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MID-TERM ASSESSMENT SUMMARY: BANKING ON HEALTH PROJECT

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ACRONYMS

BOH	Banking on Health
CGAP	Consultative Group to Assist the Poor
CTO	Cognizant technical officer
DCA	Development Credit Authority
GH	Global Health
M&E	Monitoring and evaluation
PRH	Population and Reproductive Health Office
PSP	Private Sector Program
RH/FP	Reproductive health/family planning
SDI	Service Delivery Improvement
TA	Technical assistance

PURPOSE OF THE ASSESSMENT AND SUMMARY

USAID's Bureau of Global Health (GH), Population and Reproductive Health Office (PRH), Service Delivery Improvement Division (SDI) requested that the GH Tech Project conduct an independent mid-term assessment of the Banking on Health (BOH) project. Two GH Tech consultants, Nancy Piet-Pelon and Graham Owen, conducted the assessment April 14, 2008, through May 23, 2008. They reviewed progress to date, identified opportunities for future investments, and made recommendations on the most efficient way to structure a similar activity in the future.

The mid-term assessment examined the project's progress toward planned results, the impact it has had, and lessons learned to date. The team made recommendations about which activities should be continued, modified, or augmented so that the BOH goals can be achieved, and identified both the BOH activities that warrant future investment and other credit initiatives and business skills development approaches not currently used by BOH that might help improve access, quality, and use of RH/FP and other health products and services.

USAID requested that GH Tech produce a summary document extracting the key conclusions and recommendations from this mid-term assessment as a useful reference for PRH/SDI staff. The information in this document combines information provided by the evaluation team with comments and additional information provided by BOH and USAID.

BACKGROUND

BOH is a five-year (September 30, 2004, through September 29, 2009) worldwide Task Order under the Private Sector Program (PSP) indefinite quantity contract (IQC). The Task Order consortium prime contractor is Abt Associates with Banyan Global as the technical lead; the consortium also includes ACDI/VOCA, Bitran and Associates, and IntraHealth. Other than Banyan Global, the partners have been used sparingly. For example, IntraHealth contributed 25 percent of the time of one professional in the first year. Bitran and Associates, a Chilean firm, worked only with the Nicaragua program. ACDI/VOCA worked in the Philippines and Uganda.

The project is core-funded with a ceiling of $6,605,917, of which $1,214,000 was received as field support from three Missions—the Philippines, Peru, and Nicaragua. This was not part of the design of BOH and the project ceiling was too low. With the cognizant technical officer (CTO) aware of this issue, a $2 million ceiling increase was requested and approved.

The GH office has been using a variety of methodologies to find ways to engage the private sector more effectively in providing RH, especially FP, services. The immediate predecessor to BOH was the Summa

Foundation, which loaned funds to individual health organizations around the world. However, its activities ended when USAID/Washington determined that direct funding to health care businesses was less effective than working with country-based financial institutions to lend to the private health sector. BOH was thus designed with two goals in mind:

- Increase access to financing by working with local financial institutions to promote lending in the health sector
- Improve the credit readiness of private providers.

BOH was also tasked with managing the close-out of the Summa Foundation, which had loans outstanding to private health providers. As loans were repaid, Summa funds were returned to USAID/W (all loans now have been repaid).

BOH had four planned outcomes:

1. Improve the financial viability of private health providers.
2. Add RH/FP services to the range of services they offer.
3. Extend private services to underserved and hard-to-reach communities.
4. Increase quality of care provided through improvements in facility, capacity, and commodity supply.

BOH has worked in nine countries in five regions: the Philippines, Nicaragua, Peru, Romania, Jordan, Uganda, Zambia, Nigeria, and Ethiopia. Currently work has been completed or halted in the Philippines, Nicaragua, Romania, and Peru. During the mid-term assessment, a BOH staffer was in Georgia at the invitation of the USAID Mission to discuss a program, and Ghana has also requested BOH assistance.

The country contexts are quite different. Some, like Romania, are closing their USAID Missions. Others are very low-resource countries where the private sector is struggling. Still others have vibrant private sectors but their impact is not well-documented or understood. In most the countries where BOH works, private providers have difficulty accessing financing.

