

The Living Goods Results-Based Financing Scale-up

Driving Impact for Community Health in Uganda

I. Project Background

Community health services have tremendous potential to reduce infant, child, and maternal mortality—central outcomes of the global development agenda.¹ Estimates suggest that community health services could avert half of child deaths worldwide.² In certain cases, community health is also more cost-effective than facility-based services, as in-home care eliminates transportation costs to remote health facilities, and the poor infrastructure at facilities once they get there. In Zambia, it was shown that treating malaria at the community level was 1.45 times more cost-effective than providing those services through a health facility.³

Living Goods has more than 10 years of experience providing high-impact interventions at the community level in Uganda and Kenya. The organization supports networks of performance-driven government Community Health Workers (CHWs) with technology, diagnostics and treatments so that they can go door-to-door teaching families how to prevent disease, assess and treat children who are sick, and support women through their pregnancies and with family planning. Each CHW supported by Living Goods goes through a rigorous core training on maternal and newborn child health; integrated community case management of malaria, diarrhea and pneumonia; and family planning and immunization—in addition to a regular cadence of in-service refresher trainings. Once trained, the CHWs visit families within their communities, registering households and pregnant women, and providing integrated preventative and treatment services. For serious cases, referrals are made to nearby health facilities. Their offerings includes home-based diagnoses and treatment for malaria, diarrhea, and pneumonia; support for pregnant women, including registering pregnancies as early in term as possible, providing basic antenatal care, promoting the use of iron folate, a healthy diet, and prophylaxis for malaria, delivering maternal vitamin supplements, and helping all mothers deliver in proper facilities; and, importantly, ensuring proper newborn care practices, including visiting newborns within 48 hours of birth. A Randomized Controlled Trial conducted in 2014 in Uganda shows that Living Goods' approach reduced child mortality by more than 25 percent⁴ and cost less than \$2 per person per year.

2. The Structure of the RBF Scale-up

This scale-up is designed as a Results-Based Financing (RBF) financial mechanism. RBF offers an approach to drive greater impact from social spending.⁵ By tying at least part of the funding for social programs directly to measurable results, RBF can improve a program's impact and offer funders an additional guarantee of value-for-money. By linking the funding of social programs to results rather than to activities and inputs, well-designed RBF introduces performance incentives. Further, it provides implementers with greater flexibility to adjust their programs, empowering them to innovate, learn, and adapt their programs in pursuit of impact.

The RBF Scale-up is structured as an outcomes fund. In addition, it incorporates elements of an impact bond as 100% of funding is tied to results and there is the potential to raise capital from investors who assume the financial risk. An outcomes fund brings together multiple actors to serve in the following three roles:

Outcome payers: pay for pre-defined results

Service provider: deliver community health services to improve child and maternal health

Financiers: provide up-front working capital for service providers' interventions

Through an outcomes fund, **outcome payers** pool resources and commit to paying **service providers** for the achievement of verified results. To finance operations, service providers raise working capital from **financiers** such as impact investors or philanthropists. When results are achieved, as confirmed by an external evaluator, the outcomes fund disburses outcome payments to the service provider, who can repay financiers for upfront capital per those agreements. For the Living Goods RBF Scale-up, a financier is not needed, since Living Goods has unrestricted funding

¹ United Nations. 2018. "Sustainable Development Goal 3." <https://sustainabledevelopment.un.org/sdg3>

² Perry, Henry, Zulliger, Rose. 2012. 'How Effective Are Community Health Workers?' Johns Hopkins Bloomberg School of Public Health. https://www.chwcentral.org/sites/default/files/How%20effective%20are%20community%20health%20workers%20%20-%20Johns%20Hopkins%20University_0.pdf

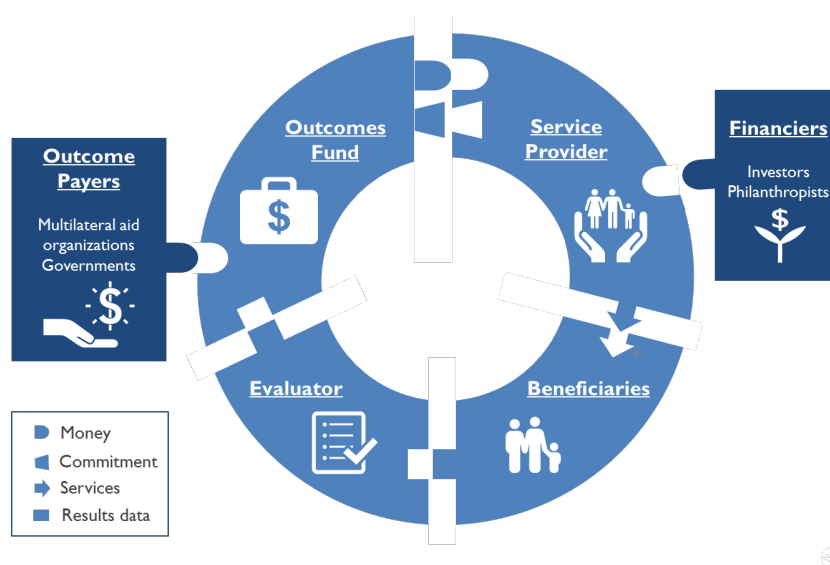
³ Chanda, P, B. Hamainza, H.B. Moonga, Victor Chalwe, P. Banda, F. Pagnoni. 2011. "Relative costs and effectiveness of treating uncomplicated malaria in two rural districts in Zambia: implications for nationwide scale-up of home-based management." *Malaria Journal*. 10: 159.

