# Strategic Purchasing for Family Planning in Kinshasa

## Investment opportunities for the Bill & Melinda Gates Foundation

BREAKING NEW GROUND


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## ACCRONYMS

| | |
|---|---|
| **AAP** | Agence d'Achat de Performances |
| **ASF** | Association de Santé Familiale |
| **BMGF** | Bill & Melinda Gates Foundation |
| **CDR** | centrales de distribution regionals |
| **CGAT** | Centre des Risques et d'Accompagnement Techniques des Mutuelles de Santé |
| **CBHI** | community-based health insurance |
| **CNT-AS** | Cellule Technique Nationale – Achat Stratégique |
| **CTMP** | Comité Technique Multi sectoriel Permanent / Planification Familiale |
| **CYP** | Coupe Years of Protection |
| **DEP** | Direction d'Etudes et Planification |
| **DPS** | Divisions Provinciales de la Santé |
| **DRC** | Democratic Republic of Congo |
| **ECZS** | équipes cadrés des zones de santé |
| **EU** | European Union |
| **FEDECAM** | Fédération centrale d'achat et de distribution des médicaments essentiels |
| **FNSS** | Fonds national de sécurité sociale |
| **FP** | family planning |
| **GFATM** | Global Fund to Fight AIDS, Tuberculosis and Malaria |
| **GFF** | Global Financing Facility |
| **LARC** | long acting reversible contraception |
| **mCPR** | modern contraceptive prevalence rate |
| **MosP** | Ministre de la Santé Publique |
| **NORAD** | Norwegian Agency for Development Cooperation |
| **NGO** | non-governmental organization |
| **OOP** | out-of-pocket expenditures |
| **PATS** | Projet d'Appui Transitoire à la Santé |
| **PBF** | performance-based financing |
| **PCA** | Paquets Complémentaires d'Activités |
| **PDSS** | Projet d'Appui des Services de Santé |
| **PMA** | Paquet Minimum d'Activités |
| **PNDS** | Plan National de Développement Sanitaire |
| **PNSA** | Programme National de Santé des Adolescents |
| **PNSR** | Programme National de Santé de la Reproduction |
| **RMNCH** | reproductive, maternal, newborn and child health |
| **SPA** | service provision assessment |
| **SPARC** | Scholarly Publishing and Academic Resources Coalition |
| **UHC** | Universal Health Coverage |
| **UNFPA** | United Nations Population Fund |
| **USAID** | United States Agency for International Development |

## EXECUTIVE SUMMARY

**This report explores how the Bill & Melinda Gates Foundation (BMGF) can invest in improving the delivery of affordable family planning (FP) to vulnerable populations in Kinshasa through strategic health purchasing.** While BMGF has several existing investments in the Democratic Republic of Congo (DRC), it contracted ThinkWell to better understand how ongoing strategic health purchasing reforms in the country can be leveraged to improve access to FP services for women and girls in Kinshasa. Based on an extensive literature review and stakeholder interviews, ThinkWell analyzed the FP financing landscape in DRC broadly and in the Kinshasa region specifically. Our findings and recommendations are presented below.

### FP Challenges in Kinshasa

**The unaffordability and unavailability of FP services poses a major barrier to the uptake and continuation of FP methods in Kinshasa.** The last Demographic and Health Survey (DHS) in 2013-2014 reported a modern contraceptive prevalence rate (mCPR) of 19% in Kinshasa, nearly double the national average. However, unmet need was 23.4% among married women and 31.3% among sexually active unmarried women. According to a recent service provision assessment (SPA), 58% of facilities in Kinshasa offer FP services and short-term methods still account for nearly two-thirds of the method mix. These methods are mainly accessed from private drug shops, most of which are unregistered. Since both public and private providers charge fees for FP services, poor women and girls face a significant financial barrier to access, especially for long acting reversible contraceptives (LARCs), which are more expensive than short term methods. LARCs are very popular when they are offered for free, such as through donor-supported programs and campaigns, but campaigns only happen on a limited, ad-hoc basis. Private providers not receiving donor support do not view LARCs as commercially viable.

### Why support strategic purchasing for FP

**While not a panacea for addressing all FP service delivery challenges, strategic health purchasing reforms have the potential to improve FP access and quality using financing as the lever**. At its core, strategic health purchasing links payments to providers to information about their performance and the health needs of the population. Making purchasing more strategic involves influencing provider behavior to enhance access and quality; in the DRC context, that translates to using financing to influence providers such that they offer a comprehensive range of affordable high-quality FP services. Strategic purchasers can channel financing to both public and private providers, thereby harnessing all the capacity in the system. Finally, strategic purchasing can be used to reduce the cost of services – in this case for FP counseling and contraception – for clients. In an extremely resource-limited setting such as DRC, where provider quality is poor, supply constraints are rampant, and the FP market is mostly unregulated, strategic purchasing will not serve as a silver bullet. This report focuses on purchasing reforms, but investments in other related areas to address FP supply chain bottlenecks and fundamental service quality issues are urgently needed as well.

**DRC is already experimenting with a range of strategic health purchasing approaches to improve access to priority health services.** Community-based health insurance (CBHI) schemes have mushroomed all over the country since the 1980s, but they still only cover a negligibly small part of the population and focus on curative services. Since the 2000s, the country has rolled out a range of performance-based financing (PBF) programs that have included short- and long-term FP methods. These PBF programs, currently operational in 19 out of 26 provinces, have shown mixed results in terms of impact on FP uptake and quality. The government's vision, as articulated in its strategy for achieving universal health coverage (UHC), is to strengthen existing strategic purchasing mechanisms and ultimately transition them to a mandatory health insurance scheme.

**With support from the Global Financing Facility (GFF) and the Buffet Foundation, Kinshasa will launch its first PBF program this summer.** Compared to other PBF programs in the country, the Kinshasa pilot design has many "firsts": it is the first PBF program in an urban area, the first to involve a financial commitment from

the Government (to the tune of $1 million) , the first to include post-abortion care, and the first to contract a large number of private providers (55% for-profit providers, 29% faith-based and only 16% public facilities).

### Recommendations for BMGF

**Our recommendations to the Foundation focus on how it can strengthen the way FP is positioned within government-owned strategic purchasing reform in Kinshasa.** The Government of DRC has a strategic purchasing policy that identifies the mechanisms it wants to use. The provinces have invested in developing institutional arrangements for purchasing. We strongly believe that partners should refrain from starting additional, parallel purchasing schemes and instead work to improve, strengthen and harmonize ongoing strategic health purchasing reforms. BMGF can improve how strategic purchasing in Kinshasa addresses FP challenges faced by women and girls by investing in the following three inter-connected strategies:

1) **Support systematic learning from purchasing initiatives on what drives FP impact and test potential improvements**. Evaluations of PBF projects in DRC over the last two decades have yielded mixed results in terms of FP outcomes. There has been no effort to conduct operational research in a consistent manner to identify best practices and potential improvements. As the country is aiming to expand strategic purchasing, systematic learning and program improvements, especially on how FP should be positioned within PBF, will benefit all stakeholders. Additionally, a learning platform could improve the sharing of lessons learned between the PBF pilot in Kinshasa and other schemes. Specifically, BMGF could:
    - 1.1 Institutionalize operational research around the Kinshasa PBF pilot with a focus on FP.
    - 1.2 Test innovative approaches that can improve FP outcomes through PBF based on lessons learned.
    - 1.3 Establish an independent learning platform for strategic purchasing actors.

