POLICY BRIEF

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EXAMINING FREE MATERNITY SERVICE PROGRAM USING THE STRATEGIC PURCHASING PROGRESS TRACKING FRAMEWORK:

Early Implementation Results in the Democratic Republic of Congo

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Background

Despite being preventable, worldwide, the maternal mortality rate remains high with more than 287,000 women reported to have died during pregnancy and childbirth in 2020; 95% of all maternal deaths occurred in Low- and Middle-Income Countries (LMICs). Sub-Saharan Africa (SSA) accounts for more than 70% (202,000) of maternal deaths [1,2]. This challenges achieving the targeted maternal mortality goals set below 70 per 100,000 live births in the Sustainable Development Goals (SDGs).

With a high skilled birth attendance at 80% and the percentage of women receiving ante-natal care at 88%, the Democratic Republic of Congo (DRC) has unfortunately one of the highest maternal mortality ratios in the world at 846 deaths per 100,000. The percentage distribution of live births in the last decade by type of delivery assistance is as follows: trained birth attendance 35%, nurses 38%, doctors 7%, village matron/ midwives 10%, others 9% and no-one 1% [3,4]. To minimize access barriers, especially for the very poor and vulnerable households' reforms in health financing of maternal health services are critical [5]. In SSA, countries have used the removal of user fees and/or subsidy reforms to strengthen the financing of maternal health services [6,7,8].

Total Subsidy Program (TSP) for the care of Pregnant women, mothers and newborns aims to remove financial barriers and increase the number of mothers who deliver under the care of skilled health personnel. It is one of the flagship programs as the Country prioritizes interventions towards the realization of Universal Health Coverage (UHC). The pilot program began in Kinshasa on 30th June 2023 but will eventually be rolled out in all 26 provinces by 2025. Since 2018, Amref Health Africa, through the Strategic Purchasing Africa Resource Center (SPARC) initiative has been supporting technical partners such as the School of Public Health of the University of Kinshasa to offer capacity development and technical assistance to the Ministry of Health in the DRC. The partner has supported the Ministry of Health in generating evidence that will help influence policy reforms health financing and strategic health purchasing. This is made possible through support from the Bill and Melinda Gates Foundation (BMGF).

This policy brief provides an in-depth analysis of the TSP in the DRC, i.e. the national free health care program for women and children, using the Strategic Health Purchasing Progress Tracking Framework developed by SPARC [9].

