, 2012).

Some of the programs seek to consider client waiting times at health facilities. Cameroon's PBF verification form includes questions about the length of wait times and the client perceptions of wait times – “How did the mother appreciate the time?” – while Lesotho asks similar questions and also includes a question about whether the wait time had an effect on the client or the child's health (Consortium AEDES/IRESKO, 2012; Lesotho Ministry of Health, 2013).

Cameroon and Lesotho also give attention to client financial acceptability. Both countries' verification forms include questions about whether and how much money was paid for services and what healthcare users think about the payments made (see Tanzania example on affordability under Accessibility).

Lesotho also made efforts to increase community acceptability, alongside accessibility, by rewarding the VHWs for community sensitization outreach. Rwanda's PBF program similarly incentivizes community sensitization via CHWs to encourage healthcare utilization. For FP, CHW outreach seeks to sensitize women to benefits of long-term methods and to expand contraceptive options for consumers (Republic of Rwanda Ministry of Health, 2009).

Tanzania gauges clients' perceptions about the attention and approachability of its health facility providers. The Client Satisfaction Questionnaire asks: “When being attended to, were the medical staffs taking time to listen to you carefully?” “Was the staff at the facility caring, friendly and welcoming?” and “Did the medical staffs at the facility explain matters to you appropriately?”

In summary, there are performance measures related to new acceptors, community sensitization, and quality; and verification related to service appropriateness linked to wait time, costs, and satisfaction with care provision. Among the subset of PBF programs to address acceptability, all managed to cover its multiple dimensions.

## ACCOUNTABILITY, TRANSPARENCY, AND PARTICIPATION

*Definition: Mechanisms exist for community members and FP clients to provide input and feedback about services, and for health system to investigate and remedy allegations of/confirmed violations of rights; members of the community are involved in planning and monitoring FP services; 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*

Given the centrality of contract and verification practices of PBF programs, all the PBF operational manuals included accountability measures to ensure appropriate and effective implementation and transparent

governance of their respective PBF programs. In addition to the standard third-party verifications required by the RPBF model, countries such as Afghanistan, Argentina, Benin, and Kenya also conduct internal audits regularly over the course of the year. Many of the countries require routine work plans, often quarterly, that inform continuous monitoring and evaluation plans. Monitoring and evaluation activities are common among many of the reviewed program manuals. Additionally, many programs request business plans from levels as high as the ministries in charge down to the implementing health facilities, often updated on a regular basis; as well as systematic monthly, quarterly, or semi-annual performance reports due to and from different entities.

The roles and responsibilities of personnel were also dictated in the operations manuals. Most countries highlighted a separation of power and functions for managing the PBF programs, seemingly to insure against the perception of containing power by a few or at one level of authority. Some countries convened coordination or steering committees to guide and supervise the implementation of PBF programs. Afghanistan, Armenia, and Djibouti are among those countries, each of which specifies the tasks for each group. Additionally, other roles were plainly set and defined. Kenya overtly distinguished between the regulator, fund holder, purchaser, internal and external verifiers, and service providers. Liberia and Nigeria also provided similar levels of detail.

Given the financial rewards provided by PBF programs, some programs defined possible penalties. Benin, Nigeria, and Kenya all spoke to the potential for sanctions around issues such as fraud or negligence, mostly at the service provision level. It was interesting to note the absence of sanctions for fraud at higher administrative levels.

Client participation in accountability measures was also significant across program designs. Most of the verification processes include client satisfaction surveys to ensure that services were indeed provided and to consider how fulfilling the experience was for healthcare users. In addition to in-person surveys and interviews, Sierra Leone also has a hospital level indicator for “management of patients’ complaints and suggestion box,” making it possible for more anonymous feedback.

In summary, there are extensive and robust accountability systems with penalties and sanctions built into PBF programs. Structures are in place to ensure responsibilities are set out, discharged, verified, and rewarded or penalized. However, these are mostly upward-oriented accountability systems to ensure system performance. There is little reference to consumer and community participation and feedback mechanisms, whether suggestion boxes, hearings, or health committees.

## **AGENCY/AUTONOMY/EMPOWERMENT/VOLUNTARISM**

*Definition: Knowledge that one has the right to make decisions about healthcare; ability to make one’s own decisions independent of system, spouse, family, or community pressures; informed, voluntary decision-making supported; meaningful participation of clients in program design and monitoring; client-controlled methods offered; supportive community gender norms; women/men/young people know to and ask for services based on their needs, within their rights.*

While there was discussion of autonomy in terms of PBF programs giving more agency to health service actors at points of service, there was no discussion of client agency or autonomy in any of the reviewed PBF operational documents. The distinction is an important point to make in discussing rights to agency, autonomy, empowerment and voluntarism. A program design that supports access to client-controlled methods does not signal the existence of these (unspoken) rights in that program. An explicit acknowledgment of a client’s right to agency, autonomy, empowerment, and voluntarism is needed to ensure

that program implementers are (a) aware of these rights and (b) understand why client-controlled methods or other rights-enhancing attributes in the PBF program are important for effective FP service delivery.

## AVAILABILITY

*Definition: Broad choice of methods offered; sufficient and needs-based distribution at functioning service delivery points.*

Only six of the 23 country documents addressed the principle of availability. Of these programs, there was a focus on the availability of commodities, and several programs reported available personnel skilled in the provision of specific services.

