Case Study on Narrowing the Gaps for Equity

Benin

Equity in access to health care for the most vulnerable children through Performance-based Financing of Community Health Workers in four districts of Benin
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ABSTRACT
To address the current inequality in access to health care, the Ministry of Health (MOH) and UNICEF initiated a performance-based financing (PBF) approach at community level, in four health districts: Sakété-Ifangni, Pobè-Adja-Ouèrè-Kétou, Malanville-Karimama and Sinendé-Bembèrèkè. This aims at reducing infant and child morbidity and mortality through the management of major childhood illnesses including immunization, and promotion of Essential Family Practices (EFP). The approach is based on a partnership between the health district representing the Ministry of Health, the municipality, and UNICEF. At operational level, terms of reference were designed and signed between the Head of health center, the Village Chief and the Community Health Workers (CHW) who liaise the community and the health system.

To ensure sustainability, incentives are paid to CHWs depending on their performance. After 12 months of implementation, results are encouraging: 112,560 under-five boys and girls benefited from access to health in 461 villages.

BACKGROUND
According to The Lancet, the main causes of infant mortality include neonatal illnesses (28.5%), malaria (22.9%), ARI (12.0%) and diarrhea (9.8%). The 2006 Demographic Health Survey (DHS) revealed that 2 deaths out of 3 among under five children occur within the community. This highlights the challenge of offering health services to children in remote areas. To address this, CHWs were identified and trained for health interventions. CHWs living more than 5 km from a health center offer a full package of interventions (case management of common illnesses and promotion of EFP), while those living less than 5 km offer only a promotion package (for EFP).

After a promising start, many CHWs gave up activities, due to lack of both supervision and financial motivation.

Taking into account the decentralization process which devotes responsibilities to municipalities in all sectors, the MoH jointly with UNICEF and other partners promoted, the PBF approach in 4 health districts selected on the basis of poverty, high U5MR, malnutrition prevalence, low immunization rate, low access to water and sanitation.

This approach should demonstrate that incentives improve CHWs’ performance and contribute to reducing infant and child morbidity and mortality in the targeted districts.

STRATEGY & IMPLEMENTATION
Objectives:
- Improve access to high impact intervention packages at community level for the most vulnerable children;
- Facilitate sustainability through the strengthening of partnership between the Ministry of Health, the communes and technical and financial partners through contracting;
- Encourage CHW’s loyalty through financial motivational measures.
The implementation process is shown in the diagram below and comprises different steps:

**AFBP model diagramme**

**National level**

**National Steering Committee:** Ministry of Health, TFPs including UNICEF, USAID, NGOs, Ministry in charge of Decentralization

**Operational level**

**Operational steering Committee:** health districts supervisory team and Departmental Health Directorates, Prefectures

**Municipality (buyer)**

- Technical/financial support of UNICEF
- Monitoring and community evaluation
- Payment of incentive

**Health team (Assessment)**

- Submission of performance outcomes
- Evaluation performance/Supervision

**Community outreach worker (seller, service provider)**

- Interventions package proposal

**Under-five children, mothers, fathers or child caregivers (beneficiaries)**

**Village level**

**Identification and training of CHWs**

1,087 community health workers including 41% women were identified and trained on the full intervention package at community level (facilitation techniques, management of malaria, diarrhea, ARI and malnutrition cases, promotion of essential family practices). 57% of CHW offer the full package while 43% offer the promotion package. The CHWs were given kits made up of essential drugs (ACT, Cotrimoxazole, paracetamol, SRO/Zinc, aquatabs), diagnostic tools (timer, MUAC, etc.) and data collection materials (record books for health care, home visits, and newborn follow-up).

The programme aims at serving 55,509 households and 112,560 under-five children registered by census. Hence, each CHW is responsible for about 51 households.

**Advocacy and social mobilization activities**

The signing of a tripartite partnership agreement (municipality, health district, UNICEF) assigns responsibility to the municipality to pay incentives to CHWs with funds provided by UNICEF for 18 months, and on their own budget after this period. It also specifies the technical support to be provided the health district.

The signing of the terms of reference between the CHWs, the Head of the health center and the village chief, defines the roles and responsibilities of each stakeholder.
**System and process assessment**

The monthly supervision of CHWs and the quarterly monitoring by health agents enable the assessment of the performance, recorded on the basis of 10 indicators:

- For the CHWs providing the full package: number of cases of malaria, diarrhea and ARI managed, adequate case management, number of health education sessions completed, number of home visits performed, contribution to routine immunization, and number of malnourished children identified.
- For the CHWs providing the promotion package: number of children sleeping under an impregnated mosquito net, rate of exclusive breastfeeding, number of malnourished children identified, number of children not fully immunized identified and brought to an immunization session, hand washing facility beside latrines, use of aquatabs, etc.

A household survey was conducted to validate data collected by CHWs. The health district team presents the results of the monitoring to locally-elected authorities who pay the CHW the corresponding allowance.

**Capacity building in interventions coordination and monitoring**

Quarterly meetings with key stakeholders and international technical support missions contribute to the staff capacity building, coordination and monitoring of implementation of the entire system.

**PROGRESS & RESULTS**

**Preliminary outcomes**

For results monitoring, two working hypothesis have been used. 1) it is assumed that each child will have one episode of each disease per year, and 2) that 60 per cent of cases are managed at the health center while 40 per cent are managed at community level.

Over a twelve-month period, 26,772 cases of malaria, 5,964 of diarrhea and 7,520 of ARI were managed by CHWs. These are respectively 59 % of malaria cases, 17 % of ARI and 13 % of diarrhea cases treated as compared to the cases expected during the last 12 months as per our working assumption. As for the quality of care, it is generally satisfactory in 84 % of the malaria cases, 82% of diarrhea and 82% of ARI treated.

For promotion activities, CHWs contributed to: (i) the immunization of 73% of the expected targets for anti-measles antigen, (ii) the monitoring of 54% of the identified malnourished children. Interviews of mothers visited by CHWs revealed that 82% are able to detect at least 2 danger signs, 20% of children sleep under Insecticide treated bednets, 89% of children below age 6 months were exclusively breastfed. The rate of potable water utilization or aquatabs (31%) and availability of hand-washing equipment at latrines (20%) still remained low.

As for CHWs’ performance, three levels were adopted: poor performance (outcomes below 50% on each of the 10 indicators), fair performance (outcomes between 50 and 80 %) and good performance (outcomes above 80% of the 10 indicators). The number of poor performers appears to decrease over time.
CHALLENGES
It proved challenging for each CHW to reach every family under her/his responsibility. This led to the review of the number of households and children each CHW should care for and it was decided, in line with the national guidelines for the Promotion of Community Health CHW offering the full package (management of illness cases, promotion of essential family practices) would cover 30 households and the CHW offering exclusively the promotion package (promotion of essential family practices) would cover 50 households. The supervision of CHWs by health staff has not always been conducted on a regular basis, especially with regard to the verification and control of activities carried out within households.

LESSONS LEARNED
1. The sustainability of the system established implies an actual commitment of all stakeholders at community level, from the CHWs to the mayors, through health center managers. UNICEF-supported interventions pertaining to the performance-based financing approach are focused on the level of the CHWs. They do not target the health centers level which is supported by other donors such as the World Bank. A partnership to establish a continuum of the PBF approach across the health system should improve the effectiveness of the programme by better addressing issues of referral and supervision.
2. If our working assumptions are correct, there is a tendency to over-diagnose malaria and treat all fevers with ACT. To correct this, the MoH is introducing a specific training on the use of RDT to diagnose malaria before prescribing ACT.

INNOVATION

- CHWs have always been requested to work on a voluntary basis. They devote part of their time to health and nutrition activities and they expect in return, in addition to recognition, a financial retribution. In the long term, too often, they give up their assignment. This proves the limit of volunteering within a low income environment. In front of such a reality, it was urgent to find a sustainable mechanism to address the issue of CHW’s financial motivation. Benin is the first country in the West African sub-region to initiate the "performance-based financing approach at community level". Its key principles are the financial motivation of CHWs through the payment of incentives based on their performance calculated according to the quarterly monitoring of their activities;
- The empowerment of the local community which proceeds to the quarterly payment of the incentives based on the monitoring of the health of the population;
- The sustainability of community based services through the commitment of the CHWs and the engagement of local authorities.

POTENTIAL APPLICATION

The experience of the collaboration with the CHWs can be replicated in other related fields including:

- Birth registration: this would give children living in remote areas, the opportunity to have their birth certificates issued within a short time.
- The provision of mobile phones could help CHWs collect accurate data on the community, and would serve to provide early warning to the population on imminent dangers (protection measures in case of epidemic, emergency, etc.). The mobile phone could also serve as a tool to send educational messages for awareness-raising on danger signs for pregnant women, newborn and their mother, and help ensure referral of cases thus giving vulnerable children and women an additional chance to survive.

NEXT STEPS

- Continue advocacy with health districts for secure funding, in order to ensure sustainability of interventions.
- Extend the performance-based financing approach to 2 other health districts.
- Introduce the mobile phone strategy to support interventions in 2 health districts.
- Establish a partnership with the World Bank to develop a global approach of performance-based financing at the institutional and community levels.
- Document the performance-based financing approach at community level during the 18 months of implementation.

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