Inter-American Development Bank

Not Your Cookie-cutter Results-based Aid Initiative

Social Protection and Health Division

Salud Mesoamerica Initiative's experience improving health for the poorest in Mesoamerica

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Ferdinando Regalia
Rena Eichler
Susan Gigli
Mariam Cleason
Roberto Tapia Conyer
Francisco Javier Gavilanes
Daniel Kress
Ethan Wong
Ricardo Mujica
Miguel Betancourt Cravioto
María Cruz Ciria Matilla
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http://www.iadb.org

scl-sph@iadb.org

www.iadb.or/health

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Diego Ríos-Zertuche[vi]
Susan Gigl[i]
F. J. Gavilanes Hernández[v]
Ricardo Mujica[iv]
María Cristina Álvarez[v]
Paola Zúñiga Brenes[vi]

Abstract

Salud Mesoamerica Initiative (SMI) is a unique results-based aid initiative that rewards countries for achieving health targets in the poorest municipalities in Mesoamerica. A partnership between private and public donors and governments, it offers lessons for philanthropists, corporate social responsibility teams, and bilateral donors about how to alter development assistance from the usual model of paying for inputs to a new one in which countries are paid for achieving results for their poorest populations. What makes this model of RBA feasible is its reliance on the staff, relationships, systems, and implementation capability of the Inter-American Development Bank and the dedicated unit that supports countries. Countries commit to achieve targets that progress from system readiness metrics to outcomes. Verification is based on externally conducted household and facility surveys. Five out of the eight countries achieved first-phase targets and received a performance payment, and all countries improved on key health system metrics.

Key words: Results Based Aid; Results Based Financing; Pay for Performance; Performance Based Financing; Aid Effectiveness; Philanthropy

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[i] Inter-American Development Bank, Washington, DC, USA.
[ii] Broad Branch Associates, Washington, DC, USA.
[iii] Bill & Melinda Gates Foundation, Seattle, WA, USA.
[iv] Carlos Slim Foundation, Mexico City, Mexico.
[v] Spanish Agency for International Development Cooperation, Madrid, Spain.
[vi] Salud Mesoamerica Initiative, Inter-American Development Bank, Panama City, Panama.
* Corresponding author: Emma Iriarte, emmai@iadb.org

Abbreviations and Acronyms

BMGF	Bill & Melinda Gates Foundation
COMISCA	Council for Ministers of Health in Central America
CU	Coordinating Unit
IDB	Inter-American Development Bank
IHME	Institute for Health Metrics and Evaluation
LMIC	Low- and Middle-Income Countries
ORS	Oral Rehydration Salts
PforR	Program for Results
RBA	Results-Based Aid
SMI	Salud Mesoamerica Initiative
TA	Technical Assistance

Introduction

The Salud Mesoamerica Initiative (SMI) is a unique results-based aid (RBA) initiative that aligns the efforts of countries with the priorities of two private philanthropists — the Bill and Melinda Gates Foundation and the Carlos Slim Foundation — and one public donor — the Government *of Spain* — to achieve maternal, newborn, child health and nutrition results in the poorest municipalities in Mesoamerica. Rather than paying for inputs and hoping that results will follow, as is typical in development assistance, RBA pays countries a portion of funding only when they achieve predefined results. Our research demonstrates that the SMI model of RBA is strengthening health systems to improve the health of the poorest populations. The donor governance structure and the operational and implementation support arrangements facilitated the early success of this initiative. As countries move from the first into the second of three phases, SMI holds lessons for donors and countries that seek to generate value from their health development dollars.

The first-phase success of SMI is attributed to factors that include its time-bound nature, how results are measured, technical support, and unique governance arrangements. The SMI design rewards countries for achieving targets that capture: processes (e.g. essential medicines are in stock in facilities), outputs (e.g. women receive their first antenatal care visit in the first trimester of pregnancy) and outcomes (e.g. seroconversion for measles vaccine among children). The initial phase rewarded countries for strengthening their systems to be ready to achieve output and outcome results in subsequent phases. Measurement by an independent external entity, the Institute for Health Metrics and Evaluation (IHME), both provided donors with assurance that what they are paying for is real and stimulated countries to strengthen monitoring systems and to use data to identify problems and hold people accountable for results. The Inter-American Development Bank (IDB) played a pivotal role as the intermediary between the three donors and the countries, with IDB systems and staff facilitating implementation. Countries received technical support from a dedicated team based in Panama, through technical assistance (TA) from two contracted firms, and by IDB team leaders. SMI's regional nature also facilitated cross-country learning. In addition, countries felt a reputational push to achieve targets because results are shared among peers. Governance of the donor committee bound donors to stay true to the rules of paying only when results were achieved.

This paper presents an overview of SMI, contrasts it with other experiences with RBA in the health sector, and offers lessons for private philanthropists, foundations, corporate social responsibility teams, and public donors about how to form partnerships with other donors and countries to use RBA to stimulate health results. Lessons can inform other RBA aid approaches and may present a new model of pro-poor development assistance to low- and middle-income countries (LMIC).

Methods

The data used to develop this paper come from key informant interviews conducted between May and June 2015 with donors, IDB team leaders, personnel of the SMI Coordinating Unit, contracted TA providers, and national- and local-level Ministry of Health officials. These qualitative data were complemented by analysis of SMI documents. Interviews focused on respondents' positive and negative experiences with SMI and their perceptions of system-strengthening changes, spillover effects that benefit non-SMI regions, the value of TA, and the external measurement process. Respondents reflected on SMI as a regional initiative and offered suggestions to strengthen the model and its implementation.

Overview of Salud Mesoamerica Initiative

Motivated by a desire to find a high-impact aid mechanism to support the countries of Mesoamerica to improve the health of their poorest women and children, the Bill and Melinda Gates Foundation, Carlos Slim Foundation and the Government of Spain forged a partnership with the eight participating countries and the IDB to provide financial rewards to countries for attaining pre-defined performance targets within a timeline.

SMI concentrates on improving health results in the municipalities in Mesoamerica where the largest proportions of bottom socioeconomic-quintile households live. In each phase, governments commit to achieve negotiated targets for eight to 12 indicators. The first phase concentrated on service readiness indicators such as reliable availability of key commodities. The second and third phases focus on health outputs — such as whether women deliver children according to internationally recommended protocols which include active management of the third stage of labor (Stanton 2009; Jangsten et al. 2011; Rogers et al. 1998) — and health outcomes — such as whether anemia in children has declined — and are comparable across countries. Whether targets are achieved is determined through fully independent measurement by the Institute of Health Metrics and Evaluation (IHME) (Mokdad et al. 2015). Each achieved target receives a value of 1, and those that fall short receive a 0. To receive the performance payment, countries need to achieve at least 80% of targets.

SMI donors contribute approximately half the funding, with the rest from domestic resources, which in a few cases are funded IDB loans. At the end of each of three 18- to 24-month phases, if targets are met, donors pay a performance payment equal to half the amount contributed by governments. The only condition is that performance payments must be used in the health sector. In effect, the RBA payment rewards governments with a sum equivalent to half of their investment *if* they achieve results.

In the first phase, five countries earned the performance payment; one country fell short but was allowed to continue to the next phase; and two countries entered a performance-improvement phase during which they achieved targets and were allowed to continue to the second phase without receiving the performance payment.

Implementation of SMI is overseen by the IDB, drawing on its network of country offices and technical team leaders that work with each country government in the region. In addition, a SMI Coordinating Unit (CU) based in Panama provides direct technical support to countries and oversees contracts with two firms that provide TA in areas such as commodity systems, information systems, policy development and implementation, and health worker training. Together with IDB team leaders, the dedicated CU serves as the intermediary between the countries and the donors.

A new aid model that conditions funding on results and enables private philanthropists and foundations to have a steering role

In the search to generate the most value from aid for health, donor interest is growing in initiatives that condition a portion of funding on whether predefined, agreed-upon results have been achieved (Department for International Development 2014; The World Bank 2015). Paying for

verified results resonates with philanthropists who come from the private sector, where a focus on results is fundamental. However, to design, implement, and support an RBA model requires capacities that many private and public donors don't possess. Staff and systems are needed to design indicators and negotiate targets with countries, provide technical support, verify whether results have been achieved, and transfer funds. By leveraging the structures and staff of a multilateral institution such as the IDB, SMI provides a replicable model of RBA that could allow private philanthropists, foundations, corporate social responsibility units, and bilateral donors to pay for verified results together.

