Question 1: *How have systems thinking approaches and tools been incorporated in activities to improve health equity? Were these approaches useful in achieving health equity goals? If so, what are the pathways by which these approaches helped to address the root causes of inequity?*

Using Performance Base Financing to Boost Covid Vaccination

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Context

The COVID-19 pandemic has put a strain on healthcare systems, destabilizing large swathes of the economy and causing unexpected consequences. For these reasons, mass vaccination was essential to prevent severe forms of the disease and death.

Senegal, thanks to its Expanded Program on Immunization (EPI), has a wealth of experience in terms of routine vaccination and specific campaigns. So, to tackle Covid, the country opted to use the existing system for vaccination against COVID-19. However, the latter required a number of adaptations. These relate to the organization of vaccination activities against COVID-19 for an adult target group that is not the usual one, the adoption of more appropriate service offering strategies, the weekly rather than monthly management of vaccination data for optimal monitoring of stocks received on an ad hoc basis, and appropriate waste management.

Indeed, following an inclusive process of reflection, the Government has drawn up a recovery plan that focuses on vaccinating high-risk groups, including the elderly, people with co-morbidities and front-line health workers. Senegal's immunization acceleration phase is based on community mobilization, strengthening community dialogue and relying on organized networks, with an approach centered on districts and regions.

These indications from MSAS have prompted partners such as USAID to use performance-based financing (PBF) to boost immunization. PBF, after having been initiated in Kaffrine, is now moving from a pilot project to a nationally managed program, with the involvement of central authorities in its management. This is why we believe that this transition phase can only be completed if a new policy is drawn up.

It should be remembered that the introduction of the PBP was marked, in the health sector, by a series of problems having a negative impact on the health system. The most important of these were:

- repeated strikes by health unions,
- lack of motivation among healthcare staff
- weak management and resource mobilization capacities, and the level of decentralization.

One of the objectives of implementing the PBF was to overcome these bottlenecks. To this end, the objective of PBP in Senegal was to motivate healthcare providers by awarding them a bonus based on their performance on seven indicators.

Activity Description

Performance-based financing has been used to stimulate the motivation and involvement of all players at operational level. This strengthens the dynamics and coordination of activities. USAID piloted the use of performance-based funding to improve COVID-19 immunization coverage, helping district management teams to develop immunization campaigns. Activities include:

- The organization of a Local Development Committee around the administrative authorities, to which all community players have been invited, to enable the population to take ownership of the initiative.
- Orientation of district management teams and health post vaccination teams on the new COVID-19 vaccination relaunch strategy and the AVC initiative of the USAID/B2SR project;
- Strengthening communication at local level to increase community involvement in the development of accelerated campaigns.
- Motivating vaccination teams through a performance-based funding mechanism that will require the signing of performance contracts between the district and the health posts;
- Share best practices with peers at district, regional and national levels.

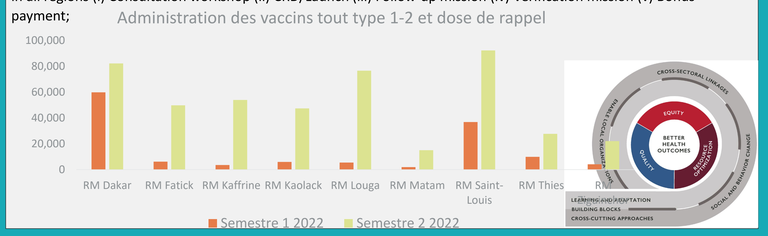
In an effort to strengthen the resilience of the health system to prevent further negative secondary impacts of COVID-19, USAID has adopted a strategic approach that integrates the emergency response to COVID-19 and COVID-19 vaccinations and, where possible, the strengthening of the existing health system. :

- Digital health systems: strengthening data collection and use. COVID-19 data and vaccination status are integrated into DHIS2.
- Healthcare personnel: IPC training to improve quality of care for patients and enhance safety for healthcare workers.
- Governance: USAID is combating widespread misinformation and declining confidence in public institutions. Strengthening coordination and collaboration to mobilize financial, human, drug, medical supply and other resources at regional and district levels.
- Equitable access: USAID is working to reduce barriers to access for vulnerable populations by creating acceleration campaigns. Vaccines are available at 1,700 health posts and through routine immunization systems.

Activity Impact

The key players who have experienced performance-based financing (PBF) have appreciated its purpose and vision. For them, the strategies and changes introduced by the mechanism have been very useful in improving the management and organization of healthcare facilities. The introduction of the PBF has an impact on the results obtained once a job has been completed. This new way of working has an influence on the whole system. While it is recognized that governance and the management of drugs and other inputs should be improved to help health facilities deliver attractive services.