2) **Promote harmonization of existing purchasing approaches.** DRC is testing a range of different purchasing approaches and contracted providers are heterogenous in terms of the package and quality of services they offer. There is a need to harmonize these approaches and articulate how the country will eventually transition to a national health insurance model. Harmonization of quality frameworks, costing tools, and poverty targeting methods, as well as the standardization of providers' service offering can simplify processes, increase transparency and ultimately improve the efficiency of purchasing mechanisms. Within a rapidly evolving purchasing context, harmonization should be an ongoing process to ensure coherence between purchasing mechanisms. Specific options under this strategy include:
    - 2.1 Standardize processes and align PBF tools to national guidelines by supporting the National Technical Unit on Strategic Purchasing
    - 2.2 Support private providers to engage with purchasers and standardize service quality through provider networks
    - 2.3 Pilot a digital client registration mechanism to improve the coherency between CBHIs and PBF schemes and lay the groundworks for the future expansion of contributory schemes
    - 2.4 Prepare the EUPs for the long-term envisioned transition to a contributory system

3) **Invest in expanding the reach of strategic purchasing mechanisms.** Through the GFF, BMGF is already supporting the existing PBF program. Additional investments in the Kinshasa PBF pilot would allow the PBF program to roll out in more health zones, and thereby reach a larger number of women with affordable FP methods. It would also increase BMGF's leverage to shape the scope and ensure FP is front and center in the design of this important reform. Alternatively, the BMGF could also consider expanding strategic purchasing in Kongo-Central, where fewer partners are present. Options under this strategy include:
    - 3.1 Add or re-channel BMGF funding to the PBF pilot project in Kinshasa
    - 3.2 Invest in an expansion of strategic purchasing in Kongo-Central

## I. INTRODUCTION

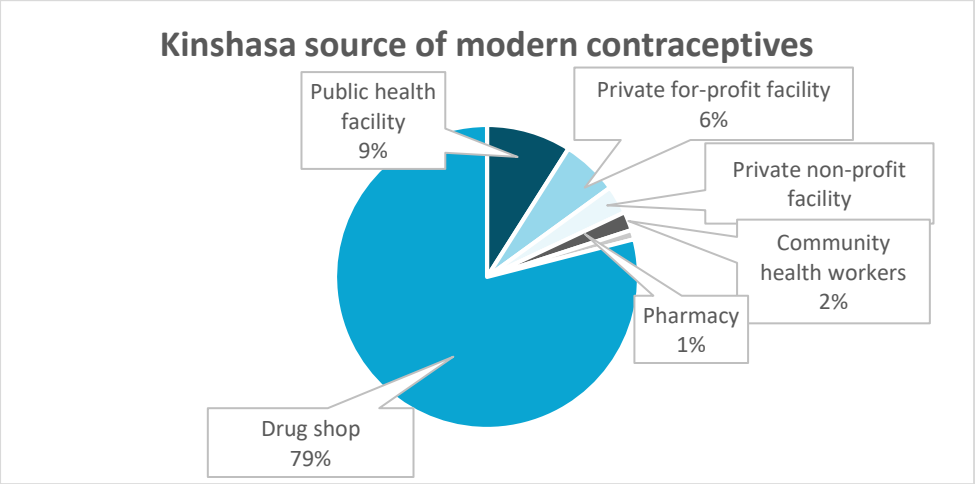
**This report explores investment opportunities for the Bill & Melinda Gates Foundation (BMGF) to support strategic purchasing for family planning (FP) in the Kinshasa region of the Democratic Republic of Congo (DRC).** Improving the uptake of contraception and the quality of FP services is a key priority for the Government of DRC. Ongoing strategic health purchasing reforms, which enjoy high-level support from the Ministry of Public Health (Ministre de la Santé Publique, MoSP), have the potential to improve provider performance while also making FP services affordable for women and girls who need them. BMGF is exploring how it might strengthen the use of strategic health purchasing to improve affordability and quality of FP methods for vulnerable women and youth in Kinshasa. BMGF contracted ThinkWell to study the dynamic but fragmented purchasing landscape in the country more broadly and in Kinshasa specifically. The ThinkWell team undertook an extensive literature review as well as stakeholder interviews in Kinshasa (see Annex 3). From this analysis, ThinkWell has identified programmatic and financing trends, current challenges and opportunities, and recommendations for future investments.

## II. THE FAMILY PLANNING CONTEXT

### FP DEMAND & SUPPLY

**While Kinshasa outperforms the rest of the country in terms of FP uptake, women and girls living in the province face several challenges related to the supply, quality, and affordability of contraceptive services.** Kinshasa had a modern contraceptive prevalence rate (mCPR) of 19% in 2014, compared to a national average of 8%[1]. More recent estimates suggest that Kinshasa's mCPR had increased to 27% as of 2018.[2] Despite this positive trend, the unmet need for FP in Kinshasa –23.4% among married women and 31.3% among sexually active unmarried women– remains high. Approximately 58% of all public and private facilities in Kinshasa offer some form of modern FP services, which is below the national average of 69%. Method choice is limited, with only 41% of facilities offering at least three reversible modern methods[3]. Many providers do not have the minimum credentials and sentinel equipment to provide the FP services they claim to have on offer.[4] As shown in Figure 1, private drug shops account for 79% of the outlets providing modern contraceptives in Kinshasa.[4] The exact number of private drug shops is not known, but it is assumed that only 1% of these are registered.[5] In essence, an unregulated private market determines the availability, choice and prices of FP commodities and services for women and girls in the city. A 2016 study named the cost of methods as the second most important barrier to modern contraceptive use.[6] Indeed, all health facilities in Kinshasa – public and private – charge for FP services, and this poses a financial barrier to access, especially for poor women and girls.

*Figure 1 – Source of modern contraceptives in Kinshasa*

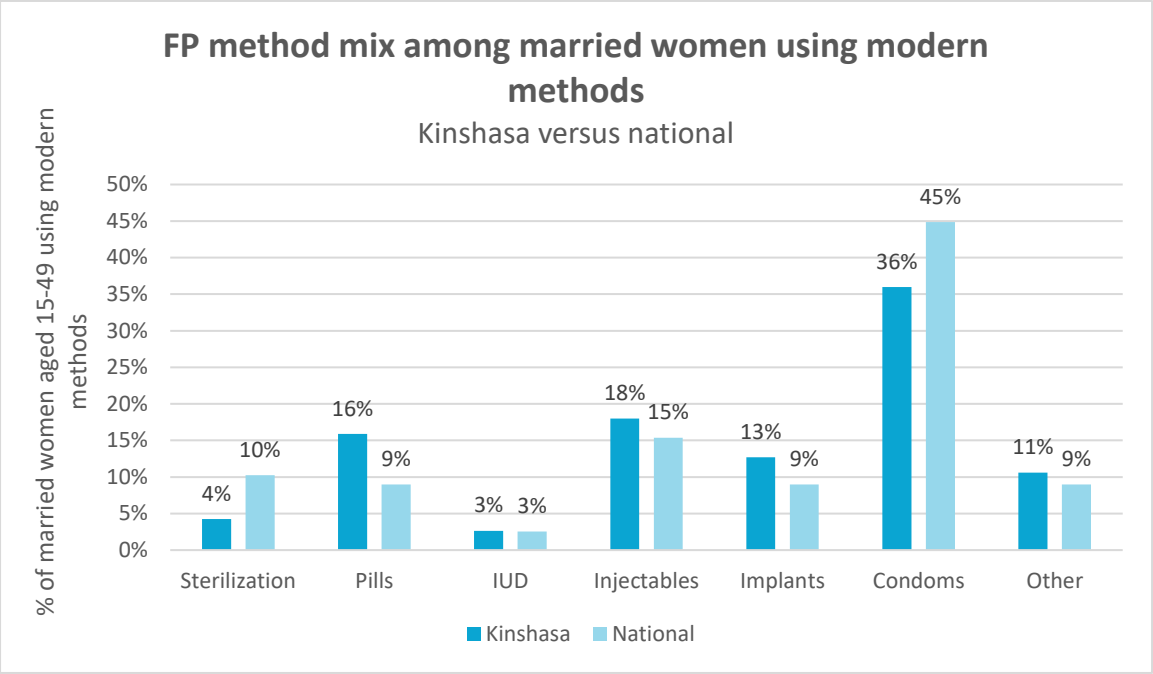



*Source: FPwatch outlet survey 2015*[4]

**The cost of long-acting reversible contraceptives (LARCs) makes them unaffordable for most women; thus most providers do not offer LARCs and Kinshasa's method mix is dominated by short term methods.** Out of all women aged 15-49 using modern methods, 77% nationally and 63% in Kinshasa rely on short-term methods (Figure 2).[1] It is worth noting that the use of injectables is much lower in DRC than in most other sub-Saharan African countries, although they cost only around $0.55.[4] Use of short-term methods is often associated with higher discontinuation rates. LARCs are usually more expensive, and likely to be unaffordable to many women. Even if subsidized, the costs associated with getting an implant range between $2-3 for a consultation, $3-5 for the implant and between $3-13 for the extraction[7]. In a country where the average person earns $40 a month, these costs will certainly deter users.[13] Therefore, private providers do not view these as commercially viable and those not receiving some form of support from a donor or implementing partner typically only offer inexpensive short-term methods, such as condoms and emergency contraception. Evidence suggests that when LARCs are offered for free, such as through donor-supported programs and campaigns, there is an increase in uptake of the method, including amongst new users.[89] However, donor-supported programs and campaigns only happen on a limited, ad-hoc basis.