Few RBA initiatives pay countries for health results. However, donors are supporting a growing number of LMICs to pay public sector facilities (The World Bank 2015), NGOs (Eichler and Ergo 2015; Eichler and Levine 2009), central medical stores (Spisak et al. 2016), and sub-national entities (Gertler, Giovagnoli, and Martinez 2014). Exceptions are GAVI, which rewards governments for DTP3 and measles coverage (GAVI 2014), and the World Bank's Program for Results (PforR) instrument that disburses against attainment of pre-determined metrics. (As of 2015, roughly $20 billion is programmed for the health sector.)

Table 1 provides a snapshot that contrasts elements of each RBA model. Key differences can be found in donor governance arrangements, how results are measured and verified, and how countries access technical support. All support health system strengthening. SMI and GAVI reward equity, and the World Bank's PforR has this potential if the indicators linked to disbursement are crafted to reward equity.

While all countries in Mesoamerica have health policies or plans that include statements about equitable access to health for all (Government of Mexico 2013; Government of Chiapas 2013; Government of Guatemala 2008; Ministry of Health, Costa Rica 2010; Ministry of Health, Panama 2010; Ministry of Health, Nicaragua 2008; Ministry of Health, Belize 2006, 2014; Ministry of Health, El Salvador, n.d.; Ministry of Health, Honduras 2005; Ministry of Health, Mexico 2007), health outcome disparities still exist[4]. These inequities suggest that countries may *need to strengthen both political will and know-how to achieve their stated goals of equitable access.* At the start of SMI, measurement of baseline performance revealed disparities that were even greater than expected by countries (Mokdad et al. 2015).

RBA, modeled after SMI, holds potential as a model of development assistance to LMICs with pockets of underserved people. As countries move from low- to middle-income status, external aid for health programs and the TA that accompanies it tends to decline. By focusing governments on their poorest populations and providing technical support to enable countries to achieve results, the SMI model of RBA may provide value for money in the short term by improving health results and for the longer term by establishing a new equilibrium of greater performance, strengthened political will, fortified health systems processes, and shifted health system cultures to manage based on achieving results, changing behavior, and holding people accountable for their contributions. SMI also contains lessons for countries with federalist structures, such as Brazil and India, about how to condition federal-to-state transfers on results. Donors who care about improving the lives of women and children may want to consider a model like SMI to target their support on those most neglected populations.

Table 1: Features of Health Results Based Aid Initiatives

Feature	SMI	GAVI	Program for Results (PforR) World Bank
Equity focus	Yes; all rewarded targets occur in municipalities with the highest numbers of lowest socioeconomic quintile households	Yes; rewards that at least 90% of districts have GTE 80% DTP3 coverage	Possible; If disbursement linked indicators (DLIs) include equity focus
RBA model	Three 18-24 month performance periods (approximately 5-6 years); 8-12 process, output and outcome targets; reward is non-earmarked funds to be used in the health sector equal to half of the funds the country dedicated to achieve results in priority municipalities.	Five year with annual performance periods; per head payment for additional DTP3 and measles and for maintaining high coverage; High performing countries have additional equity target.	Some up front funding for investments. Further disbursements linked to attainment of "disbursement linked indicators".
Sources of performance data for payment	Completely external household and health facility surveys concentrated on poorest municipalities. Not based on country information systems or national household surveys	Country routine information systems plus at least 2 independent national household surveys each five years.	Country information systems that could include surveys.
Verification or measurement of country performance for payment	Completely external measurement by independent entity	Country administrative data not more than five PP higher than the WHO/UNICEF estimates, independent assessments of quality of administrative data, periodic household surveys.[1]	Country information systems generate results that are verified by either independent entities or by government entities with no conflict of interest.
Technical assistance	Inter-American Development Bank staff and country representation provides technical support to countries. Dedicated Coordinating Unit based in the Central American region provides technical support. Two technical assistance firms also provide direct TA.	GAVI is a financing entity. Technical assistance is provided by other development partners.	World Bank staff and country representation provides technical support to countries, primarily at national level. Technical assistance can be funded through complementary or hybrid loans and managed by the country.
Donor governance	Three donors with active oversight; all decisions are unanimous	27 member board provides formal input into development of policies and management of operations. Operational decisions by secretariat staff.	World Bank structure approves loans and technical staff oversee operations.
Payment to countries	Managed by the Inter-American Development Bank	Managed by the GAVI Secretariat	Managed by the World Bank

How does SMI aim to improve the health of the poorest in practice?

