Public Disclosure Authorized
Public Disclosure Authorized
Public Disclosure Authorized

WORLD BANK GROUP
Health, Nutrition & Population

Knowledge Brief 4

Process Evaluation of Community Result-Based Financing for Health and Nutrition in Nagaland, India

Lessons from Early Implementation

The community results-based financing component of the Nagaland Health Project has been scaled-up to over 450 sites, supporting formation and operationalization of health committees, and initiating work to achieve targets on selected indicators of key maternal and child health services.

Several key processes require more attention, such as improving capacity and autonomy of health committees, especially the women co-chairs, simplifying the verification strategy, and monitoring through an integrated data management system using a dashboard. Coordination should be improved by more effectively involving state- and district-level health service administrators such as National Health Mission staff and Chief Medical Officers.

Introduction

Under the term "communitization," in 2002 the state government of Nagaland transferred responsibility for local services to Village Councils and sector-specific Committees. In the health sector, Village Health Committees were made responsible for management of local health services, including salary payment as well as use of small funds transferred by the state government. Some 1,300 Village Health Committees have been constituted and their level of functionality varies widely, with many hardly active. In 2016, the World Bank-financed Nagaland Health Project included a US$15 million component to provide technical and financial support to strengthen implementation of the communitization strategy.[1] A major focus of the project is on enhancing knowledge and skills of Health Committees at the village and facility levels, as well as engaging other stakeholders including women's groups and Village Councils. The project uses a Result-Based Financing (RBF) strategy, providing financial incentives to Health Committees for achieving targets for pre-determined indicators.[2] Health Committees are trained to design a six-monthly action plan to achieve these targets, and use the financial incentives to implement their plans for subsequent cycles. The project was initially piloted in 30 villages in two districts, and has been scaled-up to about 450 sites in all 11 districts in a phased manner since late 2017.

Methods

The process evaluation draws on a mix of primary data sources: a structured survey of Health Committee Chairs and Co-chairs, facility-based health providers and frontline workers, namely ASHAs and Anganwadi Workers from purposively selected committees (n=35) implementing the project across 11 districts;[3] a qualitative study including in-depth interviews with Chairs and Co-chairs of 10 committees[4] and key informant interviews with District Project Management Units and Chief Medical Officers in 5 districts; and ethnographic observations of the workings of 4 committees in 2 districts. The evaluation includes of a review of project documents and reports, such as the Programme Implementation Manual, the Project Operations Manual and training materials, and an assessment of routinely-collected project monitoring data including roll-out of the implementation status, target achievement, and action plans and expenditure reports for the 10 committees in the qualitative study sample. The analytical framework involved understanding the design of key processes, actual implementation practices, and challenges faced, along with examining various factors at the committee, health systems and contextual-levels which mediate their implementation.

Findings

This brief presents key findings from the process evaluation of early stages of implementation of the project, documenting achievements, challenges and lessons learnt related to the following implementation processes:

Scale-up

The scale-up of Community Action for Health and Nutrition began in late 2017, with a target of 462 sites, including 77 Health Center Management Committees (HCMC), 90 Health Sub-center Management Committee (HSCMC) and 295 Village Health Committees (VHC). At the time that this study was conducted (early December 2018),[5] training had been completed in all, but five sites and the initial one-time grant had been disbursed to 232 (50 percent) of the targeted sites. About 20 percent had received at least one RBF payment, most of which had been made by mid-2018. Among the pilot sites, 23 had progressed to the second and 6 to the third RBF payment cycle.

Training

While the project had trained all committees within two years, the coverage of training across members was found to need further improvement. Interviews with the Chairs and Co-Chairs suggested that there was a lack of clarity regarding attendance, resulting in low participation by committee members. While respondents indicated that they gained new knowledge from the training, their recall of training topics was low due to short, one-time training and low literacy levels.

Achievement of Pre-conditions[6]

Although all sampled committees had a woman Co-Chair, committees struggle to fulfil this mandate effectively. Non-transparent processes were followed for appointment of women Co-Chairs, which undermines their agency in decision-making as committee members. Development of the first Action Plans were almost fully led by project staff.

Subsequent Action Plans

Action Plans reviewed were found to follow a set template, with few innovations. Certain items proposed in the plans are consistent across sites, namely awareness camps to cover the following topics: antenatal and delivery care, communicable diseases, family planning, sanitation, drug addiction, HIV/AIDS, birth registration, and improvements in health facilities. Examples of strategies included in Action Plans include: offering nutritional supplements or eggs to encourage pregnant women to seek antenatal care; incentives (INR 100) to ASHAs for reports on delivery care; funds for emergency transport and medicines; repair of health facilities; and distribution of ASHA kits. Key informant interviews with project staff suggested that external facilitation for preparation of Action Plans reduced over time but took at least two or three cycles.