It was envisioned at the start that BOH would work extensively with the Development Credit Authority (DCA), but this has happened only in Nicaragua and the Philippines. However, efforts are underway to use DCAs in four more countries: Zambia, Nigeria, Ethiopia, and Georgia. Whether to work with the DCA is usually decided by a country's USAID Mission, not BOH.

BOH is managed by four full-time professional staff and one part-timer based in the Bethesda office of Abt Associates and one at Banyan Global in New York. Both international and local experts have been employed either as long-term consultants or as program managers. In most situations, however, BOH staff themselves travel to manage the programs and provide the necessary TA.

ASSESSMENT METHODOLOGY

Since BOH is a core-funded program being implemented worldwide, the team spent considerable time in the United States interviewing informants and reviewing documents and also traveled to Kampala and Lira in Uganda and Bucharest, Calarisi, and Tirgu Mures in Romania to assess BOH work and meet local partners.

Review of Documents: USAID, BOH, and financial institution partners provided the evaluation team with documents to review. Particularly valuable was the self-assessment conducted by the BOH team.

Interviews: The team interviewed GH leadership, the CTO and technical advisor for BOH, and several professional staff from SDI who had been or are currently working with BOH. They interviewed the Summa Foundation's Executive Director, members of the Board of Directors, and BOH staff who are responsible for this work. The team spent a day with the BOH staff at their offices in Bethesda, where the team also met with PSP staff and others engaged with BOH.

Field Visits: In Uganda the team was able to attend a trade fair, which has become a signature activity for BOH in three of the nine countries where it works. The fair, held in Lira, was attended by more than 300 invited private practitioners and drug store owners. Exhibiters included financial institutions, medical supply companies, and associations. In Kampala the team visited BOH partners, including their primary partner for trade fairs, the Uganda Health Market Group, five financial institutions, four private practitioner associations, and five private nurse/midwife clinics. They also conducted a focus group with several midwives. In Romania, the team met with financial institutions in both Bucharest and Tirgu Mures and interviewed BOH's main partner, the Society for Education in Contraception and Sexuality, and the Romtens Foundation, which had conducted the nationwide survey of family doctors under a subcontract to BOH. The team conducted a focus group with family doctors in Bucharest and visited several family doctors in their practices in Calarasi.

Mission Questionnaires: The team drafted a brief questionnaire for the eight Missions engaged with BOH; six returned the questionnaire or responded to the questions in interviews during country visits.

PROJECT ACCOMPLISHMENTS

BOH works in nine countries rather than just the five targeted in Task Order Two. They are Ethiopia, Jordan, Nicaragua, Nigeria, Peru, the Philippines, Romania, Uganda, and Zambia. The tasks of the BOH programs in the Philippines, Nicaragua, and Peru have now been completed, and BOH activity in Romania ended when the country joined the European Union. BOH also recently conducted a country assessment in Georgia. The programs in the other countries are at different stages.

BOH has projects in five regions, in countries that vary tremendously in population, effectiveness of RH/FP services, and the breadth of the financial sector. At one end of the spectrum is Romania, where the financial sector is sophisticated, booming, and willing to lend to the health sector. The country health system includes specialists and family doctors working in both rural and urban areas—the doctors were the focus of the BOH project. Zambia is quite a different story; its financial sector is far less sophisticated and rarely lends to private health providers. Those working with BOH are mainly nurses, nurse/midwives, clinical officers, pharmacists, and some doctors who have small private practices. BOH conducts market research and educates financial sector personnel about the health sector in order to bridge the gap.

BOH has provided technical assistance (TA) to commercial lending institutions, has made use of an existing DCA in two countries, and is exploring four more DCAs in other countries. It has leveraged financial sector funds for private health care providers; provided TA to financial institutions on creating loan instruments for private health care providers; trained service providers in practice management, and introduced the providers to the financial sector.