Context in the Democratic Republic of the Congo

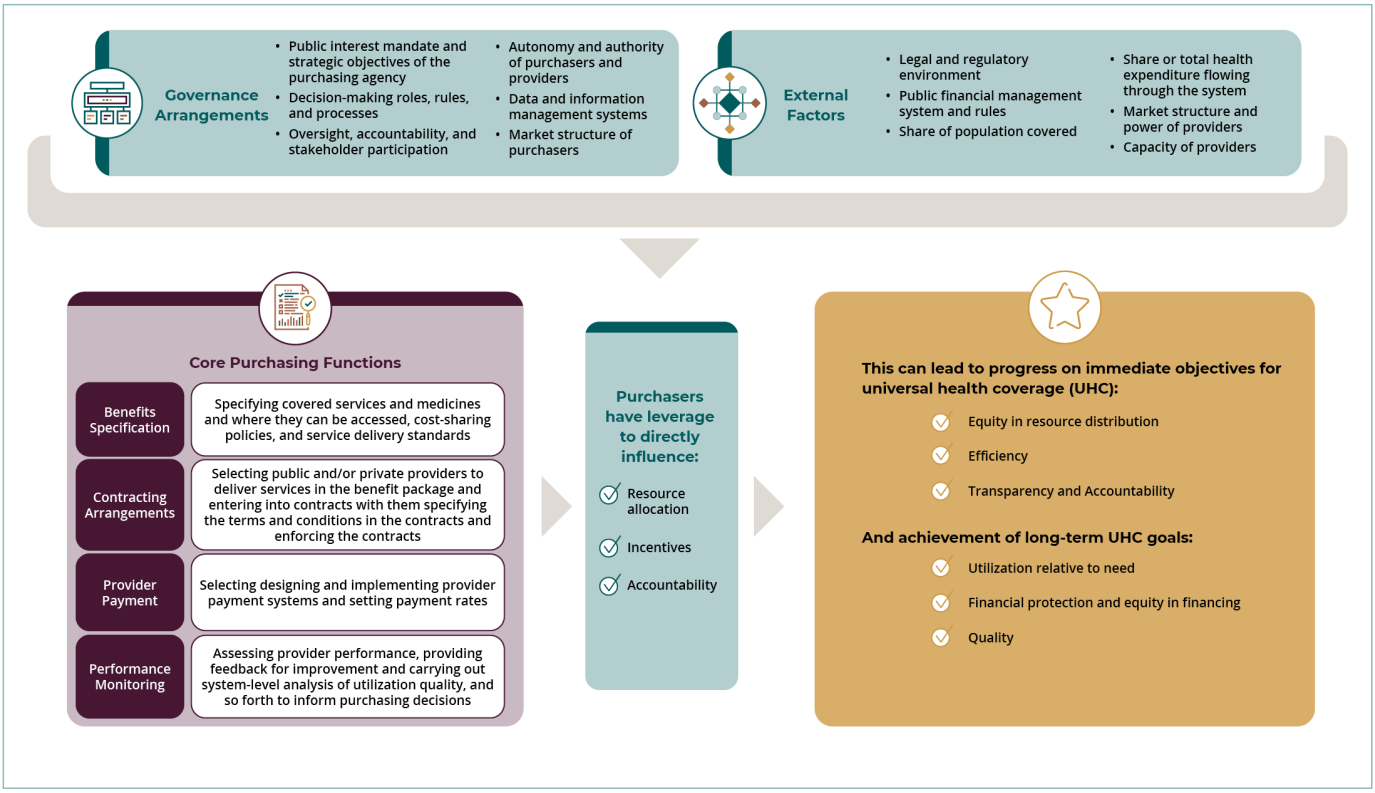
The DRC is the largest country in Sub-Sahara occupying 2.3 million km2 and with a population of approximately 100 million [10]. DRC's current health expenditure (CHE) per capita is $ 23 (4.9%) compared to $ 86/person or 5% of the GDP needed to make progress towards the attainment of UHC [11]. High levels of poverty together with the long history of political instability and ongoing humanitarian crisis do have negative implications on access to health services including maternal health. On health financing, government transfers account for 18%, external aid 39%, out-of-pocket health expenditure 40%, and others 3% of the total health expenditure [12,13].

Methodology

The Strategic Purchasing Progress Tracking Tool was utilized to evaluate the TSP for the care of Pregnant women, mothers and newborns scheme in DRC. The methodology employed to evaluate the TSP involved a multi-faceted approach. Data was collected primarily through reviews of policy documents, decrees and directives reports from the MoH and development partners. Gaps in the documents were supplemented by 12 key informant interviews (KIIs). Key informants were purposively selected based on their depth of understanding of the implementation of the

TSP. Institutions of the UHC such as INSP[i] and FSS[ii] facilitated access to data and resource persons to ensure the accuracy of the information. In addition, we reviewed the early performance of the TSP from data obtained from FSS and DHIS2. The evaluation covered the period of September to December 2023. Being a baseline report, data was not collected for comparison with the previous periods.

Figure 1: Strategic Health Purchasing progress tracking framework.



Source: SPARC

Findings

This section describes the analysis of the TSP using the SHP tracking framework with three main themes; governance arrangements, external factors, and purchasing functions.

Early results:

These results of the TSP launch reflect the early implementation findings from the first four months of the implementation.

Deliveries: Only 52% (44,452 deliveries) of all 85,428 deliveries in Kinshasa City were covered by the FSS in the first four months of the implementation of the TSP. The remaining 48% may have been paid through out-of-pocket (OOP) and low participation of the accredited health facilities through non-submitted claims. In December 2023, there was a notable increase where 92% of all the deliveries were covered by the TSP showing improvements in the claims process by the participating facilities (Table 2).

Maternal mortality: For all 321 primary health providers, there were concerns about the quality of care and maternal deaths for the 9 selected PHC providers. There were 21 deaths for the 9,595 livebirths, 10 deaths for 1,117 livebirths, 8 deaths for 1,171 livebirths and 12 deaths for 1.167 livebirths for the period between September to December 2023.

i INSP : Institut National de Santé Publique

ii FSS : Fonds de Solidarité de la Santé

Table 1: Synoptic table of the care of pregnant women, women who have given birth and newborns in Kinshasa from September to December 2023 as part of the total subsidy program.

	September		October		November		December	
	FSS data	DHIS2 data	FSS data	DHIS2 data	FSS data	DHIS2 data	FSS data	DHIS2 data
1. Delivery								
Health center	5942		9042		10367		3450	
General Hospital	2569		3132		3196		1384	
2d Referral Hospital	418		435		440		437	
Cesarean delivery	666		1176		1168		630	
Sub-total	**9595**	**21690**	**13785**	**22243**	**15171**	**23146**	**5901**	**18349**
% FSS deliveries	44		62		66		32	
2. Prenatal								
Health center	6507		11739		12855		3817	
General Hospital	3693		5792		5400		2373	
2d Referral Hospital								
Sub-total	**10200**		**17531**		**18255**		**6190**	
3. Neonatology section - in 9 health facilities ***(Ngaliema, Cliniques Universitaires, Hopital provincial, Saint Joseph, Kalembelembe, Tshiatshi, Roi Baudouin, HASC, CH Kingasani)***								
General Hospital	93		110		185		226	
2d Referral Hospital	382		356		549		340	
Sub-total	**475**		**466**		**734**		**566**	
4. Hospitalization								
Mothers	336		590		821		271	
5. Death								
Maternal deaths								
In community		7		7		22		160
Corrected data	21	2	10	5	8	13	12	6
Sub-total	**21**	**9**	**10**	**12**	**8**	**35**	**12**	**166**
Newborn deaths		**7**		**7**		**22**		**160**
Fresh stillbirth		92		105		100		54
Macerated stillbirth	64	125	130	113	66	142	78	92
Sub-total	**64**	**224**	**130**	**225**	**66**	**264**	**78**	**306**

Source: FSS and DHIS2 September to December 2023

Infant mortality: 381 deaths were recorded against 2153 newborns for the period under review, meaning 177 deaths for 1000 live births at the health facility level. As reported by health facilities involved in this report, the causes of infant mortality rate are attributed to septicemia and lack of the essential equipment for the newborn unit necessary for the care of premature babies. This highlights further gaps in quality of care that will need additional research.

Table 2: Evolution of deaths in neonatology in nine healthcare facilities supported by FSS from September to December 2023

Month	Frequency	Death
September	408	100
October	436	76
November	734	93
December	575	112
Total	**2153**	**381**

Source: DHIS2

Results from the application of the Strategic health purchasing progress tracking framework

Governance arrangements:

a. Mandate and authority of purchasers

The TSP has a designated purchaser which is the Health Solidarity Fund (FSS) which was duly constituted through the Prime Minister decree No. 22/13 of April 09, 2022, on its organization and operation as a public institution. The FSS is placed under the supervision of the Minister of Employment, Labor and Social Security, and it is strengthened through the DRC UHC National Strategic Plan 2021-2030 and its roadmap 2023-2025. The ongoing FSS action plan 2023-2024 is mainly focusing on the scale-upscale-up of the TSP program nationally.

The funding for the TSP is transferred from the Ministry of Finance to the FSS and then directly to the health facilities upon raising legitimate claims for health services that are provided. FSS also coordinates all engagements of other government agencies that are supporting the Universal Health Coverage (UHC). The Technical secretariat in charge of the TSP at the FSS determines the annual budget, quarterly commitments and the terms and conditions of the scheme. FSS only accredits facilities that have met the policy requirements on quality as certified by the UHC Regulatory Agency (AR-CSU). FSS also should pool resources from other pre-paid pools in the health sector for both formal and informal workers.

The FSS relationships with the central and provincial administration of the Ministry of Employment, Labor and Social Security still need to be strengthened, capacities built and mechanisms for accountability established. FSS is directly linked with health facilities in Kinshasa, however, this will be a big challenge in the process of extending the TSP across the 26 provinces in the country. The FSS governance is led by an Administrative Council Board, supported by the Management Board which ensures the daily management and the implementation of Council Board decisions. FSS has formal engagements with accredited health facilities (public and private Primary health care centres and hospitals). At the end of December 2023, 316 out of 358 health facilities in Kinshasa city had progressively joined the TSP by signing the collaboration agreement with FSS.

b. Autonomy and power of health providers in decision making and accountability mechanisms

In DRC, in the absence of additional governmental grants to the functioning of the public health facilities, health providers are allowed to retain and use all revenues obtained from use fees through out-of-pocket payments (OOP) and from other schemes such as the TSP program. The Public Financial Management (Laws) provide for the autonomy of the public health providers (across all levels - primary secondary and tertiary) and outlines a framework for accountability. This further provides for controls, and audit mechanisms for resources used at district, provincial and national including programs such as TSP.