**The central commodity procurement agency (*Fédération centrale d'achat et de distribution des médicaments essentiels,* FEDECAM) faces many challenges, which has resulted in an array of fragmented procurement efforts.** Contraceptives procured with government funds are handled by UNFPA, then channeled via FEDECAM to the regional distribution centers (*Centrales de Distribution Régionales,* CDR), from where health zones can request them. However, the system is not functioning well, as warehouses in the chain lack capacity, and information systems at facilities are absent or inadequate to assist in planning supply at the provincial level.[10] As a result, most of the largest donors procure the commodities for their intervention sites separately, further aggravating a lack of financial resources flowing through FEDECAM. Social marketing organizations, such as DKT and former PSI-affiliate Association de Santé Familiale (ASF) also supply some pharmacies and private clinics in Kinshasa and Kongo-Central, though mainly with short-term methods. Other facilities must procure commodities on the open market. There are no restrictions on the suppliers from whom public or private providers can procure commodities and this may compromise quality. For example, Gynaecosid, a pill meant to treat secondary amenorrhea, is incorrectly sold as an emergency contraceptive. It has been banned in most other countries as it is potentially harmful.[11]

*Figure 2 - Kinshasa and national FP method mix*



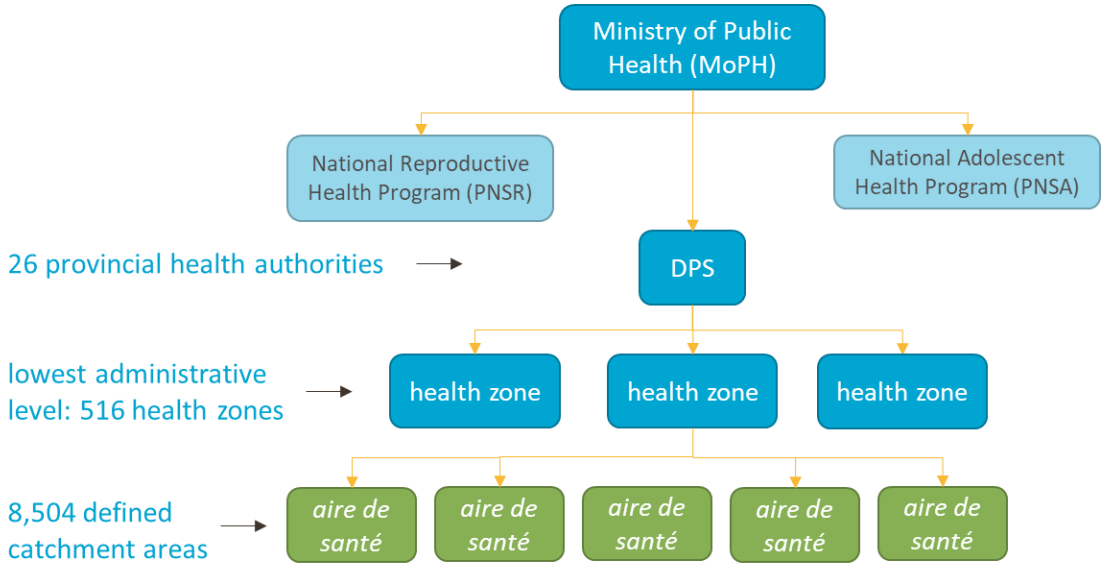

*Source: DHS 2013-2014*

## FP POLICY

**Although coverage of many maternal and child health interventions, such as facility-assisted delivery, are now near-universal, FP coverage has lagged far behind.** Although DRC has recognized the crucial link between improving access to FP services and reducing maternal mortality in policy, in practice it has focused mainly on other maternal and child health interventions. Almost 80% of deliveries now take place at a health facility, assisted by a skilled provider, and utilization of antenatal care services is comparable to neighboring countries. Approximately 90% of DRC's 8,266 public and private facilities offer maternal care, yet only half of those offer contraceptive services.[16] FP is an explicit part of DRC's essential health benefit packages for health centers (*Paquet Minimum d'Activités*, PMA) and hospitals (*Paquets Complémentaires d'Activités*, PCA), and is included as part of the post-natal care package.[30] However, uptake of post-partum FP remains very low; only an estimated 6% of mothers receive it within the first six months. This represents a considerable missed opportunity to reach women.

**Improving RMNCH outcomes is front and center in the MoSP agenda, which also emphasizes increased integration of services and improved coordination between partners.** Several reforms in the MoSP are underway to reduce the number of vertical programs, and increasingly approach RMNCH as an integrated health area.[23] FP is stewarded centrally by the MoSP, through the National Reproductive Health Program (PNSR) and the National Adolescent Health Program (PNSA). Implementation is decentralized at the provincial level (DPS), which oversee the health zones, the lowest administrative level (Figure 3).

*Figure 3 – Governance of FP*




**Although Permanent Multisectoral Technical Committees for FP (*Comité Technique Multi sectoriel Permanent*, CTMP) coordinate donor efforts at national and provincial level, support for FP service delivery in Kinshasa is patchy.** Since 2009, CTMPs have been established at the national-level and in more than eight provinces. Stakeholders note that the coordination mechanism has functioned well. Nevertheless, in Kinshasa the type of support provided focuses mostly on national level advocacy or institutional capacity building. There is little 'hands-on' support at the health service provider level. Where partners do work with facilities, projects are mostly small or in pilot format. They sometimes overlap in the same health zones and interventions are not always well-coordinated or scalable. Therefore, the partner landscape still shows large gaps. However, the PNSR considers Kinshasa "saturated" with partners and encourages partners to support other provinces instead.

