Save the Children

INVESTING IN MATERNAL AND CHILD HEALTH: DEVELOPMENT IMPACT BONDS

POTENTIAL AND EARLY LEARNING

SEPTEMBER 2018

Save the Children

Save the Children works around the world to give children a healthy start in life, and the chance to learn and to be safe. We do whatever it takes to get children the things they need – every day and in times of crisis.

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Foreword

Results-based financing. Pay for performance. Milestone-based payments. Conditional cash transfers. *Development impact bonds*. The labels and tactics have evolved over time, but the fundamental objective remains the same: payment based on the attainment of results.

Impact bonds — sometimes referred to as Social Impact Bonds (SIBs) or Development Impact Bonds (DIBs) — are a relatively new tool in the financing toolkit of development practitioners. Leveraging private-sector characteristics, these multi-stakeholder agreements are designed to help finance critical social and economic programs through a combination of government or donor initiatives, private investments, and social service provisions.

Governments or donors explicitly define, *upfront, what measurable outcomes* constitute success, and then only pay *if those measurable outcomes are achieved* and independently validated.

Structured correctly, impact bonds have the potential to save substantial taxpayer dollars, creating win-win scenarios that bring added efficiency and private-sector rigor to public-sector programs. But context is key, and DIBs are not a catch-all solution. Conditions for use include the identification of outcomes that are meaningful, measurable and attributable to the intervention being provided. Should these conditions be met, impact bonds have also been shown to provide an additional level of transparency: They allow governments or donors to measure what they are paying for, hold service providers accountable for outcomes, and only compensate for successful execution.

Even the most ardent supporters admit that while impact bonds are often heralded as an exciting and potentially game-changing financing model, they are still in infancy. The first impact bond was developed in this decade to address prison recidivism in the United Kingdom. Since then, more than 100 impact bonds have been launched worldwide. The growth trajectory is promising. But results often take years to achieve, and most of these projects require time to be completed and properly evaluated.

In maternal and child health, we are excited to see promising new examples of impact bonds being utilized in low- and middle-income countries, such Cameroon and India. The Cameroon Newborn DIB and the Utkrisht Maternal and Newborn Survival DIB in India are both featured in this report.

During my time at USAID, I spent more than two years developing the Utkrisht Maternal and Newborn Survival DIB with our partners. As the evidence base for these new pay-for-success financing models grows, we are optimistic that their unique value proposition will add new sources of funding from governments, donors, investors and private philanthropists alike.

Supported by in-depth case studies, this report provides a thorough examination of the challenges and opportunities of impact bonds in the field of maternal and child health, and international development writ large. We hope that by collecting and sharing the experiences of the many partners involved in these two projects, this report can serve as a starting point for a deeper conversation and movement towards future action to save maternal and child lives.

Joseph Wilson
Senior Advisor (former)
USAID, Center for Accelerating Innovation and Impact

Grina Antonio recently gave birth to an unnamed newborn baby. She had spent several days at the neonatal ward at Queen Elizabeth Hospital, Malawi.

Photo: Save the Children

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Executive Summary

The global decrease in child and maternal deaths is one of the great achievements in international development in recent decades.

Child mortality rates have fallen by more than half, from 12.7 million under-5 deaths in 1990, to 5.6 million in 2016. U.S. leadership and foreign assistance played instrumental roles in this achievement, saving the lives of millions of children around the world.

But preventable maternal and child deaths are still too high. Globally, 15,000 children continue to die each day from causes that are often preventable, such as pneumonia, diarrhea, and malaria.

The global health community knows how to reduce maternal, newborn, and child deaths, but continued progress faces a financing gap. Proven life-saving interventions are only effective if there are resources to disseminate them and increase their scale.

To fulfill its commitment to work toward ending preventable child and maternal deaths by 2030, the U.S. government should explore innovative financing tools that engage new stakeholders – particularly from the private sector – and unlock new resources. At the same time, U.S. foreign assistance will continue to play a key role in supporting maternal and child health in the poorest and most conflict-affected regions, as innovative financing is not intended to replace international development funding, but rather to supplement it with new thinking, models, and means.

One of the key objectives of DIBs is to attract new investors through financial incentives, such as earning a profit by investing in a development outcome. At the same time, DIBs aim to attract new stakeholders to international development through reduced risk: Public sector and philanthropic entities are guaranteed that they will only spend their funds on successful interventions.

Presented in this report are analyses of two case studies of DIB projects in the field of maternal and child health and survival. Information is based on in-depth interviews with stakeholders about the experiences, challenges, lessons learned, and potential to create new DIBs in this area.

This report is intended to contribute to the growing evidence base on DIBs. It focuses *on the process of formation*, which will allow potential stakeholders to better understand and, where appropriate, use DIB financing for maternal and child survival (MNCS) interventions.

Specifically, we analyze the following two MNCS development impact bonds:

- **A project in Cameroon that seeks to extend Kangaroo Mother Care training for newborns in private and public hospitals; and**
- **A statewide project in Rajasthan, India, aimed at improving the quality of maternal care in private healthcare facilities**

Based on these two case studies, we have developed the following recommendations for the U.S. government and other potential stakeholders to engage in DIBs.

1) DEVELOP A CENTRAL DIBS PLATFORM

Since DIBs are a nascent development finance tool that involve a complex and new array of development stakeholders, they need a more coherent system for aligning varied interests. Specifically, the sector needs ***a central DIBs platform*** where entities interested in taking on one of the various DIB roles can coalesce. These entities may include investors, outcome funders, intermediaries, evaluators, and local and international implementers.

As the case studies below demonstrate, and as one respondent stated, "Doing DIBs ad hoc doesn't work." Given its leadership on global maternal and child health, the United States can use its convening power to assess the nature and utility of a global platform to facilitate DIB supply and demand. The U.S. is well positioned to convene stakeholders on this issue. Just as it was a leader in the creation of the Global Financing Facility, the U.S. could also lead the creation of a DIB hub.

2) CONVENE AND EDUCATE INTERNAL AND EXTERNAL STAKEHOLDERS

While a central platform is a long-term tool to mainstream DIBs, a short-term need is for ***potential stakeholders to be***

A beneficiary of Kangaroo Mother Care in Bungoma district Hospital, Kenya.

Photo: Allan Gichigi

educated about what DIBs are, as well as about where, how, and when they can address the maternal and child health goals of donors, philanthropists, and others. There are still many misconceptions regarding DIBs, and these need to be demystified for DIBs to be taken up more broadly.

Given its focus on innovative finance, USAID should convene – both within the U.S. government and with its global donor peers – DIB knowledge exchanges. For example, there is already a pay-for-success inter-agency group focused on domestic impact bonds within the U.S. government. As the leading U.S. development agency, USAID should draw from their experience to educate both U.S. government and international donor community practitioners on how to apply DIBs to foreign assistance challenges.

3) INCREASE THE EVIDENCE BASE ON WHAT WORKS FOR DIBS

MNCS DIBs need a more substantial evidence base. More learning on DIB formation and field impact is needed across the board. DIBs are in the early stages of implementation and evidence building. Ensuring rigorous program evaluations – and disseminating evidence and learnings on the formation process and outcomes – will be important in strengthening the DIB model and building confidence among risk-averse organizations.

4) INSTITUTIONALIZE INNOVATION WITHIN USAID

The U.S. government must signal its commitment to innovation on maternal and child health. ***To accomplish this, the Administration should provide high-level political support for the Center for Accelerating Innovation and Impact (CII)***. The CII resides in USAID's Global Health Bureau and invests seed capital in promising ideas, using a business-minded approach to the development of health interventions.

USAID should empower CII and direct the various USAID missions and program offices within the Bureau for Global Health to devote a small percentage of their annual funding to programs that use CII's development finance expertise. Building and strengthening CII's consulting work within USAID can help integrate its expertise throughout all global health programs.

Introduction

Since 1990, the United States has played a leading role in the global initiative to reduce mortality rates for children under 5. Partly as a result of this U.S. leadership, these rates have fallen by more than half, from 12.7 million under-5 deaths in 1990, to 5.6 million in 2016.[1] Maternal mortality rates are also improving. Between 1990 and 2015, global maternal mortality rates declined by 44 percent, from 385 deaths per 100,000 live births to 216.[2]

Millions of mothers and children now live healthy, productive lives due to this global movement to reduce preventable maternal and child deaths. In spite of this tremendous progress, however, maternal and child deaths are still too high: 15,000 children continue to die each day, often from preventable causes such as pneumonia, diarrhea, and malaria.[3]

The interventions needed to reduce maternal, newborn, and child deaths are well known, as well as backed by strong evidence. Experts attest that while the goal of ending preventable child and maternal deaths (EPCMD) is ambitious, it is achievable if these interventions are implemented where they are needed most. Extending these live-saving interventions to the world's most vulnerable children is a central goal of Save the Children.