SMI mobilized health sector actors to concentrate on all elements of health systems needed to achieve maternal, newborn, and child health results for the poorest populations in a comprehensive way. The first phase focused on strengthening health systems to pave the way for achieving health output and outcome targets in the second and third phases. Strengthening health systems requires tremendous efforts from country actors, donors, the IDB, and the CU.

Management by results was perceived as catalytic in all countries in changing mindsets and fostering new partnerships across national units and between the national and local levels of the Ministries of Health. The deadline to achieve targets introduced urgency. Countries were observed to move through a series of stages in their reaction to and perception of the SMI RBA model. Initially, the opportunity to earn the performance payment was viewed as an intriguing prize model. Once country authorities and their teams began to digest what needed to change to achieve targets by the deadline, they became concerned. Countries next worried about how they were performing in comparison with their peers, which created a spirit of competition that strengthened countries' commitment to results. In the final phase, country authorities and their teams felt pride in the progress they had achieved.

SMI set in motion an assessment process that resulted in plans to address system barriers. Respondents described a painful process to dissect actions needed to achieve every target. National leaders visited remote communities to understand health system challenges, and collaboration with local health workers and managers was strengthened. For instance, most countries added the use of zinc with ORS to treat diarrhea. But for this policy change to benefit children living in poor municipalities, the following steps needed to be laid out clearly to ensure follow-through to prevent mortality and reduce malnutrition: 1) enact policy; 2) add zinc to essential inputs list; 3) procure zinc; 4) distribute zinc to health facilities; 5) create guidelines for health workers; 6) train health workers; 7) create household awareness and generate demand; 8) add monitoring of zinc to health information systems. For all of this to happen, personnel at national Ministries of Health had to collaborate with district health managers, enabling health workers to reach the individual households they serve.

A similar process was replicated for multiple interventions aimed at reducing maternal, newborn, and child mortality and morbidity, and enhancing health.

The CU was deemed by both countries and donors as vital to the success of the initiative and is a central feature of this new RBA model. The CU serves as an intermediary that implements the initiative, supports countries, reports to donors and is a custodian of donor money. Effectiveness of the CU was driven by both its strong leadership and technical staff and its feeling of accountability to both countries and donors.

This new RBA model elevated countries' appreciation for TA, as it was directly linked to what was needed to attain performance targets. The CU provided countries a menu of possible TA that covered areas such as planning and project management, information system strengthening, supply and cold chain strengthening, health worker training, and community engagement. Countries appreciated that they were given the opportunity to select the TA that they most valued. Providers of TA shared that country counterparts were more engaged than usual in development projects because the support was oriented toward reaching targets that the country was held accountable for achieving. IDB Team Leaders also appreciated the umbrella contracts to provide

TA to all SMI countries managed by the CU, as this provided continuity of assistance, facilitated learning and adaptation of tools across countries, and reduced transaction costs.

Feedback gathered from one representative from a National Ministry of Health revealed:

> The first technical assistance we received was on project management. This discussion was very different from the discussion we have with our other projects. We began with the deadline when we had to have completed everything and went backwards to lay out what needed to happen to meet that deadline. We had very specific dates and we had to make sure that we knew the person responsible for each step.