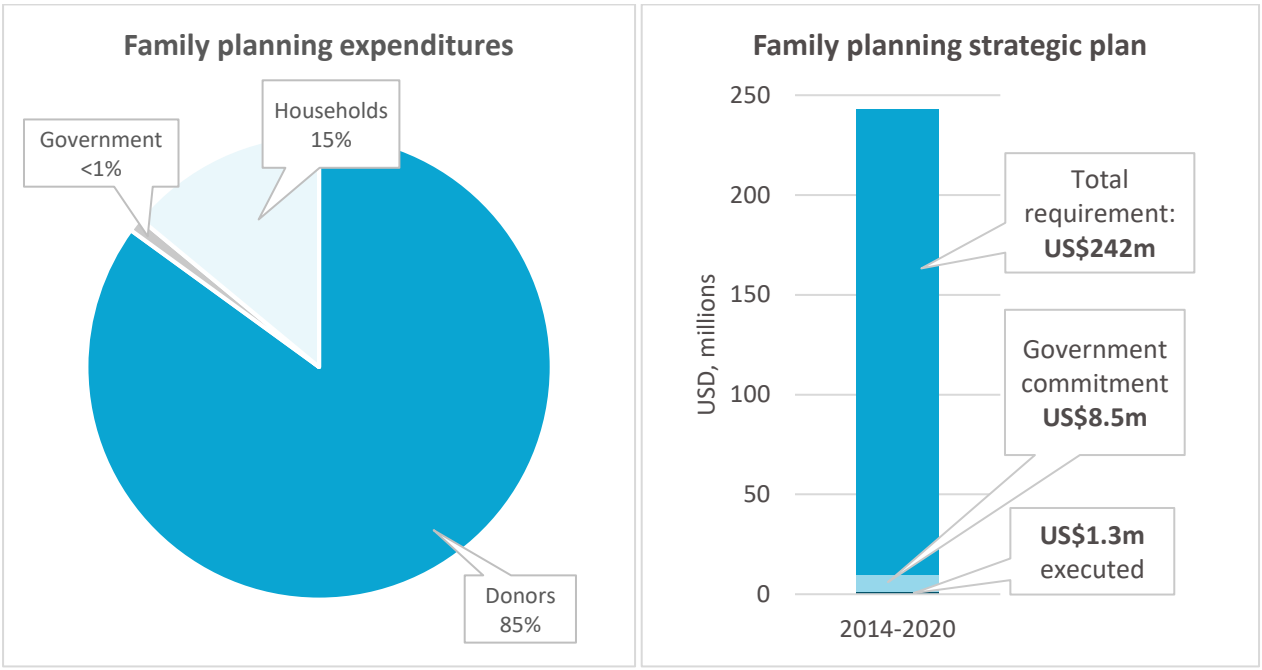
## III. THE HEALTH FINANCING CONTEXT

### FINANCING FOR HEALTH & FP

**Development assistance and out of pocket expenditures (OOP) expenditures are the two biggest sources of financing in DRC.** At $21, health expenditure per capita in DRC is one of the lowest in the world.[12] Donors fund the largest share of health spending (43%). With 72% of its population living in extreme poverty, DRC's population is one of the poorest globally[13]. Yet households account for 41% of health spending, 90% of which takes the form of OOP expenditures. In 2016, the government accounted for only 12% of all health spending, which mainly served to pay salaries of public health workers (78%).[20] Very little additional funding flows down to provincial and zonal levels, and then to health facilities. To cover their operating costs, facilities rely mostly on user fees (90% of their running costs).[20] In addition, facilities are asked to contribute to the zonal costs, so that the system is characterized by an odd reverse funding flow system known as 'la pompe' or bottom-up financing.[14]

**The reliance on external financing is even more extreme for FP.**[15] At the time of the development of the Family Planning National Multisectoral Strategic Plan for 2014-2020, donors were funding 85% of all FP services and commodities while government accounted for less than 1% and households financed the rest (Figure 4).[16] Donor funding levels for commodities have fluctuated over the past decade, and has been insufficient to make up for the lack of government funding. Despite large additional commitments from donors (e.g. $30 million from the World Bank) the commodity financing gap for the 2016-2020 strategic period is $48 million. Donors were mainly financing condoms until 2015 but have increased their investment in implants since then, while injectables remain only a small part of the total. This explains the method mix illustrated in Figure 2.

*Figure 4 – Financing of family planning*




*Source: Plan Stratégique de PF á vision Multisectorielle 2014-2020 & Revue mi-parcours 2017*

**DRC's government has made only limited financial commitments to FP2020, and budget execution remains a critical issue.** In its 2013 FP2020 announcement, the government committed to allocate $1 million to FP that year, but only about 10% of that materialized.[17] Thanks to extensive advocacy efforts, the national budget has featured a line for the purchase of FP commodities, supplies and equipment since 2015. But until mid-2017, only $1.3 million had been disbursed out of a total expected sum of $8.5 million for the duration of the strategic plan.[17] Only three out of 26 provinces have dedicated budget lines for FP and their execution rates remain low. [1] [18]

## HEALTH FINANCING STRATEGY

**DRC has a well-articulated vision for how it wants to organize health financing to achieve Universal Health Coverage (UHC).** As per the National Health Sector Plan 2019-2022 (*Plan National de Développement Sanitaire*, PNDS 2019-2022)[19], DRC aims to increase equitable coverage, quality of care and financial

[1] In 2017, in North Kivu $300,000 was allocated out of the $2,610,833 requested, in South Kivu $21,000 was allocated out of the $210,000 requested, and in Lualaba: $57,781 requested and allocated to the purchase of contraceptives.

protection for all its citizens. The Health Financing Strategy for UHC, which was finalized in 2018, emphasizes the need for increased resource mobilization, improved pooling to combat fragmentation of financial flows, the development of risk-sharing mechanisms, and the optimization of resource-use through strategic purchasing.[20]

**In the medium to long term, DRC plans to create a National Health Solidarity Fund (*Fond National de Solidarité Sante*, FNSS) to pool funds from all sources, but how this will be operationalized remains unclear.[20]** A new law, passed in early 2019, sets the stage for a mandatory health insurance scheme to cover the whole population.[21] All formal sector schemes would be financed through employer and employee contributions, while CBHIs (*mutuelles de santé*) would remain fully dependent on member premiums. The poorest would be fully subsidized; a dedicated budget line has already been created at the national level, but no funds have been allocated towards this so far. The near-poor, who are likely to be working in the informal sector, would not receive any public subsidies.

**To reduce fragmentation of financing and implementation, provinces have introduced a mechanism called the "single contract" (*contrat unique*).** Previously, some provincial health authorities had up to 30 different contracts with donors and partners.[22] The new single contract between the provincial health authorities and partners active in a given province pools all financial resources to provide predictable support for a single, integrated provincial health action plan. In line with DRC's move towards decentralization, its performance framework is intended to improve governance and transparency of the provincial health authority's performance, as well as accountability of partners. Eight out of 26 provinces have already started to introduce single contracts,[23] but it is unclear how these virtual basket funds will eventually be integrated into a single national fund.

## IV. PURCHASING MECHANISMS

**DRC is politically committed to using strategic health purchasing to optimize resource-use in the health sector.** It encourages all payment mechanisms to move from input-based financing to output-based payments, preferably in the form of case-based payments (tarification forfaitaire). The MoSP has developed detailed implementation guidelines for the introduction of a case-based payment system (*Guide de oeuvre de la tarification forfaitaire dans les formations sanitaires en République Démocratique du Congo*)[24]. With the World Bank's support, the country set up a National Technical Unit on Strategic Purchasing (*Cellule Technique Nationale - Achat Stratégique*, CNT-AS) in 2011, and in early 2019 DRC finalized a National Strategic Purchasing Policy[25] which recognizes two main purchasing mechanisms: (1) health insurance schemes and (2) PBF, both of which are explained below.

### HEALTH INSURANCE SCHEMES

**Several small voluntary insurance schemes exist, but the share of the population participating in them remains negligible.** Since the 1980s, community-based health insurance (CBHI) schemes or *mutuelles de santé* have emerged in several places, typically organized by community members, churches or groups of professionals. Several CBHI schemes have received financial and technical support from international NGOs and faith-based organizations to get started, but most rely only on their membership contributions. Due to the poverty amongst the population, the premiums that they can charge members have to be very low, meaning that both the package and the financial protection they can offer is limited (two of the most mature networks charge less than US$6 annually and require co-payments of 20-50%).[26] Many have not been financially sustainable and have collapsed after a short period of time. The only schemes that have achieved some level of success are those for civil servants such as teachers and the military. These schemes collectively

cover less than 5% of the population.[1] Among the wealthiest quintile, 9%-13% of men and women, are enrolled, while for the lowest three wealth quintiles, enrolment is below 0.5%. Most schemes do not include preventative services, including FP.

### PERFORMANCE-BASED FINANCING

**DRC has a long history of using PBF approaches, most of which have been consolidated into the World Bank's Health System Strengthening for Better Maternal and Child Health Results Project (Projet d'Appui des Services de Santé, PDSS).** [27] [28] As early as 2002, donors started to introduce programs to reward health workers based on their performance[29] and the first full PBF program in DRC was introduced in South Kivu in 2005.[30] Other large PBF programs have been implemented by the European Union (EU), the World Bank and USAID. An overview of PBF experiences in DRC is presented in Annex 1. PBF projects often had very different quality and quantity indicators, as well as payment and management structures, resulting in some facilities receiving support from multiple projects based on different indicators.[30] Born out of the Global Financing Facility (GFF) mechanism,[31] the PDSS project pooled funding from BMGF, the Norwegian Agency for Development Cooperation (NORAD), the Government of Canada, USAID, the Global Fund, and the World Bank to introduce PBF in over 3,000 facilities in 14 provinces.[32]

**Under the PDSS, facilities are paid a unit price for each service out of the PCA and PMA packages delivered, which is increased by a quality bonus.** For FP, health centers get paid for two quantity indicators: each new and renewed user of (1) oral contraceptives and injectables, (2) IUDs and implants. Hospitals receive a payment for each (1) implant or IUD and (2) each tubal ligation or vasectomy. Reimbursement fees are negotiated with each individual facility and are paid directly to the facilities. They are intended to cover the services as well as the commodities, but as the rudimentary costing exercises cannot confirm that the fees will indeed cover the full cost, facilities are allowed to continue to charge user fees. A comparison of the average commodity costs and average reimbursement fee is shown in Table 1. The quality bonus can increase the payment by 25% for health centers and 40% for hospitals. Annex 2 includes more details on the details of the PBF structure.