The global progress made to date would not have been possible without the United States. Despite this generosity, continued progress on maternal, newborn, and child health (MNCH) is challenged by a significant financing gap. In 2016, international development assistance among major donors reached almost $143 billion. However, given the array of development and humanitarian funding needs, this is not enough to fully fund the Sustainable Development Goal 3 target of ending preventable child deaths.[4] According to the World Bank, achieving the Sustainable Development Goals (SDGs) related to maternal, newborn, child, and adolescent health requires an additional $33 billion annually.[5]

Domestic Resource Mobilization (DRM) is the largest and most sustainable source for nations to improve maternal and child health and survival**.** DRM is the process through which countries raise and spend their own funds to provide for their own people.[6] This primarily includes nations' tax systems, which generate revenues that pay for basic services, including those pertaining to maternal and child health care. The potential of DRM to generate resources for reducing maternal and child deaths is massive. In 2012 in developing nations alone, DRM generated $7.7 trillion for national treasuries, an annual increase of $6 trillion since 2000.[7] Increasing and allocating DRM efficiently and fairly is a central part of achieving the SDGs' MNCH goals. A number of emerging global agreements, such as the Addis Tax Initiative, intend to scale-up donor and developing nations' commitments to DRM.[8]

Overseas Development Assistance (ODA) is also crucial to saving maternal and newborn lives. But globally, ODA allocations are increasing only incrementally, with little prospect for the large increases needed to achieve major reductions in maternal and child mortality. For its part, U.S. foreign assistance mirrors this global trend and has not significantly increased in recent years. In 2016, U.S. overseas development assistance (ODA) was about $33 billion, roughly the same amount as in 2005.[9] Moreover, due to statutory budget constraints, the current trajectory of U.S. ODA is unlikely to increase significantly in the near future.

To fulfill its commitment to end preventable child and maternal deaths by 2030, the U.S. government must address this financing gap by exploring innovative financing tools to engage new stakeholders – particularly in the private sector – and unlock new resources.

While ODA will continue to be central to developing nations' funding of MNCH, it is no longer the dominant source of capital in an increasing number of USAID global health priority countries. Historically, nearly $3 out of every $4 sent from the United States to developing countries was in the form of ODA. However today, more than 80% of U.S. resources going to emerging and developing economies is in the form of foreign direct investments, remittances, and private philanthropy.[10] Innovative finance – alongside DRM and ODA – has the potential to close the financing gap and extend life-saving interventions to the world's most vulnerable mothers and children.

- **Innovative Finance:** Innovative finance has various definitions, but it often includes engaging the private sector to achieve a desired social outcome.[11] USAID describes innovative finance as, "approaches to mobilize resources and to increase the effectiveness and efficiency of financial flows that address global social and environmental challenges." The agency states that this definition incorporates two distinct functions of innovative financing:

  1) Generating a complementary source of capital for traditional development financing; and

  2) Making development more effective and efficient by redistributing risk, improving the availability of working capital, and matching the length, or tenor, of investments with project needs.[12]

Gerardo, 36, holds his baby boy in Kangaroo position at their home in Bosa, Bogota.

Photo: Erika Pineros

Within the broad and varied definition of innovative finance, there are multitudes of specific mechanisms, which include, but are not limited to: credit guarantees, pooled investments, market shaping programs, and development impact bonds. Analysts have estimated that innovative financing models have mobilized more than $100 billion for international development since 2000.[13] Given the global potential of the private sector, this represents only a fraction of the amount of capital that could be harnessed to address the world's pressing health and development problems.

A NEW FINANCING FRAMEWORK FOR HEALTH

Due to this large financing gap and the untapped potential of the private sector, the U.S. should use its position as the largest bilateral donor in the world to catalyze investments from other sources. USAID is starting to demonstrate leadership on this front in terms of recognizing the need for new and alternative sources of finance to enhance maternal, newborn, and child survival.

At the 2014 U.S.-Africa Leaders' Summit, USAID committed to developing a framework to reduce existing EPCMD financing gaps. This framework was subsequently launched in July 2015, designed to educate USAID missions—primarily those comprised of health and development experts—about the underlying economic problems that may be hindering progress in improving public health. It also provides information about a variety of innovative financing mechanisms that may be used to address these problems, as well as how USAID mission staff can access assistance in carrying out these mechanisms, including DIBs.

Current USAID leadership also supports these efforts. Administrator Mark Green launched USAID's first development impact bond in November 2017 in the state of Rajasthan, India (named the "Utkrisht" bond for the Hindi expression for excellence). The Utkrisht bond, which is analyzed below, focuses on maternal healthcare facilities.

At the official bond launch, Green said, "This results-based financing mechanism…takes a business approach to development, while still targeting basic needs like improving the quality of care and private facilities. By leveraging the assets and skills of a diverse group of partners across the public and private sectors, we are stretching our investments further, while saving more lives."[14]

In Congress, members of both chambers and parties have demonstrated interest in USAID's innovative finance efforts. The bipartisan Reach Every Mother and Child Act of 2017 – a proposed bill to make improvements to USAID EPCMD – not just encourages USAID to explore and implement pay-for-success contracting, but makes it easier to do so.[15]

Development Impact Bonds

The main goal of a DIB mechanism is to attract private capital to social projects, and for private investors to earn a profit if the social outcome is achieved. The DIB structure ensures that governments, donors, or other outcome funders in international MNCS projects, will pay for interventions *only if they are deemed to be successful by an independent evaluator* – hence the moniker *pay-for-success*. By offering a potential profit to investors, plus guaranteeing the security of impact for outcome, DIBs have the long-term potential to attract additional public and private stakeholders to international development.

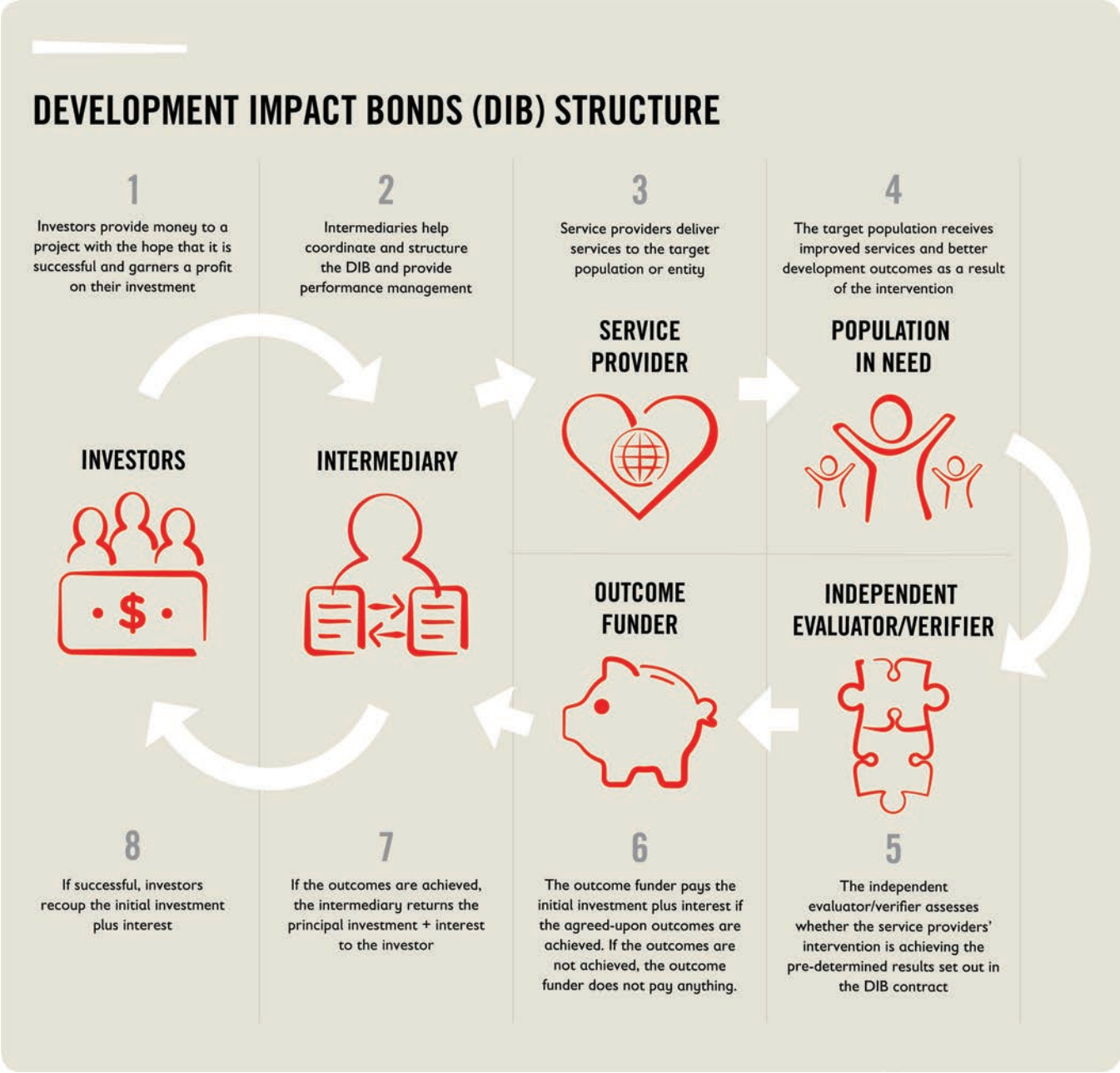
Furthermore, unlike much current international development funding, DIBs focus on outcomes, rather than inputs or outputs. By guaranteeing that outcome funders only spend resources on successful projects, DIBs require rigor and focus on the impact of development.