There is evidence from most of the countries where BOH works that access to FP information and services has improved, and that BOH has contributed to these improvements. In Nicaragua, formal guidelines for FP, as well as breast and cervical cancers, were developed by BOH and are integrated into the Instituto Nicaraguense de Seguridad Social (the Nicaraguan Social Security Institute) system. *Empresas Medicis Previsionales*, (commercial medical providers) also extended coverage of FP to spouses of workers. There has been a threefold increase in the number of FP visits per year and an increase in the range of services. In Uganda, providers surveyed said they have been providing more information about FP methods since the BOH trade fairs. In Romania, 26 percent of family doctors increased their FP services after training. The Romanian situation is particularly interesting because of the dramatic turnaround from the extensive use of abortion to a FP program offering a full range of methods. In the Philippines, FP visits to trained midwives increased 36 percent, and trade fair participants increased the number of FP visits by 13 percent. Midwives opened up 19 clinics after the 2005 BOH trainings, an increase of 44 percent. For all methods, an increase of 44 percent was shown. In Peru there was a slight

increase in FP services by providers surveyed and an increase in the percentage of providers offering five out of nine FP services.

LESSONS LEARNED

BOH has helped focus attention on the financial sector and health providers in a number of countries, notably Romania. Its project management and staff have a reputation for being professional, transparent, and responsive to their partners (Missions and USAID/Washington, both the SDI Division and the Office of Development Credit). The project has helped create new financial products for health providers and in Romania commissioned an excellent health sector survey that can serve as a model for similar surveys in other countries. BOH has also conducted market research in Uganda, the Philippines, Zambia, and Nigeria.

Now that the BOH project has experience, it is time to take stock and fine-tune a strategy for the future. The strategy needs to take into account strengths and weaknesses and determine what business plan elements are needed for the project to have a sustainable future impact.

There are several lessons learned from the BOH project experience:

- Because governments and ministries of health in many countries are unable to meet the health needs of the population, the full participation of private practitioners is essential to meet the goal of health for all.
- In the countries where it works, BOH has been able to identify ways to increase private providers' participation in RH/FP by providing training to make them more creditworthy and by introducing the private health sector to the financial sector.
- Private practitioners have an identified need for financing to improve their practices. BOH has had a catalytic role in informing the financial sector and private practitioners about each other. It has "primed the market."
- Private practitioners are willing to invest in their practice if they can see they will gain financially.
- The financial sector is willing to lend to private practitioners, though there is often still reluctance to loan to the lowest level provider, the midwife/nurse in rural areas. The team observed during their field visits that the earning power of a rural midwife is limited because her client load is

small (often only 1–2 deliveries a week) and social pressure makes it difficult for her to extract payment from some clients.

Working to improve the knowledge and ability of the financial sector to provide services to the health market is a powerful model and should be continued in the future if funding is available and if USAID decides to pursue such activity. But the USAID SDI Division and BOH management do need to address certain substantive issues, among them:

- **Project staffing:** BOH has only one part-time and four full-time staff to manage all the work. In each country where it has been engaged for some time, it has different arrangements for getting the work done. There is a local consultant in Uganda and one in Zambia; particularly close collaboration with local partners in Romania and the Philippines (the project works with local partners in all of its countries); and judicious use of consultants in Nicaragua, Peru, Zambia, Romania, and for the start-up in Georgia. The BOH team also spends considerable time traveling to country assignments. Each staff member is responsible for no more than two active countries at any time. They have accomplished much with a small staff but they are stretched thin, an issue to be addressed when their incremental funding is finalized. While it may not be necessary to bring on additional full-time staff, long-term consultant arrangements and hiring in-country nationals might ensure that the required work is completed.

- **Project funding:** BOH has shown that there is interest in the financial sector in working with private providers. This is a foundation to build on for the future. BOH should probably remain within a larger program like the PSP IQC. Any possible future work that USAID might choose to pursue needs a combination of core and field funding to be truly effective. It also requires sufficient funds to have staff based, if not in each country, at least in each region.

- **Communications:** To be more effective, BOH needs to get its message out to more Missions. SDI can encourage this by assisting BOH in finding opportunities to present lessons learned, successes, and concerns at brown-bag events or seminars.

