

# The Initial Prize in the Salud Mesoamerica Initiative Results-Based Aid Initiative

Strengthened Health Systems for  
Reproductive, Maternal, Neonatal and Child  
Outcomes

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Social Protection and  
Health Division

TECHNICAL  
NOTE N°  
IDB-TN-1314

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October 2017

Cataloging-in-Publication data provided by the  
Inter-American Development Bank  
Felipe Herrera Library

The initial prize in the Salud Mesoamerica initiative results-based aid initiative / Emma Iriarte, Rena Eichler, Susan Gigli, Jennifer Nelson, Paola Zúñiga Brenes, Diego Ríos-Zertuche.

p. cm. — (IDB Technical Note ; 1314)

Includes bibliographic references.

1. Medical care-Central America-Finance. 2. Maternal health services-Central America. 3. Child health services-Central America. 4. Reproductive health-Central America. 5. Nutrition-Central America. 6. Public-private sector cooperation. I. Iriarte, Emma. II. Eichler, Rena. III. Gigli, Susan. IV. Nelson, Jennifer. V. Zúñiga Brenes, Paola. VI. Ríos-Zertuche, Diego. VII. Inter-American Development Bank. Social Protection and Health Division. VIII. Series.  
IDB-TN-1314

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Strengthened Health Systems for  
Reproductive, Maternal, Neonatal and Child Outcomes

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### Abstract

The Salud Mesoamerica Initiative is a public-private partnership that provides funding to national governments in Mesoamerica (the region consisting of southern Mexico and Central America) that is conditional on attaining health results in their poorest municipalities. SMI has set into motion a dynamic process that is strengthening health systems for reproductive, maternal, neonatal and child health. The complementary and mutually reinforcing factors driving these changes include: reputational and financial incentives; competition among the participating countries; learning across national boundaries; external monitoring and the use of credible data to measure and reward results; technical assistance; and a sense of urgency created by the imposition of clear, time-bound performance goals. This results-based focus at the population level has also triggered changes in health systems that include: government commitment; strengthened leadership and operational management practices; enhanced coordination and collaboration between teams within the national ministries of health and between national and local levels in the health sector; new policies and norms focused on reproductive, maternal, neonatal and child health; health information data collection and analysis for decision-making and accountability; strengthened commodity management systems; increased demand for health services at community levels; and enhanced service delivery readiness. These system-strengthening measures are providing the foundation for the eight Mesoamerican countries to improve maternal and child health results among the poorest in the subsequent phases of SMI, when improved health outcomes will be rewarded. This results-based aid initiative contains unique features that offer lessons to strengthen other results-based aid initiatives and inform future donor partnerships with countries or between national and subnational governments.

**Key words:** Results-based aid; results-based financing; health system strengthening; maternal and child health; supply chain strengthening; reproductive health; nutrition; public-private partnerships

**JEL Code:** I140

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## Abbreviations and Acronyms

HSS	Health System Strengthening
IDB	Inter-American Development Bank
IHME	Institute for Health Metrics and Evaluation
ORS	Oral Rehydration Salts
RBA	Results-Based Aid
RMNCH	Reproductive, Maternal, Neonatal and Child Health
SMI	Salud Mesoamerica Initiative
TA	Technical Assistance
WHO	World Health Organization



## Introduction

Motivated to find a high-impact aid mechanism to support the countries of Central America and the state of Chiapas, Mexico to improve the health of the region's poorest women and children, the Bill & Melinda Gates Foundation, the Carlos Slim Foundation and the Government of Spain forged a partnership with these countries and the Inter-American Development Bank (IDB) to provide financial rewards to countries that attain predefined performance targets within a specific timeline. While financial incentives are integrated into this results-based aid model, focusing exclusively on the program's financial incentives misses the system-strengthening element catalyzed and supported by the program and are crucial for achieving sustainable results. While earning the performance payment may be the most visible prize, a strengthened health system that can deliver services to the poorest populations and improve health outcomes is the real reward.

There are a few examples of results-based aid in the health sector, but none contain all the features included in Salud Mesoamerica Initiative (SMI): donors functioning as active members of a partnership; a development bank as administrator; a regional unit that oversees and provides technical assistance to countries; rewards for health system-strengthening metrics, in addition to health outputs and outcomes; fully independent measurement; aligned demand and supply-side incentives; and an equity focus (Eichler and Glassman 2008). Research by Perakis and Savedoff at the Center for Global Development demonstrates that enhancing attention to outcomes appears to be a more prominent driver in SMI than other drivers (such as pecuniary interests) generally thought to be more important in a results-based initiative (Perakis and Savedoff 2015).

The quality-improvement mantra that "Every system is perfectly designed to get the results it gets" (Carr 2008) is directly applicable to SMI. It starts with the desired results, and then moves backwards to make adjustment to systems to achieve them. Once targets are negotiated, teams are prompted to examine the systems and processes that need to be put in place in order to achieve improvements by the deadlines established in their performance agreements. For example, some countries have agreed to reduce anemia in children under 2. To accomplish this, they needed to begin by developing new policies for nutritional supplementation for children, followed by implementation of guidelines for district managers, health providers, and community health workers and corresponding behavior change communication strategies. Products had to be added to the countries' lists of essential commodities before being procured and distributed. This process review prompts the examination and revision of supply systems to ensure the availability of key commodities.

There is a growing body of evidence indicating that investments in stronger health systems lead to improved outcomes (Hatt et al. 2015). It is the system as a whole—the combination of different components and subcomponents and the interactions within and between them—that will determine the coverage, quality and impact of maternal, newborn and child health interventions and the impact on outcomes (Ergo et al. 2011). Hatt and colleagues reviewed 161 systematic reviews on the effects of health system-strengthening interventions on health outcomes in low- and moderate-income countries. Thirteen categories of interventions—all of which are represented in SMI country programs—were found to contribute to health outcomes. None of the reviews, however, include case studies where multiple elements of a health system were purposefully and simultaneously strengthened.

The SMI experience will contribute to filling this knowledge gap. SMI has set into motion a dynamic process strengthening the health systems in Mesoamerica to deliver results in maternal, neonatal





and child health, family planning and nutrition for the region's poorest women and children. The complementary and mutually reinforcing factors that are driving these changes include: reputational and financial incentives; competition among participating countries; learning across national boundaries; external monitoring and the use of credible data to measure and reward results; technical assistance; and a sense of urgency created by the imposition of clear, time-bound performance goals. Focusing on results at the population level has led to changes in health systems that include: government commitment; enhanced collaboration between teams within the national ministries of health and between national and local levels in the health sector; strengthened health system leadership and management at all levels; updated policies and norms focused on nutrition, maternal, newborn and child health; development and use of health information for decision-making and accountability; strengthened commodity management systems; increased demand for health services at household and community levels; and enhanced service delivery readiness. These system-strengthening measures are expected to provide the foundation to achieve improvements in maternal and child health results in subsequent phases of SMI.

The geographic focus of SMI is on the municipalities in Central America and the state of Chiapas, Mexico with the largest percentage of households in the lowest socioeconomic quintile. If the health targets set are successfully met by the conclusion of each of three phases (with each phase lasting from 18 to 24 months), SMI reimburses the government with a performance payment equal to half the amount it has contributed. These funds can then be used freely in the health sector. If, however, a country does not meet the predetermined targets for a phase, the performance payment is not provided for that phase. Phases are designed to reward a specific progression in performance—from system readiness to measured outcomes. The architects of SMI started with the end goals, working backwards to determine second- and first-phase indicators and targets that would help the countries build capacity to achieve desired outcomes by the end of the third phase. For example, if the third phase rewards reduction of anemia, the second phase rewards utilization of micronutrient powders, and the first rewards changes in policies to promote use of micronutrient powders and increase their availability in health centers.

In each phase, countries commit to achieving negotiated targets for eight to 12 indicators. These are selected from a menu of indicators that are monitored in all countries.<sup>1</sup> Payment of the performance tranche is conditional on achieving a score of 0.8 or better. This performance score is determined through external and fully independent measurement conducted by the Institute of Health Metrics and Evaluation (IHME) (Mokdad et al. 2015) and a group of regional experts. In the first phase, five countries achieved a score of 0.8 or greater and earned the performance tranche; one country fell short but was allowed to continue to the next phase; and two countries entered a remedial phase during which they achieved missed targets and were allowed to continue to the second phase without receiving the performance payment. Yet even countries that earned a score less than 0.8 made considerable improvements. Whether first-phase targets were achieved or not was determined using one-tailed Z tests that analyzed whether the result was significantly lower than the target. Attainment was considered acceptable when the Z test was not significant. Details of country performance as well as second- and third-phase indicators and targets are presented in the Annex. A detailed account of the results of the first phase as determined from external surveys has been submitted for publication elsewhere (Mokdad et al., n.d.).

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<sup>1</sup> The SMI General Framework compares the evolution of 40 indicators in the region that capture utilization and coverage with quality over a 24-month period.



Implementation of SMI strategies is funded by a combination of domestic and donor resources (39 million USD and 41 million USD, respectively) directly invested in the region's poorest areas. Approximately half of the funding comes from external aid (from the SMI donors) and half from domestic resources (funded by loans from the IDB in some countries and by existing domestic resources in others). IDB programs are on budget, helping to improve the likelihood of sustainability. Countries that achieve a score of 0.8 or higher in each phase receive a performance payment equivalent to half of the domestic resources they dedicated to SMI activities. Because these performance payments come after costs are incurred, countries view these funds as a flexible prize, and the only conditionality is that funds are used in the health sector. In the first phase, almost \$6.5 million was disbursed as part of the performance tranche.

I think we've demonstrated that big results can be obtained with little money. I mean, considering all the investments made by governments, donors and development banks, the amount invested by SMI is relatively small, especially given the results we're getting. I would be sad to see it go [...] I think it is a model to be studied and followed.