DIB STAKEHOLDERS: ROLES AND INTERESTS

DIBs can take a number of forms depending on the local circumstances, type of intervention, array of stakeholders, and other variables. While they are designed to attract private finance into development projects, the donor agencies, multi-lateral organizations and philanthropists also become engaged as investors (See below.). Generally, DIBs consist of an outcomes-based contract involving the following set of stakeholders:

- **Outcome funders** are typically donors or multilateral agencies (for example, USAID or the World Bank) who pay the project investors if, and when, the previously agreed upon project outcomes are achieved. The outcome funder is not involved in program delivery, but provides the funding to pay if the DIB goals are achieved. Outcome funders also typically pay for the project evaluation or verification (See below.). The outcome funder is informed regularly about the intervention's progress and is committed to paying only for independently verified, pre-determined results or outcomes. The outcome funder is also sometimes called the outcome payer. The terms are interchangeably in this report.
- **Investors** provide the initial investment and ongoing project capital to cover DIB costs. Since outcome funders only make payments if pre-determined results are achieved, investors bear the risk of failure (as well as a chance to earn a profit). The alignment of investors' financial returns to the achievement of results means there is strong incentive for investors to support effective performance management.
- **Service providers** implement the DIB intervention. While it is possible to have only one service provider, the complexity of DIBs often means there are multiple, coordinated service providers, such as an INGO working with a local implementer.
- **Project designers or DIB managers** help coalesce stakeholders and provide performance management and analytical support to the outcome funders and investors. This role is also often referred to as the **project intermediary.** The DIB manager oversees the delivery of agreed outputs and outcomes, continuously analyzing service delivery and outcome data, while guiding the work of service providers, including shifting resources as needed. The manager is typically remunerated by investors via an annual fixed fee for service, alongside a performance-related fee.

Other key DIB stakeholders include **independent evaluators**, also called **independent verifiers**, who determine if the project has achieved its pre-determined metrics and if payouts from the outcome funder to the investor are due. Some projects also include a **project advisory committee.**



THE POTENTIAL OF DIB FINANCING FOR MATERNAL, NEWBORN, AND CHILD SURVIVAL

- **DIBs transfer risk from donors.** Donor agencies and other organizations involved with a DIB as outcome funders will pay only if the outcome is independently deemed successful. This allows USAID, the World Bank, and foundations that take on the outcome funder role to ensure their dollars are spent wisely.
- **DIBs have the potential to increase efficiency and reduce waste.** By linking payment to outcomes rather than inputs, service providers are incentivized to better manage their resources. Ideally, ineffective approaches will be ended or altered more quickly, reducing inefficiency and waste.
- **DIBs can facilitate country investment.** DIBs can pilot proven interventions, in new contexts, to provide "proof-of-concept" for developing country governments

A nurse tends to a premature child in an incubator at the intensive care unit in San Ignacio Hospital in Bogota, Colombia.

Photo: Erika Pineros

wary of investing scare public dollars. By piloting an intervention through a DIB, donors and investors can provide assurance that the intervention generates the desired outcomes, providing confidence for governments to subsequently own, manage, and scale up the intervention.

The DIB structure can also protect taxpayer dollars from being wasted. For example, when USAID is an outcomes funder, a DIB protects U.S. tax dollars from being spent on ineffective programming. If the program doesn't deliver the desired results, the U.S. government is not on the hook to pay.

A BRIEF HISTORY OF IMPACT BONDS

The DIB model is new and, therefore, there is limited evidence of its effectiveness. As of September 2017, there were only three DIBs with operational experience.[16] DIBs, however, are similar in design and intention to social impact bonds (SIBs) and are modeled after them. SIBs are designed to overcome the challenges governments have in investing in prevention and early intervention. They mitigate the risks of failure and bring in investors that provide flexible funding to programs designed to be responsive to the needs of vulnerable groups.[17]

The NGO Social Finance UK developed the SIB model. It launched its first SIB in 2010, aimed at reducing recidivism in Peterborough, UK.[18] Social Finance and others define the difference between SIBs and DIBs as this: *SIBs have governments as the primary outcome payer, while DIB outcome payers often include an international donor.*[19] While still in their early days, SIBs have shown some evidence of success in the United Kingdom. The Peterborough, UK, SIB noted above focused on reducing recidivism and was deemed a success by independent evaluators.[20]

There has been much more experience with SIBs than with DIBs. To date, almost $400 million has been invested into more than a 100 SIBs in 19 countries.[21]

Report Goals

Given that there is little operational experience with which to assess the impact of DIBs, this report focuses primarily on the *DIB formation process*: the geographic and sector scoping, coalescing of stakeholders, and subsequent design and negotiations of the DIB contract. The bulk of this report is devoted to identifying and analyzing learnings from two MNCS DIBs:

- **Cameroon Newborn DIB.** The primary goal of this DIB is to expand Kangaroo Mother Care (KMC), a proven, cost-effective intervention for low-birthweight infants. In Cameroon and much of the world, access to KMC--despite its proven efficacy--remains low, due to a variety of financial and implementation barriers. These include inadequate hospital infrastructure and equipment, lack of qualified trained personnel, and insufficient awareness of KMC (Described below.). While the project stakeholders continue to seek an investor, two outcome funders for the project have committed $2.8 million to the project.[22]

  This DIB – which is still being formed and has not yet been implemented – aims to expand quality KMC to the four or five regions in Cameroon with the highest infant mortality levels. While the program is still in the design phase, the DIB is expected to result in KMC being implemented in up to 9 hospitals in these regions, which could help reach 4,500 additional low-birthweight children.[23] In addition, the Cameroon Newborn DIB includes the rollout of KMC to additional regions and hospitals over a three- to four-year period.

  The Cameroon Newborn DIB includes a rigorous outcome measurement framework, intended to create a replicable model for scaling up access to KMC in other countries. Such a model could have positive implications for other low- and middle-income countries suffering from high rates of low-birthweight newborns and preterm infant mortality.

- **Utkrisht Development Impact Bond in Rajasthan, India.** This DIB seeks to improve and standardize the quality of maternal care in private healthcare facilities in the state of Rajasthan. The project will take place over three years, with a total investment of $9 million ($1 million of which is set aside for results verification).[24] Rajasthan has one of the highest maternal and neonatal mortality rates in India, which researchers attribute to a lack of quality facilities. While public facilities are subject to government quality standards, private facilities are not required to meet these standards.

  The safety and quality of private healthcare facilities in Rajasthan will be enhanced by making improvements designed to help each facility achieve government-approved accreditation, based on its ability to meet specific quality standards for maternal care. Project partners will guide facilities through quality improvements to meet these standards, as well as to complete the accreditation application process. The intervention is intended to impact 200,000 to 400,000 women and newborns annually, and to save the lives of up to 10,000 women and children over five years. It is also designed to be catalytic, with the Rajasthan government expressing interest in financing the program after the initial three-year project cycle.

RESEARCH METHODOLOGY

This report is intended to provide an initial assessment on the process of forming two MNCS DIBs, as well as to assess their challenges and potential. This is not a formal program evaluation. It is an analysis of the challenges and facilitating factors identified by stakeholders themselves, through their own experience creating the DIBs. In order to extract and communicate the key issues of interest to potential stakeholders and policymakers, we organized our analysis according the following five key DIB components:

- **Project Objectives:** The goals of the project in terms of improving MNCS outcomes in the targeted population and project geography. This includes quantitative measures of project impact as provided through stakeholder interviews and a review of project documents. Projected costs are also included in this section.

Financial difficulties make it harder for families to attend check-ups, so the Kangaroo Foundation facilitates home visits for follow-up.

Photo: Erika Pineros

- **Project Stakeholders:** A description of all the key stakeholders for the DIB being analyzed. This section includes background on how and why stakeholders chose to participate in the DIB, seeking to discern their motivations through in-depth interviews. Since not all stakeholders have been identified for both DIBs, the report does not include an exhaustive list of all stakeholders. This section also analyzes how the stakeholders were brought together, as well as identifies the key facilitating factors for DIB formation.
- **Project Potential:** This section examines how the stakeholders view the potential of the DIB to transform their organizations, impact MNCS in the project target area, and transform international development broadly.
- **Project Challenges:** While this report is intended to communicate early findings on what works in terms of building a DIB for MNCS, we also analyze the challenges to forming an MNCS DIB in a new, unstructured, and evolving market.
- **Lessons Learned:** This section combines findings from both DIBs on key lessons learned in terms of the DIB formation process.

DATA COLLECTION AND ANALYSIS

This case study research was developed through two primary qualitative data analysis methods:

- To ground our analyses, we began our research with a **review of relevant secondary documents**, including project documents from the two DIBs, project stakeholder documents, and existing research on DIBs. This review provided background and context on the goals, scope, and nature of the interventions, and on the DIBs context globally.
- The large majority of data and analyses in this report were generated through **in-depth, semi- structured interviews with DIB stakeholders**. Interviews were conducted remotely and in person, and were organized and coded for qualitative analysis of key themes, according to the analytical framework discussed above. Eight stakeholders were interviewed for the Rajasthan maternal care DIB, and six stakeholders were interviewed for the Cameroon Newborn DIB. All interviews were conducted between August and December 2017.

The prevalence of themes across interviews was assessed by a simple thematic coding and counting procedure. Following analysis of the interviews and recurring themes, we incorporated quotes and other materials. Draft reviews of the report were also shared with respondents and external experts for their input, prior to publication.

Maternal, Newborn, and Child Survival DIB Case Studies

Cameroon Newborn Development Impact Bond

In 2015, Cameroon had an under-5 mortality rate of 88 per 1,000 live births. While this represents a 36% decline from its 1990 rate of 138, Cameroon is still burdened with Africa's 19th highest rate of under-5 mortality. There were 71,000 under 5-children deaths in Cameroon in 2015.[25]

Newborns – children less than 28 days old – are a subset of under-5 children. They face specific mortality challenges and respond to specific interventions. Globally, even as child deaths overall have decreased, there are approximately 7,000 newborn deaths every day, amounting to 46% of all child deaths under the age of 5 years.[26]

In Cameroon, the newborn mortality rate is 26 per 1,000 live births.[27] Among these newborns, 60-80% of deaths are due to low birth weight (LBW). LBW continues to plague newborns in Cameroon in spite of overall progress on maternal and child survival, while LBW and preterm birth are the leading causes of under-5 child deaths worldwide and in Cameroon.[28]

Kangaroo Mother Care (KMC) was developed in Colombia during the 1970s as a cost-effective intervention suited to low-resource areas like those in Cameroon. Named for its similarity to how marsupials carry their young, KMC was designed specifically for preterm infants in countries where incubators were either unavailable or unreliable. KMC involves long periods of skin-to-skin contact between child and caregiver, along with exclusive breastfeeding.

The Kangaroo Foundation Colombia (KFC) was created in 1994 and has trained more than 75 teams from 35 countries. Newborns and infants who receive this type of care are typically discharged from the hospital earlier. It has also been shown to effectively reduce both infant mortality and hospital-acquired infections.[29]

PROJECT OBJECTIVES

In addition to being the leading causes of newborn death, LBW and preterm births can lead to high incidences of health complications. Even when a child survives, these complications can create additional negative health outcomes, many of which can last into adulthood.

KMC was first implemented in Cameroon by the KFC in 1998, through a training of pediatricians and nurses from the La Quintinie Hospital in Douala. This led to the creation of the Kangaroo Foundation Cameroon in 2015, but access to KMC in Cameroon is still limited due to financial and implementation barriers, including inadequate hospital infrastructure, equipment, and protocols; lack of ongoing KMC training and support for personnel; and insufficient awareness of KMC.[30] Furthermore, widespread dissemination of KMC was hampered by its lack of integration into the local health system and the retirement of key KMC-trained personnel.[31]

Scaling up KMC to reach more preterm and LBW infants is included in the Cameroon Ministry of Public Health's current five-year operational action plan for improving newborn health. The main goals of the $2.8 million, three-to four-year Cameroon Newborn DIB are to:

1) Roll out KMC in up to 9 hospitals across four or five regions in Cameroon, with the ultimate outcome of significant and verifiable improvements in LBW infant health. Intermediate outcomes include lower evidence of severe infection like sepsis, as well as above-average weight gain. Project stakeholders anticipate reaching up to 4,500 LBW children through the intervention.

2) Integrate high-quality KMC into Cameroon's public healthcare system to ensure the DIB investment's long-term sustainability, including further expansion to hospitals nationwide.

CAMEROON NEWBORN DIB

$2.8 million total project budget

The project will be implemented across four or five regions in Cameroon

The project will focus on train-the-trainer methods in up to 9 hospitals in the five regions

Project stakeholders intend to reach up to 4,500 LBW newborns through the intervention

PROJECT STAKEHOLDERS

The Cameroon Newborn DIB has not yet been implemented. It is still in the formation phase. The main challenge over the past year has been to secure commitments from an investor. Grand Challenges Canada (GCC) initially sought to play the outcome funder role in the project, but due to the difficulty noted above, decided to take on the investor role, for which it is now in the advanced stages of due diligence. This section describes the process and history of the formation of the DIB, with a focus on how the DIB was conceptualized, key project stakeholders, challenges creating the DIB, and its potential in terms of impact.

Outcome Funders

Ministry of Public Health, Cameroon (via the Global Financing Facility)
Nutrition International

Ministry of Public Health, Cameroon (via the Global Financing Facility)

Encouraging country ownership is an important goal of the Cameroon Newborn DIB, and it includes the active participation of the Government of Cameroon (GOC). Part of the impetus for the DIB came from the GOC's own priority to improve newborn health. As a part of the Global Financing Facility (GFF), Cameroon generated an investment case to improve maternal and child survival – specifically to improve newborn health and reduce newborn mortality.

Dr. Martina Baye, Coordinator of Cameroon's National Program to combat Maternal Newborn and Child Mortality at the Ministry of Public Health, said the available funding for Cameroon through the GFF made a DIB particularly appealing. "Using a DIB, we are sure of attaining the results," Baye said. "It's not like other funding, where you look for results that you may or may not have."

The Cameroon Ministry of Public Health (funded by the GFF, which is hosted by the World Bank) will play the role

of an ***outcome funder*** in the DIB, contributing $2 million to pay the investor if the outcome is achieved.[32] Canadian INGO Nutrition International (See below.) are also outcome payers, committing $800,000 each for a total outcome commitment of $2.8 million.

The interests of the government of Cameroon to use a DIB to extend KMC coincided with that of the Kangaroo Foundation Colombia – the originator and propagator of KMC globally – who already had a history of working with the government on KMC in Cameroon. After years of providing KMC technical assistance and capacity building in the country, KFC Director Dr. Nathalie Charpak spoke with Grand Challenges Canada about ways to use innovative finance to further extend and embed KMC in the Cameroonian healthcare system.

Nutrition International

The second outcome funder for the project is Nutrition International (NI), an Ottawa-based INGO focused on global malnutrition. Increasingly interested in innovative finance, NI was drawn into the Cameroon Newborn DIB in 2016 as a prospective project partner, approached by Grand Challenges Canada. "We see KMC both as a health intervention and a nutrition intervention," NI Portfolio Director Erik Nielsen said. "We saw this as a way to be able to use our money to prioritize nutrition." Given their close relationship with GCC, their focus on nutrition, and the emphasis on innovative finance, NI committed to the project as an ***outcome funder***.

Service Providers

Kangaroo Foundation Cameroon
Laquintinie Hospital
Kangaroo Foundation Colombia

One of the major reasons Cameroon's KMC work was selected for a DIB intervention was the strength of the evidence supporting its efficacy. While DIBs' contracting, coordination, managerial, and legal structures are complex, the actual MNCS intervention financed by the DIB – KMC – is proven.

The ***service providers*** for the Cameroon Newborn DIB – the Kangaroo Foundation Cameroon, the Kangaroo Foundation Colombia, and Laquintinie Hospital – are all experienced with KMC. The Kangaroo Foundation Cameroon will lead the training in partnership with Cameroonian government hospitals, with the support of a DIB manager.

The Kangaroo Foundation Colombia has a long history working on KMC in Cameroon. Beginning in 1998, KFC trained pediatricians and nurses from Laquintinie Hospital in Douala. But because the KFC practice was not integrated into the local health system, the expertise disappeared when the Laquintinie Hospital pediatric unit chief retired.

More recently, in 2015, GCC supported a KFC project that resulted in the creation of a KMC center of excellence in Douala, along with the creation of the Kangaroo Foundation Cameroon. KFC collaborated with the other project stakeholders on the DIB design and the development of the project indicators, and it will continue to provide technical support to the Kangaroo Foundation Cameroon during implementation.

OUTCOME FUNDERS

Cameroon Government drawing on the GFF Trust Fund (managed by the World Bank) committed $2 million

Nutrition International committed $800 thousand

POTENTIAL INVESTOR

Grand Challenges Canada

ADDITIONAL STAKEHOLDERS

Cameroon Ministry of Public Health: Providing operational support and has integrated commitments to extend KMC coverage into its national health plans

Kangaroo Foundation Cameroon: Will implement the train-the-trainer model by providing KMC training to health staff in target hospitals

Kangaroo Foundation Colombia: Will provide technical support to the Kangaroo Foundation Cameroon

DIB management team: To oversee DIB implementation and performance management, based in Cameroon

MaRS Center for Impact Investing and Social Finance: Will design and take the DIB to launch, and where appropriate, provide support to the DIB in-country team on performance management, analysis and reporting to outcome funders and investors

DIB Advisory Council The DIB Advisory Council provides ongoing support on DIB design and includes external experts from the **Gates Foundation, UNICEF, the Children's Investment Fund Foundation, and the London School of Hygiene & Tropical Medicine**

Project Intermediaries

The MaRS Centre for Impact Investing
Social Finance UK

With a large and diverse array of stakeholders, DIBs require strong project management. The Cameroon DIB has two main ***project intermediaries***: The MaRS Centre for Impact Investing – a Toronto-based consultancy that previously advised GCC – and Social Finance, a UK-based nonprofit advisory organization that developed the first impact bond in 2010.

Given its previous partnerships with GCC, the MaRS Centre recommended the GCC-supported KMC work in Cameroon as ideal for scale up through a DIB. "They were looking to scale this through an outcomes-based, data-driven, pay-for-success model," MaRS Centre Senior Associate Kia Kavoosi said. "KMC came to the top because of its strong evidence base. It's quite important in this model to have that." Social Finance, which also had a previous relationship with GCC and the MaRS Centre, was subsequently brought into the DIB design team due to its history pioneering impact bonds.

Investor

Grand Challenges Canada

Funded by the Government of Canada and other partners, Grand Challenges Canada (GCC) supports development innovators in low- and middle-income countries. GCC's Karlee Silver said the Cameroon Newborn DIB was a strong fit for her organization's focus on supporting "bold ideas for big impact" in global health. Silver said there is also a growing focus at GCC on how to integrate innovative financing models to support these goals. "Our mandate for the last seven years has been how to scale the most promising ideas out there to overcome the largest health challenges," she said.

As Silver and GCC reviewed their portfolio for potential DIB projects, the Kangaroo Foundation Cameroon's work stood out for its strong evidence base. "KMC has been known for ages. There's lots of evidence behind it on the mortality front, a unique amount of evidence," Silver said. "But there's a real block in terms of how to actually scale it. Those were our two starting points." After deciding on the KMC project, GCC eventually initially considered the role of outcomes funder, but eventually decided to take on the ***investor*** role.[33]

Evaluator

The project team is has also identified a Cameroon-based ***independent verification agent*** – a key position responsible for assessing whether the pre-determined outcomes were met, and if payments to the investor are due. As of August 2018, the project team was finalizing the the scope of work and service agreement with the local evaluator.

PROJECT POTENTIAL

The Cameroon Newborn DIB is still in the design phase, with plans to launch in the second half of 2018. Feasibility studies for the DIB began in 2015 and, if the project is implemented as planned, will be completed in 2022.[34]

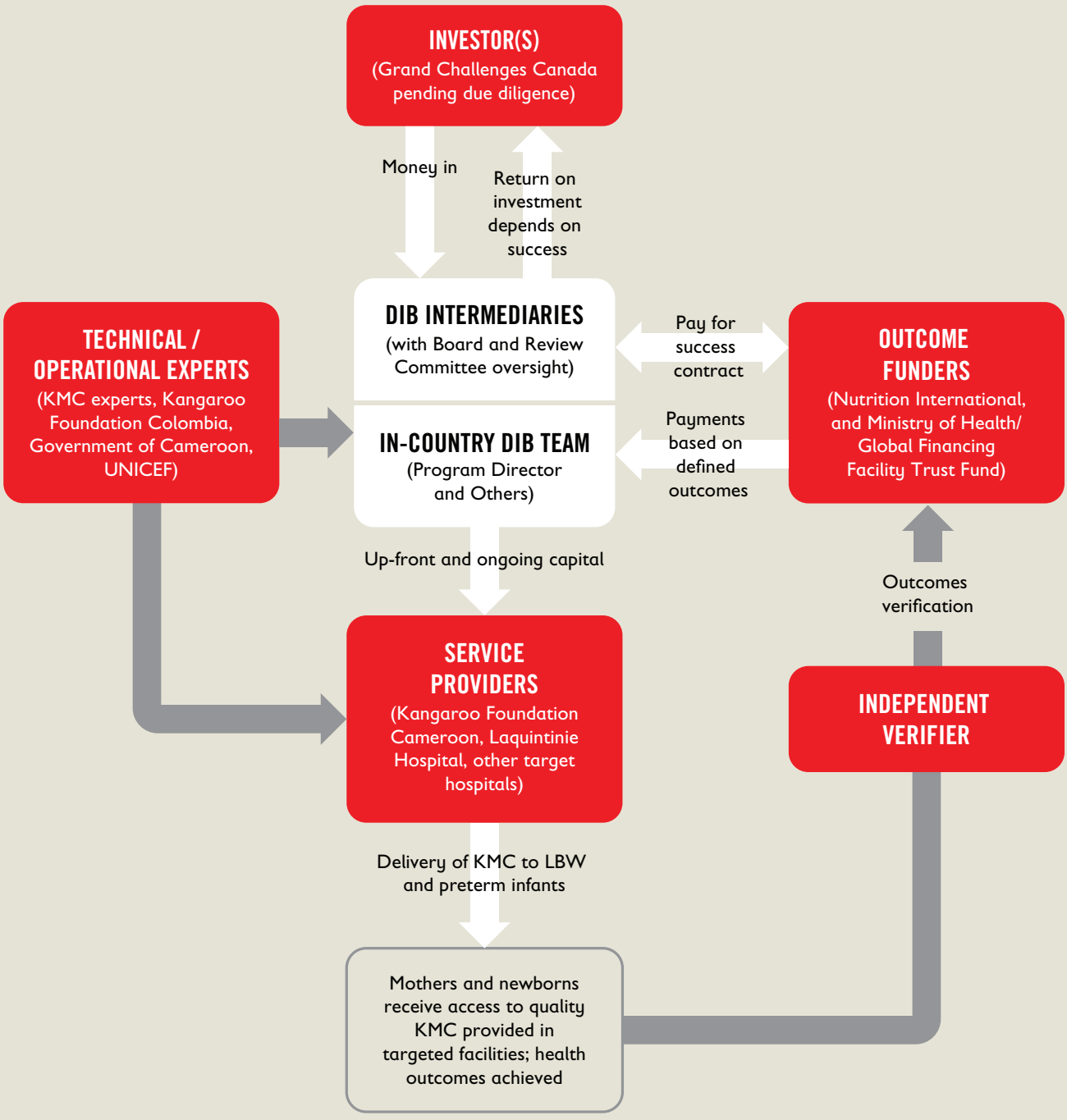
There are many challenges related to creating a DIB, but the DIB model has the potential to transform MNCS financing. This section discusses key potential benefits of the Cameroon DIB that go beyond the primary goal of ensuring the health of thousands of LBW newborns

- **Support country ownership.** Given the previous failure of KMC training to endure in Cameroon, local ownership is important to ensure the Cameroon DIB is sustainable. The DIB is championed locally and will be integrated into Cameroonian government systems. The Cameroonian Ministry of Health will only pay for the intervention if there is proven impact. "A DIB comes with an obligation for results," Dr. Martina Baye from the Ministry said. "We don't just want to go ahead with the usual way of doing things, where you are not sure what the outcome will be." For Grand Challenges Canada's Karlee Silver, part of the appeal of the DIB is the leadership by Cameroon: "They really want to…make this happen, and they really want to see what the promise of this is within their own country."
- **Paradigm shift in development finance.** Stakeholders said that the Cameroon DIB and others like it have the potential not only to improve the health of their target populations, but to set an example that could accelerate change in development finance globally. "From an outcome funder perspective, they are excellent because you've transferred all the risk," said Erik Nielsen of Nutrition International. "From an investor's perspective, you can get quite a good return on this… We should be moving in this direction more aggressively. You're never going to get near [enough] money from ODA [overseas development assistance]. You have to encourage additional sources of money from other sectors to be brought in."
- **Rigorous evaluation.** An integral component of DIBs is a rigorous system of payment metrics. Since investors want specific and measurable metrics to assess program success, DIBs must include strong, independent evaluation. This is a practice that can strengthen the development sector generally, beyond their requirement in DIBs. "One could argue that this is the type of thing we should be doing all the time in terms of vigorous monitoring and evaluation and performance metrics," Karlee Silver of Grand Challenges Canada said. "More often than not in development, we don't go to that level."

PROJECT CHALLENGES

Stakeholders also cited a number of challenges that are instructive in terms of designing a MNCS DIB. As the

CAMEROON NEWBORN DIB STRUCTURE



The exact structure of the DIB is currently being refined, pending legal advice.

Information / Service Flows

Financial Flows

Photo: Save the Children

Maria, 35, from Choco, Colombia is assisted by a nurse from the Kangaroo Foundation on one of her first visits to her baby in the hospital.

timeline and continuing search for an investor demonstrate, DIBs are neither quick nor simple to assemble. MNCS DIBs are in the experimental vanguard of development finance and a work in progress. Given this status, the following are a list of key challenges identified by the Cameroon DIB stakeholders:

- **DIBs are not easily understood and require extra awareness building and education.** "There's a lot of conversation on why we would use this [a DIB] versus [a more traditional grant]," GCC's Silver said. "That [includes] a lot of proof points on how a DIB can transfer responsibility…to the government." Other respondents echoed this challenge. "[It takes time] getting people over the learning curve," the MaRS Centre's Kia Kavoosi said. The lack of understanding includes legal, financial, contractual, and managerial issues. "Accountants are not trained in results-based financing," Erik Nielsen from Nutrition International said. "You need lawyers to provide guidance and advice."
- **DIBs lack a template. Every DIB is bespoke.** "The field is so nascent that it's almost starting from scratch… every single time," Silver said. "[There isn't] a model where they can pull things off the shelf." Dr. Martina Baye from the Cameroon Ministry of Public Health echoed the long timeline required to create a DIB. "It takes a lot of meetings," she said. It also requires detailed mutual understanding of financial, legal, and contractual issues. Much of this design and consensus-building work falls to the project intermediaries – in this case, Social Finance UK and the MaRS Centre. "Any product that is new [includes] transaction costs and time to launch," the MaRS Centre's Kia Kavoosi said. He added that in many early stage DIBs – including the Cameroon DIB – a lot of the up-front work to design the DIB is done pro bono, "to subsidize what would typically be more efficient…for a more mature market."
- **Aligning DIB project stakeholders' incentives and outcomes.** DIBs bring together an array of philanthropic, private sector, bilateral and multilateral donors, and developing nation government stakeholders. But given the specificity with which DIB outcomes and payments must be designed, aligning organizations with differing goals is challenging. "The challenges from our end are…making sure all partners can agree on…outcomes and how they trigger payments," Social Finance's Nita Colaco said. "Making sure that outcomes and incentives are aligned with the theory of change; that…is a unique challenge of DIBs," she added. Kia Kavoosi from the MaRS Centre agreed that designing agreed-upon payment metrics was a challenge: "Everyone cares about the mortality and morbidity of these children, but tying them to payments becomes extremely difficult when you have a lot of attribution problems and confounding variables."