The PFM also provides guidelines on the management of public resources including those entrusted to the health sector. This includes clarifying the budget structure, process, and tools knowing that 40% of all government revenue is earmarked for the provincial governments. The FSS implements all the guidelines on PFM to manage entrusted public resources. Theoretically, health facilities exercise autonomy in financial procurement and human resources management using resources transferred to Ministries of Health. FSS on the other hand is held accountable through government agencies like the inspectorate, treasury inspectorate and other agencies that conduct internal audits.

Therefore, regardless of their status being either public, Faith-Based Organizations (FBOs) or private institutions, health facilities do have financial, procurement and managerial autonomy, knowing that all of the Human Resources for Health (HRH) are getting directly paid prime incentive (bonus) in addition to the regular salary paid only to those civil servants who have a civil servant number. In general, all providers retain incentives generated from health facility revenue, including from the TSP.

The Ministry of Health has maintained control of the strategic and operational planning process and reporting. Thus, according to this autonomy, no revenue collected at the health facility level is sent up to the reporting line neither at provincial nor national levels. There is room to improve accountability at the health providers as they continue attracting additional resources from the FSS as part of the larger government-wide reforms on the PFM.

Purchasing functions and capabilities

a. Financial management: How much is flowing in the TSP program?

The FSS is financed by the DRC government through the budget for a total of $ 41,789,379 annual allocation, with an estimate of $ 2,000,000 per month. The TSP subsidizes care for pregnant women, deliveries including mothers and their newborns for the first 42 days. A significant proportion of the budget (75%) budget is earmarked for health services costs while 25% is earmarked to finance the functioning of all Institutions supporting the UHC implementation process. Reports from FSS indicate that payments/reimbursements for the last 4 months in 2023 have been made, but a closer look at this however shows that only maternity costs have been paid, leaving out other payments such as prenatal and neonatal care consultations.

> 75% of the resources under TSP are earmarked for health services and transferred to health providers

As shown in Table 3 below, compared to forecasts, all funds are not yet available. There is a Gap of $1,009,700 for September, $706,340 for October, $695,433 for November and $699,000 for December 2023. This gap in funding has resulted in a narrow benefit package compared to the one promised in the TSP policy.

Table 3: Snapshot of the payments invoiced by primary health providers contracted with FSS in 2023 (in US $)

RUBRIQUES	30/09/2023	31/10/2023	30/11/2023	31/12/2023	TOTAL
Monthly maternity benefit payments	990 300	1 293 660	1 304 567	1 301 000	4 889 527
Pre-natal and pre-school consultation payments	0	0	0	0	0
TOTAL	990 300	1 293 660	1 304 567	1 301 000	4 889 527
Monthly estimates	2 000 000	2 000 000	2 000 000	2 000 000	8 000 000
GAP	**1 009 700**	**706 340**	**695 433**	**699 000**	**3 110 473**

Source:FSS

b. Benefit package: what to purchase?

The TSP has an explicit benefit package with the services reflecting the health priorities for the reduction of maternal mortality. This package is called the "mother and child package". It was built from a consensus among stakeholders through workshops under the FSS authority. Minimum standards criterium were defined focusing on the availability of human resources and basic equipment that maternity should comply with. The care package consists of 12 benefits, as explained below. For outpatients, these are Ante-Natal Care- ANC visits and ambulatory care at primary health facilities. For in-patient: normal deliveries, complicated deliveries at secondary hospitals, cesarean delivery at secondary level hospitals, ambulatory care of pregnant women at the general reference hospital, ambulatory care of newborns, hospitalization of pregnant women, hospitalization of newborns and specialist care hospitalization in pediatric intensive care for newborns. It should be noted that this policy aims to fully subsidize the care of pregnant women, women who have given birth (the first 42 days after childbirth) and newborns, including the required medicines and other supplies.

The TSP MoUs provide mainly for maternal health services as out-patient, normal delivery (at primary health providers); and cesarean sections, complications of baby and mother at secondary and tertiary hospitals.

c. Contracting arrangements: from whom to purchase maternal health services

The TSP program uses selective contracting between FSS as the purchaser and the health providers based on an annual accreditation and defined quality standards by the ARC-CSU. FSS issues collaborative agreements/memorandum of understanding describing the formal contracting process, both for public and private health facilities.