In Benin, commodities are measured, inspected, and verified by ministry inspectors and community-based representatives. Nigeria also has indicators for the availability and visibility of FP methods; for having an “adequate” stock of pills, injectables, implants, and IUDs; and for vasectomies and tubal ligations. Lesotho’s PBF manual plainly states indicators for “at least five IUDs and five implants available” and “at least three months’ stock of oral and injectable contraceptives”. Sierra Leone includes the availability of vital and tracer drugs and consumables as well as stock out delays as hospital indicators. Inventory records and summary reports are also listed as hospital indicators related to the availability of commodities. In Tanzania’s program, verification includes direct observation of rooms used for FP services and the supplies for six contraceptive methods. Additionally, Tanzania and Lesotho also verify availability through client questionnaires. The Lesotho manual asks, “Were the medicines prescribed for you available at the hospital?” while Tanzania’s asks, “Have you ever gone home without medication because they were out of stock?”

Many of the operational documents spoke to measuring the numbers of trained and working staff. Lesotho’s program requires at least one trained staff member for each implant method and for IUD insertion, and it also has a staff performance measure of “never absent from service without known or valid motive.” Likewise, Sierra Leone has a “cross-cutting quality adjustment criteri[on]” of attendance at work. Tanzania’s program has a broader indicator for providers than Lesotho’s, measuring the availability of trained FP providers through their quality assessment tool for dispensaries and health centers. In Kenya, alongside counting the number of qualified staff employed by health facilities and deployed in each of its counties, the program also counts the number of counties implementing a community-based RMNCAH strategy, the number of counties with defined strategies for increasing access and utilization of RMNCAH services, and the percentage of counties fully implementing those strategies (also see Accessibility).

In summary, there are a range of performance indicators related to the availability of supplies in addition to some quality and verification procedures. There are also indicators and procedures to ensure an adequate distribution of appropriately trained staff. However, there was limited discussion on the importance of measuring method mix, which is critical metric underlying functional consumer choice.

## INFORMED CHOICE/INFORMED DECISION-MAKING

*Definition: Women and youth make own decisions about whether and what method of FP to use, without pressure from anyone, with free access to accurate information they can understand and a range of options to choose from.*

Four PBF operational manuals address issues of informed choice. Tanzania’s program states that it included questions about informed choice around FP methods in its client exit interviews, conducted at random within health facilities. The country’s quality and verification questions include:

- “What methods were you taught? [Must be able to name 3 of the following: condoms, injectables, pills, implants, IUCDs]”; and

- “Did you receive your method of choice or advised which methods were appropriate for you following examination today? If not, were you provided information on where you could receive the method, or referred to a facility or outreach service where the method is provided?”

The questions are scored 1 point for a “yes” response and 0 or 1 point for a “no” response.

Cameroon’s household survey form used for service verification asks if a price list was displayed in the health facility and if the health staff explained and presented all the existing modern methods to the client and allowed her to choose one freely. Similarly, Lesotho measures whether and which FP methods (injections, implants, IUDs, pills, male and female condoms) were available for demonstrations to clients. Further, Sierra Leone’s PBF program expects direct observations and reports about the organization of health education sessions and information provided to patients, “including patient circuit for getting services, schedules.”

In summary, there were performance and quality measures as well as verification procedures assessing and rewarding whether and how much information was shared. However, only the Tanzania PBF program attempted to assess if the information was understood by consumers.

## NON-DISCRIMINATION/EQUITY

*Definition: Everyone, no matter what group they come from, age, or any other circumstance, has the same access to quality information and services; everyone is treated fairly and the same*

Four of the 23 PBF manuals addressed equity and nondiscrimination standards within their programs. Three of the four were concerned with reaching groups based on income or wealth scores, and one was concerned with indigenous groups.

Afghanistan is utilizing an equity of care concentration index, in which a score of zero indicates equal utilization of services by all wealth groups, a negative number indicates that lower income groups are utilizing services at higher rates, and a positive number indicates that wealthier groups are utilizing services more. This is measured at the provincial level along with the contraceptive prevalence rate, whereas all other indicators for the country’s PBF program are measured at the health facility level. Funds are similarly paid at the provincial level for achievements related to these indicators (*Operations Manual: Results Based Financing Intervention in BPHS Facilities and Hospitals in Afghanistan*, n.d.).

PBF programs in Nigeria and Tanzania are also focused on low-income groups. The Nigeria PBF program takes place at the state level with the parastatal state primary healthcare development agency (SPHCDA) acting as the purchaser. The SPHCDA incentivizes household visits and providing allowable free healthcare for select impoverished populations. Its indicators include a category labeled “new consultation for an indigent patient,” signifying that the poorest people can access health services without service fees (Federal Ministry of Health et al., 2013). Tanzania is prioritizing enrolling regions with poor health outcomes and higher poverty indices in its PBF program. One indicator measures the number of low-income individuals (a) registered in its system, (b) attending, and (c) receiving outpatient services during a defined period (The United Republic of Tanzania Ministry of Health and Social Welfare, 2015).

In a different way, Argentina is incentivizing the increase of coverage to indigenous populations. Coverage is indicated by the number of providers who deliver services to eligible indigenous populations, with personnel trained in specific cultures and health needs (Cortez et al., 2012).