The Utkrisht Impact Bond – Maternal and Newborn Survival in Rajasthan, India

In 2012, India, along with the United States and Ethiopia, convened the Child Survival Call to Action in an effort to re-energize the global child survival movement. This meeting launched the global goal to end preventable child and maternal deaths. Following this global gathering, 178 governments — as well as hundreds of civil society, private sector, and faith-based organizations — pledged to end preventable deaths among women and children.[35]

India was one of the first countries to develop a costed national plan for MNCH and, in recent decades, it has made impressive strides on this front. Between 1990 and 2015, the number of under-5 deaths in India decreased by 62%, from 3,357,000 in 1990 to 1,201,000 in 2015.36 But in spite of its commitment to reduce maternal and child deaths, India still accounts for the largest number of under-5 deaths of any country in the world, and 20% of the global total.[37]

Within India, the state of Rajasthan has one of the country's highest maternal and neonatal mortality rates. While India's overall newborn mortality rate is 28 per 1,000 births, in Rajasthan the rate is 32 per 1,000 births. Similarly, India's overall maternal childbirth mortality rate is 178 per 100,000 births, while in Rajasthan, it's 255 of every 100,000.[38]

Like India as a whole, Rajasthan has advanced in reducing maternal and child mortality. As part of this effort, the government of Rajasthan (GOR) increased the number of women delivering in maternal care facilities. But this intervention did not result in the expected improvement in maternal and newborn survival outcomes. Researchers found that this is at least partially due to the lack of *quality* facilities in the state.[39]

There has been a significant shift in Rajasthan over the past 10 years from home births to hospital births. Due to the increased demand for hospital births, many families – accounting for about 25% of all births in Rajasthan – use private hospitals that are filling the gap in government maternal and newborn health provision.[40] Public facilities are required to meet government quality standards to be considered for reimbursement, but private facilities in Rajasthan are not.[41]

Births in maternal health care facilities will not improve outcomes if they are not high-quality facilities. Therefore, the GOR has prioritized high-quality maternal care as essential to increasing maternal and newborn survival. The Utkrisht Impact Bond is intended to address this lack of quality in private maternal care facilities.

PROJECT OBJECTIVES

The Utkrisht Impact Bond officially launched in November 2017 as the world's first health impact bond. The bond is named for the Hindi expression for excellence.[42] It is intended to improve and standardize the quality of maternal care in Rajasthan's private healthcare facilities. The project will take place over three years, with a projected total investment of $9 million.

The DIB's broad goal is to provide incentives for private facilities to be accredited through the government-approved healthcare facility certification process. This certification will be granted only when private healthcare facilities are upgraded to meet specific maternal care quality standards. The project's implementing partners will guide the targeted private healthcare facilities through quality improvements to meet these government standards, as well as assist them with the application process.

Over the course of the DIB, the intervention is projected to be implemented across the state of Rajasthan, covering a total market of 68 million people, and impacting between 200,000 and 400,000 women and newborn babies. The project partners state that it could save the lives of up to 10,000 women and children in Rajasthan.[43]

Similar to the Cameroon Newborn DIB analyzed above, this pilot project includes country ownership components intended to ensure that project impacts are sustained by the state of Rajasthan. The Rajasthan State Ministry of Health signed an MOU pledging to support the intervention if it is deemed successful by the independent evaluator. The DIB stakeholders also said that one of the reasons for focusing on quality of care was its importance to the GOR. This made

long-term local ownership more likely. "Taking on issues that are high priority to the state [of Rajasthan]…seems like a great idea in terms of sustainability," one stakeholder said.

After implementation is complete, the specific long-term health impacts of the Utkrisht Impact Bond – are projected to include:

- Up to 10,471 women and children saved
- Up to 400,000 patients impacted
- 20% reduction in newborn mortality rate
- 5-6% reduction in maternal mortality rate

These are not outcomes to be measured by the DIB, but are projected impacts if the DIB outputs of improved maternal care facilities are achieved, stakeholders say.

PROJECT STAKEHOLDERS

This section describes the DIB formation process and history, with a focus on how the DIB was conceptualized, the key project stakeholders, and how the contractual foundation for the DIB was created.

Outcome Funders

USAID
Merck for Mothers[44]

Like the Cameroon Newborn DIB, this project will have multiple ***outcome funders.*** USAID and Merck for Mothers will collectively provide up to $8 million in outcome funds. Furthermore, as with the Cameroon Newborn DIB, the Utkrisht Impact Bond includes an MOU with the Rajasthan State Ministry of Health to invest in, and scale-up, the partnership if the pilot program is deemed successful by the independent evaluator.[45]

Joe Wilson, former Senior Advisor for Innovative Finance at USAID, said this DIB is part of the agency's growing emphasis on paying for outcomes. "Performance-based finance is going to be a critical piece of what [USAID Administrator Mark Green] does," Wilson said. "[DIBs] are going to be one of the tools in the tool box to drive an efficiency conversation."

Merck for Mothers has a history of working on maternal health in Rajasthan. It supported the DIB as a way to ramp up its previous work in this region and sector. "What better

THE UTKRISHT IMPACT BOND PARTNERS

United States Agency for International Development (USAID) is an independent federal government agency that receives overall foreign policy guidance from the Secretary of State. USAID has extensive experience in working toward improving maternal and child health globally. The USAID Mission in India will be the key contact for this project.

Merck for Mothers is the 10-year, $500 million initiative of Merck focused on improving the health and well-being of mothers during pregnancy and childbirth through collaborations with governments, multilateral agencies, non-government organizations, businesses, physicians and researchers. Merck is currently working in India to strengthen maternal healthcare in three states, including Rajasthan.

Palladium is a global leader in the development and delivery of positive impact. Palladium has worked in more than 120 countries on more than 600 projects. With 50 years of experience, Palladium has developed technical depth and leadership in the health space and has implemented USAID contracts for over 40 years, predominately in the health sector.

Population Services International (PSI) is a nonprofit organization and a global health network focused on improving health outcomes in the developing world. PSI has programs in 69 countries and has been working in India since 1988 with a focus on maternal health, child survival, and malaria prevention among other areas. The organization also specializes in creating quality health franchises, with 33 franchises in 30 countries.

Hindustan Latex Family Planning Promotion Trust (HLFPPT), established in 1992 as a social enterprise, is a non-profit organization promoted by Hindustan. HLFPPT aims to make available affordable health solutions to help communities overcome healthcare challenges. As one of the largest social franchises in the world, HLFPPT seeks to establish efficient public-private partnerships in order to help people at the bottom of the pyramid.

UBS Optimus Foundation (UBSOF) is a Swiss charitable foundation established by UBS AG in 1999. It supports projects in education, health and child protection by making financial contributions to experience partner organizations. UBSOF acts as a grantor in the first-ever development impact bond launched in India in 2015.

Nurse Rekha Samant counseling a mother of a newborn on Kangaroo Mother Care at the Neonatal Ward of Seth GS Medical College & KEM Hospital in Mumbai, India.

Photo: Ritam Banerjee/Getty Images for Save the Children

Photo: Save the Children

Sunil, two, who is suffering from pneumonia, sits with his mother, Seema, 20. Also in the clinic is his brother, Mohit, nine months, who is suffering from pneumonia and malnutrition. Both children are being cared for by the staff at Tonk General Hospital Rajasthan, India.

way to measure actual results other than have a pay-for-performance type of structure," Scott Higgins of Merck for Mothers said. "You're putting your money where your mouth is….From a scalability standpoint, that makes it attractive… It's a mechanism that you are only paying for results."

Service Providers

Population Services International
Hindustan Latex Family Planning Promotion Trust

Also similar to the Cameroon Newborn DIB, the Utkrisht DIB includes international and local ***service providers***: Washington-based Population Services International (PSI) and the Rajasthan NGO Hindustan Latex Family Planning Promotion Trust (HLFPPT).

PSI's transition to exploring innovative finance began in 2014 as the agency explored the future of international NGOs, which included learning to leverage more private and philanthropic capital. PSI's exploration of the impact bond market initially began with support from Zurich Insurance. Through its work with Zurich Insurance and in conversations with USAID and other development partners, PSI identified a set of proven interventions that might be of interest to potential outcome funders and impact investors. This led to PSI's engagement with USAID and then Palladium, which was exploring its own impact bond in Rajasthan with Merck for Mothers.

Starting with a grant from USAID, the HLFPPT has worked with private health facilities in India for more than a decade. Currently, the social enterprise has a network of 800 private providers across five Indian states. In Rajasthan, HLFPPT has worked with Merck for Mothers to engage the private sector to address maternal and child health issues. With a focus on maternal and newborn health, the Utkrisht DIB is a continuation of previous partnerships between USAID, HLFPPT, and Merck for Mothers.[46]

Intermediary

Palladium

The project ***intermediary*** of the Utkrisht DIB is Palladium. This global consulting firm helped design the DIB and is also the DIB performance manager. This Australian company has been involved in private-sector development for more than 50 years. "Cross-fertilizing with the private sector is what we've been doing most of our existence," Palladium Innovative Impact Financing Lead Peter Vanderwal said. "Impact bonds really spoke to us: the transparency, the engagement. It makes sense for our company to take the leap and to commit to being a partner…because we have the pockets, the risk appetite, and a portfolio of projects across the world."