– IDB Team Leader

SMI resources account for less than 1% of overall yearly expenditure in health (WHO 2014). While it may seem to be a relatively small amount, it demonstrates the potential power of catalytic funding. It also indicates that elements such as reputational incentives and technical assistance to obtain results play a bigger role than originally thought and require further analysis.

Each country program is designed to align with national strategies to improve health for its poorest women and children. Therefore, different system elements are included in each country. For example, as El Salvador was already implementing a family health model, and Nicaragua a community platform, their participation in SMI was designed to support and strengthen these measures. Countries selected indicators from a menu that covers RMNCH, based on their priorities.

## Methods

The analysis in this paper was based on recompilation of documents, literature reviews and in-depth qualitative interviews. Review of numerous SMI planning and reporting documents provided insight into design decisions and progress in each country. Review of IHME external measurement reporting provided details on country results after the first operations. More than 40 key informant interviews were conducted between May and June 2015 with donors (5), IDB team leaders (8), staff of the SMI Coordinating Unit (which supports countries) (8), external evaluators (1), technical assistance (TA) providers (2), Ministry of Health officials at national and local levels (12), and district health managers (6). These provided insight into the following key areas of interest: respondents' positive and negative experiences with SMI; their perception of external measurement and the systems-strengthening TA provided; their reflections on SMI as a regional initiative; SMI effects on health systems; and their views on how the SMI model and implementation could be strengthened. Lastly, a literature review identified different approaches to measurement and verification in results-based financing schemes and the trade-offs associated with these approaches. Results were then organized and presented by the authors into health-system building-block elements, which in the SMI model, includes a demand-side category. In the case of indicators that could be characterized under multiple health system elements, consideration of the primary system driver was used to determine categorization. All interviews, transcription and data management were conducted by a team external to SMI to ensure that the confidentiality of key informants was respected and bias minimized.



## Results

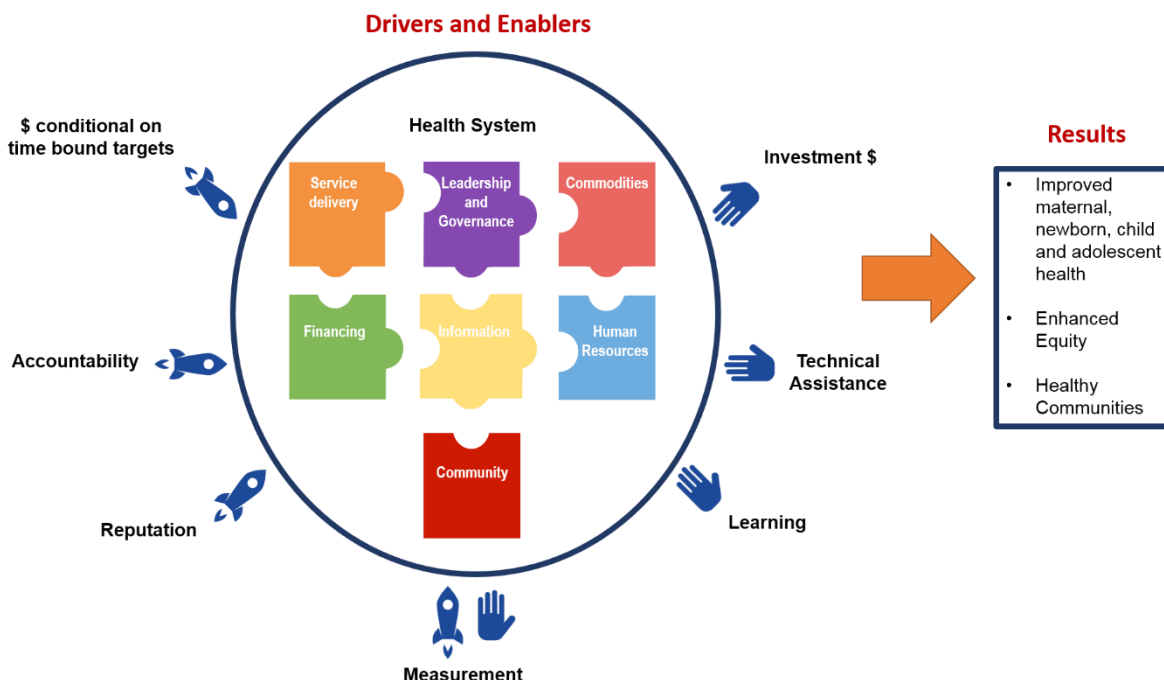
At the outset, country governments did not fully understand how the results-based aid model would work. In some cases they did not pay enough attention to the details of the composite indicators and which elements needed to change in order to achieve results within the initial 18-month timeline. Some countries lost points because one element of a composite indicator was missed, resulting in a loss for the entire indicator. Respondents at the country and support levels suggest that a better model might involve paying out for each indicator attained rather than the “all-or-nothing” approach requiring countries to achieve an overall score of 0.8.

Respondents believe that having a deadline is important for creating a sense of urgency. But an 18-month timeline is too short to assess bottlenecks, develop and implement system-strengthening changes, and achieve results. Two full years appears to be more realistic. External measurement provides credibility at both the country and donor levels that the results reported are real.

SMI has allowed us to integrate the different divisions of the Ministry of Health. At the beginning, we worked in an isolated fashion. Each division would carry out its own actions without any interrelations. But after working with the Initiative, the relationships, cooperation and sharing that we didn't have before solidified ... and that, in my view, is the most positive experience the Initiative has had on us.

– Ministry of Health official

**Figure 1: SMI Health System Change Framework**

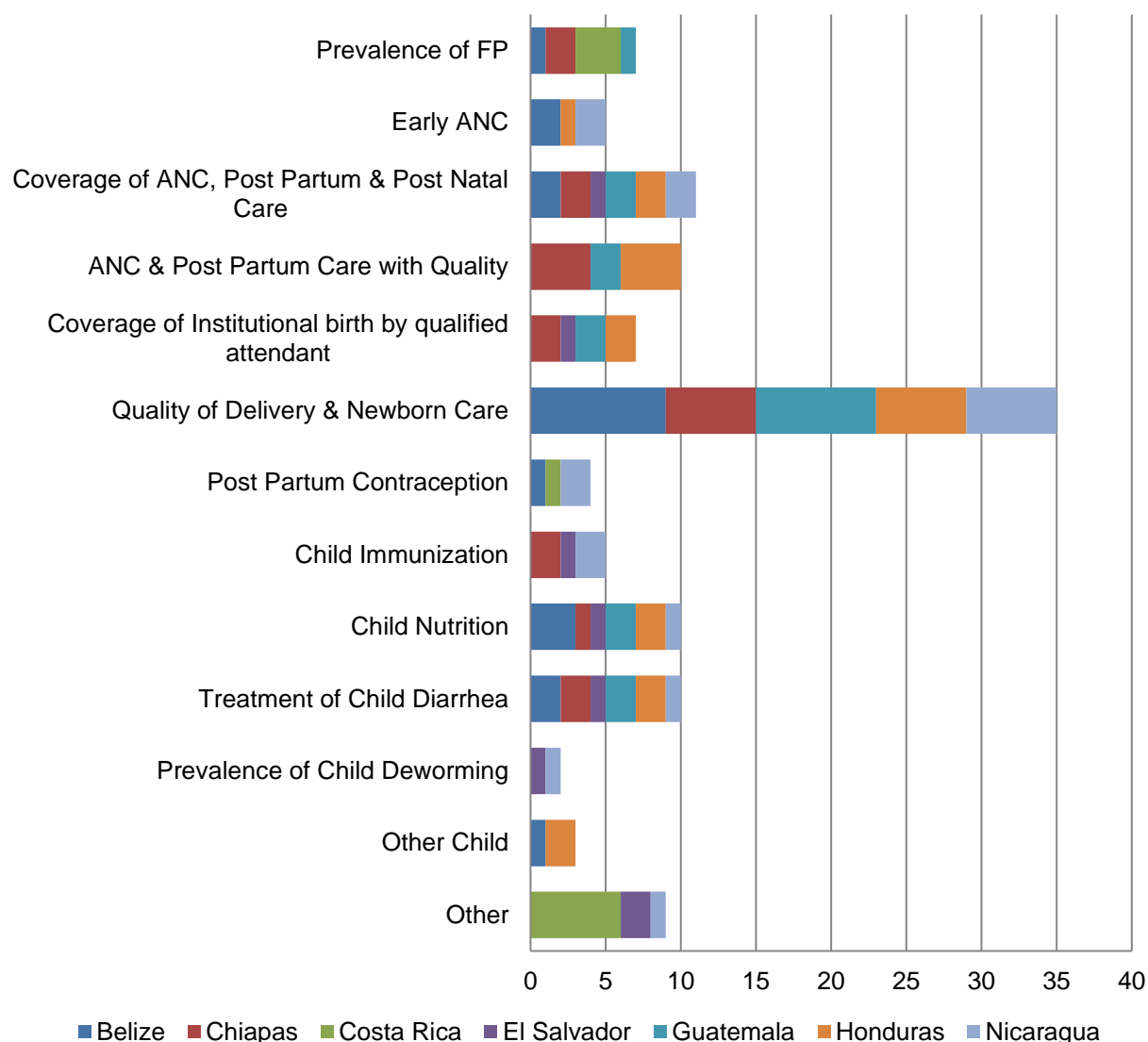


The SMI health system change framework, presented in Figure 1, illustrates the elements that combine to enable countries to meet their performance targets. These include technical assistance; learning within and among countries; reputational and financial incentives; credible



information through external evaluation; and investments to strengthen elements of the health system. To attain SMI targets, countries altered the health system “control knobs” of financing, organization, leadership, regulation and behavior (Roberts 2008). These simultaneous adjustments triggered the changes that strengthened the performance of health system building blocks and captured the additional community/demand side element introduced by SMI (Kerr et al. 2007; Claeson et al. 2001). Teams first selected the outcome indicators in the third and second operations (Figure 2), and then worked backwards to identify HSS targets that would need to be made to achieve results (Annex I).