Implementation

One of the main challenges to implementation of the Action Plans was inaccurate estimation of costs which resulted in under- or over- budgetary allocations. Secondly, fund disbursements required the approval of Action Plans for subsequent cycles. This requirement was found to be the main cause of delay in disbursement, thereby reducing the time available for implementation of the plans.

Verification and Data Use

Project staff reported to be overwhelmed by carrying out verification of the results reported by the committees, often due to lack of adequate guidance, non-standardized templates, and scheduling. The verification exercise was found to be largely mechanical, without significant implications on learning or performance. Similarly, while committees at various levels were reporting their progress routinely, data were found to be collected and collated mechanically and not used to inform further plans or actions.

Committee Functioning

While committees met regularly, there was often lack of clarity on roles. Although decision making was seemingly democratic within the committee, there were stark differences in perceived autonomy between (male) Chairs and (female) Co-Chairs. The woman Co-Chair was found to be largely notional, with no real participation.

Health System Constraints

Indicator achievement was also constrained by systemic factors outside of the control of the committees, such as limited cold chain facilities (for vaccination), lack of health personnel (for example at Village Health and Nutrition Days), systematic delays in releasing payments for conditional cash transfers for delivery care (through Janani Suraksha Yojana), and inadequate coordination between different government departments and levels.

Achievement of Indicators

As described in Figure 1, most of the committees were successful in achieving the targets for indicators on conducting Behavior Change and Communication campaigns, ensuring adequate equipment and water supply at facilities, registration of pregnancies, weighing

child at birth, and full immunization for infants age 9-11 months. On the other hand, most committees struggled to meet the targets for indicators on four antenatal care visits, receiving cash incentives through Janani Suraksha Yojana while performance on indicators pertaining to conducting monthly Village Health and Nutrition Days and birth registration was mixed across type of the committee.

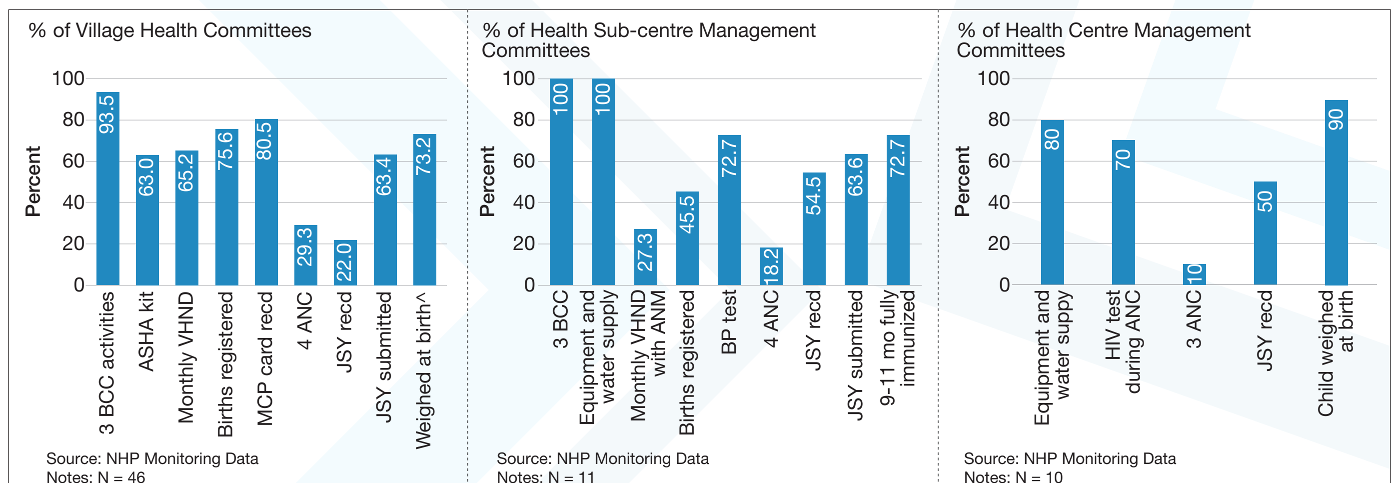
Conclusion

The project was successfully able to scale-up implementation to over 450 sites in about two years' time, ensuring fidelity to implementation design to a large extent, including the formation of committees according to government guidelines, opening bank accounts, preparing and implementing action plans, and maintaining records for verification. At the same time, several key processes require more attention to achieve higher fidelity and results for payment. For example, to improve effectiveness of capacity building of Health Committees the project should consider transitioning from knowledge-based to skills- or competency-based training, with introduction of interactive e-learning materials and refresher trainings. Similarly, to improve the development of Action Plans, the project should provide guidelines on common unit costs, establish continuous feedback loops and simplify the process with an annual rather than half-yearly planning cycle. De-linking the release of the funds from Action Plan approval and simplifying the verification strategy with clear objectives (such as course correction and learning) may also enable better implementation. Further, monitoring and learning would be facilitated through integrated data management using a dashboard, as well as data use guidelines and training for effective utilization and analysis of data by project staff as well as the committees.