Independent Verifier

Mathematica Policy Research

Mathematica Policy Research (MPR) will be the project ***independent verifier*** that confirms needed facility quality standards have been achieved, and that outcome payments are warranted.[47] Like many others, MPR stakeholders said that their engagement with the DIB was tied to the focus on maternal and child health, along with the innovative financing structure of the project. "There's a lot of staff

interest in maternal and child health in general, but also in trying to understand this new financing structure and being on the cutting edge of a new area," said MPR Senior Researcher So O'Neil.

Investor

UBS Optimus Foundation

The UBS Optimus Foundation (UBSOF) will play the role of the ***investor*** in this DIB, providing 80% of the $4 million upfront working capital needed for the project. The remaining 20% of investment capital will be provided by other project stakeholders: Palladium, PSI, and the HLFPPT.[48]

UBSOF is the investor in the first-ever DIB, which focused on girls' education and was also launched in Rajasthan in 2015. In this evolving field, UBSOF is rare in terms of its experience with impact bonds. Maya Ziswiler, Head of Social and Financial Innovation for UBSOF, said the organization drew on its experience with the girls' education bond in designing the Utkrisht impact bond. "We leveraged a lot of the thinking we did around the governance structure… and on the contracting side," Ziswiler said. "In the first DIB, we had one service provider. In the new DIB, we have two service providers, which can be more efficient in delivering the outcomes. Part of any DIB is delivering outcomes in a cost-efficient way, so working with several service providers is a step forward."

Supporting impact bonds also aligns with two of USBOF's key priorities. "We've made it a priority to leverage innovative finance to attract private capital on the one side," Ziswiler continued, "and on the other side to make the [development] sector more efficient." Like other MNCS DIB stakeholders, UBS also approached their engagement with DIBs with a "pilot" mindset to test the feasibility, Ziswiler said.

PROJECT POTENTIAL

The Utkrisht maternal care impact stakeholders discussed a range of potential impacts the DIB could generate. This section discusses the key potential benefits as identified by the stakeholders themselves.

- **New coalitions.** One of the major potentials of a DIB is creating new partnerships. To some degree, the Utkrisht impact bond has already achieved that goal. "The ability to leverage funds from multiple partners, identifying non-traditional co-funders we haven't anticipated…is huge," Merck for Mothers' Scott Higgins said. "We probably would not have done co-funding with [the philanthropic arm of a] Swiss bank," Higgins said. "You could fund five projects in India on maternal health and have five different parties funding those projects, and have them work against each other," he added. "[This is a] huge opportunity to align multiple interested parties on the exact same outcomes. That can be pretty powerful."
- **Country ownership.** Stakeholders also emphasized the local ownership potential of the Utkrisht DIB. "It's not a solution being pushed upon a third party in a country that they may not be familiar with," Higgins said. "It's actually the in-country partners delivering innovative approaches." As an organization that has been implementing maternal health care interventions in Rajasthan for decades, PSI also views the potential of the DIB far beyond its three-year project timespan and sees broad relevance for the Rajasthan state health system. "This is a potential mechanism that can be utilized across [Rajasthan] for quality indicators," PSI's Marcie Cook said.
- **Catalyst for organizational transformation.** Global development organizations, donors, and others can also benefit from the new thinking and culture that DIBs can impart. The impact of a DIB can extend beyond the intervention itself, providing local and state organizations and governments with an impetus for change. "It brings a private-sector creativity, and a private-sector discipline, to a sector that doesn't always have that," Cook said. "It's a launch pad for other investments to be made into the DIB over time if it proves to be working. The DIB is about… leveraging capital differently…This is an intervention we can test hypotheses with."

PROJECT CHALLENGES

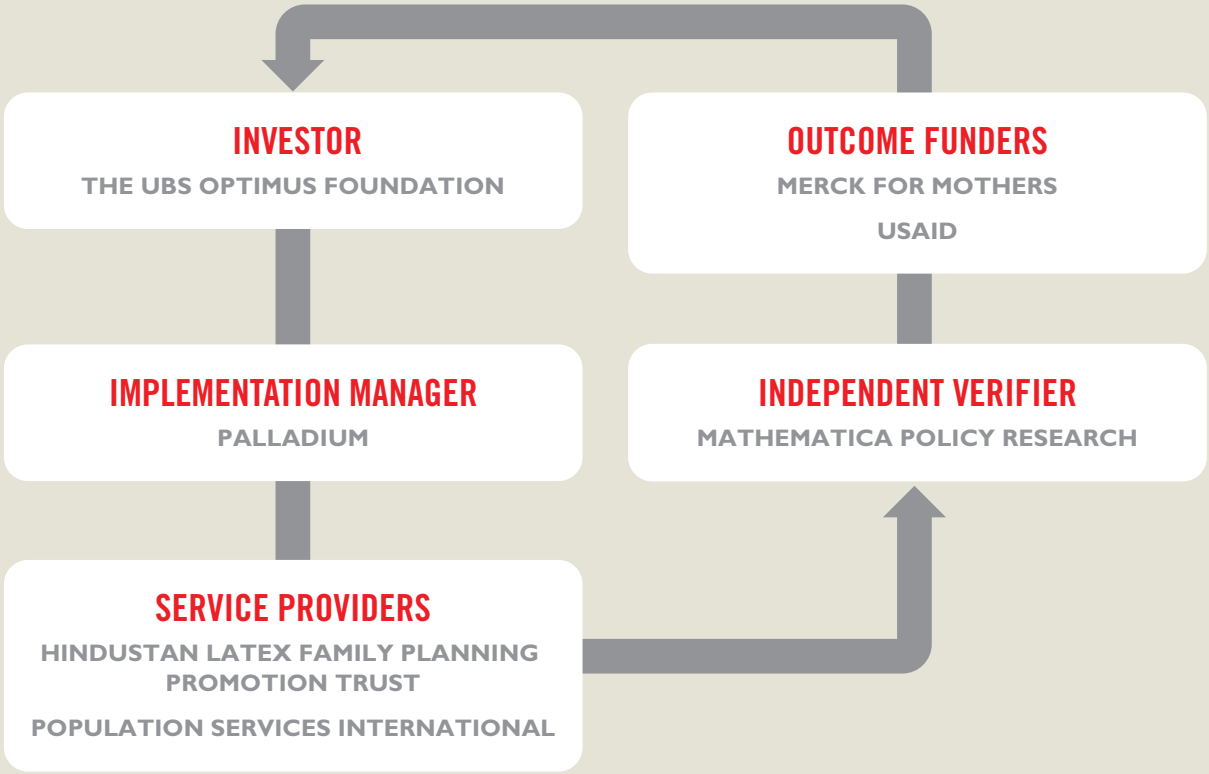
Stakeholders from both DIBs featured in this report cited similar challenges, although the extent of these challenges varied. Key challenges identified by both the Utkrisht DIB stakeholders included:

- **The bespoke nature of DIB formation.** Like the Cameroon Newborn DIB, the lack of a DIB template was a major challenge identified by Utkrisht bond stakeholders. This led to an onerous DIB design process that was clearly identified as the largest challenge for the Utkrisht DIB.

  The lack of a template was compounded by many of the stakeholder organizations' lack of experience operating within the DIB structure, particularly in regard to project finance, contracting, and legal frameworks. "We are trying to go into these [DIBs] with a system and a process that has been established for something that is very different," Marcie Cook of PSI said. Cook's PSI India colleague Pritpal Marjara agreed that building the DIB from scratch was laborious "We spent quite a bit of time developing the theory of change," he said.

  Peter Vanderwal of Palladium, which invested years helping design the Utkrisht impact bond, said the costs of starting the design from scratch were significant. "We tried as much as possible to create templates, so that there was the potential of replicability," Vanderwal said. "I don't believe we achieved that. The contract is too bespoke, the structure is too bespoke, the vehicle too bespoke. There's absolutely no template."
- **Aligning stakeholders' diverse interests.** Also similar to the Cameroon Newborn DIB, aligning diverse organizations' interests was a challenge. "You're going

THE UTKRISHT IMPACT BOND



to have to be flexible in order to make the…parties happy," Cook said. Much of the negotiating centered on defining maternal quality of care indicators and metrics. "The partners come with different objectives," Merck from Mothers Scott Higgins said.

- **Organizational support to participate in the DIB.** Due to the bespoke nature of DIBs, there was often extreme tentativeness among stakeholder organizations' leadership to join the impact bond team. This slowed the formation of the legal, financial, and contractual negotiations needed to create the bond. Palladium's Vanderwal noted the cautiousness of the public sector, in particular, in terms of pay-for-results financing. "Public sector agencies are the most risk averse," he said. But, noting the large start-up costs and lack of structure currently inherent to DIBs, he also noted challenges engaging the private sector. "It's not something that most companies would have the appetite for. We've got to have leadership from government and leadership from donors. They've got to be willing to put in the effort to understand what's needed to structure one of these."

  Somewhat of an outlier on this front, Merck for Mothers stakeholders said it was not difficult to build organizational support for the DIB, despite that it was their first impact bond, and that they had no previous relationship with Palladium. "Merck is into taking risks, so the question of leadership supporting this has never been an issue," Merck for Mothers Director of Operations Scott Higgins said.