*Table 1 – Comparison of median commodity prices and PDSS reimbursement fees*

| | **Median commodity prices** at private for-profit health facilities, pharmacies and drug shops | **Approximate reimbursement fee** for services and commodities under the PBF pilot in Kinshasa (health centers/hospitals) |
|---|---|---|
| Male condoms | US$0.03 | - |
| Female condoms | US$0.11 | - |
| Oral contraceptives | US$0.33 | US$3.00 |
| Injectables | US$0.55 | US$3.00 |
| Implants | US$4.95 | US$6.00 / US$15.00 |
| IUDs | US$4.95 | US$6.00 / US$15.00 |
| Female sterilization | US$148.50 | US$50.00 |

*Source: FPWatch Outlet Survey 2015*[4] *& Kinshasa PBF pilot implementation guidelines*[43]

**The operational manual established for the PDSS project has turned into the national guidelines on how to introduce PBF approaches in any location in the country**. It outlines the institutional structure, including the flow of payments, and verification mechanisms. Contracts and reimbursement rates are negotiated with each individual facility, which can be public or private. Facilities are encouraged to lower the user fees they charge and are required to make their prices clearly visible in the facility. However, there are no set rules on the amount by which they should lower their user fees. As of 2019, including the PDSS and EU-supported provinces, the country has a PBF program in 19 out of 26 provinces (but not in Kinshasa), and the country's aim is to expand PBF nationwide.

**Although PBF is tremendously popular with the government, evaluations of PBF programs in DRC have yielded mixed results, especially for FP.**[33] [34] Two evaluations of the PBF program in South Kivu in the early 2000's found overall positive effects on health outcomes, but noted FP as an exception for which uptake did not increase.[35] [36] A study of a Haut-Katanga pilot[37] [38] in 2014 also found that although pay-for-performance had a positive effect on health worker effort and increased outreach sessions, it did not increase uptake of FP services compared to sites that received non incentive-based capitation payments. Because PBF-supported facilities shifted their focus to the PBF package, income from the most lucrative (i.e. curative) services outside of the package decreased, resulting in an overall decrease in facility revenue, with declining investments in infrastructure and quality improvement as a result. A World Bank evaluation of that same pilot confirmed no increase in the use of FP services, and showed that the PBF mechanisms might have decreased intrinsic motivation of staff.[39] Only one study of a USAID program in four provinces found a significant effect of PBF on the use of modern contraceptives. However, the focus was on short-term methods such as condoms, injections and pills, which the study attributed to supply shortages for LARCs.**Error! Bookmark not defined.**

**After ten years of experience with PBF programs, the EU has moved away from "pure" PBF towards a combination of case-based and capitation payments.** The EU is active in seven provinces, some of which overlap with the PDSS project, though they cover different health zones. The EU has changed its payment structure in recognition of the fact that high quality scores cannot be expected in a setting where the baseline quality is as low as it is in DRC. In a review of a number of different PBF programs in DRC, a set of prerequisites for a successful PBF scheme included a minimum level of quality and infrastructure, sufficient and qualified staff, and adequate availability of medicines and supplies.[29] These prerequisites are almost never in place in DRC, and some studies have argued that in very-low-capacity settings, where not all inputs to deliver quality care are available, a stepped approach to rewarding the clinical content of care may be more appropriate.[40] Without ensuring the presence of these fundamentals, rewarding (and punishing) facilities for the quality of services they provide is not likely to be effective. Some stakeholders in Kinshasa also indicated that PBF payments were mainly financing fundamentals, instead of quality improvements.

**In the EU's new payment system, quality scores play only a limited role, and capitation payments result in more predictable funding for the facilities.** A set of priority services are reimbursed according to case-based payments that are set per health zone. At health facilities, this includes consultations and deliveries, and at hospitals, it covers a set of 11 curative services. These payments are meant to cover everything from medicines to the services themselves, laboratory expenses, etc. The other component is a capitation payments, which is provided twice per year, consisting of a fixed payment based on the catchment population size, and a small payment linked to the quality and quantity of care provided during the half year period. The quality verification system is therefore lighter and less influential. All other services, including FP, are expected to be covered by the two subsidization systems and offered for free. However, assessments have not been conducted to confirm whether the payments are able to cover the costs and whether user fees have been abolished.

## SIMILARITIES AND DIFFERENCES ACROSS PURCHASING SCHEMES

**The PDSS and EU programs both utilize a well-established structure for purchasing and have established autonomous contract management and verification agencies in each of the provinces they support.** The Public Utility Institutions (*Établissements d'Utilité Publique*, EUP) used in some provinces are legacies of the EU's PBF projects, which set up these autonomous structures, and are now being shared by the EU and the PDSS projects. The main difference between the two projects is that the EUP also functions as the payer in the EU project, while in the PDSS project, the Planning and Evaluation Directorate (*Direction d'Etudes et Planification*, DEP) at MoSP makes the payments (see Annex 2 for more details about the institutional structure and Annex 3 for a schematic comparison of the EU and PDSS project).

**Both projects have a dedicated policy to support indigents but use different mechanisms to identify them.** In the PDSS project, indigents are identified by community members, while in the EU project, the term indigent is not used, and the poor are simply those that indicate at the facility that they are unable to pay. PDSS providers can treat indigents for free as long as they make up no more than 10% of the total volume, while the EU uses a 5% cap. The PDSS also offers additional incentives for treating indigents. However, in a context where such a large share of the population lives below the poverty line (64% below the national and 77% below the international poverty line),[41] the cost-effectiveness and rationale for a mechanism to identify indigents is questionable at best. How these project-based funds will eventually be consolidated into a national fund for indigents is not clear.

**Facilities continue to charge user fees over and above the PBF reimbursements they receive.** Both the PDSS and the EU project conduct costing studies at each contracted health facility. In the PDSS project, reimbursement fees are different for each facility, while the EU-funded project standardizes reimbursement fees per health zone. In the PDSS program, there is an expectation that user fees will be lowered at least in part due to the reimbursements for FP services, but this is not mandatory. In the EU project, FP is part of a preventive package, which is a recognition that FP should be offered for free. However, as part of a large package of services, this bundling may also result in FP receiving less attention from the provider. It is also not made explicit that preventive services should be offered for free at a supported facility. Facilities have not abolished user fees completely and nor are they required to do so. The prices they set must be visible to clients, but these are not regulated or standardized. Facilities have considerable autonomy to decide how they spend funds collected though user fees and PBF reimbursements.

**The purchasing platform has been used to introduce additional financing schemes, including a first pilot to use it to expand health insurance coverage.** As part of the country's Ebola response strategy, the purchasing platform has been utilized to introduce free services in affected areas.[42] The presence of an existing purchasing system considerably eased the introduction of *gratuité* in North Kivu, using $3 million in financial support from the PDSS project. Last year, the EU also started to pilot a new program in Kongo-Central, using a CBHI called MUSAKIS as the purchaser and fiduciary agent, instead of setting up an autonomous EUP. Members get services for free at facilities, while others pay standard user fees. One year into the program, the program has enrolled an additional 6,000 people in the insurance scheme and now has 10,000 members.

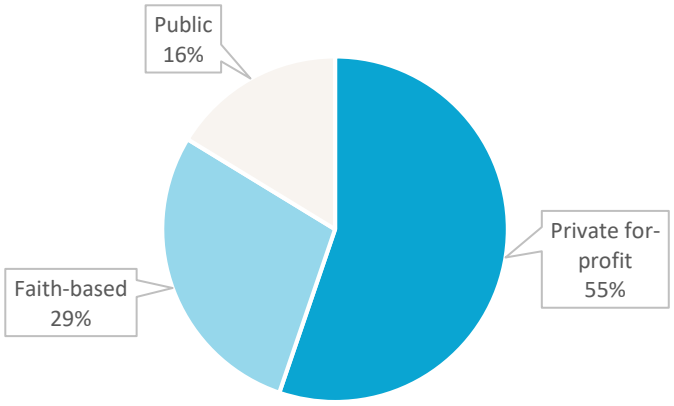
## PURCHASING INITIATIVES IN KINSHASA

**An upcoming PBF pilot in Kinshasa will be the first large-scale strategic purchasing initiative in an urban setting.** The pilot was born out of the prime minister's promise to offer free maternal services for all, and it will be the first PBF project to which the government has committed funding. The government is expected to allocate $1 million in the first year (out of an annual budget of $20 million), while the World Bank and the Buffett Foundation cover the rest of the program and commodity costs. Phase 1 of the Kinshasa project is

expected to start in June 2019 for a period of 18 months, and will cover selected facilities in the nine poorest health zones, reaching around 3.6 million people out of a total population of around 12 million.[43] Phase 2 and 3 are intended to increase the coverage of the pilot to a total of 32 out of the total 35 health zones in Kinshasa.