Rigorous measurement is one pillar of SMI. In all initiatives that pay based on results, a process is needed to measure whether rewarded results have been achieved. Both GAVI and the World Bank in PforR mechanisms rely on country information systems complemented by periodic household surveys that use a national sample to verify the results self-reported by countries. Results-based financing initiatives that reward health facilities for results also tend to rely on self-reported data with audits to verify what was reported. In contrast, SMI measures results using an external measurement process based on primary data from health facilities and households in the poorest municipalities. Health leaders at the national level valued this independent measurement because it was believed to be credible and it convinced governments that baseline performance was weaker than they had initially believed. The donors required independent measurement to provide assurance that the results they were paying for were true. According to one IDB team leader:

> The focus on results has caused people to work differently because it's quite obvious that somebody is paying attention and somebody is going to know what you did and how you did it. I think it has made people prioritize implementing SMI. I think at the national level SMI always goes first because they know that they have to report and that this is going to be discussed in COMISCA and with the donors and the IDB every three months. This is all leading to the very public and visible measurement of performance.

The regional nature of SMI provided unique opportunities to stimulate competition among and learning across countries. In contrast, other RBA models are country-specific. Sharing achievements with peers from neighboring countries and high-profile donors motivated health leaders to strengthen political commitment and to implement plans to address system challenges. Senior Ministry of Health officials participate in a regional body, the Council for Ministers of Health in Central America (COMISCA), where SMI performance is shared. Interviews with SMI stakeholders at national and local levels demonstrated that reputational incentives are as important as financial incentives to solidify commitment of senior health leaders to strengthen health systems and deliver results to poor women and children in underserved municipalities.

Countries are learning from each other. For example, the state of Chiapas and Guatemala learned how to use the dashboard developed to monitor availability of supplies and service provisions in El Salvador. Countries report that lessons from neighbors with similar cultures, populations, and systems are more directly relevant than learning from a country outside the region.

Lessons from the first few years of implementation

At the time of writing, all countries had completed the first phase and had progressed to the second phase. This timing provided an opportunity to take stock of what has been learned during

design and implementation with an eye toward suggestions for refining and potentially improving this new RBA model.

The innovation in SMI is not something new. Rather, it is finally achieving what has eluded countries for decades. Few truly new strategies were introduced. Instead, the innovation comes from considering all the system elements that needed to be in place and in catalyzing achievement of each required element. Country plans have been transformed from aspirational to operational. Says one Ministry of Health representative:

> It's not something totally new to us, but it is something which allows us to integrate and advance. That is to say, what we should have always done, what we have established, what our programs dictate, our working guidelines dictate, or you might call it the process. The difference being that now we are following through with it, whereas before we didn't.

Indicators and targets and the timeline needed to achieve them are the backbone of any RBA initiative. Prior to the first phase, countries were overly optimistic about what they could achieve in the timeline. Country respondents reflected that national health leaders committed to achieve results that were challenging to reach. Donors and the IDB also learned how to specify indicators and establish targets.

The time-bound nature of targets is critical, as it maintained pressure and motivated countries. However, the majority of respondents agreed that the initial 18-month timeline was too short; 24 months was more feasible.

Variation in number of and content of indicators across countries led to some countries with easier-to-attain targets than others. Most indicators were comprised of a composite of other indicators. For example, the indicator that facilities are stocked with essential supplies and medicines was further defined by the precise list of commodities and the definition of how "in stock" would be measured. It would have been fairer to have consistent numbers of indicators, composition, and magnitude of improvement across countries.

Targets were established through a combination of means — a statistical assessment of global and local trends in improvements in each indicator performed by IHME, a review of international literature, a cost-benefit analysis based on a model developed by the IDB, statistical power calculations, and expert consultations — as well as negotiation. In countries where baselines were not available in time to establish targets, percentage-point increases were agreed upon, with the idea that the actual target figure would be determined after baseline data were made available. This proved to be a workable solution. Additionally, SMI adjusted targets in a few cases after baseline data became available. This adjustment was critical for the credibility and the fiduciary soundness of the SMI RBA model.

The "all or nothing" model that rewarded countries for attaining a score of 0.8, which was determined by fully attaining every component of 80% of indicators, was viewed by some as excessively rigid. Others felt that the model maintained pressure on countries to address every weakness. Yet an exclusive focus on scores alone does not capture improvements. The three countries that failed to earn the first performance payment achieved considerable progress.