Recommendations

DIBs are not intended to replace traditional bilateral or multilateral assistance. The new financing models that fall under titles like *pay-for-performance, pay-for-results,* and *innovative finance* seek to add new funding sources to address social and economic needs in developing and developed countries.

Based on the analysis of the two case studies in this report, several key lessons and recommendations have been identified to make DIBs a more streamlined, cost-effective, and scalable development finance option for the United States and other donors. This is not a definitive statement on MNCS DIBs. It is intended to contribute to the growing knowledge base on how DIBs are formed.

LESSONS LEARNED

- **Key criteria must be in place before deciding whether to launch a MNCS DIB.** To ensure the DIB is launched from a solid foundation, project advisers must analyze whether the cause or idea is suitable for a DIB. According to Social Finance's Nita Colaco, some of the key questions are, "Is there a clearly identifiable target population? Are there clearly measurable outcomes on which payments can be made? Is private financing required?" Colaco said if the proposed project does not meet these and other basic criteria, a DIB might not be the best choice.
- **DIB outcomes must be measurable.** Utkrisht DIB stakeholders said the ability to identify and measure outcomes was crucial. Joe Wilson, formerly of USAID, said that DIBs must be, "Measurable, costable, and quantifiable. The availability of quality data is essential." Given the complex structure of DIBs, agreeing on metrics must also be addressed early in the DIB design. Without addressing this early in the DIB formation process, it can take years for all DBI stakeholders to come to an agreement.
- **Time and energy for stakeholder education must be budgeted at the outset.** Respondents said this was particularly needed among senior organization decision makers. "There's a general level of education and awareness needed before you even start talking about what the opportunity is," Grand Challenges Canada's Karlee Silver said. Dr. Martina Baye added that an important part of Cameroon's involvement in the DIB was generating buy-in from government decision makers. "The very first thing to be done was to sensitize the minister of health and other stakeholders…to understand why they should invest through [a DIB]," she said. "Decision makers need to understand what this means…They want to know the money they are putting on the table will actually bring results."

Jair, 20, holds his baby in kangaroo position. Jair, along his wife Cirley, 17, have been part of the Kangaroo Program for 8 days.

Photo: Erika Pineros

- **Early adopter DIB stakeholders are not motivated solely by profit.** At this early piloting and testing stage, DIBs remain primarily motivated by organizations' and individuals' passion to make an impact and to innovate. Profit is not paramount. "[You need] a group of people who primarily care about the social impact, no matter whether you sit on the investor side or the outcome side," GCC's Karlee Silver said. "You have to care that more low-birth weight newborns in Cameroon are going to get quality KMC. It's not enough of a financial bonus so that a returns-only investor would be interested." Other respondents echoed the emphasis on social impact. "We're finding that the first wave of investors are likely to be more socially motivated," Nita Colaco of Social Finance UK said, "such as foundations, or even high net-worth individuals."

  Similar to those involved in the Cameroon Newborn DIB, Utkrisht stakeholders emphasized the importance of an intrinsic interest in the social issue the DIB addresses. Peter Vanderwal of Palladium said, "Someone [has to want] to pay to resolve that issue…The investors need to be interested in the social challenge."

- **Costing.** While closely related to the importance of outcomes measurement, costing deserves its own discussion in terms of creating a DIB. "From an NGO perspective, we had to do a lot to really understand our costs and be able to present those in a way that we don't [typically] do," Marcie Cook of PSI said. "In a traditional contract, you are not necessarily rewarded for being more efficient at the end of the year."

  Joe Wilson, formerly of USAID, said he spent six months at the beginning of the DIB process working to identify both costs and candidates. "[We were] working with PSI and others on where [outcomes-based finance] is appropriate, and where it's not. What can we measure, what we can cost out," Wilson said. "Having more clarity around that is the first step. If you have no idea what something is going to cost you, you can't possible push it, particularly in this environment, where we have really tight budgets. At the end of the day, if you can measure it and cost it, you are well on your way." Peter Vanderwal of Palladium added: "We can figure out the types of costs, the number of lives saved. So it's a very compelling space to do [a DIB] in."

RECOMMENDATIONS

1) Develop a Central DIBs Platform

Since DIBs are a nascent development finance tool that involve a complex and new array of development stakeholders, they need a more coherent system for aligning varied interests. Specifically, the sector needs ***a central DIBs platform*** where entities interested in taking on one of the various DIB roles can coalesce. These entities may include investors, outcome funders, intermediaries, evaluators, and local and international implementers.

As the case studies above demonstrate, and as one respondent stated, "Doing DIBs ad hoc doesn't work." Given its leadership on global maternal and child health, the United States can use its convening power to assess the nature and utility of a global platform to facilitate DIB supply and demand. The U.S. is well positioned to convene stakeholders on this issue.

Just as it was a leader in the creation of the Global Financing Facility, the U.S. could also lead the creation of a DIB hub. "More and more explicitly, positive impact is around coalitions," Peter Vanderwal of Palladium said. "You need different players to bring different pieces of the jigsaw together."

May Ziswiler of UBS also said a global fund is the future of DIBs: "We are hoping to…move from small transactions to larger transactions, to a fund where you are pooling outcomes funds…where you can attract more mainstream investors."

2) Convene and Educate Internal and External Stakeholders

While a central platform is a long-term tool to mainstream DIBs, a short-term need is for ***potential stakeholders to be educated about what DIBs are, as well as about where, how, and when they can address the maternal and child health goals*** of donors, philanthropists, and others. There are still many misconceptions regarding DIBs, and these need to be demystified for DIBs to be taken up more broadly.

Given its focus on innovative finance, USAID should convene – both within the U.S. government and with its global donor peers – DIB knowledge exchanges. For example, there is already a pay-for-success inter-agency group focused on domestic impact bonds within the U.S. government. As the leading U.S. development agency, USAID should draw from their experience to educate both U.S. government and international donor community practitioners on how to apply DIBs to foreign assistance challenges.

Many of the stakeholders interviewed for this report are *still* learning about DIBs, but became involved because of their eagerness to participate in an innovative development finance project. "We are not there yet, but we are learning how DIBs are structured in terms of the risk, in terms of shifting the accountability to the results and not to the process," Pritpal Marjara of PSI India said. For his part, Joe Wilson, formerly of USAID said: "Having a little bit more collaboration and communication between investors and outcome funders up front, and then allowing them to communicate that out to the entire world of implementing partners, is probably the best starting point."

The Brookings Institution has disseminated multiple DIB research reports that emphasize the importance of educating both potential outcome funders (such as donor agencies, foundations, and governments) and private sector investors.[49] If DIBs are to grow and achieve global reach, these two stakeholder groups must be better educated about when DIBs are an appropriate funding option.

Newborn Ellesi spent several days at the neonatal ward at Queen Elizabeth Hospital, Malawi.

Photo: Save the Children

3) Increase the Evidence Base on What Works for DIBs

MNCS DIBs need a more substantial evidence base. More learning on DIB formation and field impact is needed across the board. DIBs are in the early stages of implementation and evidence building. Ensuring rigorous program evaluations – and disseminating evidence and learnings on the formation process and outcomes – will be important in strengthening the DIB model and building confidence among risk-averse organizations. As Emily Gustafsson-Wright of the Brookings Institution has stated: "Funders want to support interventions and service providers that have a record of achieving outcomes."[50]

4) Institutionalize Innovation Within USAID

The U.S. government must signal its commitment to innovation on maternal and child health. ***To accomplish this, the Administration should provide high-level political support for the Center for Accelerating Innovation and Impact (CII)***.

Established in 2012, the CII resides in USAID's Global Health Bureau and invests seed capital in promising ideas, using a business-minded approach to the development of health interventions. Over the past five years, CII has catalyzed more than $300 million on an annual budget of roughly $5 million.[51]

USAID should empower CII and direct the various USAID missions and program offices within the Bureau for Global Health to devote a small percentage of their annual funding to programs that use CII's development finance expertise. Building and strengthening CII's consulting work within USAID can help integrate its expertise throughout global health programs.

CONCLUSION

As this report shows, there are immense challenges involved in reducing maternal, newborn and child mortality. As domestic revenue mobilization grows, countries are increasingly able to finance their own maternal and child health system enhancements. However, until developing nations become fully self-sufficient, there is a clear, continuing need for other financial mechanisms to fill the gaps in supporting maternal and child survival.

DIBs are a potential tool to meet this challenge.

The United States is a global leader in the fight against maternal and child mortality and has one of the largest investor communities in the world. Given this potential, the U.S. government should be a leader in innovative finance tools such as DIBs.

The need to take calculated risks to achieve efficiency gains is clear: it has been clearly conveyed by both the U.S. legislative and executive branches, and with 15,000 children dying each day from preventable causes, the need for additional sources of funding is urgent. It is now incumbent upon the U.S. development community and its global interlocutors to fully embrace the creation and testing of development impact bonds as an additional tool to continue its lifesaving work for mothers and children around the world.

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Katherine and her newborn baby, Ellesi, spent several days at Queen Elizabeth Hospital, Malawi being taught KMC.

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ON THE COVER: *Zainabu and her seven-day-old son, Yasini, at the Kangaroo Mother Ward in Mtwara District Hospital, Tanzania.*
Photo: Colin Crowley / Save the Children