Sixteen months after the start of Covid 19 vaccination in the country (March 21, 2021) the Kaffrine district had a vaccination coverage rate of 10.64%. USAID signed a Memorandum of Understanding with the Medical Region, committing to purchase the performance of the pilot district if in one month it managed to improve its vaccination coverage by 18%. To achieve this, the district's chief medical officer signed contracts with the district's 30 Service Delivery Points (SDPs), and each SDP set itself a target to vaccinate, giving the district a total of 12330 doses to administer. Below shows the results obtained during the one-month acceleration campaign. Once the results of the pilot had been evaluated and shared, USAID proposed scaling up the process by enrolling the 9 regions involved in the implementation, with a total of 59 districts to be enrolled in the nine regions. This scale-up involved 5 priority activities in all regions (i) Consultation workshop (ii) CRD/Launch (iii) Follow-up mission (iv) Verification mission (v) Bonus payment;



Evidence

We believe that extending this mechanism requires a new policy to ensure its sustainability. This new policy will be based on the achievements of the pilot phase, but above all, it will need to define the contours of real ownership and the milestones of effective participation by the community and local authorities. For the Ministry of Health, each region or district could become a laboratory for introducing new improvements to the system, which could be replicated in the event of success and serve as a lesson in the event of failure.

In 2013, considering the recommendations of the annual review, some changes were made in the operation of this mechanism. Thus, an office called the PBF Program was created. This Program became responsible for coordinating, implementing and monitoring the project at national level. This was the first step towards ownership. The verification process also changed with the introduction of an independent verification agency.

A new dynamic is created by the fact that the management of the mechanism is coordinated by an entity of the Ministry of Health, but ownership must go further than the creation of the PBF program, the premium was to be provided and paid by the government.

It was also expected that the steering committee would include all the key players at central level, such as the Ministry of Finance, the Ministry of Local Authorities, all the other donors interested in the mechanism, and so on. To ensure full ownership of this mechanism, it was hoped that the premiums would be entered on a budget line. With a view to strengthening the system, the definition of the indicator will be based on the priority of each locality. Local communities will feel more involved in the process, and community participation will probably be more effective.

Also:

- Direct motivation of providers has strengthened their commitment;
- Community dialogues helped to identify the factors contributing to refusal and to find solutions;
- Awareness-raising caravans coupled with vaccination campaigns have resulted in greater public support;
- The vaccination of administrative and territorial authorities during the launch of the program helped to reduce the reluctance to vaccinate:
- The institutionalization of verification helps to improve the use of DHIS2;
- Verification helps identify training needs in the use of management tools and indications of fraud;

Facilitators

If we look at the various phases of PBP project implementation, we can see both positive and negative factors. Nevertheless, the most important aspect is to improve the involvement of local authorities and the effective participation and commitment of the population through the management committees. At central level, the PBP project did not require parliamentary approval, and there was no question of increasing political ownership.

While key players at central level were trained, this was not often the case at district and regional level. Technical assistance and incentive payments are provided by donors, who have played the main role in the process. The design of the PBF was exogenous and top-down. In addition, the programming and design phases were extremely rapid, and did not allow for the appropriation of a totally new and unfamiliar concept.

What aspects and pathways of the health system, context, or external partner support helped make this successful? For example, were there existing working groups in place that enabled efficient coordination between stakeholders on this activity? Did you use a tool or knowledge resource from a global partner like WHO or UNICEF to help inform your activity?

Scaling up requires..;

- Involvement of local administrative authorities in implementation: Governor / Prefect / Sub-prefect ;
- Involvement of Ministry of Health authorities in stroke implementation;
- Commitment and involvement of MCR MCD and ICP;

Challenges

Without political ownership and technical capacity at national level and within the Ministry of Health, the decision and actions required to ensure the transition of the PBF from pilot to program do not work as planned, despite the availability of the fund. However, it has been shown that an external actor or donor can help the piloting phase of the mechanism through the creation of a pilot. Nevertheless, from the pilot phase to the transition phase, the condition of ownership must be put in place. This requires much greater commitment from national players, at both political and technical levels.

It would be useful for players to take real account of their needs in terms of capacity building and information exchange on the program, so as to be better prepared to take ownership of this PBP. This phase should also include a commitment to funding from external donors and a well-planned transfer of capacities, skills and key roles to the Ministry of Health.

We believe that full understanding and ownership of the PBF by national actors can increase and assume a successful full extension of the mechanism into a national program.

Lessons Learned

In the pilot phase, community participation was limited to supporting the health facility to improve its performance. But it must go beyond this support, as community participation is an important mechanism for stimulating the development of collective responses adapted to public health problems linked to primary health care, the reduction of maternal and neonatal mortality, and other specific problems (HIV, tuberculosis, malaria). It always involves the voluntary and active participation of local groups and communities in all stages of a health program.

It is therefore important to seek out organized and representative community structures to channel this social mobilization, so that it can support the activities of health care structures and maintain a constant dialogue between providers and the community. The preferred body for this action is the Health Development community (CDS).

Health workers have come to understand the importance of the information they collect; thus, completing and classifying health information tools is becoming more important, as the data provides the information to calculate the indicators for their remuneration. Another important aspect is improving the quality-of-service delivery. We noticed that the Ministry of Health's National Quality Program (PNQ) had no systematic tools or approach for measuring and improving the quality of care. That's why, in the PBP policy, quality was part of the calculation of facility performance. In the traditional healthcare systems of low-income countries, citizens have little or no means of influencing the availability and quality of healthcare services. In the PBP project, on the other hand, the community can help verify results and provide feedback on the quality of services received.

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