Table 3 . Distribution of health care facilities accredited by Health Zone and by the Political Administrative District of Kinshasa

District	Health Center	General Hospital	Total
Funa	25	13	38
Lukunga	41	22	63
Mount Amba	47	13	60
Tshangu	118	22	140
Police	1	3	4
Military	4	7	11
Total	**236**	**80**	**316**

The accreditation institution "ARC-CSU" identified 358 out of the 1,600 health providers that sent an application for accreditation. 316 (representing 20% of all facilities)t health facilities were accredited comprising 236 primary health centers and 80 hospitals. Compliance with the agreements is rigorous with provision for voiding in the event of undesirable behaviours, fraud or poor quality of health services.

d. Provider payment mechanisms: How and how much to pay the providers?

FSS uses a combination of the fixed fee and fee for service provider payment models (PPMs) with the costs for the services pre-determined including general examinations in public health centres can cost about 27,000 Congolese francs (10$), while ultrasounds can cost 22$. C-sections cost about 194$.

We noted that health providers raised claims for payments, with overcharged bills, i.e. in September 2023, verification of the bills received by the FSS resulted in a drastic reduction to $ 1.415.523 and it came down up to $ 781.213$ after the audit, resulting in 55% of reduction. Thus, health providers have not fully adhered to all the terms and conditions of the scheme resulting in rejections or non-payments. In addition, for the first two months of September and October 2023, FSS made payment bills with a consecutive delay of one month and then two weeks. From November 2023 up to January 2024, FSS is prepaying more than 70% of the previous bill of health facility in the perspective to avoid delay.

Performance monitoring:

The FSS engages and builds the capacities of a total of 38 medical advisors to support the regular monitoring of the quality of health services and to carry out the verification of invoices. They are also intermediaries for purchasing services and conducting monthly risk monitoring missions. Performance monitoring is done once every month and is designed to strengthen compliance for improved health outcomes, using the adapted "Structure-Process-Outcomes" model of quality care. Therefore, medical advisors are major players in efficiently implementing the TSP scheme.

As a framework for accountability, the FSS has set some provisional prudential rules for risk management, comprising: capping the monthly amount payments to health facilities to guarantee solvency for the entire period, a monthly monitoring of discrepancies occurred after validation of services declared to control the moral risk of service providers, an alert system for the cross-checking mission, and the use of Inspectorate General of Finance (IGF) for the supervision.

Policy recommendations for health systems improvement:

- The early results demonstrate the need for adequate funding per projections to allow the program to deliver the full promised benefit health package. This is to ensure the program actively participates in contributing to improving health outcomes through the reduction of maternal and child mortality.
- Strengthening the health information system to reduce significant discrepancies between DHIS2 data and health insurance data will

result in a great positive impact on the extension of the implementation of the TSP program.

- Enhance governance and inter-ministerial coordination: strengthen the linkage between the FSS (housed under the Ministry of Labor) and the Ministry of Health. Establish clear lines of communication, accountability and collaborative mechanisms to ensure seamless implementation of the TSP program and alignment with broader health sector goals.
- Improve financial management and transparency: The development of an Operational Action Plan with a budget for all subsidy health facilities is crucial to overcome the lack of transparency in income distribution and drug purchased on an ad hoc basis.
- Optimize provider payment mechanisms: regulate and standardize invoicing processes in health facilities to facilitate the negotiation of lump-sum payments for health insurance. Consider transitioning to other provider payment methods like performance-based financing to incentivize quality care and cost-effectiveness.

Conclusion

The Total Subsidy Program (TSP) in the Democratic Republic of Congo marks a significant step towards Universal Health Coverage and improved maternal and child health outcomes. This baseline assessment, using the Strategic Health Purchasing Progress Tracking Framework, reveals both promising aspects and challenges in the program's early implementation in Kinshasa.

Key successes include the removal of financial barriers for maternal and newborn care, with 52% of deliveries covered in the first four months, and the establishment of the Health Solidarity Fund (FSS) as a designated purchaser. However, challenges such as funding gaps, information system discrepancies, and governance issues require attention.

This report serves as a crucial first step in defining priorities for the TSP's ongoing implementation. As the program expands nationwide, the lessons learned from Kinshasa will be invaluable. Regular assessments will be essential to monitor progress and inform necessary policy adjustments.

By addressing identified challenges and building on early successes, the TSP has the potential to significantly contribute to the DRC's progress towards Universal Health Coverage, ultimately improving the health of mothers and children across the country.

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About SPARC

SPARC is an initiative implemented by Amref Health Africa in partnership with Results for Development (R4D) and more than nine technical partners (Universities & Research organizations), and Amref Country Offices in more than 14 countries in Sub-Sahara Africa and with support from Bill & Melinda Gates Foundation (BMGF). For this brief, SPARC has partnered with the University of Kinsasha in the Democratic Republic of Congo (DRC).

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