



Institutionalizing Community Health Conference



27-30 March 2017 | Johannesburg, South Africa



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Integrated Health Project Plus in the Democratic Republic of Congo



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The involvement of community-based organizations: a major factor in the success of results-based financing projects

The case of the USAID Integrated Health Project in the Democratic Republic of Congo



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Outline

- I. Background
- II. Community participation in RBF
- III. Methodology
- IV. Results
- V. Discussion
- VI. Challenges
- VII. Conclusion

I. Background

1.1. INTERNATIONAL CONTEXT: BAMAKO INITIATIVE

The results-based financing (RBF) concept, born in the 1980s, was adopted following a meeting of African health ministers in Bamako, Mali in 1987 (at the 37th WHO Regional Committee).

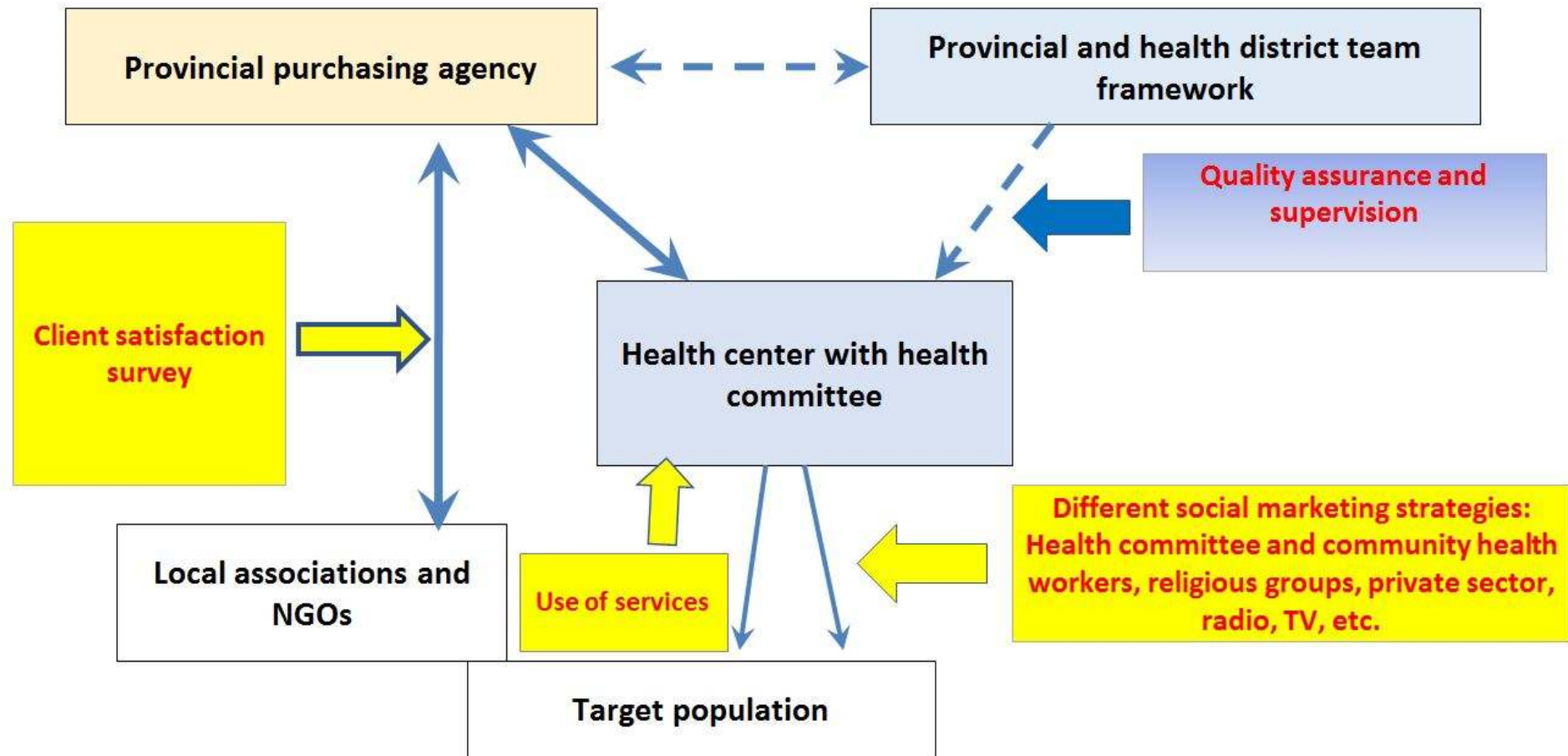
Objectives:

1. Strengthen management and financing mechanisms at the local level: cost recovery (setting service fees)
2. Promote community participation with the creation of health committees
3. Strengthen mechanisms for the provision, management and use of essential medicines
4. Provide ongoing sources of funding for the operation of health care units

1.2. NATIONAL CONTEXT OF COMMUNITY PARTICIPATION

1. Historically poor functioning of community facilitation structures of health districts in the DRC
2. Insistence of some community health workers that they be paid for time spent on health-related activities
3. Low membership rates in health committees (COSAs), meaning that several health areas do not have the required number of community health workers
4. Irregularity in the holding of meetings

II. Community participation in RBF



III. Methodology (1/2)

The USAID-funded Integrated Health Project (IHP) implemented the RBF program in 7 health zones with an estimated population of 951,000.

a. Prior to implementation:

- Choose intervention health zones according to established criteria
- Conduct baseline evaluation: 118 health areas, 7 general referral hospitals, and 7 health zone coordination offices
- Select 14 community-based organizations (CBOs) to perform community verification of RBF data
- Develop a framework for supporting CBOs
- Integrate community indicators into the implementation of social marketing through health development committees (CODESA)
- Train CBO members to verify data
- Draw up contracts with CBOs
- Educate stakeholders: politico-administrative authorities, MOH, community, religious groups, etc.

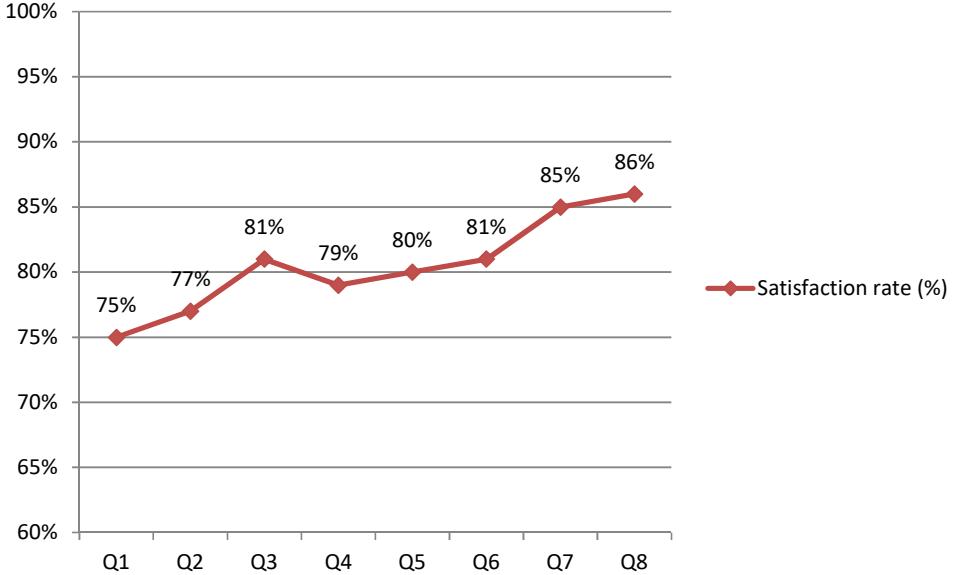
III. Methodology (2/2)

b. During implementation:

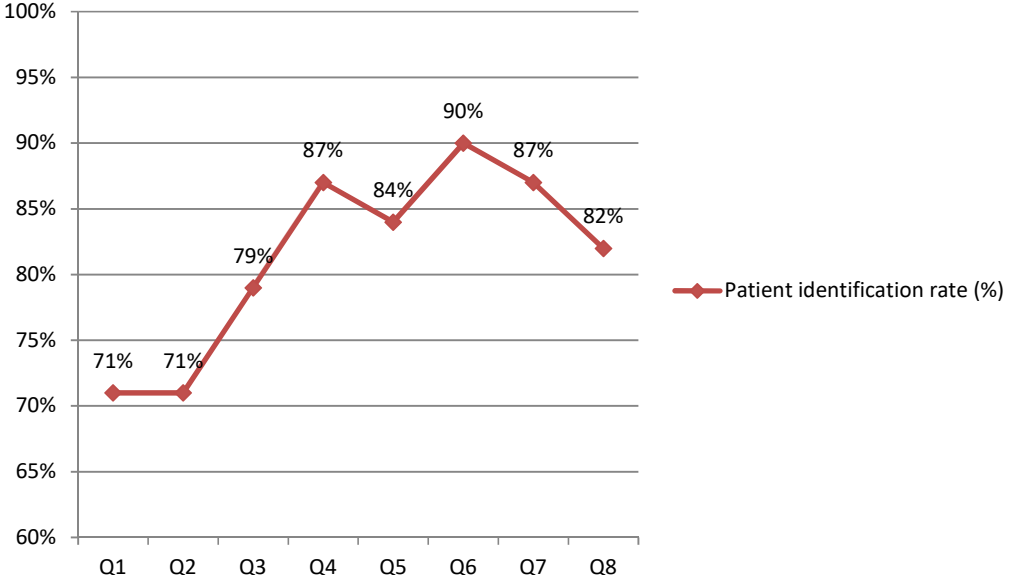
- Involve community in developing management/business plans, integrating data from community surveys
- Negotiate service fees
- Support CBOs in data verification
- Administer quarterly community surveys, according to standard RBF procedures
 - Household questionnaire on perceptions of cost of care, hospitality, availability of services, availability of medicines, cleanliness of the facility, wait times
 - Results broken down by clients' social status and gender, confidentiality, and knowledge of CODESA
- Monitor client satisfaction survey results
- Integrate community care site data
- Implement follow-up social marketing plan
- Encode community data in the RBF portal before paying health facilities