**Figure 2: 2nd and 3rd Phase Indicators by Service Type**



Note: Some indicators are the same for the 2nd and 3rd Phase with more ambitious targets. The graph presents the total number of indicators considered for both Phases

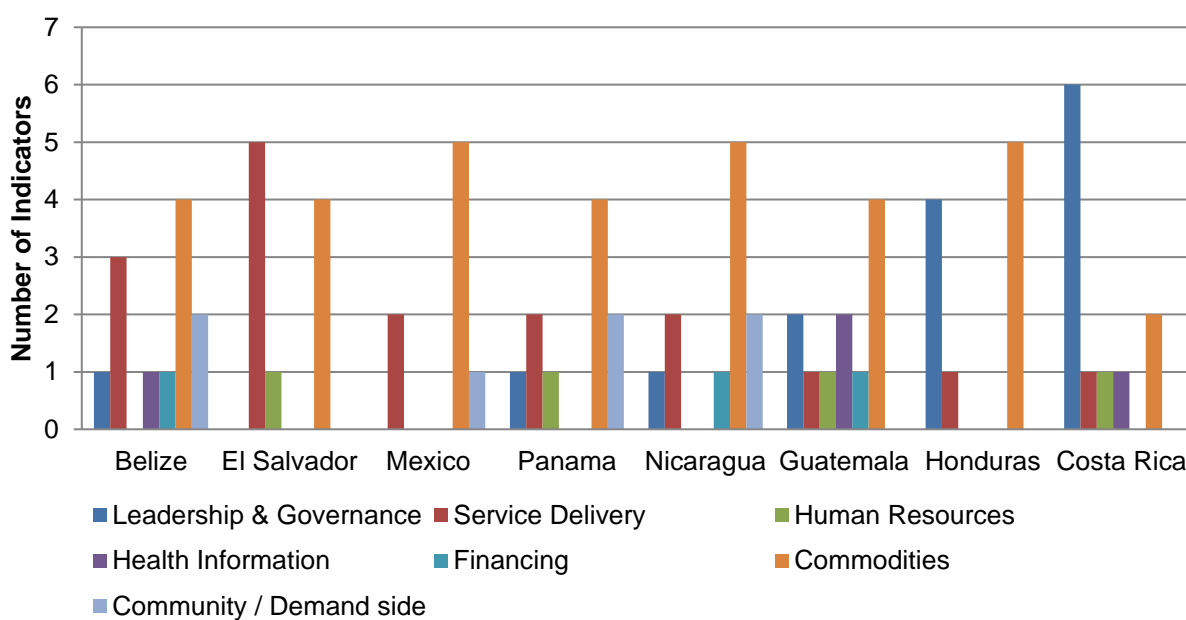


Figure 3 presents an analysis of the indicators from the first phase of SMI organized by WHO health system building blocks, including the additional “community/demand side” element that captures the demand and community interventions that are central to the SMI health system strengthening model. These indicators do not, however, capture the actions taken to drive changes to the system that are reflected in performance on the health system building block indicators. The indicators that are rewarded are those that capture the way countries are held accountable for achieving changes in these building block elements. In the first phase, most indicators were linked to leadership and governance, commodities, and service delivery building blocks.

It's what we should have been doing all along, but now we're doing it in an organized manner. So it is innovative, in terms of integration, which we didn't have before but now we have achieved. It's not more of the same. We're getting organized.

– Health sector manager

**Figure 3: Indicators from Phase 1 by Health System Element**



## The whole system is more than the sum of its parts

SMI strengthened the diverse building blocks of country health systems in preparation for achieving significant health outcome targets in subsequent phases. The number of indicators in each block varied between countries.

### Leadership and governance:

The focus on achieving rewarded results was integrated into the process of how countries planned, budgeted, monitored, supervised, and held people accountable from the national to the local level. By defining precise indicators and targets that must be achieved in each phase, health sector managers were clear and well-informed about their responsibilities for achieving results within a specified

When we have that partnership between the technical team, local government, and communities, we really get results. That's what the Initiative has reinforced: a three-way partnership that is the key to implementing a variety of programs with the SMI Initiative.

– Local leader



timeline. The indicators that captured changes in leadership and governance include: establishment of new norms for reproductive and child health care and nutrition, community-based strategies, and systems to report and take action on maternal death audits in Guatemala, Honduras and Mexico. As seen in Figure 3, six of the eight participating countries have performance targets linked to this element.

The SMI focus on results catalyzed vital partnerships among Ministry of Health units and between national and local players to collectively achieve common goals. In each country, Ministry of Health officials traveled to poor communities to understand the challenges of providing services in demanding conditions. Interviews with local health managers and political leaders indicate that they experienced greater attention and commitment from the national level to solve problems in their communities. Virtually all the countries adopted new national strategies and/or norms. For example, Chiapas adopted a National Health Strategy for Indigenous Populations to drive demand by incorporating cultural sensitivity. Five countries established new norms for the delivery of micronutrients to prevent anemia in children, and some included adaptations for indigenous populations. Two countries formulated national norms for adolescent care. Two countries approved community-based service delivery platforms and formalized the roles of community health workers. In some cases, policies and norms developed for specific communities were applied nationwide, providing evidence that some system-strengthening benefits have spilled over from SMI regions to benefit the country as a whole.

SMI provides evidence that when you take certain steps, you get results. And those results are being carefully documented with data. Data moves people, convinces politicians about the technical results.

**– Ministry of Health official**

Reputational incentives were also an important driver in fortifying commitments at the senior ministry level. This was apparent in the spirit of competition that surfaced when sharing results at regional health ministry meetings and at the SMI-hosted regional learning event held in Panama in November 2014. The requirement that countries submit quarterly progress reports on achieving their targets pushed government officials to focus on SMI. Turnover in senior-level leadership was discussed as a challenge by both IDB staff and country respondents. However, respondents shared that the Initiative has been strategic at cultivating high-level commitment within Central America, where political commitment is deemed crucial for success.

#### *Information:*

SMI has strengthened the generation and use of information by the participating countries. Their commitments to meet performance targets necessitated the ability to track their progress toward attainment of targets and to identify bottlenecks. As shown in Figure 3, three countries had performance indicators linked to health information in the first operation. El Salvador received technical assistance from SMI to develop a national performance dashboard that combines and integrates data from multiple sources to generate illustrative graphs, dynamic tables, and an alert system for decision making. The dashboard enabled health officials to understand the status of diverse components at different system levels and provide timely data to inform corrective actions. Chiapas, Honduras, Costa Rica and Guatemala have made adaptive modifications to the original software to develop their own customized performance dashboards, and Panama and Belize have begun implementation. The new system in Chiapas has shortened the time between identifying a problem and arriving at a solution. In key country and support interviews, respondents point to more intensive use of health information to monitor progress, provide feedback, supervise, and take action to address gaps, driven by the desire to meet targets.





### *Commodities:*

All countries strengthened supply systems, as medicine, equipment and the vaccine cold chain form part of the foundation required to achieve second- and third-phase outcome targets. Countries received technical assistance that included tools to monitor stocks at the facility level and reorganized supply systems to plan, procure and distribute essential commodities. New products such as zinc, micronutrient powder, and family planning commodities were added to essential commodities lists, procured and distributed. Thus the availability of essential commodities and equipment increased substantially to deliver pre- and postnatal care, family planning, and child health services, and to manage deliveries and emergency obstetric care during the first phase (and during the performance improvement period that was extended for Guatemala and Chiapas, as illustrated in Annex I: Phase 1 Performance on Supply Indicators). Respondents from Guatemala and Chiapas indicated that their countries' bureaucratic procurement and distribution processes impeded attainment of supply targets by the first-phase deadline; however, they were able to meet these targets in the performance improvement period.

We now have real-time information on the supply situation, which allows us to plan proactively instead of simply reacting.

– **Ministry of Health, Chiapas**

### *Service delivery:*

SMI supported and strengthened ongoing reforms to the structure of the service delivery system already underway in some countries and stimulated new service delivery approaches in others. All countries had performance targets linked to this element in the first operation. The Initiative energized attention to preventive and promotive care, increased service delivery in remote communities, and engaged communities to stimulate demand and support self-care. Countries also strengthened systems to manage obstetric and neonatal complications, manage child illnesses, and reach households with nutritional supplements and education to reduce child anemia.

Ongoing reforms were strengthened in El Salvador, Honduras, Nicaragua and Belize, and new service delivery approaches were developed and implemented in Chiapas, Guatemala, Costa Rica and Panama. For example, El Salvador's Family Health model was supported through the development of annual operational plans with monthly targets aligned with the country's SMI goals. Honduras strengthened its ongoing reform by implementing results-based contracting mechanisms between the Ministry of Health and autonomous hospitals, as well as between hospitals and obstetricians and pediatricians to manage obstetric and neonatal complications. In Chiapas, service delivery networks were redefined and strengthened to provide obstetric services and emergency maternal and neonatal care. Panama enhanced the delivery system to manage obstetric and newborn care in indigenous municipalities in the Comarca region. Costa Rica implemented an innovative model to provide reproductive health services to adolescents that engages multiple national institutions, which now oversee multi-sectoral Local Coordination Units that facilitate implementation of the adolescent services at local levels.

SMI has offered the possibility for us to be able to propose a model for the prevention of teen pregnancy. It allowed us to gather all the available evidence, analyze all the characteristics and conditions of Costa Rica, identify the determinants of pregnancy in the adolescent population of Costa Rica, and then propose a model. So from this point of view, it has been a good space for experimentation.

– **Ministry of Health official**



### *Human resources:*

El Salvador, Guatemala, Panama and Costa Rica selected performance indicators related to this element (Figure 3). Health workers and managers were trained at the hospital, primary care and community levels to provide micronutrients to children; counsel mothers on treatment of diarrhea with zinc and ORS; identify pregnancy early to provide prompt and ongoing prenatal care; manage deliveries and complications; and provide postpartum care, family planning counseling, and child health services. Additional health workers were also hired.

As shared in interviews, health workers are more motivated because supplies are available, feedback is prompt, and bottlenecks are addressed. Interviews with respondents revealed that some countries reduced turnover by providing incentives to encourage workers to remain in challenging posts.

The health units that handle deliveries give the women one transportation voucher to receive birth control ... and another at the time of her delivery (either to go to a maternity care home or directly to the health unit). This intervention may be highly effective, but in my view it creates too much dependency, comes at a high cost, and is unsustainable.

**– Local health manager, Nicaragua**

### *Financing:*

SMI activities were financed by a combination of domestic and donor resources that supported systems elements such as information systems, training, commodities, and labor. Two countries (Belize and Nicaragua) had performance indicators linked to this element. Chiapas and Nicaragua experimented with demand-side incentives to cover transportation costs to facilities equipped for birth care. While SMI in Nicaragua is viewed as effective, the country has expressed concern about sustaining the intervention. Budget management was described as a challenge in a number of countries, and erratic funding was experienced as a bottleneck. This challenge was confounded by a gap in time between external measurements and donor approval to fund the performance tranche, which delayed payment.

Social contracts for community health and well-being are agreements between the community and family health team serving that community. They contain actions to meet the indicators, the key indicators of the health team, and actions of health promotion and prevention. The social contracts systematize and encapsulate all the health actions into a single strategy. For me, this is the most promising action of the Initiative. It is sustainable, I believe. It empowers the community, and the results can be seen in the short and medium term.

**– Local health manager**

### *Community:*

Through SMI, countries implemented interventions at the community and household levels that are not addressed by the health service delivery system, and three countries (Panama, Belize and Nicaragua) chose performance indicators linked to this element. For example, Panama was rewarded for ensuring that 100% of the targeted communities have a plan in place that specifies short- and long-term solutions to improve sanitation and water quality, and 87.5% of communities have a community birth plan. Building on an existing community strategy, Nicaragua was rewarded because 95% of municipal health units in SMI-targeted municipalities entered into social agreements on community health and well-being with local health committees. As countries enter the second phase, they are devoting more efforts to household education and behavior change because the countries have recognized that health is impacted at the community level and that self-care is an important cornerstone in an effective health system, particularly in poor and marginalized communities.





## Participants' reflections and perceptions of the SMI results-based model

Qualitative research confirms that countries' buy-in of SMI was not only due to the promise of funds paid conditional on results, but also that their attainment had a deadline. According to key informant interviews, external measurement was an additional driver that convinced countries that the results-based aid model has teeth while providing assurance to donors that their money is paying for verified results.

In order to achieve population level results, countries had to make adjustments to their health systems. Although countries have outcomes in common in the second and third phases, each country chose distinct HSS elements in the first phase to focus on in order to meet their targets, tailoring needs to their own systems.

The first challenge was overcoming the apathy and doubt that SMI could really change the indicators. At the end of the day, the indicators are ambitious: reduce maternal mortality after 20 or 30 years of intense effort with no significant impact. Then along comes SMI, and you're told that in five years we will reduce maternal mortality, and your first reaction is one of disbelief, right? Our first challenge has been to instill faith in people; to ensure that SMI, through its own actions, can truly reduce those indicators. I believe we have met this challenge and people now believe in us.

**– Ministry of Health official**

Results-based management was described in interviews as a new model that is viewed as catalytic. Targets crystalize goals; the requirement to meet targets in a specific time period provides focus; and funding conditional on attainment of targets—along with the high visibility inherent in such a multinational initiative—keeps health sector actors determined. Stakeholders report that SMI has spawned new dialogue and partnerships across national-level units in the Ministry of Health and between national and local and community levels. Technical support provided by the IDB and SMI Coordinating Unit in Panama City and by two international firms contracted to support countries has increased country capacity. New evidence-based strategies and results-oriented interventions are holding health sector actors accountable, and supply systems have been strengthened as a result of deeper process analysis and the actions they inform.

In other assistance programs it is more a one-sided type technical assistance. They come and offer you what they think is important for you. I feel like in this particular situation it was the other way around. We saw some needs and we were offered the opportunity to access technical assistance. I think that works so much better. With other projects, the external agency comes and says well you know we will give you this kind of technical assistance and countries tend to accept just because it is available.

**– Ministry of Health official**

While respondents from participating countries are generally positive about their experiences with SMI, they also describe challenges arising from the model's structure and how it intersected with their own health systems. Respondents felt that the 18-month period for the first phase was too short and was inconsistent with annual budgeting processes. At the outset, faulty understanding of what improvements would be feasible hindered the leaders' ability to negotiate targets in an informed way. Countries launched the Initiative with only a partial understanding of what needed to happen in order to meet first-phase targets, compounded by slow-moving Ministries of Health with weak capacity and unmotivated health personnel, unaccustomed to working in teams and



I think several factors were at play; the rules were clear but there was some variation in the way indicators and targets were negotiated. I don't think there was full understanding among the parties. I think there was a little bit of blind negotiation.

– IDB Team Leader

used to being held accountable for results. Supply systems did not function properly, and countries often lacked the knowledge or will to fix them. While countries reported that it was a challenge to meet the first-phase targets, they also shared that the Initiative's time-bound nature pushed them to solve bottlenecks and hold people accountable for achieving results. In addition to a being a driver of performance, measurement in SMI is also an enabler, as countries received technical assistance to develop monitoring systems (called performance dashboards) to track performance in real time using routine health information systems. Such information is invaluable in solving problems that impede attainment of targets. Technical assistance was provided through the SMI Coordinating Unit, two contracts with external firms, and IDB team leaders. Technical assistance includes areas such as: planning, logistics, information systems, evidence-based norms, and health worker capacity-building. What makes SMI's technical assistance model different from the standard donor-funded model is that it is primarily demand-driven. Countries requested assistance because they realized they needed help to strengthen their systems to achieve the rewarded results.

At first, people viewed the Initiative as a burden. They thought it was an addition to their work. Little by little they began to see that it was part of what they already do day to day, but with a different planning system. So now they view the Initiative differently. The idea of recognizing and rewarding local health care teams' performance is very important and has increased team motivation and helped SMI meet its public goals.

– Ministry of Health official

## Conclusions

SMI is a RBA model that has catalyzed system change by focusing on population-based outcomes. Although in the first operations each country emphasized distinct elements of the health system as captured by the rewarded indicators, these system enhancements were necessary to prepare countries for the second and third operations. Given the starting point of the health systems, changes in the health system were a necessary predecessor to changes in health results. Money alone, however, was not enough to make these changes; teams value the

technical assistance that accompanied these system changes. The decision to reward system-readiness indicators in the first phase was taken because experts from the IDB who work closely with these countries and donors who support the Initiative believed that to start with systems targets was a necessary step to strengthen health systems in order to improve outcomes in subsequent phases. Another option might have been to begin the first phase with utilization, content of care, and outcome indicators, rather than the current predominance of service-readiness indicators. If incentives were a powerful enough driver, the desire to achieve the results might have catalyzed countries to strengthen underlying systems even without direct incentives linked to system-strengthening metrics.

– Ministry of Health official



One powerful piece of evidence that countries value SMI's results-based aid model is that the three countries that did not attain the first-phase performance tranche continued to participate in SMI. These countries value the changes that have been catalyzed and the opportunity to learn from other countries in the region.

Most respondents believe that, at a minimum, the health system modifications not dependent on ongoing domestic financing will be sustained. Such modifications include policy and guideline changes; results-based management; use of information for decision-making; and improved obstetric, newborn and nutrition care. In some countries, these changes have expanded beyond the SMI-targeted municipalities. While most respondents expressed optimism about strengthened supply systems, some are not certain that their governments will continue to procure sufficient commodities and expressed doubt about whether support for demand-side transportation vouchers will be sustained. A potential countervailing factor is that communities may pressure their governments to continue to provide the higher-quality services they have experienced through the Initiative.

Results-based aid is much more than a financial incentive. In fact, reputational incentives may be even more important, as countries care about performance in front of their peers and high-profile donors. Metrics, information, financial incentives, external measurement, demand-driven technical assistance, and the requirement to achieve results in alignment with national strategic priorities appear to provide the glue that drives the strengthening coordination of systems. In future periods, the global community will learn whether these system changes lead to improved health outcomes in the allotted timeframe.

The focus on results in the SMI results-based aid model is driving countries in Mesoamerica to strengthen their health systems in a comprehensive way. A myopic focus on each building block misses the benefits of this comprehensive approach and its influence on the attitudes and behaviors of the many people who comprise the health system and the ways in which they collaborate to solve problems and deliver services. As system changes become imbedded, health system actors may consider the results orientation as a new normal, which will contribute to scaling-up and sustainability.

## Funding

The study was performed as part of Salud Mesoamerica Initiative, a program supporting countries improve maternal and child health. The Initiative is funded by the Bill & Melinda Gates Foundation, the Carlos Slim Foundation, and the Spanish Agency for International Development, and administered by the Inter-American Development Bank. Funders had no role in study design, data collection and analysis, decision to publish, or preparation of the manuscript. The opinions expressed in this publication are those of the authors and do not necessarily reflect the views of the Inter-American Development Bank, its Board of Directors, or the countries they represent.