**The regulatory, payment and verification structure resembles the larger PDSS project, but a key difference is the large share of private facilities**. In other PBF provinces, the majority of the facilities included are either public, faith-based or operated by NGOs. Due to a lack of public facilities meeting the selection criteria in Kinshasa, approximately 80% of facilities selected for the first phase of the pilot are private, of which nearly two-thirds are private for-profit facilities (Figure 5). The pilot is also the first to include post-abortion care in the quality and quantity indicators, due to the financial support from the Buffett Foundation.

*Figure 5 – Facilities selected for Phase 1 of the Kinshasa PBF pilot[43]*




**There are several active CBHI schemes in Kinshasa, but none currently cover FP services or commodities.** The biggest ones are those that have been set up for public sector employees and teacher groups, and a new mutuelle for police officers has also recently been created. Locally, they receive support from an agency linked to the MoSP (*Programme national de promotion des mutuelles de santé*, PNPMS), which will be in charge of licensing and supervision following the recent passing of the new mutelles law. [44] Additionally, the technical assistance organization CGAT (*Centre des Risques et d'Accompagnement Techniques des Mutuelles de Santé*), which receives support from a number of international partners, provides support to CBHIs, and has also created a number of CBHIs in Kinshasa and throughout DRC. Thus, although some development around CBHIs have taken place, the PBF pilot is the major strategic purchasing initiative of relevance in Kinshasa.

## V. RECOMMENDATIONS FOR BMGF

**Poor uptake of FP and high unmet need in Kinshasa is a result of a range of supply- and demand-side factors**. The detailed assessment of the FP and financing landscape in Kinshasa revealed several challenges. Among them are the following: (1) user fees for FP services at both public and private providers pose a financial barrier to access for many poor women and girls, (2) many facilities in Kinshasa offer some form of FP, but the method mix is limited to short-term methods mainly because providers do not see a market for LARCs, and (3) the quality of infrastructure and services at public and private providers is extremely poor.

**While not a panacea for addressing all FP challenges, strategic health purchasing reforms have the potential to improve FP access and quality using financing as the lever**. Making purchasing more strategic involves

influencing provider behavior to improve access and quality. In the context of FP services, it means using financing to motivate providers to offer a comprehensive range of high-quality FP services. Strategic purchasing can be used to reduce the cost of services – in this case contraception – to clients, thereby making the services affordable for poor women and girls.

**The Foundation should consider using its investments to support and enhance government-owned strategic purchasing reforms that are underway in Kinshasa and making them work for FP.** The Government of DRC has a strategic purchasing policy that identifies the mechanisms it wants to use. The provinces have invested in developing institutional arrangements for purchasing. We strongly believe that partners should refrain from starting additional, parallel purchasing schemes and instead work to improve, strengthen and harmonize the existing strategic health purchasing schemes. Kinshasa is launching its first PBF program, which has the potential to address the challenges listed above if it can overcome some critical issues. The track record of PBF schemes improving FP access and quality has been mixed in DRC. Moreover, PBF as currently conceptualized does not do away with user fees, which pose a financial barrier to access. Addressing these gaps will be critical for PBF to successfully improve FP access and quality, especially for the poor. Below, we discuss how BMGF investments could contribute to strengthening strategic purchasing for FP in Kinshasa.

## PROPOSED APPROACH: LEARN, HARMONIZE, EXPAND

**To improve availability and affordability of FP services and commodities in Kinshasa, ThinkWell proposes that BMGF pursue a three-pronged approach of "learn, harmonize, and expand."** The timing is opportune for BMGF to make investments that leverage the current political momentum for strategic purchasing to improve FP access and quality. We suggest a three-pronged approach: (1) introduce systematic learning within and across existing purchasing schemes on how to improve FP outcomes through strategic purchasing and test innovative potential improvements, (2) harmonize common components of purchasing schemes, and (3) expand the reach of strategic purchasing to reach more women and girls.


We describe the rationale for each of the three strategies and provide examples of interventions that BMGF could support under each. We distinguish between short-term investments that can have a direct effect on FP service delivery (denoted by ST) and investments that will improve system coherence in the medium to long term (denoted by LT).

### Strategy 1: Support systematic learning from purchasing initiatives on what drives FP impact and test potential improvements

**Rationale:** Although some of the PBF projects in DRC have been evaluated over the last two decades, these have yielded mixed results in terms of FP outcomes, and there has been no effort to conduct operational research in a consistent manner to identify best practices and potential improvements. Lessons learned on what works and what does not are not synthesized in a systematic fashion, and there is no shared knowledge

base on purchasing for FP. Currently, the national level vision of strategic purchasing is predominantly driven by the World Bank. As the country is aiming to expand strategic purchasing, a learning platform to analyze purchasing programs and share best practices will benefit all actors.

**Key activities:**

### Activity 1.1: Institutionalize operational research around the Kinshasa PBF pilot with a focus on FP ST

- *What*: While the PDSS project has provision for an evaluation, there is scope for much more learning on how to include FP into the PBF design so that the program most effectively increases FP uptake and continuation. Operational research could explore the impact of PBF incentives on user fees for FP, bottlenecks in financing flows, the ability of providers to purchase commodities, and the impact of PBF on staff willingness to provide FP services. In addition, the Kinshasa pilot offers the opportunity to learn about specific "novel" topics, such as the introduction of post-abortion care, the development of new quality measurement and improvement tools, approaches to improve access for poor women, the identification of poor households in urban settings, and large-scale contracting of private providers. Lessons from the pilot have the potential to not only improve the performance of PBF in Kinshasa, but also inform the design of other purchasing schemes. Both the National Technical Unit on Strategic Purchasing and the MoSP expressed great interest in building a learning workstream for the project and were open to the development of operational research protocols. By leading this effort, BMGF can ensure that FP outcomes are a central research topic.
- *How*: Operational research should be conducted by an independent agency. BMGF could consider the Kinshasa Public School of Health as a potential partner, which has experience collaborating with international partners such as WHO and the University of Antwerp on several health financing related studies and is well-positioned to lead this work. Alternatively, FP CAPE could be considered, given its existing role in facilitating learning across BMGF grants.

### Activity 1.2: Test innovative approaches that can improve FP outcomes through PBF ST

- *What:* Based on findings from the operational research, BMGF could support the design and prototyping of cost-efficient improvements to the way FP is purchased within the current PBF project in Kinshasa to accelerate improvements in FP outcomes. Interventions that could be tested include new approaches to measuring and rewarding both the volume and the quality of FP services. For example, Couple Years of Protection (CYP) could be counted instead of the number of new and renewed users, it could test the Population Council's new tool for measuring counselling quality, and it could consider the recommendations from Collectivity's PBF and FP working group. Other interventions of interest could be offering increased reimbursement fees in return for further user fee reductions, and mechanisms to encourage new delivery modalities (such as outreach campaigns).
- Given its extensive network of implementing partners in Kinshasa, BMGF is in a great position to rapidly implement, monitor and improve new interventions in select PBF-facilities.
- *How*: An operational research partner could work in close collaboration with implementing partners, including those that are supported by the BMGF, at facility level.

### Activity 1.3: Establish an independent learning platform for strategic purchasing actors LT

- *What*: Creating a platform for the exchange of evaluations and analyses could catalyse cross-fertilization between strategic purchasing initiatives. For example, it could improve the sharing of lessons learned between the PBF pilot in Kinshasa and the EU's project in harnessing a CBHI as a purchaser in Kongo-Central. Ultimately, a learning platform could enable a more holistic approach to

the roll out of strategic purchasing in the country. Currently, the national level vision of strategic purchasing is predominantly driven by the World Bank. Having an independent learning platform could increase transparency around evidence generation as well as foster critical thinking and dialogue around existing approaches.