IV. Results (1/4): Evolution of client satisfaction and patient identification rates in health facilities under RBF

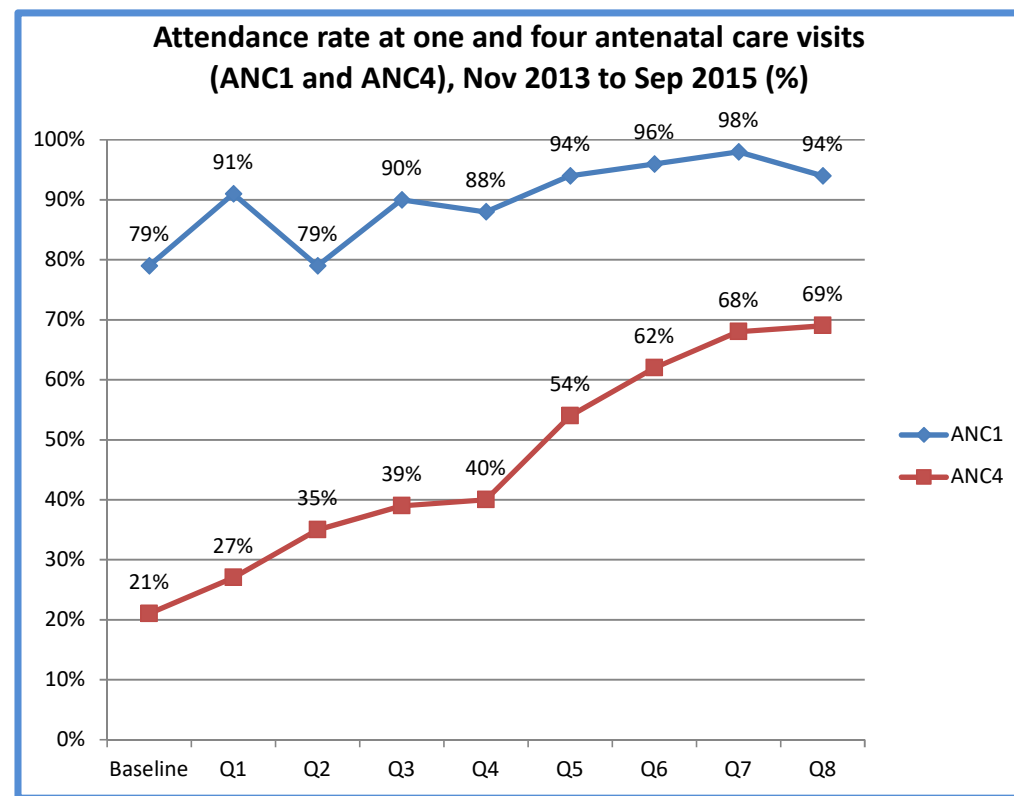
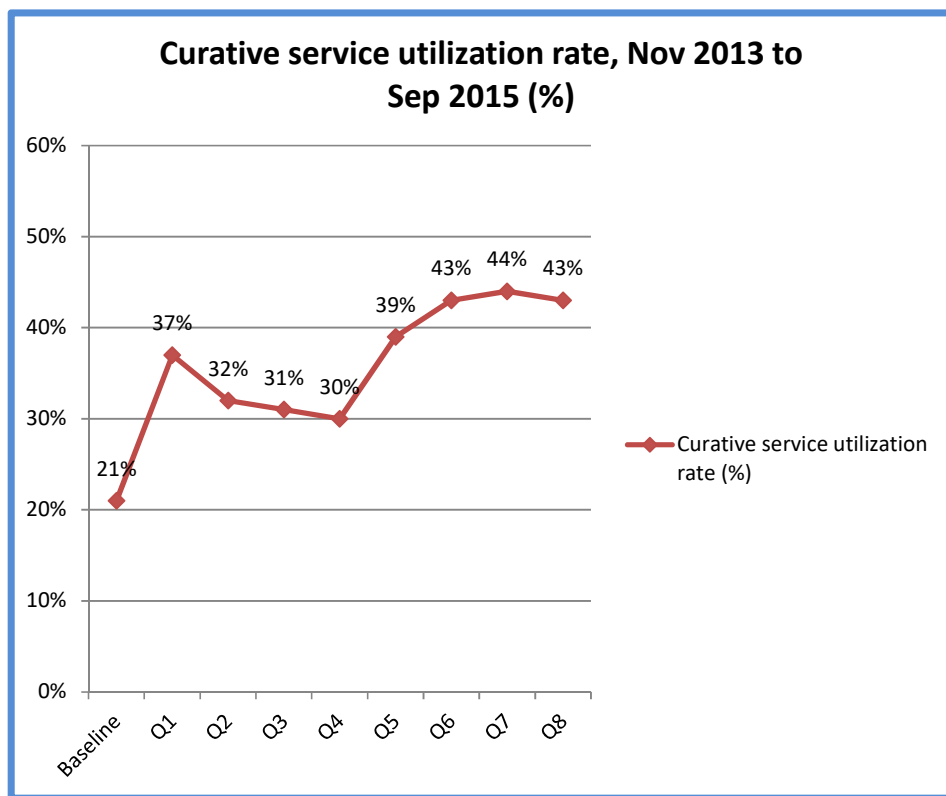
Client satisfaction rates from Nov 2013 to Sep 2015 (%)



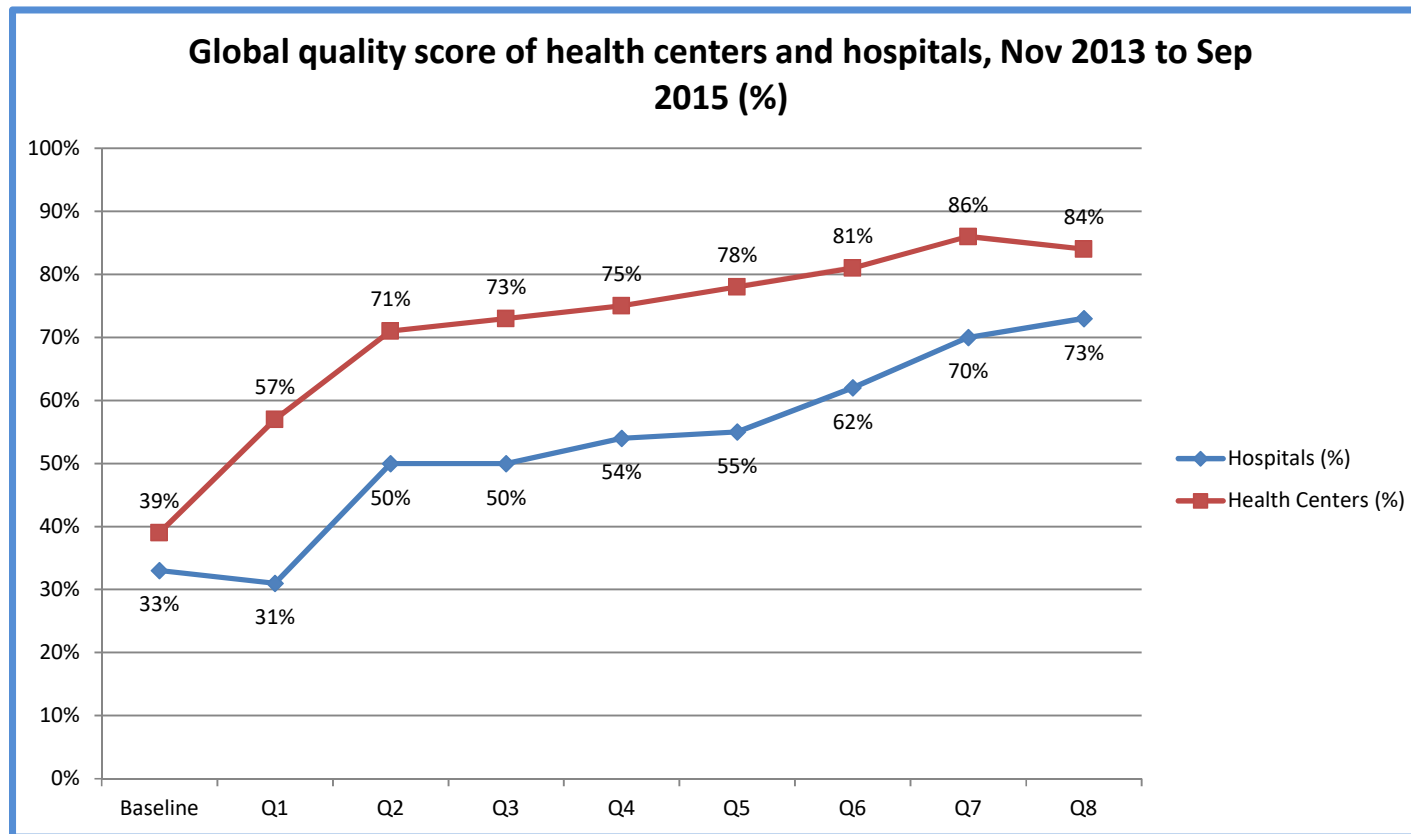
Patient identification rates from Nov 2013 to Sep 2015 (%)



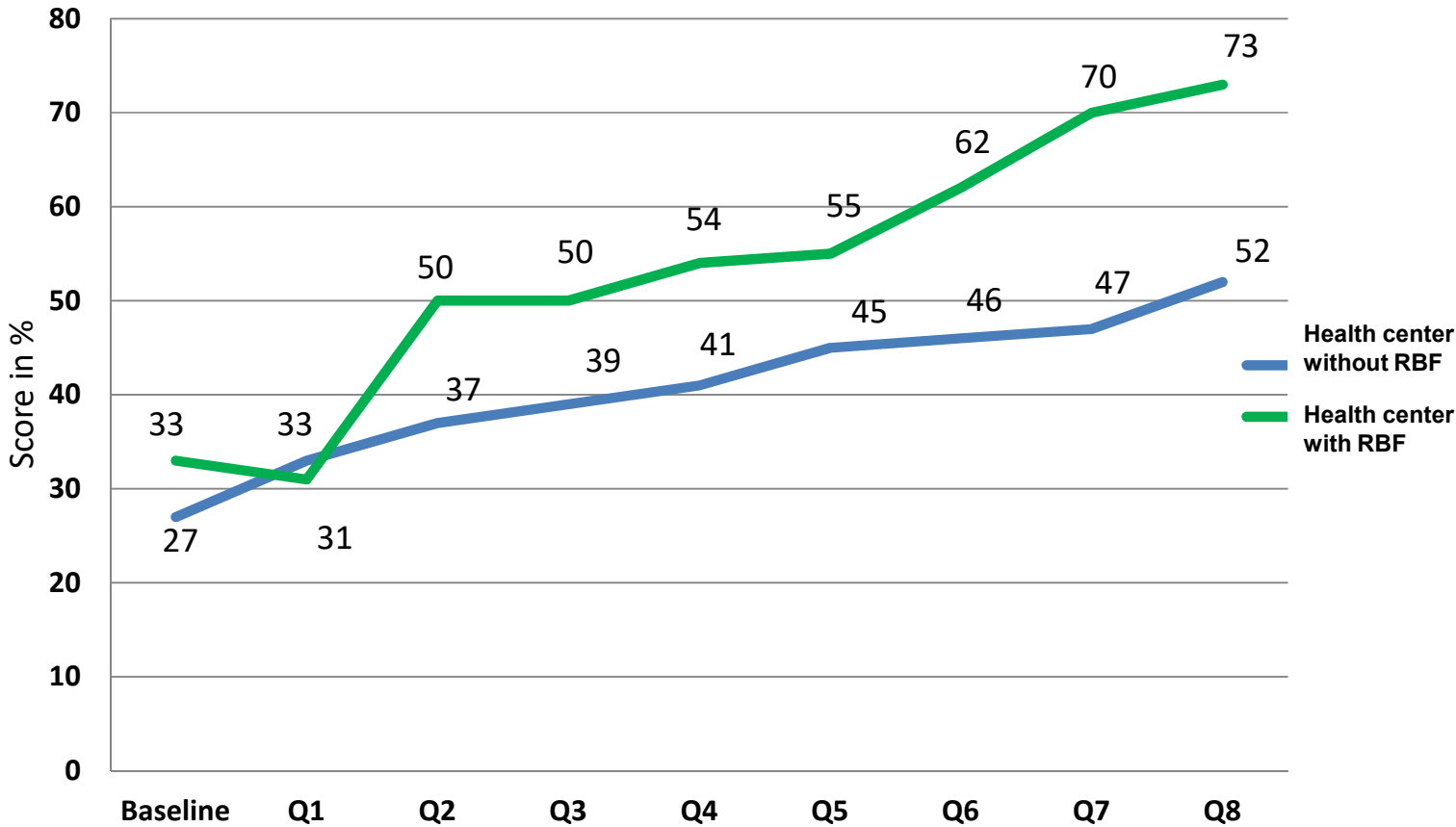
III. Results (2/4): Evolution of curative service utilization and antenatal care visits in health facilities under RBF



IV. Results (3/4): Evolution of the quality of health services and care for hospitals and health centers under RBF



IV. Results (4/4) : Comparative evolution of the quality of health services and care in health centers with and without RBF, Nov 2013 to Sep 2015 (%)



V. Discussion

- Clients reported an increase in service quality during the two-year RBF program (from 75% to 86%), and facilities' global quality score increased (from 33% to 73%).
- Over the same period, the utilization of curative services increased from 21% to 43%, and ANC4 increased from 21% to 69%.
- An independent study by the Kinshasa School of Public Health after Year 1 of RBF implementation showed greater improvements in quality and usage of curative services in intervention health zones than in comparison health zones.
- The patient satisfaction score of 86% was confirmed by an independent mid-term review of the RBF program, in which 90% of community members interviewed were satisfied with the services offered.
- These results show that as the quality of care improves, so does the rate of client satisfaction and service utilization.

VI. Challenges

- Low geographic coverage of local CBOs meeting the minimum standards for participation in the RBF program
- Low number of trained community surveyors
- Supporting CODESAs in the implementation of their social marketing plan

VII. Conclusion

- Strengthening the voice of the community can contribute to the success of RBF projects.
- The use of community survey data in the development of management plans improves the interaction between health facilities and the community.

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**Thank you for your
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