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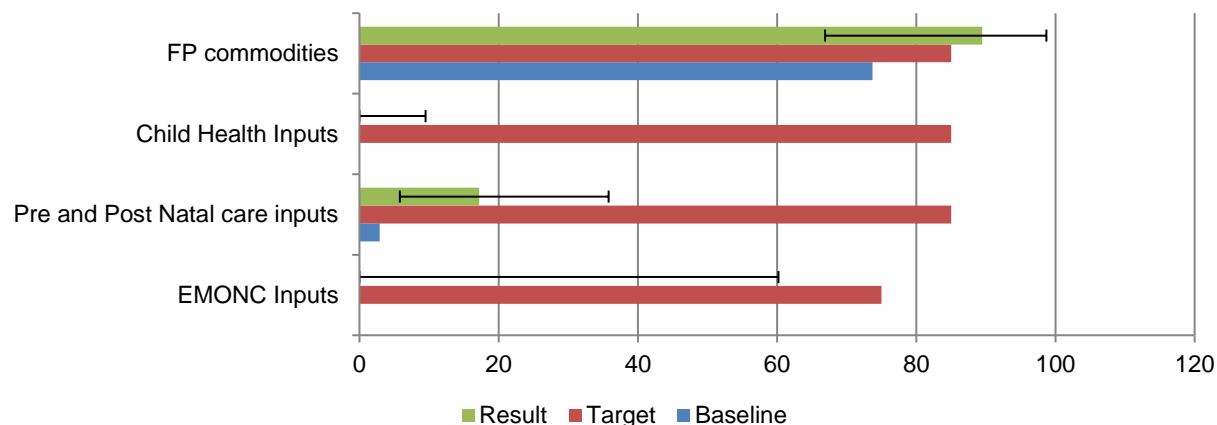
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## Annexes

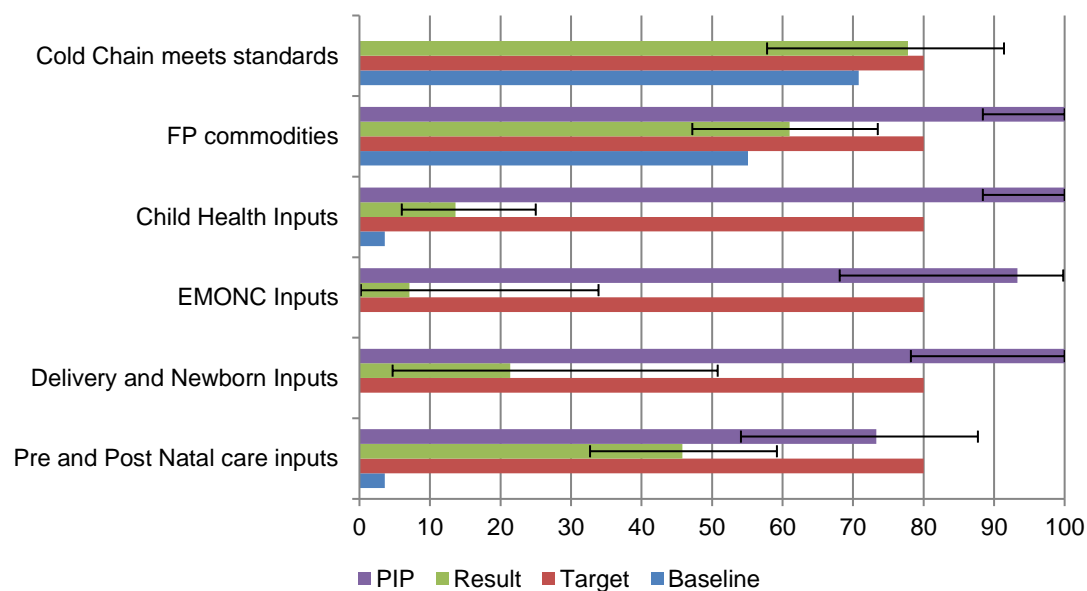
### Annex I: Performance Indicators and Targets by Country

#### Belize Phase 1 Performance on Supply Indicators



Note: Brackets show the Confidence Intervals for Phase 1 results.

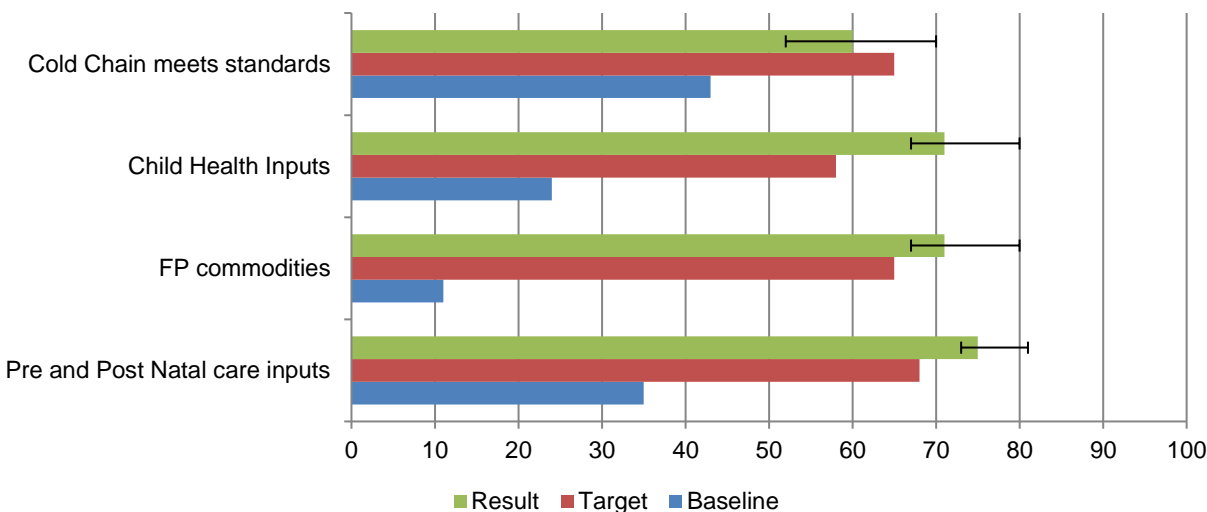
#### Chiapas Phase 1 and Supplementary Period Performance on Supply Indicators



Note: Brackets show the Confidence Intervals for Phase 1 and PIP results. Targets were considered met if the result was lower than the target after performing a statistical significance test (one-tailed Z test). Indicators that were met on Phase 1 were not remeasured on the Supplementary Period. This is why the target for the *Cold Chain meets standards* indicator was met in Chiapas and was not remeasured on the Supplementary period.

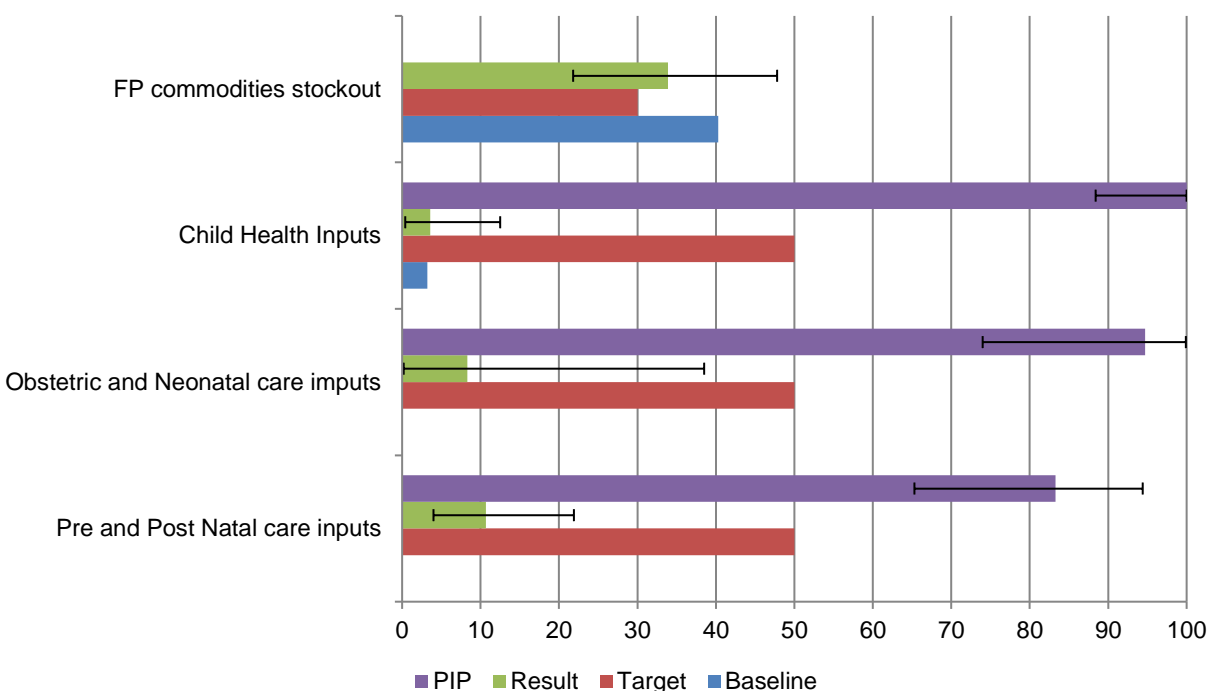


### El Salvador Phase 1 Performance on Supply Indicators



Note: Brackets show the Confidence Intervals for Phase 1 results.