TA was viewed as critical to help countries achieve the targets in a constricted time period. Basing the CU in the region facilitated communication, responsiveness, engagement with countries, and coordination with IDB team leaders. A structure with "boots on the ground" was especially important, given that the focus of SMI is on areas with the poorest populations, which necessitated

engagement at subnational and community levels as well as with national Ministry of Health counterparts. One donor representative stated afterward:

> We recognized we needed to leave in the budget a small amount of money for technical assistance, because these countries are not ready. We knew it would take time to build some capability. We also knew they shouldn't have agreed to these targets because even if they believed the targets were achievable there would be delays typical of procurement, supply chain management, etcetera, and they are going to fail. Some of these failures are preventable. Do you want to let them fail knowing that this could be prevented?

The SMI donor governance arrangement is unique, with each donor contributing skills and perspectives arising from their private sector, foundation, or public-sector vantage points. SMI is governed by a donor board comprised of representatives from the Carlos Slim Foundation, Bill and Melinda Gates Foundation, and the Government of Spain. Each donor is assigned one vote, and decisions must be unanimous. Some decisions required debate and eventual compromise, and in other cases, donor members had to capitulate to the preferences of another donor. While this decision-making structure brings challenges, donor representatives who were interviewed believe that the strengths outweigh the challenges.

Each donor came from distinct institutions with different histories, mandates, and attitudes toward programmatic risk. The BMGF is interested in learning about how an RBA initiative can improve the health of the poorest, partly because they perceive similarities between the poorest in Central America and other countries. The BMGF is also interested in learning about how the Initiative functions as a public-private partnership with its unique governance and country support arrangements. Coming from the private sector, the BMGF is results-oriented. While the BMGF is a mature philanthropic institution, it has little experience providing grants to country governments. In contrast, the Carlos Slim Foundation is a less-seasoned donor with a strong focus on results and obtaining value for money and deep knowledge of the region. The Government of Spain has been engaged in the region for decades and takes a long-term view of development assistance. Conditioning funding on results required a culture change for Spain, as they expressed concern that this may conflict with Paris Principles on AID Effectiveness. Through the process of steering SMI, donors learned and converged in understanding.

The role played by the IDB was also new and, while it imposed a larger burden on team leaders than management of other loans, the skills learned are being applied to design of IDB operations in Mesoamerica and in other countries. IDB staff experienced a shift in engagement with country-client counterparts towards greater policy dialogue and results and action-oriented discussions. The process of working together with countries to diagnose system barriers and to develop plans to solve them in order to achieve SMI targets sharpened the project design and supervision skills of IDB team leaders. In addition to motivating results at the country level, SMI is stimulating changes in how the IDB operates in the sector.

Since this article presents the experience of SMI during its first phase, one unknown is whether strong first-phase performance will continue into the second and third phases. It is encouraging to see that the foundation for reaching the poorest has been enhanced, but whether this will translate to better outcomes will only be understood in the future.

There are good reasons to be optimistic that some changes stimulated by SMI will be sustained. All governments have enacted policies that impact the entire country — such as micronutrient supplementation and ORS and zinc to treat diarrhea — that are likely to be continued. Many health system processes have been strengthened, such as planning, procurement processes

within the Health Ministries, distribution, and supply chain management, and many are likely to be sustained. The intensified focus on monitoring and data and the new monitoring tools appear likely to be continued, particularly in countries that have invested heavily in enhancing their information systems. For example, almost all countries are developing information systems to monitor commodity availability with support from SMI. Programs that are in question for the long term are those that rely on ongoing funding, such as transportation support programs for pregnant women. Also in doubt is whether countries will continue their commitment to keep facilities in poor municipalities fully stocked with essential medicines, vaccines and supplies and whether challenges with national procurement systems that extend beyond Ministries of Health will hamper progress in the health sector. Some respondents postulate that citizens will pressure their governments to continue to support health services at the level that they have grown accustomed to receiving through SMI.

Conclusion

Lessons from SMI can inform RBA approaches in other regions and in countries with a federalist structure. The SMI donor governance and implementation arrangements can also guide other groups of philanthropists interested in hard-wiring results into how they provide development assistance. From the recipient country perspective, by establishing targets that need to be achieved by a deadline, offering a financial prize for their attainment, providing technical support to enable countries to strengthen their systems, and strengthening political commitment by attracting the attention of senior leaders, SMI holds much promise. However, given that this paper captures the first phase, results from the second and third phases will reveal more about the strength of SMI as a new model of development aid.

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