Strategic purchasing for nutrition in primary health care

A proposed diagnostic assessment approach
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Design by Alberto March.

Purpose

This document is intended to strengthen understanding of how nutrition services can be incentivized within purchasing arrangements for primary health care (PHC) to improve the quality, coverage and efficiency of nutrition services. The document builds on Strategic purchasing for nutrition in primary health care: Overview and proposes a diagnostic approach for systematic assessment of how nutrition services are purchased within existing health purchasing arrangements. The intent is to provide an approach to be used by country teams to document and assess the place of nutrition in broader PHC purchasing arrangements within a tested, established PHC purchasing framework. It provides four steps and 28 guiding questions to help governments and other stakeholders to become more strategic in purchasing nutrition services within PHC.
Introduction

As found by the Lancet Global Health Commission on financing primary health care (PHC), strategic health purchasing is an important aspect of effective spending to achieve universal health coverage (UHC) goals (1). Through strategic health purchasing, purchasers (e.g., a ministry of health or national insurance agency) communicate their service delivery priorities to providers (e.g., hospitals, health centres and community outreach sites), thus providing direction to providers to ensure that service delivery meets the desired system objectives. Both financial and non-financial incentives may be used to promote certain behaviour or to remove disincentives.

Strategic health purchasing involves strategic decisions on what to buy, from whom to buy and how to buy with pooled financial resources. It requires strong information systems for monitoring performance (i.e., to determine whether services are being delivered at the scale and quality to meet the purchaser’s expectations) and spending within public financial management systems. Strategic health purchasing comprises the core purchasing functions of specifying benefits, contracting arrangements, provider payment and performance monitoring. Additional information on strategic health purchasing and how it can be linked to nutrition services can be found in Strategic purchasing for nutrition in primary health care: Overview (2).

Strategic purchasing for nutrition in the context of strategic health purchasing for PHC could help countries to improve the coverage and quality of nutrition services delivered within broader PHC services. Essential nutrition actions (ENAs) should be delivered as part of comprehensive PHC and integrated within PHC services, as indicated in the Compendium of health interventions for universal health coverage (3). Over the past 20 years, however, only slow, modest gains have been made in coverage of life-saving nutrition interventions in comparison with the gains made more broadly within PHC, although nutrition should be integrated within PHC (4). For example, the coverage of maternal iron folic acid supplementation is significantly lower than that of antenatal care (four or more visits) in low- and middle-income countries; coverage of initiation of early breastfeeding (within 1 hour of delivery) is lower than that of delivery in a facility; and, while the coverage of community health has increased over time, screening for child wasting is often deleted from the long task list of community health workers (4, 5, 6).

ENAs should be embedded within PHC to improve the quality of both health and nutrition services and to optimize health outcomes. Integration of nutrition within PHC is not, however, enough for progress in nutrition outcomes. Determining how PHC purchasing arrangements might incentivize or disincentivize improvements in nutrition service delivery could be a critical means for improving both health and nutrition outcomes. Some countries have begun to explore approaches to making purchasing for nutrition more strategic (see section 2).

There is little documentation of how nutrition is currently included within health purchasing arrangements and little guidance on how nutrition purchasing could be made more strategic. The kinds of purchasing signals that could influence provider behaviour should be ascertained to strengthen nutrition service delivery, especially in the context of PHC. This publication offers an approach to systematic exploration of how nutrition services are purchased within PHC to facilitate the design of policy to improve nutrition service delivery. The approach builds on the framework for tracking progress developed by the Strategic Purchasing Africa Resource Center (SPARC) (7).
Unpacking strategic purchasing for nutrition

There are important considerations to keep in mind when exploring strategic purchasing for nutrition in the broader context of PHC financing.

How does strategic purchasing for nutrition fit within broader PHC financing?

Purchasing arrangements should enable PHC providers to deliver high-quality nutrition services within PHC and not to further fragment nutrition programming from PHC. Integrating nutrition into PHC is key to ensuring that ENAs are not siloed from other essential health services and for beneficiaries to receive comprehensive care. Purchasing arrangements (specification of benefits, contracting, provider payment methods) should promote integration of nutrition services into PHC by encouraging providers to deliver ENAs and meet quality standards, while also ensuring that ENA services are adequately prioritized by providers. Nutrition purchasing should not result in funding for a narrow, vertical programme.