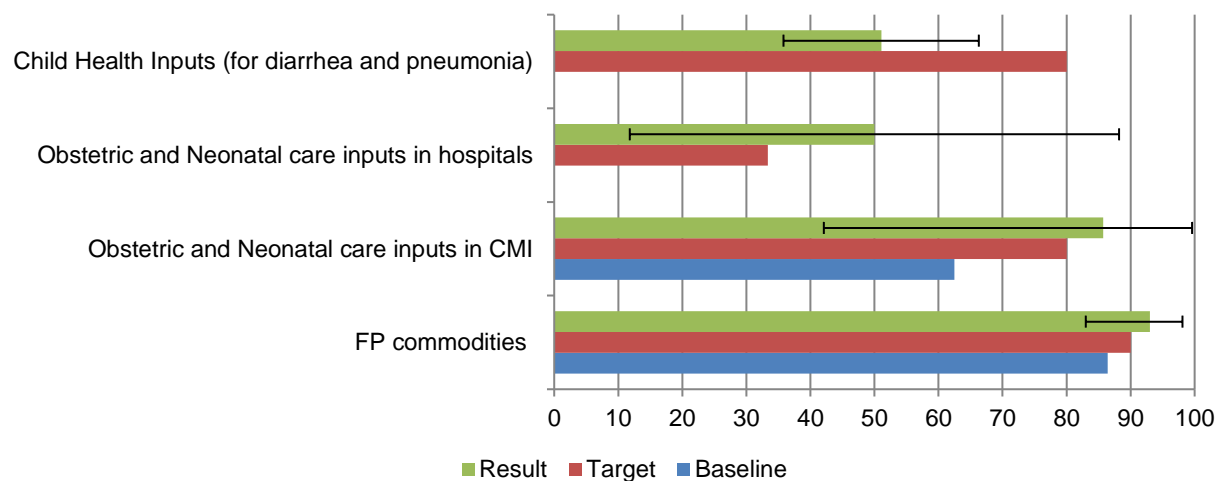
### Guatemala Phase 1 and Supplementary Period Performance on Supply Indicators



Note: Brackets show the Confidence Intervals for Phase 1 and PIP results. Targets were considered met if the result was lower than the target after performing a statistical significance test (one-tailed Z test). Indicators that were met on Phase 1 were not re-measured on the Supplementary Period. This is why the target for the *FP commodities stock out* indicator was met in Guatemala and was not remeasured on the Supplementary period.

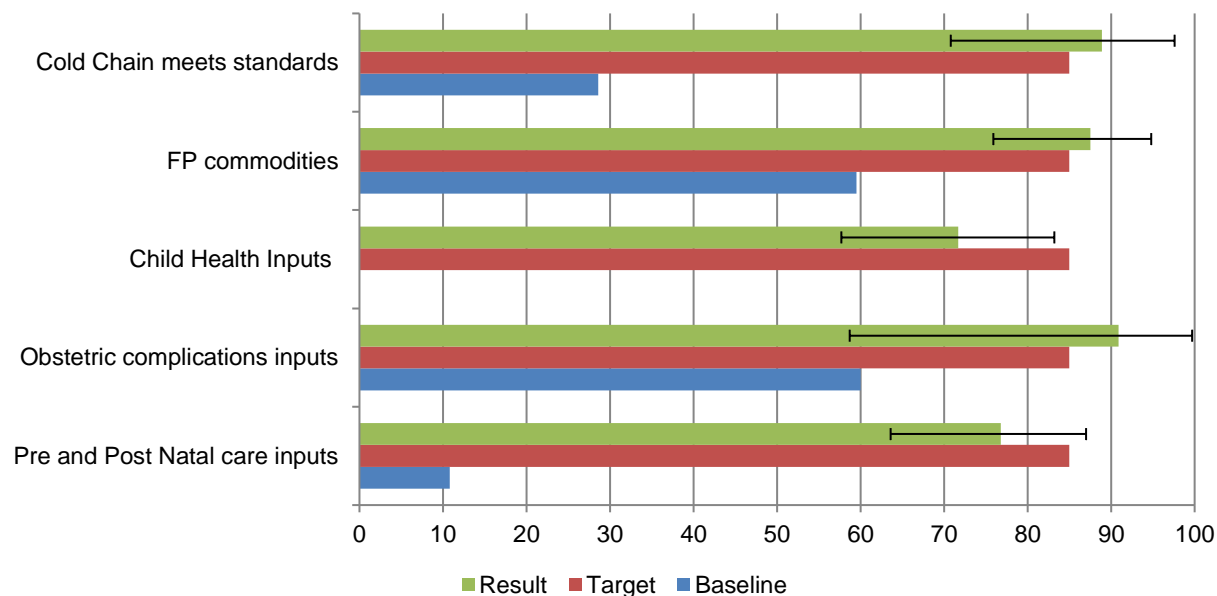


### Honduras Phase 1 and Supplementary Period Performance on Supply Indicators



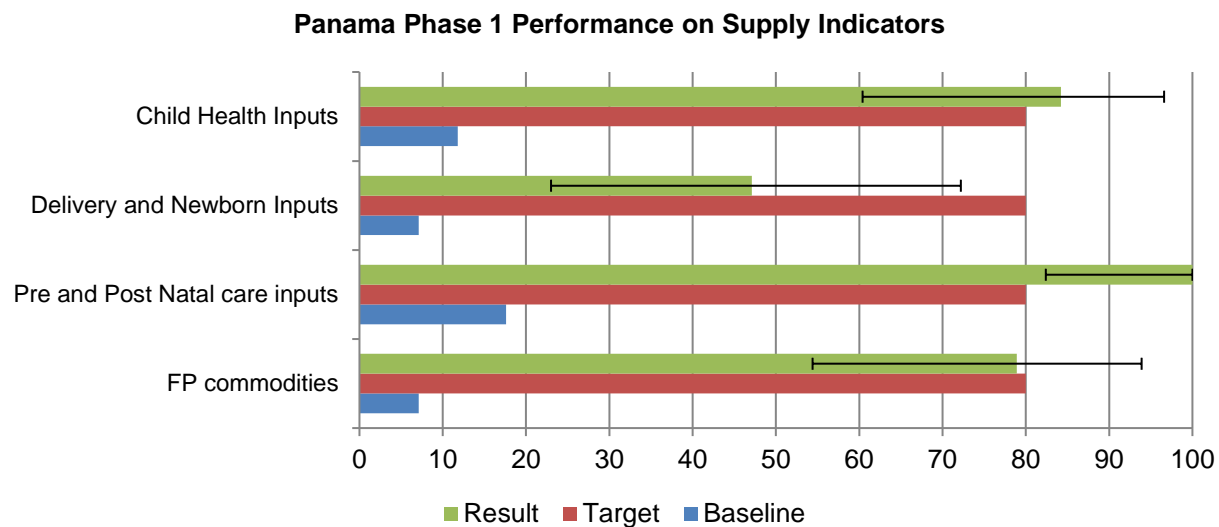
Note: Brackets show the Confidence Intervals for Phase 1. Targets were considered met if the result was lower than the target after performing a statistical significance test (one-tailed Z test).

### Nicaragua Phase 1 on Supply Indicators



Note: Brackets show the Confidence Intervals for Phase 1. Targets were considered met if the result was lower than the target after performing a statistical significance test (one-tailed Z test).





Note: Brackets show the Confidence Intervals for Phase 1 results. Targets were considered met if the result was lower than the target after performing a statistical significance test (one-tailed Z test). Indicators that were met on Phase 1 were not remeasured on the Supplementary Period. This is why the target for the *PF commodities* indicator was met in Panama.



## Annex II: Performance Indicators by Country

### Performance Indicators: Belize

Performance Indicator	Measurement Unit	Baseline	Target 1st Phase	1st Measurement	Target 2nd Phase	Target 3rd Phase	VS <sup>1</sup>
Health facilities that have the necessary inputs for providing emergency obstetric and neonatal care according to the norms	%	0	75	0			HF <sup>1</sup>
Health facilities that have the necessary inputs for providing pre- and post-natal care according to the norms	%	2.9	85	17.2			HF
Health facilities that have submitted a Quality Improvement Fund (QIF) proposal to the national quality audit team	%	0 <sup>2</sup>	75	95			HF
Health facilities that have the necessary inputs to provide child health care according to the norms	%	0 <sup>2</sup>	85	0			HF
Health facilities that have implemented quality-of-care job aid tools for reproductive health	%	0 <sup>2</sup>	85	55.3			HF
Health facilities that can submit and receive data from the Belize Health Information System (BHIS)	%	0 <sup>2</sup>	85	30			HF
Health facilities that have permanent availability of all five types of modern family planning methods (injectable, barrier, oral, IUD, permanent) according to the norms	%	73.7	85	89.5			HF
Health facilities that have sexual and reproductive health (SRH) educational materials specifically targeted at adolescents	%	0 <sup>2</sup>	85	63.9			HF
Norms for improving the quality of reproductive and child health and nutrition services and for the establishment of a community platform of services adopted	Yes/No	No	Yes	Yes			ER
Community health workers (CHW) trained in the community platform	%	0 <sup>2</sup>	85	58			ER
District Health Education and Community Participation Bureau (HECOPAB) Officers that are currently monitoring the Community health workers (CHWs)	%	0 <sup>2</sup>	85	100			ER



Health facilities with a mechanism in place for carrying out patient satisfaction surveys	%	0 <sup>2</sup>	85	55.3			HF
Institutional deliveries for which oxytocin was administered immediately following birth as part of Active Management of the Third Stage of Labor (AMTSL) in the last two years for the most recent delivery	%	34.1			49.1	49.1	HF
Pregnancies for which the woman attended at least one antenatal care visit during the first trimester for the most recent pregnancy in the last two years	%	22.8			29.8	36.8	HF
Institutional deliveries for which immediate (within 24 hours) neonatal care was provided to the infant according to the norms in the last two years	%	19.4			39.4	59.4	HF
Neonatal complications (prematurity, low birth weight, asphyxia and sepsis) managed according to norms in the last two years	%	7.5			37.5	82.5	HF
Obstetric complications (sepsis, hemorrhage, severe pre-eclampsia and eclampsia) managed according to the norms in the past two years	%	2.6			37.6	72.6	HF
Children 0-23 months with low weight-for-age managed according to norms in the last two years	%	2.7			37.5	75	HF
Contraception post-delivery in the past two years	%	7			17		HF
Diarrhea cases in children 0-59 months presenting in health facilities that were treated with Oral Rehydration Solution (ORS) and zinc during their last visit	%	20			80		HF
Newborns enrolled for child health services within seven days of birth in the last two years	%	25.3			35.3		HF
Live births for which the women received post-partum care before the first seven days of birth in the last two years for the most recent pregnancy	%	22.8			37.8		HF
Women of reproductive age (15-49 years) who were not using/unable to obtain contraception during last year	%	47.4				42.4	LQA S
Mothers with a child 0-23 months that that can recognize three out of five signs of danger	%	15.8				55.8	LQA S



Percentage of children aged 6-23 months that consumed 60 sachets of micronutrients in the last six months	%	0				30	LQA S
Mothers who gave their children (0-59 months) ORS and zinc supplements during the last episode of diarrhea in the two weeks	%	5.3				45.3	LQA S

<sup>1</sup>VS: Verification Source; HF: Health Facility Survey; LQAS: Population-Based Lot Quality Assurance Survey; ER: Expert Review

<sup>2</sup>New intervention; baseline set at 0.