- *How:* The learning platform could be hosted at the CNT-AS, with support from a development partner such as SPARC, which has the mandate to facilitate learning on strategic purchasing.

**Potential risks:**

- Timing of the start of the Kinshasa PBF pilot will not allow operational research to start immediately.
- Strong foothold of the PDSS and its partners might entail political reluctance to change the design of the purchasing project

### Strategy 2: Harmonizing existing purchasing approaches

**Rationale:** The country already has three broad categories of strategic purchasing schemes – the PDSS PBF program, CBHI and the EU's mix of case-based payments and capitation**.** Within each category, there are multiple variants of the scheme running in different provinces and contracted providers are heterogenous in terms of the package and quality of services they offer. There is a need to harmonize these approaches and articulate how the country will eventually transition to a national health insurance model. BMGF can provide technical support to aid this process. Harmonization of quality frameworks, costing tools, and poverty targeting methods, as well as the standardization of providers' service offering can simplify processes, increase transparency and ultimately improve the efficiency of purchasing mechanisms. Within a rapidly evolving purchasing context, harmonization should be an ongoing process to ensure coherence between purchasing mechanisms.

**Key activities:**

#### Activity 2.1: Standardize processes and align PBF tools to MoSP national guidelines by supporting the National Technical Unit on Strategic Purchasing ST

- *What*: There is a lot of room for standardization of underlying tools, indicators and procedures within the PBF project in Kinshasa. BMGF could support the standardization of the costing exercises that inform provider payments, as well as the user fees charged to clients in facilities supported by purchasing projects. In addition, it could facilitate the harmonization of cost components in PBF projects with other financial tools in non-supported facilities that are still funded through input-based financing. BMGF could also support efforts to assess the rationale and effectiveness of existing indigent identification mechanisms, and if deemed purposeful, standardize the way in which indigents are identified and subsidized in the various purchasing schemes. Finally, BMGF could help to align the quality checklists used in the PDSS project with MoSP national guidelines.
- *How*: BMGF could support the National Technical Unit on Strategic Purchasing team to harmonize their tools and protocols by funding an embedded senior technical advisor to join the team or offer mentorship to the group from external strategic purchasing experts.

### Activity 2.2: Support private providers to engage with purchasers and standardize service quality through provider networks ST

- *What:* Currently facilities participating in the PBF project in Kinshasa do not offer a standard set of FP services. There are international implementing partners who are working with private providers and could support standardization at existing private facilities and aggregation of private providers. Social marketing organizations have provided pharmacies with a brand, so that they are recognized as stocking their products, and have offered accompanying trainings to providers. However, they do not necessarily encourage the providers to offer a comprehensive package of services. Standardizing the FP package at contracted facilities will potentially attract more FP clients. It could also facilitate monitoring and ease the enforcement of quality standards. Moreover, aggregating private providers will simplify contracting procedures and negotiations for both private providers and the contracting agency.
- *How*: Work through existing implementing partners (such as MSI and Pathfinder) to engage with facilities directly or, if deemed feasible, embed a staff in the private sector association to revive it.

### Activity 2.3: Pilot a digital client registration mechanism to improve coherence between CBHIs and PBF schemes and lay the groundwork for the future expansion of contributory schemes LT

- *What*: Technological registration platforms can facilitate the transition of the current PBF approach, which is solely supply-side focused, to a member-based scheme, as envisioned in DRC's health financing strategy. While this is a long-term investment that will not yield quick wins for FP, it can lay the groundwork for the future transition from a direct payment system to prepaid schemes. BMGF could fund a partner to assess the feasibility of introducing a digital registration mechanism or piggy-backing on existing technology and pilot the method in Kinshasa, working together with existing purchasing mechanisms such as CBHIs and the PBF project.
- *How*: BlueSquare already has a portfolio of IT projects in DRC related to strategic purchasing and could be well-placed to take this on.

### Activity 2.4: Prepare the EUPs for the long-term envisioned transition to a contributory system LT

- *What*: To support a future move from the supply-side PBF scheme to member-based system, the autonomous purchasing agencies should be prepared to function as a CBHI. Currently, the only strategic purchasing initiative bridging health insurance with PBF is the EU, which is using a CBHI to purchase services in three health zones in Kongo-Central, and is looking into expanding this in Ituri. Following the country's vision as confirmed in the recently passed law on health insurance schemes, there is a need to ensure that CBHI schemes are linked up with the current PBF pilot. Learning from the EU experience in Kongo-Central, BMGF could support both the CTN-AS and the EUP in Kinshasa to harmonize their approaches.
- *How*: BMGF could support the Kinshasa EUP or the CNT-AS team by either funding an embedded senior technical advisor to join the team or offer mentorship to the group from external strategic purchasing experts.

**Potential risks:**

- Unclear roles in the provision of technical assistance from partners to purchasing mechanisms
- Weak IT infrastructure at facility level
- Government fear of the negotiation power of 'aggregated' providers

### Strategy 3: Expand the reach of strategic purchasing

**Rationale:** Efforts to strategically purchase FP services in Kinshasa are still nascent, with PBF about to be launched in June. In the other BMGF-supported province, Kongo-Central, the EU has a small pilot purchasing through a CBHI. A lot of additional funding will be required in order to increase population coverage and improve the affordability of FP in these provinces. Adding financial resources to roll out strategic purchasing will provide BMGF with increased leverage to influence the direction of existing and expanding purchasing initiatives.

**Key activities:**

#### Activity 3.1: Add or re-channel BMGF funding to the PBF pilot project in Kinshasa ST

- *What*: Currently, only phase 1 of the soon-to-be-launched PBF pilot is fully funded, and additional funding commitments are needed to start phases 2 and 3 to cover the province entirely. Funding subsequent phases will help increase population coverage. Adding additional funding to the PBF pilot's envelope also offers BMGF the leverage required to influence the direction of the project. For example, the additional investment can be made conditional on an obligatory increased reduction in the prices of FP charged to clients visiting facilities that are contracted by the PDSS project or to modify or add FP indicators used to measure and reward provider performance. This could either be additional funding or rechannelled funding that is currently flowing directly to implementing partners to support commodities or running costs of facilities. Some of these facilities are already contracted as part of the pilot, and rechannelling funding into this mechanism could support harmonization, while for other facilities, BMGF could encourage the PBF pilot to include and contract their selected facilities as well.
- *How*: BMGF has already contributed to the larger PDSS project and could similarly support an expansion of the Kinshasa-specific pilot project. It could also consider rechannelling existing funding to implementing partners that are currently supporting selected facilities. Investments within the PDSS project could be earmarked for specific FP services

#### Activity 3.2: Invest in an expansion of strategic purchasing in Kongo-Central LT

- *What:* Apart from the opportunities in Kinshasa, BMGF could also consider expanding strategic purchasing in Kongo-Central, where fewer partners are present. BMGF could consider supporting the efforts of the EU, which is currently purchasing RMNCH services through a CBHI in three health zones.
- *How*: As the EU's project of purchasing services through a CBHI is only active in three health zones, it could work with the EU's implementing partners to support an expansion in other health zones in Kongo-Central.

**Potential risks:**

- Some may argue that increased donor funding is unsustainable, though at the same time, without adequate funding for PBF, it will not have a big enough impact on FP.
- As many large donors are already involved in the existing schemes, capacity to influence the direction may be limited.

## CONCLUSION

**The timing is right: the political momentum for strategic purchasing of RMNCH services offers an extraordinary opportunity to systematically improve availability, quality, and affordability of FP services in Kinshasa and beyond.** Moving from uncoordinated small-scale projects to driving systemic changes in the way providers are contracted, paid and supported can put DRC on a sustainable trajectory towards UHC. However, just making purchasing mechanisms more strategic is not enough. In an extremely resource-limited setting such as DRC, where provider quality is poor, supply constraints are rampant, and the FP market mostly unregulated, strategic purchasing will not serve as a silver bullet. The recommendations in this report focus on health financing and purchasing from providers, but investments in non-purchasing related areas to address FP supply chain bottlenecks and fundamental infrastructure and service quality issues are urgently needed as well. Nonetheless, coherent purchasing mechanisms are one essential component to achieving UHC and can facilitate change in other health sector areas as well. In working towards solidified and coherent purchasing structures, engagement with related efforts will be critical to ensure a coordinated approach. By making strategic investments in improvement, harmonization and expansion of purchasing schemes, BMGF can ensure that FP is front and center in the transition towards UHC.