FUTURE DIRECTIONS

Country Activities: For the immediate future it is important for BOH to consolidate its current work and not take on any new countries except for Georgia. BOH made its first visit to Georgia during the mid-term assessment. The health system there is about to make a radical shift to privatization, much as Romania did in 1989. Most of the service providers will be setting up private practice for the first time. The Mission is interested in pursuing a DCA for them and using BOH expertise to train them in financial management, as well as working with the financial sector on lending to private service providers. BOH could perhaps apply lessons learned in Romania to this new country.

Nicaragua has signaled interest in restarting its cooperation with BOH. This should also be pursued because the considerable initial investment of time, effort and funds in Nicaragua has had some good results. BOH has the contacts and the expertise to restart this work quickly and have a real impact.

DCAs need to be finalized for Ethiopia, Zambia, Nigeria, and Georgia. Based on their experience in other countries, BOH is well-positioned to ensure that the DCAs reach the target providers in each country. These DCAs should be pursued with vigor.

The BOH work in Uganda has accomplished what it can with trade fairs by providing opportunities for private providers and drug store owners to network with equipment companies and banks. These have shown good results and are well attended by both sectors, but once the last two are over, each region of the country will be covered. It is then time to work actively on following up with the participants and providing the TA they have been requesting. BOH should encourage the Uganda Health Market Group to take on follow-on tasks. In addition, the associations that BOH has worked with—Uganda National Association of Nurses and Midwives, Uganda Private Midwives Organization, and Uganda Private Health Units—need technical support to engage their members in increasing their RH/FP work and build relations with the financial sector. To manage this, BOH staff must spend more time in Uganda in the immediate future.

In countries where BOH has worked, successfully and less successfully, with DCAs, there are lessons to be learned. These should be documented in-depth, as was done in Nicaragua. Though work has ended in Romania, there are lessons to be learned from the successes there and applied elsewhere in trying to engage the private providers in public health. It would be very useful for BOH to write a case study of the work in Romania and draw out the lessons learned. This could be presented in a seminar or round table forum for USAID, other CAs, and partners to learn from this valuable experience.

Role for PRH/SDI: SDI should continue to play its current multiple roles in any possible future work in this area, taking into consideration the time remaining to implement the project and funding available to complete ongoing work:

- SDI should continue to help BOH in selecting countries by alerting Missions and CAs to how BOH activities might fit their portfolio of programs.
- SDI should facilitate more opportunities for BOH to present its successful programs in seminars and workshops where lessons learned and application to other country programs can be discussed.
- SDI can help market BOH to other health sectors. Of particular interest to the Missions is using BOH to work with malaria, tuberculosis, infectious diseases, and HIV/AIDS programs. This is already possible under the existing project, but the low ceiling has limited the ability of the project to accept field support.
- SDI could facilitate a meeting to explore future options for a BOH-type project and to determine the best fit.

Funding: Core funding allows innovative programs to move into countries and provide services without a Mission investment. However, in the long term having only core funding is a constraint. BOH needs field funds to sustain its work. In countries where it was able to leverage field support (Nicaragua and the Philippines), it was able to provide sustained assistance. There are some disadvantages of field funding when the Mission insists on BOH collaboration with projects that have already set their direction and cannot fully accommodate BOH's direction and expertise. However, managed effectively, field support can offer a good opportunity to get in the mainstream of the Mission's interest. Field funding would also allow BOH to get the local staff they need.

A combination of core and field funding would be ideal. BOH has done a commendable job with core funds but is not usually able to ensure that what it has initiated is applied. Field funding is necessary for a sustainable impact. Sustained field presence rather than an in-and-out approach is essential to success. Thus, any potential future project should have both types of funding (and a sufficiently high ceiling to accept field support) for maximum impact.

CONCLUSIONS

RH/FP as Central Objective of BOH: Even though BOH is available to all health programs, the important role the project has played in RH/FP must not only continue but be augmented where feasible. In countries where BOH is now working, there is considerable unmet need for FP; therefore, it is essential that private providers have access to finance and training to ensure they can provide essential RH/FP services in their communities. This need, which will continue for the foreseeable future, should remain a central focus of BOH.