Why should governments pursue strategic purchasing for nutrition?

Strategic purchasing could improve service quality, coverage and efficiency. It can ensure that the priority placed on ENAs is clearly communicated to providers (through specification of benefits, contracts, provider payment systems and performance monitoring indicators) and that the incentives are aligned with ENA objectives. The expected benefits of strategic purchasing for nutrition include increased coverage and quality of services with reduced costs and greater efficiency. Several countries that have used strategic purchasing approaches have found significant improvements in nutrition outcomes (8, 9). As this is a new approach in nutrition, its impact in countries that have applied it is currently not known. Identification of the constraints on service delivery (at national or sub-national level) that are addressed by strategic purchasing could help in predicting the potential impact on the quality of nutrition services.

What might leaders expect from strategic purchasing for nutrition?

Strategic purchasing is part of broader work to strengthen the quality, coverage and efficiency of nutrition services. Strengthening of purchasing should be part of a broader strategy to address health workforce shortages, limited capacity, lack of infrastructure, supply chain constraints and other system issues. While strategic purchasing could help improve these aspects, it cannot solve these problems alone. Sustainable financing strategies to raise revenue, pool resources or strengthen public financial management might have to be ensured before strategic purchasing can help to improve nutrition service delivery. More information on revenue and pooling for nutrition can be found in the World Bank discussion paper Positioning nutrition with universal health coverage: optimizing health financing levers (10).

Making purchasing for nutrition more strategic must be ensured by countries, with attention to political factors. Strategic purchasing for nutrition must be based on country needs. It requires both technical solutions and political economy. Means for making nutrition purchasing more strategic could be politically controversial (e.g., shifting how funds flow, which providers are paid and how much they receive) and should be assessed for political feasibility. Nutrition should be a government priority in order to be included in health purchasing.

Making purchasing arrangements more strategic takes time and continuous work. Purchasing reforms may be transformational and therefore not necessarily “low-hanging fruit” (i.e., easy). As different countries require different approaches, inclusive dialogue with stakeholders should be facilitated and lessons learnt documented and reviewed.
A proposed diagnostic approach for systematic assessment of how nutrition services are purchased

Purchasing for nutrition should include integration of nutrition services within PHC and not fragmentation of nutrition from PHC. Thus, the first element is identifying where and how nutrition appears within PHC purchasing arrangements, i.e., how nutrition services are purchased within PHC and whether there are opportunities to be more strategic. Following the steps described below can help to answer this question. The approach offers a practical framework for describing, assessing and improving strategic health purchasing for PHC. The intent is to document and assess how nutrition fits into broader PHC purchasing arrangements with a tested, established PHC purchasing framework (8).

The process is best implemented through a strong consultative approach. An important first step is to form a working group that represents a wide range of expertise and perspectives and with a technically credible, neutral facilitator. Stakeholders to be consulted or asked to join the working group may include representatives of the ministry of health (national and subnational; both nutrition and health leaders), health insurance or purchasing agencies (national and subnational), the ministry of finance, primary, secondary and tertiary care providers (public and private), the pharmaceutical sector, academia or research institutes and civil society.

The initial step is to understand the contextual factors, including PHC performance, health financing indicators, nutrition performance and major constraints to nutrition service delivery. This can be done in a rapid “landscape assessment” comprising document review and stakeholder consultation.

1. Take stock of the broader health financing system and identify how primary health care is currently purchased.

PHC services can be funded in a variety of ways. Many health financing systems are highly fragmented, in which a number of purchasers and programmes fund different service packages (11). Ministries of health and national health insurance agencies are often the largest purchasers, although several schemes or programmes may fund PHC services together, including at different levels of government. A practical start would be to analyse the largest or most influential PHC financing arrangements, as taking stock of all financing arrangements can be time consuming.

Increasing the nutrition services delivered through PHC might add budgetary costs to the system, although these are usually balanced by an expected positive impact on health and nutrition outcomes, as nutrition interventions are highly cost-effective (12). Decision-makers require reliable, timely information on the costs and benefits of extending nutrition services within PHC in order to make a case for such an increase. Documentation of how PHC is currently purchased should include how PHC spending is tracked (including any specific tracking for nutrition funding) and how budget decisions are made.

Key questions:

1. Which purchasers and which purchasing arrangements cover PHC?
2. Are nutrition services financed separately or as part of the PHC arrangements (or some combination)?
3. Is there a system for tracking what is spent on PHC and on nutrition services?
4. Are there systems for reviewing spending on essential nutrition actions in order to identify inefficiencies or areas for improvement (e.g., possible efficiency gains)?
5. Is information available on the cost of nutrition services, and are accurate costs reflected in provider payment arrangements?

Practical considerations:

- A sense of the broader PHC financing context is necessary for embedding research on strategic purchasing for nutrition in the context of PHC. Consider what resources are available for PHC financing, and identify experts to specify the PHC financing arrangements of interest.

- Possible focus criteria: scale of the financing arrangement (e.g., share of total health expenditure), relevance to nutrition, political importance.
2. Systematically document how nutrition is included in purchasing of primary health care according to each functional area.

Box 1 summarizes the functional areas of strategic health purchasing (13): specification of benefits, contracting arrangements, provider payment systems and performance monitoring. Each function can be designed to encourage providers to achieve certain objectives, with both financial and non-financial incentives. Evidence on these functions can help countries to identify the steps to be taken for making purchasing more strategic. Key questions to help identify and document the place of nutrition are suggested below.

Box 1. Functional areas of strategic health purchasing

- **Benefit specification:** Explicitly defining which services are included in the health benefit package and clearly stating expectations (e.g., service delivery standards, costs allowable by the purchaser, cost-sharing policies, etc.) can help promote patient access and ensure that resources are allocated to essential healthcare services.

- **Contracting arrangements:** Establishing processes and rules for selecting service providers, and strategically designing the terms and conditions of contractual arrangements between purchaser and providers, can help channel funds to high-quality healthcare services.

- **Provider payment systems:** The processes and rules for how to pay contracted providers and how much to pay them can influence quality and efficiency of care. Provider payment methods could be “prospective” (line-item budget, global budget or capitation) or “retrospective” (fee-for-service, pay for performance or per diem).

- **Performance monitoring:** Tracking providers’ performance and establishing processes to provide feedback for improvement can help inform purchasing decisions to ensure funding is spent efficiently and effectively.

See also references 8 and 14.

**Benefits specification:** This function refers to defining the services and commodities that are covered by the purchasing agency, the service delivery standards that must be achieved and cost-sharing policies. The place of nutrition services in service packages, including whether they are explicitly included as such or as components of other PHC services, may influence whether providers prioritize their delivery. Specification of benefits sends a signal to providers to make them a priority and clarifies the expected standards of care.

**Key questions:**

1. Are nutrition actions specified in the health benefits package? To what extent and in what detail?
2. Are essential nutrition actions specified as components of other PHC services (e.g., well child visits, sick child visits, antenatal care, delivery)?
3. Do providers have to meet specific standards of quality, and do they include nutrition?

**Contracting arrangements** are the systems and policies for selecting public and private providers to deliver the services that are covered, setting terms and conditions in contracts and entering into and enforcing the elements of contracts. Purchasers may require providers to meet certain conditions in order to be eligible for contracting or may favour those that do (e.g., with more favourable rates). Conditions that could promote the delivery of ENAs could include adequate equipment for nutritional assessments (e.g., scales, tapes for measuring mid-upper arm circumference and growth charts), nutrition training requirements (e.g., pre-service and in-service), inclusion of nutritionists on the staff, adequate information systems to monitor and report nutrition service delivery and outcomes and/or commodity requirements (with appropriate links to procurement systems). Another example is nutrition accreditation schemes such as the international Baby Friendly Hospital Initiative (15). Health facilities designated as “baby-friendly” are accredited and equipped to support mothers to breastfeed through hospital policies, staff training plans and supportive care plans during prenatal care, delivery and post partum (16).

**Key questions:**

4. Are providers required to meet specific nutrition accreditation conditions in order to enter into a contractual agreement or receive funding from the purchasers?
5. Are providers offered more favourable contracting opportunities or terms for meeting certain conditions related to nutrition?
6. How does this differ according to public and private sector providers?

**Provider payment systems** are the systems and policies for paying providers and setting payment rates to create the right incentives for providers to direct their behaviour towards delivering prioritized services efficiently while ensuring good quality. Payment systems could be designed to incentivize health facilities to deliver ENAs as
part of PHC delivery to promote comprehensive care. As ENAs should be delivered within broader PHC services, it is important to consider how the whole package (not just the ENA) is paid for to achieve the desired health and nutrition outcomes. In strategic health purchasing, bundling services can give providers autonomy in the best use of funding to achieve performance objectives or standards. Provider payment systems can be designed to encourage providers to deliver nutrition services of high quality through both financial and non-financial incentives. It is also important to identify potential disincentives that might discourage providers from spending time on nutrition services – for example, if no nutrition-related fees are included in a fee schedule or if higher rates are offered for other services.

**Key questions:**

7. How are providers paid for delivering nutrition services? (e.g., capitation, fee-for-service)
8. Are there any financial incentives for delivering more nutrition services (e.g., performance bonuses, fee-for-service)?
9. Is demonstration of performance in nutrition service delivery or nutrition outcomes linked to payment?
10. How do nutrition services appear in fee schedules? Which nutrition services have explicit fees?
11. How do nutrition fees compare with those for other PHC services, and could lower fees be a disincentive for delivering nutrition services?
12. Do any non-financial incentives affect delivery of essential nutrition actions?

**Performance monitoring** consists of systems and processes for tracking provider performance, providing feedback for improvement and analysing the system as a basis for purchasing decisions. Strategic purchasing links payment to information on service performance. It works only with strong systems to monitor performance and processes for quality improvement. Most countries include a minimum set of nutrition indicators in their district health information system. These data can be used with data on expenditure to monitor provider performance and thus ensure that facilities are delivering services as specified in the contract and efficiently. In a supportive environment, national governments include nutrition outcomes in national health sector performance plans with PHC outcomes (benchmark-setting) in order to hold subnational parts of government responsible for their part in achieving national goals.

**Key questions:**

13. Are effective monitoring systems in place to track coverage or the quality of nutrition services (e.g., through the district health information system)? Are these nutrition data used in health purchasing decisions?
14. For claims-based payment systems, are nutrition services or outcomes included in claims data?
15. Are there means for monitoring whether accreditation and performance quality standards are being met, and do these include indicators of nutrition?
Box 2: How nutrition services are purchased in Indonesia

Indonesia has significantly improved maternal and child health over the past 50 years, with its economic growth. Nevertheless, stunting and wasting among children under 5 years persist. Indonesia’s National Strategy to Accelerate Stunting Prevention (StraNas Stunting) was launched in 2017 to improve nutrition outcomes. Access to nutrition services prioritized in the strategy has improved since the programme was launched; however, many vulnerable groups are still not reached, and the quality of services is not optimal.

A recent review of public expenditure for nutrition in Indonesia suggested that improving nutrition outcomes depends mainly on improving efficiency in the allocation and use of resources. The Indonesian national health insurance programme, Jaminan Kesehatan Nasional (JKN), is a large single-payer programme, and the national health insurance agency (BPJS-K) is the purchaser. The country has made great strides to make purchasing for PHC more strategic under JKN, and strengthening the purchasing functions for nutrition within PHC could further improve nutrition outcomes. Examples of how nutrition is purchased in Indonesia and how those functions could be improved are described below.

- **Benefits specification:** Indonesia’s minimum health service standards are those that must be provided at district-managed health centres in order to align national and district priorities in the context of decentralized governance and financing. The inclusion of nutrition services indicates to health centre managers that they are a national priority.

- **Contracting arrangements:** BPJS-K contracts with public and private health providers that are theoretically those that meet the criteria specified by the Ministry of Health through self-regulated credentialling, which is, however, not well monitored or enforced. Health centres in every sub-district (Puskesmas) are required to have a nutritionist on staff, and all health workers are required to have training in nutrition. This is not, however, always implemented in practice, as many Puskesmas do not have a nutritionist, and there is currently no standard pre-service or in-service training in nutrition for Puskesmas or community health posts.