In summary, there are indications that some PBF programs are attempting to assess and reward providers’ performance based on income and/or ethnicity of consumers. However, there was no discussion of other

forms of social disadvantage that are known to affect access to family planning for other underserved or disadvantaged groups, such as youth.

## QUALITY, INCLUDING PRIVACY AND CONFIDENTIALITY

*Definition: Service providers are well trained and provide safe services, treat clients with respect, provide good counseling, and protect client privacy and confidentiality (ensuring client information cannot be observed or heard by anyone else without the client's consent; ensuring client records are not shared with anyone and information is not disclosed); and a regular supply of contraceptives and all necessary equipment to provide the services clients want.*

Nineteen of the 23 PBF operational manuals explicitly mention quality at least once, if not throughout the document. Some manuals simply state that they will monitor and verify quality of care and quality control of processes (Afghanistan, Burundi, Democratic Republic of Congo, and Rwanda). Others, such as Argentina and Cameroon, demarcate quality. Argentina's Plan Nacer states that the five dimensions of quality are (1) enrollment, (2) knowledge of benefit plans, (3) first-level attention and hospitalization assessment, (4) nurse and doctor assessment, and (5) utilization of system complaints. Cameroon's PBF program identifies two types of quality standards: (1) a minimal threshold of quality standards for output payment and (2) a minimum adequate level of quality standards to be eligible for a quality bonus. Mali's PBF Procedure Manual states that its PBF objective is to improve the quality and quantity of long-acting reversible contraceptives and prenatal and antenatal care; quality is the program's overarching mission.

Among the 19 manuals that discuss quality, the degree to which quality is operationalized varies. Some manuals detail internal processes to monitor and evaluate quality, which are distinct from external verification procedures outlined in several manuals. For example, Benin's program requires a commitment to regular quality evaluations of health facilities that will be conducted by health inspectors and regular evaluations of quality of care provided by community-based volunteers. Sierra Leone will also conduct quality assessments on the maintenance of appropriate standards of cleanliness, cleaning of facilities, hygiene, and sanitation indicators. In Zambia, to avoid incentivized indicators becoming the centerpiece to the detriment of all other health indicators, the non-incentivized indicators will also be routinely monitored. The aim is to ensure that improvements in indicators are comprehensive and not biased towards those that are incentivized. This is monitored with a Quality Audit by the District or General Hospital, and FP indicators are included and weighted.

As well, many of the PBF manuals included or referenced quality assessments or assurance checklists. These checklists tally scores to quantify levels of quality and service readiness in line with national standards, although few countries offered a conceptual definition of quality in their manuals.

Patient satisfaction is also endorsed as a dimension of quality across PBF programs (also see Accountability). Cameroon's household survey form for verification asks, "Was the mother well received in the health facility?" In Tanzania, the quality assessment tools for dispensaries and health centers list a patient satisfaction survey as part of its verification process. Most of the other countries also include patient satisfaction surveys among their verification tools, but they are not necessarily listed on the quality assessment scales.

There are many indicators of quality in PBF implementation, many captured under acceptability, accessibility, and availability. Three other dimensions of quality are (1) technical competencies, (2) facility readiness, and (3) privacy and confidentiality. Quality checklists in Nigeria were updated for PBF programming to give greater weight to the content of healthcare, namely staff competency and performance. In Tanzania, client FP cards are randomly selected to check whether the clients were correctly examined and counseled on FP methods and choice. Cameroon checks for whether all FP consultations are carried out by at least one *Brevete* (French for "qualified" or "patented") nurse in health centers and whether there is at least one State registered nurse

trained in FP at hospitals. In Lesotho, quality of work is a measure of staff performance. Its checklist enquires if staff are "adhering to specific work-related norms and standards." PBF also dictates that health centers are required to have at least three qualified staff, per ministry of health (MOH) guidelines, and that buildings and equipment meet MOH standards (including the availability of water, and electricity or solar power). For Kenya's PBF program, it is important that health workers correctly calculate the target population for FP services and that staff are trained on screening. Similarly, Cameroon's program clearly states that it expects health staff to make accurate calculations of the expected monthly targets for IUD, tubal ligations, and vasectomies.

Facility preparedness or readiness is also a frequent measure of quality. Kenya's program checks whether a facility is ready to provide FP by verifying the level of contraceptive stock (injectables, orals, implants, condoms, and IUCDs). In Lesotho, monitoring and verification of whether clinical equipment (scales, sphygmomanometer, specula, lights, gloves, disinfectants/decontaminants, Ayre's spatula, cervical brushes, slides and fixatives, and IUD insertion kits) is available and working is within the PBF plan. Cameroon includes many preparedness indicators on its quality assessment checklists, and while there are distinct checklists for health centers and hospitals, there are some shared measures between the two: (a) the presence of a wall chart, picture book, or flip chart with demonstrations of different modern FP methods (see Acceptability); (b) an existing security stock of oral and injectable contraceptives; (c) at least five IUD methods and at least five Norplan available and staff capable of placing them; (d) a strategy in place to refer couples for tubal ligation and/or vasectomy (see Availability); (e) the availability of an FP register that is well-filled and current; (f) completion of all rubrics; and (g) the availability of completed FP forms (blood pressure, weight, varicose [sic] veins). Cameroon's hospital quality checklist also looks for whether the hospital business plan has a "convincing strategy to cover family planning," which should include the (a) integration of hospital staff, (b) collaboration with the private sector and the community relays agents, and (c) an outreach strategy and advocacy with traditional or local leaders.