## Performance Indicators: Costa Rica

Performance Indicators <sup>4</sup>	Measurement Unit	Baseline	Target 1st Phase	1st Measurement	Target 2nd Phase	VS <sup>7</sup>
Primary Integrated Health Care Teams (EBAIS) officials sensitized to provide differentiated, friendly, comprehensive and quality care to adolescents	%	0	75% of 496	114.1		HF
Community leaders trained to promote health, identify high-risk cases, and bring health services to communities	%	0	95% of 110	133.6		HF
Primary Integrated Health Care Teams (EBAIS) centers that have physical areas with conditions of confidentiality and privacy to provide care for adolescents according to a minimum standard defined in the Operations Manual	%	0	80	100		HF
Primary Integrated Health Care Teams (EBAIS) with permanent availability of modern family planning methods according to the standard (injectable, condoms, oral, IUDs, as appropriate)	%	-- <sup>2</sup>	90	90.6		HF
Primary Integrated Health Care Teams (EBAIS) that meet the norms of Sexual and Reproductive Health (SRH) counseling and have educational aides needed for counseling, education and differentiated attention to adolescents	%	0 <sup>3</sup>	80	96.9		HF
Local Inter-sector Coordination Units (UCL) created and implementing local plans according to the Operations Manual	%	0	90	100		HF
Primary Integrated Health Care Teams (EBAIS) that have the norms for comprehensive attention of adolescents with intercultural perspective and in line with the philosophical framework of the project according to the Operations Manual	%	0	80	100		HF
Primary Integrated Health Care Teams (EBAIS) that have scheduled attention for adolescents (hours designated for adolescent care)	%	0	70	93.8		HF
Primary Integrated Health Care Teams (EBAIS) that have the tools for early detection of risks associated with the reproductive behavior of adolescents	%	0	85	56.3		HF



Primary Integrated Health Care Teams (EBAIS) that have mechanisms to monitor adolescents at risk according to the technical norms and Operations Manual	%	0	85	71.9		HF
Primary Integrated Health Care Teams (EBAIS) that have records and generate statistical reports about adolescents for Local Inter-sector Coordination Units (UCL) according to the provisions of the program's Operations Manual	%	0	85	88.7		HF
Births by adolescent mothers aged 10-19 years in the last year / Total of adolescent women aged 10-19 years in the last year	%	4.87			3.5	INEC
Women with two or more children before 19 years of age in the last year <sup>3</sup>	%	20.67			15	INEC
Adolescent mothers or pregnant adolescents remaining in the education system in the last year	%	-- <sup>4</sup>			60	SINA-MEP
Adolescents that report having requested and received some method of contraception and protection in the Health Services of the Costa Rica Social Security (CCSS)	%	75			90 <sup>5</sup>	IS
Adolescents with active sex life (and/or partner) that used modern contraception method and protection for their last sexual relation in the past three months	%	74			82	IS
Adolescents adopting a modern contraception method within the first seven post-partum or post-abortion days in the last year	%	6			80	SINA
At-risk adolescents that have received follow-up (intra- and inter-institutional intervention, referral and monitoring) in the last year	%	6			80	SINA
Active adolescent and youth promoters providing information and referral to adolescents in the last year	%	6			80	SINA-Pani

<sup>1</sup> The indicators will be detailed in the Indicators Manual, which is part of the program's Operations Manual, which must be developed to the Bank's satisfaction as a condition prior to disbursement of the first operation.

<sup>2</sup> Value was not measured in the baseline.

<sup>3</sup> Total of pregnant adolescents with two or more children / total of women with at least one child.

<sup>4</sup> Baseline pending calculation.

<sup>5</sup> This target is estimated in percentages, not in percentage points

<sup>6</sup> Since this is a new intervention, the baseline is regarded as zero.

<sup>7</sup> IS: independent survey; SINA: Nominal Adolescent System; MEP: Ministry of Education; INEC: Institute of Statistics; PANI: Patronato Nacional de la Infancia; HF: Health facility survey



## Performance Indicators: El Salvador

Performance Indicator	Measurement Unit	Baseline	Target 1st Phase	1st Measurement	Target 2nd Phase	VS <sup>1</sup>
Family and Specialized Community Teams (ECOS) created	Number	37	68	59		HF
Families ascribed to Family Community Teams (ECOS)	Number	14,681	38,661	59,495		ER
Community health units with the necessary inputs for prenatal care	Number	35	68	75		HF
Community health units with stocks of four family planning methods (injection, barrier, orals, IUD)	Number	11	65	71		HF
Community health units with the necessary inputs for infant care	Number	24	58	71		HF
Community family health units with refrigerator or cool box to care for vaccines adequately	Number	43	65	60		HF
Review of the national policy for the disbursement of micronutrients in powder for children 6-23 months	Yes/No	No	Yes	Yes		ER
Inclusion in the norm of the adequate dose of therapeutic zinc for treatment of diarrhea in children younger than 5 years old (20 mg of zinc during ten to 14 days in each episode of diarrhea)	Yes/No	No	Yes	Yes		ER
Pregnant women recorded in the prenatal registry that had prenatal birth control performed by a doctor or nurse before 12 weeks.	%	67	77	64.9		HF
Children younger than 1 year registered in the system that were recorded in less than eight days	%	51	61	90.1		HF
Women in reproductive age (15-49 years) that currently use (or whose partner use) a modern method for family planning	%	53.5			60.5	HH
Women in reproductive age (15-49 years) that received their first prenatal control by doctor or nurse before 12 gestation weeks in their most recent pregnancy in the last two years	%	62.1			72.1	HH
Women in reproductive age (15-49 years) that received four prenatal attentions according to best practices by doctor or nurse in their most recent pregnancy in the last two years	%	46.2			61.2	HF
Women in reproductive age (15-49 years) that in their most recent pregnancy had a visit by health	%	81.6			91.6	HH



personnel, including medical personnel and promoters, a week after birth						
Children 6-23 months of age that have a hemoglobin value <110 g/L	%	46.5			36.5	HH
Children 12-24 months of age with vaccinations for measles, mumps and rubella (MMR)	%	66.6			73.6	HH
Children 12-59 months that received two doses of antiparasitic treatment in the last year	%	35.4			56.4	HH
Women that gave their children 0-59 years Oral Rehydration Salts and zinc in the last episode of diarrhea	%	4.4			24.4	HH
Women of reproductive age (15-49 years) whose most recent birth was attended by a skilled attendant in an institutional setting in the last two years	%	86.2			94.2	HH
Expenditure of the Ministry of Health in the First Level of Care	US\$	6,291,814			8,020,000	ER
Pregnant women with institutional attention to birth referred by the Community Teams (ECOS) as part of the activities of the birth plan	%	0			70	HF

<sup>1</sup> VS: Verification Source; HF: Health Facility Survey; HH: Household Survey; ER: Expert Review





## Performance Indicators: Guatemala

Performance Indicators Guatemala <sup>1</sup>	Measurement Unit	Baseline	Target 1st Phase	1st Measurement	PIM	Target 2nd Phase	Target 3rd Phase	VS <sup>4</sup>
Health services with the necessary equipment for prenatal care (inputs and equipment to be determined according to level of care)	%	14.1	50	10.7	83.3			HF
Health services equipped for delivery care with the necessary inputs and equipment for obstetric and neonatal emergencies, postnatal and newborn care (defined according to the level)	%	0	50	8.3	94.7			HF
Health services with the necessary equipment and inputs for pediatric care (anthropometric equipment, oral rehydration salts, zinc, anti-helminthic drugs, and powdered micronutrients)	%	3.2	50	3.6	100			HF
Health services reporting shortage of supplies in one of the four family planning methods (injectable, oral, barrier and IUD) at the time of the interview, confirmed through observation and according to level of care	%	40.3	30	33.9				HF
Children 0–23 months old, whose growth was monitored according to their age, registered in data on children in the Ministry of Public Health and Social Assistance in Guatemala (MSPAS)	%	-- <sup>3</sup>	6	81.3				HF
Updated strategic guidelines on micronutrient supplementation in children <5 years old at national level, according to international scientific evidence		n.a	yes	yes				HF
Health services with health care personnel trained in obstetric and neonatal emergencies according to their operational level and level of care	%	0 <sup>2</sup>	70	93.3				IV
Municipal health districts able to access data and generate regular reports on immunization, maternal, neonatal and infant care in the context of Health Maternity Law.	%	0 <sup>2</sup>	70	92.9				IV
Health Areas with a piloted dashboard, based on supervision and monitoring guidelines	%	0 <sup>2</sup>	2	2				IV
Maternal deaths reported and investigated according to the maternal mortality surveillance protocol	%	0 <sup>2</sup>	90	15				IV
Eligible communities with activated emergency committees (receiving an advance from the rotating fund)	%	0 <sup>2</sup>	20	27				IV