USAID's Experience in the Private Sector: USAID/GH has varied experience in the private sector. Its most far-reaching programs in social marketing have been active for decades and have increased the availability of low-cost pills, condoms, injectables, and in some countries implants and IUDs. USAID has also funded mass communications programs implemented in the commercial sector. Funding for training for physicians and other medical personnel has also extended into the private sector—mainly because providers who work for government health programs usually also have a private practice, so anything they learn for one sector is carried over into the other.

The PSP-*One* Task Order encompasses much of the work that SDI does in the private sector. Designed to increase private provision of high-quality RH/FP services, it provides technical leadership for optimal private sector strategies and also synthesizes and disseminates proven strategies. In the future, BOH and PSP-*One* should be working together as closely as possible as BOH brings an element (the financial connections) that PSP-*One* could use effectively.

Integrating Private and Public Sector Work: To work effectively with BOH, countries need to be selected based on a combination of factors: the readiness of the financial sector to lend to private providers; RH/FP statistics that reveal unmet need for FP; the readiness of the USAID Mission to help with a DCA mechanism; and the willingness of private providers to access loans to build their practice to effectively serve those in need.

The financial sector has to be willing to lend to the private providers most likely to reach the underserved. These would include community midwives or nurses who can provide RH/FP services, local drugstore personnel, and the equivalent of the Romanian family doctors. In some other countries, BOH would have to seek the private providers who are most likely to serve rural populations.

BOH is advised to focus on PRH priority countries, which are selected by PRH on the basis of such criteria as contraceptive prevalence, total fertility rate (TFR), access to FP methods, unmet need, and willingness to pay for services from private providers, among others.

Although BOH has found it is able to work successfully with financial institutions outside of a DCA guarantee framework, the evaluation team recommends that USAID Missions working with BOH be willing to explore a health DCA. In countries where DCA have been used for other programs, there is a general feeling that it is effective. From a banker's side, it reduces risk and makes the idea of lending to private practitioners more attractive. Stanbic Bank in Uganda had experience with an agriculture DCA and felt it made lending in that sector much more attractive. A DCA might create similar interest in lending to health care providers.

Private practitioners have to be willing to borrow funds to improve their practice for RH/FP. A survey or in-depth discussions to assess their willingness is recommended before BOH commits to working in a country. In Uganda, in spite of trade fairs and some training in working with the financial sector, midwives interviewed by the evaluation team in a focus group in Kampala expressed their reluctance to borrow from a bank; they prefer to go without or borrow within the family. Helping them to get beyond their understandable fear of borrowing from the formal sector should continue to be part of BOH TA in the future. However, it should be noted that under the Summa Foundation, the Uganda Private Providers Loan Fund provided loans to 15 midwives from the Uganda Private Midwives Association and all were successfully repaid.

Technical Advisory Group (TAG): The BOH project would benefit from having a strategy and business plan presented to a Technical Advisory Group comprised of BOH's partners at USAID, such as other USAID health sector offices with a financial stake in the project and the DCA, and perhaps some external partners, possibly the Consultative Group to Assist the Poor (CGAP) and the Gates Foundation. This could open up new opportunities and initiatives, give management a wider sounding board, and help to harmonize the different demands made on the project.

RECOMMENDATIONS

In the final phase of the BOH project, there should be more dissemination and sharing of lessons learned, successful programs, and ideas for the future. BOH should be used in GH Bureau-wide brown bags, and other opportunities to share its field-based learning. This would provide the opportunity needed to share their methodology and explore opportunities for future projects with private providers of RH/FP services.

Other recommendations are:

1. The strategic focus for BOH should continue to be global. Because countries are at different stages in their interactions with the private sector, the approaches must be varied. Different financial sectors have different challenges but each presents an opportunity for learning. By working in large and small programs and ones at different stages in their RH/FP goal achievements, BOH activities can provide richer learning to SDI and GH.