Privacy and/or confidentiality were often mentioned repeatedly across country manuals. Assurances of privacy and confidentiality are indicated by the PBF programs in Cameroon, Kenya, Lesotho, and Tanzania. These principles are measured by individual service provision and full privacy during the service in Tanzania, ensuring consultation spaces are available, windows, blinds, or curtains in Cameroon and Kenya, no direct passage between rooms through which other people might have to walk in Cameroon, non-transparent glass in Kenya, and rooms with closed doors in all countries.

In summary, alongside technical competency, facility readiness, privacy, and confidentiality, which are all aspects of quality, the ways PBF programs define and measure quality overlap other principles, most notably accessibility, acceptability, and availability (see relevant subsections). What is unique about quality is that it is often explicitly built into program operations through the quality checklist and performance metrics. Across the operational manuals, dimensions of quality are captured in performance and quality measures, rewards, and verification procedures.

# Discussion

Placing people and their needs at the center of the design and implementation of PBF health programs is the cornerstone of a rights-based approach and doing so promotes health equity. PBF utilizes incentives, often monetary, to encourage good practices in healthcare delivery and utilization. Focusing attention on quality of care, informed choice, and voluntarism within the context of a rights-based approach to PBF could help to encourage positive behaviors by health sector actors and counterbalance the risk of perverse and unintended outcomes.

Health systems' administration and programming must align and further governments' responsibilities to their citizens. Expanding accountability mechanisms within PBF programs can strengthen the health systems governance by including the voice of clients and communities, increasingly the likelihood that their needs are fully met through PBF programming. This is particularly interesting as ministries of health and finance are government agencies and are often chief managers of PBF programs. Improved governance of health systems might improve the quality of healthcare and simultaneously expand effective health services to more people.

Recent publications have called for rethinking PBF verification to reduce the risk of harming consumers PBF is intended to serve. Thinkwell co-founder Yogesh Rajkotia argues that “international development doesn't care about patient privacy” as he described how he saw PBF verification processes undermining patient privacy and confidentiality (Rajkotia, 2018). Another report argues that PBF implementation was hastily and poorly integrated into health systems, failing to attend to necessary long-term, systemwide reforms, such as working conditions for human resources, transparency, and accountability (Paul et al., 2018b). These calls for reform align with GFF's own recommendations to incorporate a dynamic risk assessment, greater privacy and patient confidentiality, and anticipate indicator verification in the design phase of program development (Vergeer et al, 2016). There is a well-recognized need for purposive incorporation of rights principles into PBF design to both fortify and legitimize the PBF strategy in the development space.

## CURRENT STATE OF PRINCIPLES RELATED TO A RIGHTS-BASED APPROACH IN PBF IMPLEMENTATION

Although specific principles are upheld in PBF operational manuals, across the manuals reviewed there is inconsistent inclusion of principles for a rights-based approach to PBF programs. Only one program, Argentina's *Plan Nacer*, directly spoke to protecting or championing the rights of FP, or any healthcare, clients. All the countries advance the essence of at least one of the principles in their targets, monitoring, and rewards; and some are aligned with multiple principles. However, PBF programs generally do not employ a rights-based approach to health program development and service delivery. Based on this scoping review, PBF operational documents at the country level do not explicitly incorporate a rights-based framework, but they address specific principles in the design and implementation of PBF programs. Those principles generally measured by PBF programs tend to be those that are easier to observe, making them more quantifiable and amenable for data collection by health service actors and verification parties. For instance, the number of low-income service users or the number of service delivery points in hard-to-reach locations are countable and verifiable.

## **GAPS IN INCLUSION OF PRINCIPLES RELATED TO AN RBA IN PBF PROGRAMS**

### **Partial recognition of rights principles**

Except for the principle of agency, all the principles are included to some extent across the reviewed documents, but most principles are only narrowly addressed. For instance, physical dimensions of accessibility were addressed in a few programs, but there was little to no emphasis on financial or information dimensions of accessibility. Under the right to non-discrimination and the principle of equity, disadvantage and discrimination due to income and ethnicity were addressed, yet an important dimension of disadvantage, namely adolescence, was neglected. This section highlights gaps in the inclusion of three principles among the PBF manuals reviewed.

### **Absence of the Principle of Agency**

In the operations manuals, the only principle strikingly absent was that of agency, which was grouped with autonomy, empowerment, and voluntarism for this review. Agency implies people know their right to make FP decisions and can make their own decisions about contraceptive use. It should be noted, however, that the definitions for these principles intersect; and informed choice/informed decision-making, for which there was some inclusion, albeit minimal, focused on the provision of comprehensive FP information to help clients with decision making. These principles, while discussed with regard for family planning, are imperative to all healthcare programs. Clients should be active and engaged participants in their healthcare use. In the case of family planning, clients must make voluntary, informed decisions about contraceptive use, for which the principle of agency is critical.

### **Lack of Downward Accountability**

Accountability was the only principle addressed by every PBF implementation manual reviewed. However, most of the accountability systems are internal, horizontal performance systems that are explained in detail for PBF verification purposes, connecting health service actors to PBF regulators and funders. The manuals focus largely on the major players in supply-side PBF schemes, (a) funders, (b) regulators/verifiers, and (c) health service providers, and the contracts among and between these agents. The implementation manuals and contracts concentrate on the roles and responsibilities of each as well as the contracted services that are eligible for financial reward. They do not discuss how healthcare users should be or are expected to be included in and served by the health system. In this way, there was negligible inclusion of downward accountability to clients. The responsibility of health programs to clients is determined through (a) client surveys, (b) exit interviews, (c) verification observations, and (d) reviews of various facility registers for very few and specific details, such as whether the client was truly served by a facility. As such, accountability measures in current PBF implementation documents do not speak to accountability to the communities served, which would require client and community participation in program design and implementation beyond satisfaction surveys.

### **Incomplete notion of quality**

Quality, a principal performance measure in PBF, provides an interesting challenge for many PBF programs because its definition is broad and subjective, and its performance measures remain confusing. Additionally, other principles (accessibility, availability, and acceptability) can overlap to some degree with notional aspects of quality. It would be helpful if quality in PBF was based on a clearly-defined theoretical framework. For more than 25 years, the FP field has been guided by the Bruce FP Quality of Care (QOC) Framework (Bruce, 1990). Recently, Jain has proposed a revision of the FP QOC Framework (see Box 1) that aligns it with definitions of quality of care in frameworks for rights-based FP (WHO, 2014; FP2020, 2014; Hardee et al.,

2014). This revised FP QOC framework could serve this purpose. The PBF implementation manuals tend to focus more on supply-side quality (largely not from the consumer experience) and do not explain the selection of quality indicators included in the country manual.

### Focus on supply over demand

Finally, the PBF implementation manuals reviewed focused on supply-side financial incentives and RBF “encompasses the entire range of incentive approaches on both the demand and the supply sides” (Fritsche, Soeters, & Meessen, 2014). While there are programs inclusive of or focused on demand-side schemes, these were not presented in the reviewed manuals. Demand-side programs are important for their focus on the barriers and constraints faced by the consumers trying to access desired services. They are, therefore, more directly responsive to consumer needs than programs aimed at health system strengthening and performance.

#### Box 1: Revised FP Quality of Care Framework

##### **Structure** (quality of services or readiness of services to provide intended level of care)

- Choice of methods
- Availability of the appropriate number and type of methods
- Required equipment to provide the range of methods
- Availability of space to ensure audio and visual privacy
- Availability of appropriate constellation of reproductive health services
- Availability of trained/competent provider in:
  - Providing contraceptive methods safely by ensuring compliance with correct medical procedures and infection prevention practices
  - Treating clients with dignity and respect
  - Appropriate information exchange with clients

##### **Process** (quality of care offered to clients and received by them)

- Appropriate information exchange with clients to ensure:
  - Selection of a method appropriate to client’s needs and circumstances by *soliciting information* from them about their reproductive intentions, family circumstances, prior use of contraception, and preferred method; and by providing information on alternate methods appropriate to their needs
  - Effective contraceptive use by *informing clients* about such items as how to use the method selected, potential side effects and how to manage them if they occur
  - Continuity of care and contraceptive use by *informing clients* when to come back for resupply and possibility of switching the method, provider, or service outlet whenever the selected method/provider/outlet does not remain suitable
- Interpersonal relations including:
  - Treating clients with dignity and respect
  - Ensuring audio and visual privacy and confidentiality

Source: Jain and Hardee, 2018

# Limitations

This report has been limited to the review of country-specific operations manuals for PBF programs. It does not include a full review of other PBF operational documents developed by nongovernmental agencies, which may have sourced different data or outlined other implementation approaches. Additionally, not all existing PBF operations or implementation manuals have been reviewed. Only those sourced through web searches and expert consultations in 2017 were included.

Other resources like project appraisal documents (PAD) and investment cases (IC) may illuminate whether geographic targeting was based on equity considerations. From conversations with one GFF representative, it seems as if this may be the case in some country investments. In an internal review of PADs and IC documents prior to reviewing the 23 implementation manuals, Population Council researchers did not locate discussions of equity targeting; however, further research is warranted if only to surface evidence of rights principles in existing documents and acknowledge the past efforts in this regard.

This evidence mapping of PBF operational documents sorted current PBF design and implementation elements according to the selected rights principles. As PBF aligns with the wider interest in strategic purchasing in universal health coverage and is a technical strategy for which countries increasingly seek GFF support, systematically incorporating rights principles into PBF program design beforehand becomes an ever greater priority.

# Recommendations and Conclusion

A significant share of the technical support in designing PBF programs is administered by the World Bank and funded by contributing governments that have signed on to international agreements to ensure citizens the right to the highest attainable standard of health. The review identified a need for a clearer articulation and prioritization of all principles to a rights-based approach throughout the PBF lifecycle, from investment cases to PADs and into PBF operational manuals and program tools. What is currently missing in the PBF programs is a client orientation. There is a particular need for more attention on agency, informed choice, and availability, which were absent or poorly represented in this evidence mapping. All rights principles should be clearer and consistent throughout countries' PBF programs and included in how country requests for support are assessed by GFF and partners. Relevant guidance materials ought to be developed to sensitize and support country teams when developing PBF programs. Using the existing documentation from FP2020 would be a good start for this (<http://www.familyplanning2020.org/microsite/rightsinfp>). Core indicators 14-16 at FP2020's Track20 can be considered for assessment and potentially for rewarding performance.