⁴ Bjorkman Nyqvist, M, Guariso, A, Svensson, J, Yanagizawa-Drott, D. 2019. 'Reducing Child Mortality in the Last Mile: Experimental Evidence on Community Health Promoters in Uganda'. *American Economic Journal: Applied Economics*. Vol. 11, No. 3. <https://www.aeaweb.org/articles?id=10.1257/app.20170201&&from=f>

⁵ Birdsall & Savedoff (2010); Kenny (2017); Perakis & Savedoff (2015); Ramalingam (2013).

to use as upfront capital and is willing to take on the risks associated with non-performance at current scale. However, Living Goods is open to seeking funding from an external investor as the scale of the RBF continues to grow and as new outcome payers come on board.

For reference, the diagram below illustrates the structure of an outcomes fund.



An outcomes fund provides the following benefits:

1. It lowers transaction costs and complexity by streamlining the contracting relationships and financial flows between various outcome payers and Living Goods. It delegates financial management responsibilities to a third party, allowing outcome payers to take a backseat during implementation.
2. The outcome payers credibly commit their funds via a trustee, reducing the outcome payer risk that pre-committed funds are not available for outcome payments downstream.
3. It gives Living Goods the responsibility of raising capital. Living Goods has control over how to mobilize and structure the necessary working capital to deliver results in the most cost-efficient manner. This may include raising and structuring capital from investors. This could surface new and diverse investment structures anchored in the contexts and preferences of the implementer. This was successfully achieved in the Village Enterprise Development Impact Bond that took place in Kenya and Uganda.⁶

3. Performance of the RBF Pilot

Starting in June 2018, Living Goods partnered with the Deerfield Foundation to pilot a one-year RBF contracting model for community health wherein Deerfield Foundation acted as the outcome payer and paid Living Goods for achieving pre-agreed and verified results.⁷ The pilot took place in Kyotera and Masaka districts in Uganda, supporting a network of approximately 322 CHWs, serving a population of approximately 250,000 individuals. The objective of the pilot was to demonstrate a model of contracting for high-impact, cost-effective community health services that the Ministry of Health (MoH) of Uganda and donors could adopt in the future.

An evaluation of the pilot shows the following results and learnings:

Above-expected performance, with significant variation

The overall payment for verified results (\$589,941) was \$143,794 or 32% higher than the expected payment (\$446,146), which is based on performance targets. Some payment metrics achieved significantly higher performance than expected.

⁶ 'The Village Enterprise Development Impact Bond'. <https://villageenterprise.org/what-we-do/development-impact-bond/>

⁷ Basinga et al. (2011). Effects on maternal and child health services in Rwanda of payment to primary health-care providers for performance: an impact evaluation. *The Lancet* 277 (9775): 1421-1428.

For example, in-facility ANC (antenatal care) visits achieved 143% of the target and assessments of sick children under age 5 (U5) achieved 173% of its target. However, it is also important to note that there was significant variation in payment metrics performance, resulting in underperformance on certain payment metrics. For example, in-facility deliveries achieved just 55% of the pre-defined target and post-natal care visits between 48 hours and 7 days of birth achieved 59% of the target. This variation of performance is important for recognizing how to adapt the design of the RBF to achieve the greatest impact.

Created operational upgrades for LG programming

The process of designing the RBF facilitated the identification of several clinical, operational, software, and data veracity issues. In some of these cases, identification of issues during the development of the RBF design prompted operational upgrades. For example, the design process revealed a lack of clarity within Living Goods regarding the number of newborn visits CHWs should conduct. It was established that the first newborn visit should happen within 48 hours of birth and a second visit should occur within one week of birth. As most CHWs were not aware of the need for the visit within one week, Living Goods updated this in its CHW training materials.

Improvements in the quality of data

The veracity of information collected by Living Goods improved considerably in Kyotera and Masaka districts, where the RBF pilot took place, during the period of implementation. Living Goods' external data quality checks found that data quality improved from 60% in the first quarter of 2018, to 89% in the second quarter of 2018, the first quarter in which RBF was implemented. Data quality continued to improve throughout RBF implementation, reaching 96% by the first quarter of 2019.

4. Implications for the Scale-up

Based on the success and learnings of the RBF pilot, Living Goods is now preparing to launch a scale-up of the RBF, and implementation will begin in March 2020. The scale-up will now reach four districts in Uganda – Kyotera, Masaka, Lira, and Mafubira – supporting a network of 1,280 CHWs. For this scale-up, outcome payments will be disbursed based upon the verification of the following payment metrics:



Maternal Health

- # of **pregnancy visits** completed by a CHW, up to 8 per woman per pregnancy
- # of **ANC visits** completed by pregnant women in facilities following a pregnancy visit by a CHW
- # of women **delivering in a health facility** following a pregnancy visit by a CHW
- # of **follow-up visits** conducted by CHWs with successful confirmation that a referral of pregnant women to a health facility was completed



Newborns

- # of first **household PNC visits** conducted by a CHW within 72 hours after birth, cap of up to 1 per child
- # of first **household PNC visits** conducted by a CHW between 72 hours and 7 days after birth, cap of up to 1 per child



Children under 5

- # of **follow-up visits** conducted by CHWs where immunization referral was completed by defaulters aged 9 months to 5 years who are not fully immunized.
- # of **sick child assessments** of children U5 for symptoms of cough, cold, diarrhea and danger signs (children who are unable to drink or breastfeed, convulsions, malnutrition, chest in drawing, sleepy or unconscious and fever, cough and diarrhea of longer duration) completed by CHWs, up to 51 per CHW per month
- # of **follow-up visits** conducted by CHWs with successful confirmation of a referral of an U5 child that presented danger signs to a health facility was completed



Family Planning

- # of **family planning visits** completed by a CHW. Visits include first time visits, comprehensive counseling for women and couples, referral follow-ups, refill follow-ups and counseling follow-ups.

The design of the scale-up is based on both the positive results from the RBF pilot as well the intention to incentivize quality service provision in an innovative and systematic way. Therefore, the design will incorporate the following:

Setting higher targets

Based on the high level of performance for payment metrics such as ANC visits (143% of target), U5 child assessments (173% of targets), pregnancy visits (99% of target) and referral follow-up visits (106% of target), targets will be set higher in the scale-up to push Living Goods to achieve even greater results and ultimately greater impact within the districts that they work.

Shifting payment metrics towards impact

Since the pilot was focused on testing the RBF model, many of the payment metrics measured activities rather than outcomes. With the experience of implementing the pilot, some of the payment metrics for the scale-up will now move further along Living Goods' theory of change to incentivize outcomes rather than activities. For example, rather than incentivizing whether a CHW completed a follow-up visit, they are now only incentivized if they completed a follow-up visit, and the client attended the referral visit at the health facility. In addition, the time window for CHWs to conduct the first PNC visit has increased from 48 hours to 72 hours to allow sufficient time for the mother to return home from the health facility after giving birth.

Incorporating quality measurement

In the RBF pilot, the payment metrics were based solely on the quantity of care (i.e., number of visits) rather than incentivizing the quality of care. The RBF Scale-up will include metrics that measure key aspects of the quality of services provided by the CHWs that include client knowledge of basic health care following a CHW visit, client satisfaction of the services provided by the CHWs, and CHW knowledge. Safeguards will also be put in place to ensure a certain level of quality is maintained.

Adding payment metrics

To promote high performance in a greater range of Living Goods' program activities, as well as respond to new activities, Living Goods has added new payment metrics for CHW household visits during the scale-up. These include metrics that incentivize family planning visits and immunization follow-up visits. By adding these new payment metrics, the RBF design will more comprehensively reflect maternal and child health services.

5. How to get involved as a donor

Based on the results from the RBF pilot, there is evidence that this financial mechanism improves the performance and impact of Living Goods' programs. USAID DIV, via the Global Development Incubator (GDI), has awarded Living Goods additional funding to support the RBF scale-up in Uganda. However, USAID DIV has requested for significant match funding to unlock their contribution—\$1 million from any donor going directly into the RBF outcomes fund, and an additional \$2 million from more long-term, sustainable donors such as bilateral and multilateral donors, and local government going anywhere towards Living Goods programming. Therefore, Living Goods is looking for socially motivated donors who can match the USAID DIV funding Living Goods has received to extend the RBF scale-up's reach to benefit the health outcomes of more communities across Uganda. By securing this match funding, Living Goods will be able to unlock up to an additional \$2 million from USAID DIV. If you are interested in being part of this game-changing innovation in financing community health, please contact Nayantara Watsa at nwatsa@livinggoods.org for more information.