2. The BOH management needs to take a closer look at whom and what they subsidize with TA and project support and should investigate the possibilities for cost-sharing by financial institution partners. Subsidies should be used on supporting efforts such as market studies and technical guides to be made available to local and regional players and the industry as whole. When specific TA is being provided to a single bank or microfinance institution, the possibility of cost sharing (and its potential benefits and drawbacks) should be investigated. All the major financial institution partners visited—such as Stanbic, a large South African bank, Bank of Transylvania in Romania, and Raiffeisen bank from Austria—seemed to the evaluation team to be willing and able to pay for what they are interested in.

3. For this effort to have a lasting impact, more time is needed to build sustainable partnerships and mentor associations. This has often been done by SDI programs in the past, with limited results, but unless BOH project takes a more active role in nurturing association members, it is difficult to see how its initiatives can be sustained. Associations need advice on supportive supervision and a better understanding of financial sector opportunities for members. SDI and GH must recognize that the process that BOH has embarked upon is a long one; BOH needs more time to have a sustainable impact. The associations BOH works with need considerable assistance if they are to mentor their members about financing opportunities.

4. At this point, BOH activities have catalyzed both private service providers and financial institutions. This catalyst role is still critical, but it is recommended that BOH consolidate its programs in the countries where it now works rather than taking on new countries. Exploration of

new country programs should grow out of interactions with SDI during year 4 of BOH. During year 5 and in preparation for any potential future activity in this area, decisions can be made about new country starts.

5. SDI and BOH together should explore the possibilities of increasing country presence for BOH. This would allow more time in each country and provide an opportunity to nurture relationships with local associations and other SDI or GH projects that will support the sustainability of BOH activities. This increased country presence would require sufficient field support to sustain.

6. If USAID chooses to pursue further work in this area, any future project needs a monitoring and evaluation plan funded by core funds. This is essential so that the project can gather pertinent data in each country where it works without having to depend for this on PSP. The current project was not designed with a monitoring and research component and as such, there was no budget for this work. BOH has managed to carve out a small budget for monitoring but has been stretched to meet reporting requirements with limited resources and without dedicated monitoring and evaluation staff. In addition, new output and impact indicators are needed for any future project that may be developed.

7. The BOH project needs to do additional networking with the micro to small finance sector: making presentations, offering tools and guides at regional microfinance conferences, attending conferences like ACCION's Cracking Capital Markets, and spending more time with key groups in the industry directly. Among these groups might be ACCION, CGAP, Opportunities Intl., the Cooperative Housing Foundation, Procredit Banks, and the World Council of Credit Unions (WOCCU).

8. BOH should develop additional technical tool kits and guides, such as guidance on client profiling in the medical field with examples of different market studies, and new product development in the medical field.

9. As part of preparing the business plan, BOH management and a consultant need to analyze the effectiveness of the current human resource system—with core staff based in Abt Associates offices and outsourcing for international consultants, local consultants, and local partners—and could identify alternatives. The alternatives might include increasing use of consultants who have good technical skills in relevant areas and downgrading the skills level and cost of HQ. Based upon needs, management should draw up new job descriptions and skills and experience profiles for the jobs. It could also suggest alternatives both in terms of the physical location of staff and skills profiles for each post.

10. The team recommends that the BOH project build regional technical resource networks in one or two regions. Romten's and its expert consultants in Romania are a very good example. An organization like Romten's can be useful not just regionally but even internationally in providing TA and training and putting together technical guides. Supporting a network with coordination and funding to cover TA and training services would require substantial resources and should be viewed as a long-term endeavor.

11. The weight of resources needs readjusting. There could be more focus on studies and training that build the ability of financial institutions to lend to the sector. The evaluation team recommends drawing up profiles that are of broader benefit for financial institutions, with larger banks particularly bearing an increasing share of the costs.

12. The BOH project should consider upgrades to its accounting system to better analyze costs and performance related to output and impact.

13. If there is to be a future BOH-like project, it should attempt to leverage USAID investment to acquire private sector funding partners, such as foundations and private health firms.

For more information, please visit

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