Current PBF guidance lacks a right principles framework and could draw from FP communities of practice to develop a practical implementation scheme oriented toward client rights. The PBF theory of change is framed as an empowering, equitable, efficient, and effective approach to strengthening health systems, yet in the operational guidance, it often focuses on empowerment and autonomy of the provider and facility; a similarly strong emphasis on the client is needed for better health outcomes.

The review notes that most of the implementation manuals identified here were developed prior to the establishment of the GFF. The GFF Business Plan declares that “equity, gender, and rights underpin and are mainstreamed throughout the GFF’s work” and that country ownership and guidance are some of its guiding principles. As such, the GFF provides an opportunity for a renewed, concerted focus on integrating rights principles into PBF design, as it influences agent behavior in a classic principal-agent arrangement. Under PBF in the health sector, agents are often the facility-based providers, and to some extent the district administration. Just as governments are expected to work towards the progressive realization of their citizens’ rights, an iterative learning process is critical to operationalizing a rights-based PBF program.

Some important questions have been addressed by this evidence mapping; gaps with respect to particular rights principles have been identified. A second report from the same research effort explores the rights-based approach to PBF indicators for FP services. Both reports provide an assessment of the state of rights principles articulation and operationalization in PBF programs for FP services.

From the results presented here, there is a clear opportunity for future operations manuals to more explicitly and systematically address rights principles. How rights principles are incorporated into implementation will require a thoughtful, iterative approach that documents the efforts made while accounting for contextual variation. Determining the programmatic structure of a fully operational rights-based approach in any PBF program is guided by international agreement on a rights principles framework for family planning programs as well as local stakeholder contextualization in the respective health system.

Going forward, PBF operations manuals ought to summarize their PBF theory of change from a rights-based approach to implementation. Given its centrality to funding through the GFF partners, PBF for FP services will have significant implications on the abilities of women and couples to choose if, when, and how many children to bear in their lifetimes. Placing consumers at the heart of services and ensuring they are always prioritized and protected when designing, planning, and implementing PBF programs is critical to ensuring

that people are able to make their own decisions about FP use and to sustaining PBF programs, particularly in countries supported by GFF.

# References

- Arksey, H., & O'Malley, L. (2005). "Scoping studies: towards a methodological framework," *International Journal of Social Research Methodology: Theory and Practice*, 8(1), 19–32.  
<https://doi.org/10.1080/1364557032000119616>
- Basinga, P. et al (2011). "Effect on maternal and child health services in Rwanda of payment to primary health-care providers for performance: an impact evaluation," *The Lancet*, 377(9775), 1421–1428.  
[https://doi.org/10.1016/S0140-6736\(11\)60177-3](https://doi.org/10.1016/S0140-6736(11)60177-3)
- Bellows, N. M., Askew, I., & Bellows, B. (2014). "Review of performance-based incentives in community-based family planning programmes," *The Journal of Family Planning and Reproductive Healthcare*, 1–6.  
<https://doi.org/10.1136/jfprhc-2014-100883>
- Bertone, M. P., Lagarde, M., & Witter, S. (2016). "Performance-based financing in the context of the complex remuneration of health workers: findings from a mixed-method study in rural Sierra Leone," *BMC Health Services Research*, 16(1), 286. <https://doi.org/10.1186/s12913-016-1546-8>
- Blacklock, C. et al (2016). "Paying for Performance to Improve the Delivery and Uptake of Family Planning in Low and Middle Income Countries: A Systematic Review," *Studies in Family Planning*, 1–16.  
<https://doi.org/10.1111/sifp.12001>
- Boydell, V. et al (2018). *Mapping the Extent to Which Results-Based Financing Programs Reflect a Right-Based Approach and Implications for Family Planning Services: A review of indicators*. Population Council: Washington D.C.
- Bruce, J. (1990). "Fundamental elements of the quality of care: a simple framework," *Studies in Family Planning*, 21(2), 61–91. <https://doi.org/10.2307/1966669>
- Burkina Faso Ministere de la Sante. (2013). *Guide de Mise en Oeuvre du Financement Base sur les Resultats dans le Secteur de la Sante*. [Implementation guide for results-based financing in the health sector] Chowdhury, S. et al (2013). *Economics and Ethics of Results-Based Financing for Family Planning: Evidence and Policy Implications. Health, Nutrition and Population (HNP) Discussion Paper Series*. The World Bank Group: Washington, D.C.
- Consortium AEDES/IRESO. (2012). *Performance Based Financing Implementation Procedures Manual: North-West Region of Cameroon*.
- Cortez, R., Vanina Camporeale, D. R., & Perez, L. (2012). *Results-Based Financing for Health in Argentina: The Plan Nacer Program*.
- Couture, T. (2016). *GFF falls short on family planning*. PAI: Washington, D.C. <https://pai.org/policy-briefs/global-financing-facility-family-planning/>
- Dijkers M. (2011). *What is a scoping review?* KT Update. 4(1):1-5. Center on Knowledge Translation for Disability and Rehabilitation Research  
<http://www.methods.manchester.ac.uk/events/whatis/scopingstudy.pdf>
- Eichler, R., Levine, R., & The Performance-Based Incentives Working Group. (2009). *Performance Incentives for Global Health: Potential and Pitfalls*. Center for Global Development. Washington, D.C.  
<https://doi.org/10.1080/17441692.2010.514616>