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## ANNEX 1: OVERVIEW OF SELECTED PBF PROGRAMS INCLUDING FP

| | CORDAID[29] [30] | PS9FED (EU)[29] | GIZ[29] | PARSS (WB)[2] | PROSANI (USAID)Error! Bookmark not defined. Error! Bookmark not defined. |
|---|---|---|---|---|---|
| **Time period** | 2005-2010, 2008-2012 | 2006-2012 | 2006-2009 | 2007-2011 | 2013-2017 |
| **Provinces** | South Kivu, Bas-Congo | Kasaï Oriental, Kasaï Occidental, North Kivu and P. Oriental | Bandundu | Maniema (GIZ), Equateur (COOPI), Kinshasa & Katanga (IRC) | East Kasai, West Kasai, Katanga, South Kivu |
| **Beneficiaries** | Facilities, zones, provinces, community health workers, local verification agencies | Facilities, zones, provinces, national, local verification agencies | Individual health workers, facilities, zones, provinces | Individual health workers, facilities, zones, provinces | Facilities, hospitals |
| **Sector** | Public, private, faith-based | Public, private (if integrated) | Public | Public | Public |
| **Management** | Separate purchasing agency (AAP) in South Kivu and separate MOH-led team in Bas Congo | An EUP per province, and a purchasing agency (FASS) and a fund for the upgrading of facilities (FDSS) | 1 person at GIZ, no separate organization | AEP or payments transferred via | Verification conducted jointly by PROSANI and government staff |

[2] World Bank Health Sector Rehabilitation Support Project (HSRSP, or PARSS in French)

| | | | | | |
|---|---|---|---|---|---|
| | | | | zones in hard-to-reach areas | |
| **Commodities** | Commodity fees included in the PBF payments to facilities (procurement allowed from any DPS approved supplier) | Commodity fees included in the PBF payments to facilities (procurement only allowed through CDR) | Procured by the program and distributed to facilities | Procured by the program and distributed to facilities | Procured by the program and distributed to facilities |

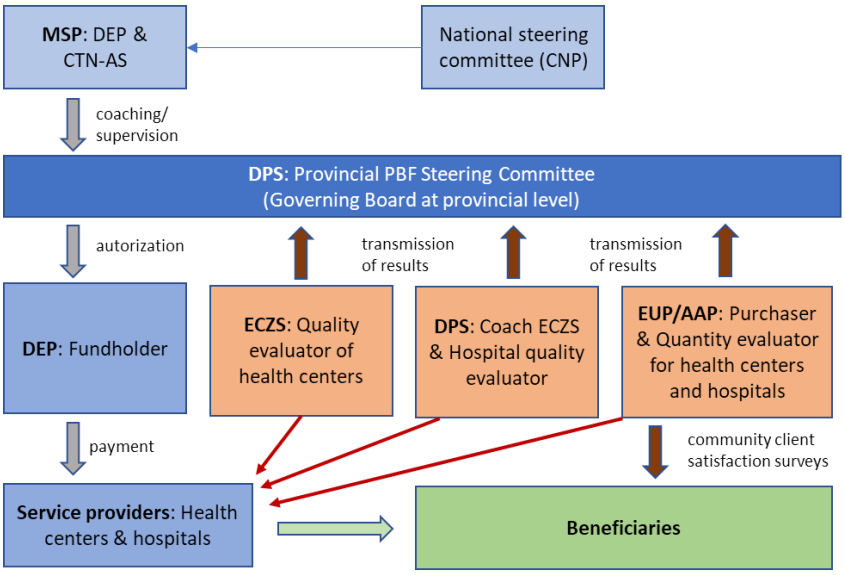
## ANNEX 2: PURCHASING STRUCTURE

**Under the PDSS project, the provinces host the secretariat of the provincial steering committee, and provide regular supervisory visits to their health zones, and assess the quality at hospitals.** The zonal health teams oversee the quality of facilities. **In addition to the fee-for-service payments, facilities can receive a quality bonus, which is a percentage increase of the amount to be paid out based on the quantity delivered.** The quality score determines whether facilities will receive the full, part or no quality bonus. At hospitals, the quality bonus is a maximum of 40% and at health centers it is 25%. FP makes up 8% of the total quality score.

Figure 6 depicts the institutional structure of the PDSS program. Strategic purchasing is under the auspices of the DEP at the MoSP, with support from a newly established and well-functioning National Technical Unit on Strategic Purchasing (CTN-AS/MS). Local Committees participate by conducting community verification of users and patient satisfaction assessments. In addition, an external counter verification agency conducts quarterly checks.

**In addition to the fee-for-service payments, facilities can receive a quality bonus, which is a percentage increase of the amount to be paid out based on the quantity delivered.** The quality score determines whether facilities will receive the full, part or no quality bonus. At hospitals, the quality bonus is a maximum of 40% and at health centers it is 25%. FP makes up 8% of the total quality score.

*Figure 6 – Institutional arrangements of the SP/PBF program*



## ANNEX 3: OVERVIEW OF THE EU AND THE PDSS PROJECT

| | EU | PDSS |
|---|---|---|
| **Geographic reach** | 5 provinces incl. Kongo-Central | 14 provinces + pilot soon starting in Kinshasa |
| **Quantity reimbursements** | Monthly reimbursements for quantity provided for 3 indicators at health centers (deliveries consultations for adults and for children) and 11 interventions at hospitals | Reimbursement fees for all PMA and PCA services |
| **Quality reimbursements** | Light touch assessment every 6 months | Maximum of 25% (health centers) or 40% (hospitals) on top of the quantity payment to be made, assessed on a quarterly basis |
| **FP inclusion** | Assumed to be covered through the reimbursement fees for deliveries and consultations | Quantity indicators for new or renewed users of:<br>– Health centers:<br>(1) oral contraceptives and injectables<br>(2) IUDs and implants<br>– Hospitals:<br>(1) implant or IUD<br>– (2) tubal ligation and vasectomy<br><br>FP has 8% weight in the quality score |
| **Payer** | Provincial EUP-FASS also serves as the payer | DEP is the payer, while the EUP is the contracting agency |

## ANNEX 4: PERSONS CONTACTED

| Organization | Name |
|---|---|
| **Government** | |
| Ministry of Public Health | Jonathan Simba<br>Pacifique Mushagalusa<br>Charly Chomba<br>Didier Ramanana |
| PNSR | Lis Lombeya |
| PNSA | Mbada Muanda |
| PDSS / CNT-AS | Didier Ramanana<br>Baudouin Makuma<br>Pacifique Mushagalusa |
| DEP | Alain Iyeti |
| PNSR Kinshasa | Vickie Mbutu |
| PDS Kinshasa | Joseph Mayungu Nsiona |
| **Donors & partners** | |
| USAID | Godefroid Mayala<br>Thibaut Mukaba<br>Jessica Petit |
| UNFPA | Achu Lorfred |
| European Union | Michel Mulohwe Mwana-Kasongo |
| World Bank | Supriya Madhavan<br>Brendan Michael Hayes |
| Buffett Foundation | Liz Bird<br>Katty Michel |
| Tulane University | Arsene Binanga |
| FP CAPE | Jean Lambert Chalachala |
| World Food Programme | Benjamin Ward |
| Pathfinder | Marie-Claude Mbuyi |

| Organization | Name |
|---|---|
| Abt Associates | Narcisse Naia Embeke<br>Wivine Mbwebwe<br>Jeanna Holz |
| Jphiego | Virgile Kikaya |
| ExpandFP / Egenderhealth | Claudine Monganza<br>Michel Mpunga |
| DKT | Jan Kreutzberg<br>Visited two health centers: Oracle de Dieu and Terra Nova |
| ICE PRODS | Abdoulaye Alassane |
| MEMISA | Servais Capo-Chichi |
| MUSAKIS-FASS | Innocent Mbala Nosa |
| BlueSquare | Antoine Legrand |
| WHO / Collectivity | Bruno Meessen |
| Independent local expert | Serge Mayaka |