Children aged 6-23 months in program that received 60 packages of micronutrient powders during the last six months	%	1.5				37.5		HH
Births attended in Birthing Center (CAPs) and Integrated Maternal and Child Health Centers (CAIMIs) that comply with the care protocols established in the Operations Manual, according to capacity of resolution in the last year	%	52				70	80	HF
Women of childbearing age (15-49 years) whose most recent birth in the last two years occurred at a health center equipped for childbirth care	%	16.7				23.7	29.7	HH
Newborns who received neonatal care from trained personnel at a health center within the first 48 hours after birth during the last two years	%	8.6				13.6	16.6	HH.
Women who report receiving counseling in family planning methods for health personal or community personnel in the last 12 months	%	17.4				32.4		HH
Mothers who gave their children aged 0-59 months ORS and zinc during their last episode of diarrhea in the last two weeks	%	0.4				10.4	15.4	HH.
Women who gave birth in the last two years and who presented an obstetric complication (hemorrhage, sepsis, severe pre-eclampsia or eclampsia) treated according to current health care standards	%	7.4				27.4	47.4	HF
Women who received institutional childbirth care with at least two culturally significant elements (position, drink, language, dress, accompaniment), defined in the Operations Manual	%	36.1				56.1	66.1	HH.
Newborns born in the last two years with complications (prematurity, low weight, asphyxia and sepsis) treated according to current health care standards	%	1				16	36	HF
Postpartum patients (vaginal and caesarean births) who were registered in perinatal clinical records and monitored for selected criteria at least every 15 minutes during the first hour and then every 30 minutes until completing the two-hour period and upon discharge from hospital, according to guidelines Births attended in Birthing Center and Integrated Maternal and Child Health Centers (CAP, CAIMI and hospital), during their most recent birth in the last two years	%	13				28	53	HF
Children aged 0-23 months with hemoglobin levels <110 g/L	%	68.8					53.8	HH.



Women of childbearing age (15-49 years) who did not wish to become pregnant and were not using or did not have access to family planning methods	%	74.9					67.9	HH.
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<sup>1</sup> Program Operating Regulations include an appendix with a manual of indicators specifying measurement criteria.

<sup>2</sup> Since it is a new intervention, the baseline is 0.

<sup>3</sup> Value was not measured at the baseline

<sup>4</sup> HF: health facility survey; HH: Household Survey; IV: Independent verification



## Performance Indicators: Nicaragua

Indicator <sup>1</sup>	Measurement Unit	Baseline	Target 1st Phase	1st Measurement	Target 2nd Phase	Target 3rd Phase	VS
Health units (health post, health centers, primary hospitals) supplied with availability of family planning methods according to standards (injectable, barrier, oral, IUD, permanent, according to the case)	%	59.5	0.85	87.5			HF
Hospitals and primary facilities (former health centers with beds) offering basic EMOC with the necessary inputs for childbirth care according to the COE norms available since March 2012	%	60	0.85	90.9			HF
Health units complying with basic equipment level specified in health standards in December 2011 for pregnancy and postpartum care	%	10.8	0.85	76.8			HF
Health units that complies with basic equipment and inputs described in the operating manual for the care of children <5 years according to the norm in effect December 2011	%	0	0.85	71.7			HF
Health units that comply with "cold chain" management regulations for vaccines according to the standards valid since December 2011	%	28.6	0.85	88.9			HF
Standards and guidelines updated for the community nutrition platform based in evidences		N/A	YES	YES			IV
Municipal health units that signed social agreements for community health and well-being with local Health Committees which prepare follow-up data according to the Operational Manual	%	0 <sup>3</sup>	0.85	94.7			IV
Health personnel and volunteers trained and certified in ECMAC, with proof of the training emitted by MINSA according to the program, and at the time of the survey	%	0 <sup>3</sup>	95% of 950	146.8			IV
Community health workers trained and certified for the Management of sick neonate in the community as programmed at the time of the survey	%	0 <sup>3</sup>	95% of 120	100			IV
Women who stayed at maternity care homes and had access to educational materials and training activities on topics defined in the Operations Manual for pregnant women reported to the health center	%	0 <sup>3</sup>	0.85	92.4			IV



District Health Center with mechanism for distributing vouchers of subsidy for transportation and accommodation for pregnant women according to the rules of operation	%	0 <sup>3</sup>	100	100			IV
Women who report having received family planning information in the last 12 months from health workers or community agents.	%	39.1			49.1		HH
Postpartum women discharged with a birth-control method (sterilization, IUD, condoms, quarterly injections) in the last year	%	2			57	67	HF
Women of childbearing age (aged 15-49 years) who received their first prenatal checkup by qualified staff before week 12 of their most recent pregnancy during the last two years	%	24.4			32.4	39.4	HF
Women with obstetric complications (sepsis, hemorrhaging, severe preeclampsia and eclampsia) treated in accordance with the standard in the last two years	%	4.4			15	40	HF
Women of childbearing age (aged 15-49 years) who received postpartum care from qualified staff within ten days in their most recent pregnancy in the last two years	%	59.5			68.5	74.5	HH
Newborns with complications (prematurity, underweight, asphyxia and sepsis) treated in accordance with the standard in the last two years	%	0			10	25	HF
Newborns who received quality neonatal care at a health unit in the first 24 hours following their birth in the last two years	%	7			22	37	HF
Infants aged 12-59 months who received two doses of antiparasite treatment in the last year	%	32			40		HH
Infants aged 12-23 months who received Measles, Mumps, and Rubella (MMR) vaccine according to their vaccinations card	%	70.9			78.9		HH
Localities belonging to the community health care and welfare social agreement that attained their targets and received seed capital and innovation funding in accordance with the guidelines set forth in the Operations Manual	%	0 <sup>3</sup>			80		HF
Women of childbearing age (aged 15-49 years) and/or their partner who currently use a modern Family Planning (FP) method	%	81.6				89.1	HH
Children aged 0-59 months with all vaccinations up to date according to	%	48				58	HH



age, based on official National Immunization Program (PNI) schedule							
Infants aged 6-23 months with hemoglobin levels of <110 g/L	%	53.5				43.5	HH
Mothers who gave their children aged 0-59 months ORS and zinc in the last episode of diarrhea in the last two weeks (measured at 54 months only)	%	1.4				16.4	HH

<sup>1</sup> Program Operations Manual will include an appendix with a manual of indicators specifying measurement criteria.

<sup>2</sup> For the baseline, the percentage of women who received family planning (sterilization, IUD, condoms, injections) after giving birth in the last two years was measured: Value = 47.3 .

<sup>3</sup> Since it is a new intervention, the baseline is 0.

<sup>4</sup> HF: health facility survey; HH: Household Survey; IV: Independent verification



## Performance Indicators: Panama

Performance Indicator	Measurement Unit	Baseline	Target 1st Phase	1st Measurement	Target 2nd Phase	VS <sup>1</sup>
Basic Health Units (IT, facility-based network) that have supply of modern family-planning methods (oral, injectable, barrier, IUD), according to programming (population covered, time of year, rotation)	%	7.1%	80%	78.9%		HF
Basic health units that have necessary supplies for providing prenatal care according to care protocol and response capacity	%	17.6%	80%	100%		HF
Basic health units that have birth plans for the communities under their responsibility (initial agreement between health services and community authorities and guidelines defined in community delivery plan) verified in the community	%	N/A	80%	87.5%		HF
Basic health units that have qualified staff to attend births 24/7, according to standard	%	60.0%	78%	76.5%		HF
Basic health units that have the necessary supplies for appropriate care of uncomplicated deliveries, according to standard	%	7.1%	80%	47.1%		HF
Inclusion of zinc in standards for diarrhea treatment (Yes or No).	Yes/No	No	Yes	Yes		ER
Basic health units that have the necessary supplies for child care (micronutrients, zinc, deworming drugs, Oral Rehydration Salts (ORS))	%	11.8%	80%	84.2%		HF
Basic health units reporting monthly Integrated Community Child Care (AIN-C) in which 80% of children younger than 24 months surveyed are registered	%	N/A*	80%	53.3%		HF
Population that lives in communities that have a plan for improvement of community sanitation and water quality (identification of problem and short- and long-term solutions)	%	N/A*	80%	100%		HF
Establishment of delivery and supervision mechanism for incentives for promoters, Integrated Community Child Care (AIN-C) monitors, women and companions (for birth), and community committees in the	Yes/No	No	Yes	Yes		ER



operating regulations for provision of Integrated Health Care Package with Integrated Child Community Care (PAISS+N)						
Women of childbearing age (15-49 years) who do not want to become pregnant and who are not using/do not have access to family planning methods	%	90.3%			84.3%	HH
Women of childbearing age (15-49 years) who received their first prenatal checkup from a physician or nurse before the 12th week of pregnancy in their most recent pregnancy in the past two years	%	25.5%			40.5%	HF
Women of childbearing age (15-49 years) who received at least four prenatal checkups by a physician or nurse during their most recent pregnancy in the past two years	%	38.8%			53.8%	HH
Births with active management of third stage: oxytocin (10 IU) administered intramuscularly one minute following birth, in the most recent birth in the past two years	%	78.3%			85.0%	HF
Women of childbearing age (15-49 years) who received postpartum care by skilled personnel within 48 hours (two days) following their most recent delivery, disaggregated by location, in the past two years	%	14.1%			29.1%	HH
Newborns who received postnatal care by skilled personnel within 48 hours after birth in the last two years	%	10.8%			20.8%	HH
Children aged 12-59 months who received two doses of deworming treatment in the past year	%	8.7%			38.7%	HH
Mothers who gave their children aged 0-59 months Oral Rehydration Salts (ORS) and zinc during the last episode of diarrhea in the past month	%	0.6%			20.6%	HH
Children 12-23 months who received at least one dose of Measles, Mumps, and Rubella (MMR) vaccines, according to vaccination card	%	69.1%			76.1%	HH
Households in the target area that use water with adequate quality	%	1.0%			16.0%	HH

<sup>1</sup> VS: Verification Source; HF: Health Facility Survey; HH: Household Survey; ER: Expert Review