- Eichler, R. et al (2010). *Performance-Based Incentives: Ensuring Voluntarism in Family Planning Initiatives. Health Systems 20/20 project*. Bethesda, MD. Retrieved from [www.healthsystems2020.org/5Cnwww.abtassociates.com](http://www.healthsystems2020.org/5Cnwww.abtassociates.com)
- Erdman, J. N., & Cook, R. J. (2008). Reproductive Rights. In S. R. Quah & K. Heggenhougen (Eds.), *International Encyclopedia of Public Health* (1st edition, pp. 532–538). Academic Press.
- Every Woman Every Child. (2016). Every Woman Every Child: About. Retrieved January 2, 2018, from <http://www.everywomaneverychild.org/about/#sect5>
- Family Planning 2020. (2014). *Family Planning 2020: Rights and Empowerment Principles for Family Planning*. Retrieved from <http://www.familyplanning2020.org/resources/4697>
- Family Planning 2020. (2017). About Us. Retrieved December 5, 2017, from <http://www.familyplanning2020.org/microsite/about-us>
- Family Planning 2020. (2018). Rights-Based Family Planning. Retrieved December 31, 2017, from <http://www.familyplanning2020.org/microsite/rightsinfp>
- Federal Ministry of Health, Ondo Nasarawa and Adamawa State Ministries of Health, National Primary Healthcare Development Agency, Ondo State Primary Healthcare Development Board, & Nasarawa and Adamawa State Primary Healthcare Development Agencies. (2013). *Nigeria State Health Investment Project (NSHIP) Performance-Based Financing User Manual*.
- Fritsche, G. B., Soeters, R., & Meessen, B. (2014). *Performance-Based Financing Toolkit*. Washington, D.C. <https://doi.org/10.1596/978-1-4648-0128-0>
- Government of Sierra Leone. (2012). *Sierra Leone Performance-Based Financing Scheme for the Health Sector Operational Manual Volume II*.
- Grittner, A. M. (2013). *Results-based Financing: Evidence from performance-based financing in the health sector*. Bonn. Retrieved from <http://www.oecd.org/dac/peer-reviews/Results-based-financing.pdf>
- Guttmacher Institute. (2017). Unmet need for modern contraception, 2017. Retrieved December 22, 2017, from <https://www.guttmacher.org/infographic/2017/unmet-need-modern-contraception-2017>
- Hardee, K., Harris, S. et al., (2014). “Achieving FP2020 Goal through Voluntary, Rights-based Family Planning: What Can We Learn from Past Experiences with Coercion?” *International Perspectives on Sexual and Reproductive Health*, 40(4), 206–214.
- Hardee, K., Kumar, J. et al., (2014). “Voluntary, Human Rights-based Family Planning: A Conceptual Framework,” *Studies in Family Planning*, 45(1), 1–18.
- Institute for Collaborative Development. (2015). *Performance-Based Financing Project Implementation Manual for Gaza and Nampula*.
- Jain A, Hardee K. Revising the FP Quality of Care framework in the context of Rights-based Family Planning. *Studies in Family Planning* 2018;49(2):171-179. <https://onlinelibrary.wiley.com/doi/epdf/10.1111/sifp.12052>.
- Jain, A. K. (2017). *Quality of Care in the Context of Rights-Based Family Planning*. New York.

- Kandpal E. (2016) *Completed Impact Evaluations and Emerging Lessons from the Health Results Innovation Trust Fund Learning Portfolio*. World Bank Group / GFF: Washington D.C.  
<https://www.rbhealth.org/resource/completed-impact-evaluations-and-emerging-lessons-health-results-innovation-trust-fund>
- Kumur, J. et al (2017). *Rights-Sizing Family Planning: A Toolkit for Designing Programs to Respect, Protect and Fulfill the Rights of Girls and Women*. Retrieved from [http://ec2-54-210-230-186.compute-1.amazonaws.com/wp-content/uploads/2017/05/DRAFT\\_FP2020\\_Rights-Sizing-Family-Planning-Toolkit.pdf](http://ec2-54-210-230-186.compute-1.amazonaws.com/wp-content/uploads/2017/05/DRAFT_FP2020_Rights-Sizing-Family-Planning-Toolkit.pdf)
- Kutzin, J. (2013). “Health financing for universal coverage and health system performance: Concepts and implications for policy,” *Bulletin of the World Health Organization*, 91(November 2012), 602–611.  
<https://doi.org/10.2471/BLT.12.113985>
- Lesotho Ministry of Health. (2013). *Kingdom of Lesotho Maternal and Newborn Health Performance Based Financing Project Implementation Manual*.
- Loevinsohn, B. (2008). *Performance-Based Contracting for Health Services in Developing Countries: A Toolkit*. Health, Nutrition, and Population Series (Vol. 86). Washington, D.C. <https://doi.org/10.1596/978-0-8213-7536-5>  
 Library
- Musgrove, P. (2011). *Financial and Other Rewards for Good Performance or Results: A Guided Tour of Concepts and Terms and a Short Glossary*. The World Bank. Retrieved from  
[http://www.rbhealth.org/sites/rbf/files/documents/Rewards for Good Performance or Results - Short Glossary.pdf](http://www.rbhealth.org/sites/rbf/files/documents/Rewards%20for%20Good%20Performance%20or%20Results%20-%20Short%20Glossary.pdf)
- Operations Manual: Results Based Financing Intervention in BPHS Facilities and Hospitals in Afghanistan*. (n.d).
- Paul, E. et al(2018a). “Performance-based financing in low-income and middle-income countries: isn’t it time for a rethink?” *BMJ Global Health*, 3(1), e000664. <https://doi.org/10.1136/bmjgh-2017-000664>
- Rajkotia, Y. (2018). International Development Doesn’t Care About Patient Privacy. *Stanford Social Innovation Review*. Retrieved from  
[https://ssir.org/articles/entry/international\\_development\\_doesnt\\_care\\_about\\_patient\\_privacy](https://ssir.org/articles/entry/international_development_doesnt_care_about_patient_privacy)
- Republic of Armenia Ministry of Health. (2014). *Performance-Based Financing Manual*.
- Republic of Liberia Ministry of Health and Social Welfare. (2012). *Performance Based Financing Operational Manual*.
- Republic of Rwanda Ministry of Health. (2009). *National Community Performance-Based Financing Implementation Manual*.
- Republic of Tajikistan Ministry of Health and Social Protection. (2014). *Implementation Manual for Performance-Based Financing in Tajikistan Health Services Improvement Project (HSIP)*.
- République d’Haïti Ministère de la Santé Publique et de la Population. (2013). *Manuel Opérationnel du Financement basé sur les Résultats en Haïti*. [Operational manual of results-based financing in Haiti]
- République de Côte D’Ivoire Ministère de la Santé et de la Lutte contre le Sida. (2014). *Rapport de Mission, Aide Mémoire et Plan Stratégique PBF 2014-2016 en Côte d’Ivoire*. [Mission report, aide mémoire and strategic plan PBF 2014-2016 in Côte d’Ivoire]