The role of women Co-Chairs should be strengthened through leadership training and by creating a support group for peer-support. The capacities and motivation of district-level project staff would be strengthened by devolving more substantial responsibilities as well as through training on public health management. Coordination should be improved by more effectively involving state- and district-level health service administrators such as National Health Mission (NHM) staff and Chief Medical Officers. There is a need for improved data convergence between the Nagaland Health Project and the National Health Mission, as well as more systematic coordination between district-level project staff and Chief Medical Officers at monthly National Health Mission district review meetings.

The Nagaland Health Project is in the process of further streamlining several of the above-mentioned processes for better implementation. For example, it has begun the process of carrying out refresher trainings for the committees and is designing competency-based training materials. It has also conducted an orientation to the project for district-level Chief Medical Officers. The project is preparing a verification protocol linked to an integrated dashboard for reducing delays in collating data, carrying out verification and using data for subsequent action plans. Similarly, it has planned for capacity building activities for district-level project staff and frontline workers.

FIGURE 1: Achievement of Indicators during the First Implementation Cycle



Footnotes

1. World Bank. 2016. Project Appraisal Document on a Proposed Credit in the Amount of US$48 Million to the Republic of India for a Nagaland Health Project. November 28. http://documents.worldbank.org/curated/en/719521482375675651/pdf/INDIA-NAGALAND-PAD-11302016.pdf
2. List of Eight indicators for Village Health Committees, eight for Health Sub-center Management Committees and five for Health Centre Management Committees is available in the full report and the project implementation manual.
3. Committees were selected from villages and facilities included in the sample frame of the project baseline survey which had completed at least one RBF cycle at the time of the survey.
4. Ten committees, including three HCMCs, three HSCMCs and four VHCs across five districts, were purposively selected based on their recent performance (timely reporting, strong leadership, innovative action plans, strength of the DPMU) in the project.
5. The evaluation team collected data on roll-out status as of 22nd November 2018 which has been used to analyse the overall roll-out status.
6. Pre-conditions for receiving project support included forming a committee as per the government guidelines and electing a female co-chair, opening a bank account exclusively for this project with designated signatories and preparing an action plan for the first six months.

© 2019 The World Bank
1818 H Street NW, Washington DC 20433
Telephone: 202-473-1000; Internet: www.worldbank.org

Some Rights Reserved

This work is a product of the staff of The World Bank. The findings, interpretations, and conclusions expressed in this work do not necessarily reflect the views of the Executive Directors of The World Bank or the governments they represent. The World Bank does not guarantee the accuracy of the data included in this work. The boundaries, colors, denominations, and other information shown on any map in this work do not imply any judgment on the part of The World Bank concerning the legal status of any territory or the endorsement or acceptance of such boundaries.

Rights and Permissions

The material in this work is subject to copyright. Because The World Bank encourages dissemination of its knowledge, this work may be reproduced, in whole or in part, for noncommercial purposes as long as full attribution to this work is given.

Attribution

Please cite the work as follows: "World Bank. 2019. India: Nutrition Determinants and Strategies in Nagaland, Knowledge Brief - Process Evaluation of Community Result-Based Financing for Health and Nutrition in Nagaland, India: Lessons from Early Implementation. © World Bank."

All queries on rights and licenses, including subsidiary rights, should be addressed to World Bank Publications, The World Bank Group, 1818 H Street NW, Washington, DC 20433, USA; fax: 202-522-2625; e-mail: pubrights@worldbank.org.

Acknowledgements

This work was led by Patrick Mullen and Aarushi Bhatnagar, with contributions from Young Eun Kim, Mohini Kak, Bathula Amith Nagaraj, Neesha Harnam, Avril Kaplan and Mamata Baruah, under the oversight of Rekha Menon. The World Bank team would like to thank the Directorate of Health and Family Welfare and Department of Social Welfare, Government of Nagaland, the Nagaland Health Project team, Oxford Policy Management Ltd., the Kohima Institute and all study participants for their contributions.

This material has been funded thanks to the contributions of (1) UK Aid from the UK government, and (2) the European Commission (EC) through the South Asia Food and Nutrition Security Initiative (SAFANSI), which is administered by the World Bank. The views expressed do not necessarily reflect the EC or UK government's official policies or the policies of the World Bank and its Board of Executive Directors.

SAFANSI

Administered by: