correlated with positive maternal, newborn and child health and survival outcomes – for example: the proportion of deliveries in an accredited facility; immunization coverage; of three doses of diphtheria, tetanus toxoid and pertussis vaccine; or coverage of insecticide-treated mosquito nets in malaria-endemic areas. These outputs and targets would be selected based on the risk factors contributing to mortality and morbidity for each country.

Key outcome indicators can be set in various forms. These parameters can measure either direct outputs, such as the absolute number of children immunized; coverage, such as the percentage of the target population vaccinated, by antigen, in a defined catchment area; or trends, such as increases in the number of children vaccinated or coverage levels achieved over time. A set of core indicators can also be defined for all projects to allow for some cross-country comparison and learning. Countries could also include additional indicators that monitor important elements of their maternal, child and newborn health programmes.

Developing innovative and equitable financing strategies

Investment in human resources and health-system strengthening requires significant resources. Countries where donor support plays a critical role in funding these programmes cannot plan for long-term activities unless financing is secure. Yet, research tracking donor assistance to maternal, newborn and child health found that the 60 priority countries that account for more than 90 per cent of child deaths received only US$1.4 billion in official development assistance in 2004, or just US$3.10 per child. While the Strategic Framework suggests that it is possible to fill the gap between present levels and near-universal coverage by 2015, it also shows that scaling up interventions will not be possible without massively increasing investment in maternal, newborn and child health. Moving towards universal access to a continuum of quality maternal, newborn and child health care, however, is not merely a question of finding money to expand the supply of services or to pay providers. Reaching the health-related MDGs will require that financing strategies focus on overcoming financial barriers to women and children’s access to services and give users predictable protection against the financial hardship that may result from paying for care. This has important implications. Calls for the immediate and universal elimination of user fees for health-care services may prove overly simplistic or unrealistic. Policy decisions regarding user fees should be addressed within the broader context of the health sector budget and the national budgetary framework. Over time, user fees may be phased out in favour of prepayment and pooling schemes, on condition that this is accompanied, from its inception, by structural changes to ensure the long-term sustainability of health financing.

IV. Obtaining national political commitment

Given the level of resources required to ensure access to quality primary health-care services and financial protection, scaling up is as much a political challenge as it is a technical one.

Performance-based financing in Rwanda

The Government of Rwanda, with support from donors, has recently scaled up several innovative programmes that transfer conditional grants from the central government to municipalities to implement essential health outputs. The health programme includes three principal elements:

Community partnerships in health: This transfers resources (about US$0.25 per capita) directly to municipalities to engage, via a performance-based contract, community-based institutions, non-governmental organizations, health promoters, private health-care providers and other related services to deliver essential interventions at the household and community levels. A performance contract called IMIHIGO – a traditional word that has become synonymous with accountability in government services throughout the country – is signed between the President of Rwanda and district mayors on behalf of their constituencies every year. The services delivered under this approach are simple and low cost, focusing on the promotion of improved health and hygiene practices, behaviour-change interventions, and such preventive services as distribution of insecticide-treated mosquito nets, oral rehydration therapy, nutritional supplementation and safe water systems.

These partnerships were introduced in several districts during 2005 and have been scaled up at the national level since 2006 using treasury funds. The central government signed performance contracts with the 30 municipalities in April 2006 and selected coverage of insecticide-treated nets as the lead performance indicator. Marked results have been achieved since its inception. An evaluation undertaken in June 2007 found that utilization of mosquito nets by children under five had increased from 3 per cent in 2004 to more than 70 per cent in 2007. The number of cases of malaria has decreased dramatically, emptying paediatric wards, and population-based surveys using blood tests show a dramatic decrease in malaria prevalence. Policymakers rate the situation as unprecedented and are working now at a strategy to eliminate malaria altogether.

Health centres: This strand transfers resources (about US$1 per capita in 2007, or about 15 per cent of government resources apportioned to health) to primary care centres through a performance-based contract. The scheme was initially piloted in two provinces, Butare and Cyangugu, with the support of non-governmental organizations and bilateral aid from 2002. The performance-based contract includes indicators related to adequate coverage (quantity), as well as effective coverage (quality) of services. An evaluation has shown a significant increase in utilization of health services, including immunization and assisted deliveries, in the provinces where the contracts had been implemented compared with provinces that were not covered by the contracts.

The Government of Rwanda subsequently decided to gradually expand the programme to other provinces, incorporating lessons from the pilots. In 2005, budget allocations for the programmes were apportioned to two provinces that had undertaken the pilot schemes. The following year, the programme was expanded nationwide and fully transferred to the national budget, and it directly linked service delivery, results and payment. A steering committee has been established in each province to independently monitor the performance of the health centres using lot quality sampling and satisfaction surveys. The results of the independent verification directly affect the amount of funding received by each centre. Again, results from the centres were impressive, with immunization coverage rates of 95 per cent and increases in the annual utilization of services from 0.4 visits per capita in 2004 to 0.7 per capita in 2006 and in assisted deliveries from 29 per cent in 2000 to 52 per cent in 2006. The full impact of these schemes on health outcomes is being evaluated through a randomized controlled prospective design. The programme has also been expanded to all district hospitals of the country.

Health micro-insurance schemes: Mutuelles – informal micro-insurance schemes that pool funds from community members to cover a package of basic health services provided by health centres and for the transfer of patients, if needed, to referral hospitals – have been piloted successful during the last decade. Their aim is to smooth the cost of health services for members, eliminating the hardship of making out-of-pocket payments. Mutuelles have an important role in intermediating between health centres, district hospitals and the general population. Evaluations show they are more effective when they have strong community participation in their governance structures and make payments to the health centres on a per capita basis, essentially transferring all insurance risk to the health centres.

Initially, the focus was on building administrative and management support and technical resources, including training and development of appropriate tools. But since 2006, the Rwandan Government has transferred funds (about US$0.15 per capita) to cover premiums for the poorest people in the community, who are identified on the basis of a participatory poverty assessment called Ubudehe. Rwanda has systematically supported the expansion of mutuelles, which covered about 70 per cent of the population in 2007, up from 7 per cent in 2003. Enrolment of the poor in mutuelles is a key indicator in the performance-based contract signed by the mayor and the president. The Government is also engaged in creating municipal pooled funds, as well as a national fund for reinsurance financed by contributions from formal workers.

See References, page 108.