- Republique de Djibouti Ministère de la Santé. (2014). *Manuel des Procédures pour la Mise en Oeuvre du Financement Base sur la Performance Djibouti*. [Procedures manual for the implementation of Djibouti performance-based financing]
- Republique Democratique du Congo Ministère de la Santé Publique Secrétariat Général. (2015). *Manuel opérationnel du Financement Basé sur la Performance*. [Operational manual for performance-based financing]
- République du Bénin Ministère de la Santé, Secrétariat Général du Ministère, & Programme de Renforcement du Système de Santé. (2014). *Document de Cadrage du Financement Base sur les Resultats (FBR) au Benin Version Validée*. [Results-based financing framework document in Benin validated version]
- Republique du Burundi Ministère de la Santé Publique. (2010). *Manuel des Procédures pour la Mise en Oeuvre du Financement Basé sur la Performance au Burundi*. [Procedural manual for implementation of performance-based financing in Burundi] Republique du Mali Ministère de la Santé. (2011). *Manuel des Procédures du Financement Base sur les Resultats au Mali*. [Procedures manual on results-based financing in Mali]
- Republique du Senegal Ministère de la Santé de l'Hygiène Publique et de la Prévention. (2012). *Manuel de Procédures du Projet Pilote de Financement Basé sur les Résultats (FBR) dans le Secteur de la Santé au Sénégal*. [Procedures manual for the pilot results-based financing project in the health sector in Senegal]
- Soeters, R. et al (2011). "Performance-based financing experiment improved healthcare in the Democratic Republic of Congo," *Health Affairs*, 30(8), 1518–27. <https://doi.org/10.1377/hlthaff.2009.0019>
- The Government of Kenya The Ministry of Health. (2013). *Results Based Financing (RBF) Operational Manual*.
- The United Republic of Tanzania Ministry of Health and Social Welfare. (2015). *Result Based Financing (RBF) Operational Manual*.
- The World Bank. (2015). *Business Plan: Global Financing Facility in Support of Every Woman Every Child*. Washington, D.C.
- The World Bank Group. (2014). Mission | History. Retrieved from <https://www.rbhealth.org/mission-history>
- UNCESCR. (2000). *CESCR General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12)*.
- United Nations. (n.d.). Goal 3: Ensure healthy lives and promote well-being for all at all ages. Retrieved December 5, 2017, from <http://www.un.org/sustainabledevelopment/health/>
- United Nations Population Fund. (2014). *Programme of Action of the International Conference on Population Development. 20th Anniversary Edition*.
- Vergeer P, et al *Verification in Results-Based Financing for Health. Health Nutrition and Population Discussion Paper* (2016). <http://www.rbhealth.org/sites/rbf/files/Verification-in-RBF-for-Health.pdf>.
- Wagstaff, A. et al (2015). *Measuring Progress Towards Universal Health Coverage: with an Application to 24 Developing Countries* (Policy Research Working Paper No. No. 7470). Washington D.C.

WHO. (2014). *Ensuring human rights in the provision of contraceptive information and services - Guidance and recommendations*. World Health Organization. Geneva. <https://doi.org/10.1109/ITAB.2007.4407404>

Zambia Ministry of Health, & The World Bank. (2011). Operational Implementation Manual for Results Based Financing (RBF) in Pilot Districts in Zambia. *Revised Final Version*, 1–128. <https://doi.org/10.1007/s13398-014-0173-7.2>

## **The Evidence Project**

Population Council  
4301 Connecticut Avenue, NW, Suite 280  
Washington, DC 20008 USA  
tel +1 202 237 9400

[evidenceproject.popcouncil.org](http://evidenceproject.popcouncil.org)