- **Provider payment:** Payments for PHC and nutrition care are somewhat fragmented, making nutrition purchasing less strategic. Under JKN, BPJS pays primary health facilities mainly by capitation (a fixed monthly payment based on the number of enrolled beneficiaries in a given facility catchment area), and payments for providing basic nutrition services are theoretically included in capitation. A few selected services (such as maternal health care) are reimbursed by fees-for-service through JKN, while nutrition commodities are procured by central Government budget transfers to district governments, and hospital care is reimbursed in a separate mechanism. A new nutrition budget transfer, called “DAK Stunting” can be used to pay the operational costs of implementing parts of the StraNas strategy, including cross-sectional coordination and meetings on stunting interventions.

- **Performance monitoring:** Data on nutrition service delivery are collected at national and local levels through various systems; therefore, integration of data from all sources for a complete picture of nutrition service delivery is difficult. Currently, no specific nutrition service indicators are linked to JKN incentives at primary or hospital level. Initiatives to improve access to data include “village convergence scorecards” for indicators of access to and use of nutrition services prioritized in the StraNas Stunting strategy.

For further details on strategic purchasing of nutrition services in Indonesia see reference 22.
3. Map provider incentives to determine how current purchasing arrangements influence providers’ delivery of nutrition services.

The next step is to assess the effects of existing purchasing arrangements on providers’ delivery of nutrition services and how incentives are aligned or misaligned to promote their delivery of nutrition services. This can be done by mapping provider incentives in health facilities and communities to determine how both financial and nonfinancial incentives influence the way in which nutrition services are delivered and what might encourage providers to deliver ENAs more effectively and efficiently. This type of mapping was conducted in Indonesia to determine how incentives influenced providers’ delivery of TB services (23).

Key questions:

1. To what extent and how is nutrition care currently offered as part of PHC services?
2. What clinical guidelines or standards exist for nutrition?
3. How does nutrition fit into accreditation requirements? What kind of training or continuing education is offered for nutrition services?
4. Is nutrition captured in the facility reporting and information system? How do you use this information?
5. What sources of funding does your facility receive for nutrition services? How are nutrition services typically paid for? Do you receive any incentives or bonuses for nutrition care?
6. How are nutrition commodities purchased? Are the supplies adequate? What happens if there is a stockout?
7. Are there any non-financial incentives to providing nutrition services, such as special recognition or professional development opportunities?
8. Are there any disincentives to providing nutrition services? What obstacles do you face in providing high-quality nutrition services?

Practical considerations:

- This step entails site visits to health facilities. Decisions on sampling should be made with government focal points, including, for example, the number of sites to include, the mix of public and private facilities, geographical representation and other contextual factors.
- During site visits, meetings with facility managers, health staff and nutritionists can help in answering the questions listed above.
- It may be useful to answer the questions above in the context of the care offered at the health facility from the point of entry (e.g., well child visit, sick child visit, antenatal care visit).
4. Identify potential opportunities for making purchasing for nutrition more strategic with key stakeholders.

In the final step, the technical working group should move from assessment to practical recommendations. As noted above, it is critical to ensure that information is continually shared with key stakeholders. This may be done in regular working group meetings and can be formalized in a workshop with all stakeholders to discuss the findings from steps 2 and 3, where they can discuss means to make purchasing for ENAs more strategic according to the findings of the assessment. As noted above, the workshop should include representatives with a variety of expertise and perspectives. Facilitators should support participants in agreeing on options to be explored and assessed.

The technical and political feasibility of the options should be assessed before recommendations are made. Assessment criteria could include: the costs and benefits of the change, budget impact, administrative burden, likelihood of influencing provider behaviour, expected impact on existing nutrition service delivery and political will. Discussing the pros and cons of each option and reviewing each assessment criterion will generate additional feedback for recommendations.

Country teams may find it beneficial to formalize the recommendations by creating a multi-stakeholder road map that includes priorities for policy (including rationale and expected outcomes) and the role of each stakeholder group involved in the change. The road map can be used to continue promoting policy dialogue and learning. The actions in the road map should be monitored over time.

Practical considerations:

- If concrete data are not available for the assessment of options (e.g., if data on cost and benefit are not available), countries may have to rely on assumptions or stakeholders’ expert opinions.
- Formulation of policy options and recommendations will take time. As noted above, the move towards more strategic purchasing arrangements requires continuous work, and moving through steps 1–4 to formation of policy options and reform may take several years.
- Formulation of policy options can be facilitated by the support of a technically credible, neutral facilitator.
Table 1: Summary of key questions across functional areas of strategic purchasing

Step 1. Take stock of the broader health financing system and identify how primary health care is currently purchased.

1. Which purchasers and which purchasing arrangements cover PHC?
2. Are nutrition services financed separately or as part of PHC arrangements (or some combination)?
3. Is there a system for tracking what is spent on PHC and on nutrition services?
4. Are there systems for reviewing spending on essential nutrition actions in order to identify inefficiencies or identify areas for improvement (e.g., possible efficiency gains)?
5. Is information available on the cost of nutrition services, and are accurate costs reflected in provider payment arrangements?

Step 2. Systematically document how nutrition is included in purchasing of primary health care according to each functional area.

**Benefits specification**

1. Are nutrition actions specified in the health benefits package? To what extent and in what detail?
2. Are essential nutrition actions specified as components of other PHC services (e.g., well child visits, sick child visits, antenatal care, delivery)?
3. Do providers have to meet specific standards of quality, and do they include nutrition?

**Contracting arrangements**

4. Are providers required to meet specific nutrition accreditation conditions in order to enter into a contractual agreement or receive funding from the purchaser?
5. Are providers offered more favourable contracting opportunities or terms for meeting certain conditions related to nutrition?
6. How does this differ according to public and private sector providers?

**Provider payment**

7. How are providers paid for delivering nutrition services? (e.g., capitation, fee-for-service)
8. Are there any financial incentives for delivering more nutrition services (e.g., performance bonuses, fee-for-service)?
9. Is demonstration of performance in nutrition service delivery or nutrition outcomes linked to payment?
10. How do nutrition services appear in fee schedules? Which nutrition services have explicit fees?
11. How do nutrition fees compare with those for other PHC services, and could lower fees be a disincentive for delivering nutrition services?
12. Do any non-financial incentives affect delivery of essential nutrition actions?

Conclusion

This document offers an approach for country teams to determine how nutrition services are purchased and incentivized within existing PHC purchasing arrangements. The information compiled can be used to identify means to make purchasing of nutrition services more strategic, thus optimizing funding for PHC to improve nutrition outcomes. The four assessment steps and 28 guiding questions, summarized in Table 1, may assist governments to assess alternatives, thus allowing efficiency in existing budgets to improve the delivery of nutrition services and taking stock on how the purchase of ENAs and incentivization in PHC can be improved.

Strategic purchasing must be part of broader efforts to strengthen nutrition services, which must be country-driven, with attention to political factors. Purchasing for nutrition should enable integration of nutrition services within PHC and not fragment nutrition from PHC. Identifying the constraints to nutrition services delivery that should be addressed by strategic purchasing could predict the potential impact on the quality of nutrition services.
### Performance Monitoring

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<td>13.</td>
<td>Are effective monitoring systems in place to track the coverage or the quality of nutrition services (e.g., through the district health information system)? Are these nutrition data used in health purchasing decisions?</td>
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<td>Are there means for monitoring whether accreditation and performance quality standards are being met, and do these include indicators of nutrition?</td>
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### Map provider incentives to determine how current purchasing arrangements influence providers’ delivery of nutrition services.

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<td>1.</td>
<td>To what extent and how is nutrition care currently offered as part of PHC services?</td>
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### Identify potential opportunities for making purchasing for nutrition more strategic with key stakeholders.

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<td>Moving from assessment towards practical recommendations:</td>
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<td></td>
<td>Potential options should be assessed according to their technical and political feasibility before recommendations are made.</td>
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<td>The recommendations should be formalized by creating a road map with stakeholders that includes priorities for policy and the role of each stakeholder group involved in the change.</td>
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STRATEGIC PURCHASING FOR NUTRITION IN PRIMARY HEALTH CARE: A PROPOSED DIAGNOSTIC ASSESSMENT APPROACH


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